State of Minnesota

HOUSE OF REPRESENTATIVES

NINETIETH SESSION

H. F. No. 887

02/06/2017 Authored by Murphy, E.; Loeffler; Moran and Bernardy
The bill was read for the first time and referred to the Committee on Health and Human Services Finance

A bill for an act

relating to state government; establishing the health and human services budget; modifying provisions governing children and family services, chemical and mental health services, community supports, direct care and treatment, operations, health care, continuing care, managed care, housing, health licensing boards, and Department of Health programs; requiring reports; modifying fees; making technical changes; appropriating money; amending Minnesota Statutes 2016, sections 13.69, subdivision 1; 103I.005, subdivisions 2, 2a, 12, 20a, 21, by adding subdivisions; 103I.101, subdivisions 2, 5, 6; 103I.105; 103I.111, subdivisions 6, 8; 103I.205, subdivisions 1, 2, 3, 4, 5, 6; 103I.208, subdivisions 1, 2; 103I.235, by adding a subdivision; 103I.301, subdivisions 1, 2; 103I.315, subdivision 1; 103I.501; 103I.505, subdivisions 1, 2; 103I.515; 103I.525, subdivisions 1, 2, 5, 6, 8; 103I.531, subdivisions 2, 5; 103I.535, subdivisions 2, 6; 103I.541, subdivisions 1, 2, 2a, 2b, 2c, 2e, 3, 4, 5; 103I.545; 103I.601, subdivisions 2, 4; 103I.711, subdivision 1; 103I.715, subdivision 2; 119B.011, subdivisions 6, 19, 20, 20a, by adding subdivisions; 119B.02, subdivisions 1, 5; 119B.025, subdivision 1, by adding subdivisions; 119B.03, subdivisions 3, 9; 119B.05, subdivision 1; 119B.09, subdivisions 1, 4, 9a; 119B.10, subdivision 1, by adding a subdivision; 119B.11, subdivision 2a; 119B.12, subdivision 2; 119B.125, subdivisions 1b, 4, 6, by adding subdivisions; 119B.13, subdivisions 1, 6; 119B.16, subdivisions 1, 1a, 1b, by adding subdivisions; 144.0724, subdivision 6; 144.122; 144.218, subdivision 5; 144.226, subdivision 1; 144.3831, subdivision 1; 144A.071, subdivision 4d; 144A.472, subdivision 7; 144D.03, by adding a subdivision; 144E.35, subdivision 1; 144G.02, subdivision 2; 146B.02, subdivisions 2, 3, 5, 8, by adding subdivisions; 146B.03, subdivisions 6, 7; 146B.07, subdivisions 2, 4; 146B.10, subdivisions 1, 2, by adding a subdivision; 147.01, subdivision 7; 147.02, subdivision 1; 147.03, subdivision 1; 147B.08, by adding a subdivision; 147C.40, by adding a subdivision; 148.514, subdivision 1; 148.519, subdivisions 1, 2; 148.5194, subdivisions 2, 3, 4, 7, by adding a subdivision; 148.5195, subdivision 2; 148.59; 148.6405; 148.6420, subdivisions 1, 5; 148.6445, subdivisions 1, 2, 3, by adding a subdivision; 148.997, subdivision 1; 148E.180; 153A.14, subdivisions 1, 2; 153A.17; 157.16, subdivisions 1, 3, 3a; 245.4661, subdivision 9; 245.4889, subdivision 1; 245.814, by adding a subdivision; 245A.03, subdivisions 2, 7; 245A.04, subdivisions 1, 4; 245A.07, subdivision 3; 245A.09, subdivision 7; 245A.10, subdivisions 2, 4; 245A.14, by adding a subdivision; 245A.151; 245A.16, subdivision 1, by adding a subdivision; 245A.18, subdivision 2; 245A.191; 245A.40, subdivisions 1, 2, 3, 4, 7, by adding a subdivision; 245A.50, subdivisions 2, 7, 9; 245C.02, by adding a subdivision; 245C.03, subdivision 1, by adding a subdivision; 245C.04, subdivisions 1, 8; 245C.05, subdivisions 2b, 4, 5, 7; 245C.08, subdivisions 1, 2, 4; 245C.09, by

adding a subdivision; 245C.10, subdivision 9, by adding subdivisions; 245C.11, subdivision 3; 245C.15; 245C.16, subdivision 1; 245C.17, subdivision 6; 245C.21, subdivision 1; 245C.22, subdivisions 5, 7; 245C.23; 245C.24, subdivision 3; 245C.25; 245C.30, subdivision 2; 245D.03, subdivision 1; 245E.01, by adding a subdivision; 245E.02, subdivisions 1, 3, 4; 245E.03, subdivisions 2, 4; 245E.04; 245E.05, subdivision 1; 245E.06, subdivisions 1, 2, 3; 245E.07, subdivision 1; 246.014; 246B.05; 246B.10; 252.41, subdivision 3; 253B.19, subdivision 1, by adding a subdivision; 254A.01; 254A.02, subdivisions 2, 3, 5, 6, 8, 10, by adding subdivisions; 254A.03; 254A.035, subdivision 1; 254A.04; 254A.08; 254A.09; 254A.19, subdivision 3; 254B.01, subdivision 3, by adding a subdivision; 254B.03, subdivision 2; 254B.04, subdivisions 1, 2b; 254B.05, subdivisions 1, 1a, 5; 254B.051; 254B.07; 254B.08; 254B.09; 254B.12, subdivision 2; 254B.13, subdivision 2a; 256.01, by adding a subdivision; 256.045, subdivision 3a; 256.962, subdivision 5, by adding a subdivision; 256.9686, subdivision 8; 256.969, subdivisions 1, 2b, 3a, 3c, 4b, 8, 8c, 9, 12; 256.975, subdivision 7, by adding a subdivision; 256.98, subdivision 8; 256B.04, subdivisions 21, 22; 256B.055, subdivisions 2, 7, by adding a subdivision; 256B.056, subdivisions 1b, 3b, 3c, 3d, by adding subdivisions; 256B.057, subdivision 9; 256B.059, subdivision 6; 256B.0625, subdivisions 3a, 6a, 7, 18h, 30, 45a, 57, by adding a subdivision; 256B.0651, subdivision 17; 256B.0652, subdivision 4; 256B.0653; 256B.0659, subdivisions 11, 21; 256B.0755, subdivisions 1, 2, 3, 4, 7; 256B.0915, subdivision 1; 256B.092, subdivision 4; 256B.0943, subdivision 9; 256B.0945, subdivisions 2, 4; 256B.15, subdivisions 1, 1a, 2; 256B.199; 256B.431, subdivisions 10, 16, 30; 256B.434, subdivisions 4, 4f; 256B.49, subdivision 11; 256B.4912, by adding a subdivision; 256B.4913, subdivision 4a, by adding a subdivision; 256B.4914, subdivisions 2, 3, 5, 6, 8, 10; 256B.50, subdivision 1b; 256B.75; 256B.76, subdivisions 1, 2, 4, by adding a subdivision; 256B.761; 256B.766; 256B.85, subdivision 16; 256C.21; 256C.23, subdivisions 1, 2, by adding subdivisions; 256C.233, subdivisions 1, 2, 4; 256C.24; 256C.25, subdivision 1; 256C.261; 256C.30; 256D.44, subdivisions 4, 5; 256I.03, subdivision 8; 256I.04, subdivisions 1, 2d, 2g, 3; 256I.05, subdivisions 1a, 1c, 1e, 1j, 1m, 8; 256I.06, subdivisions 2, 8; 256L.03, subdivisions 1, 1a, 5; 256L.04, by adding a subdivision; 256L.05, by adding a subdivision; 256L.11, subdivision 7; 256L.15, subdivision 2; 256N.26, subdivision 5; 256N.27, subdivisions 2, 4; 256P.05, subdivision 1; 256P.07, subdivisions 3, 6; 256R.02, subdivisions 4, 18; 256R.10, by adding a subdivision; 256R.40, subdivision 5; 256R.41; 256R.47; 256R.49, subdivision 1; 257.73, subdivision 1, by adding a subdivision; 327.15, subdivision 3; 364.09; 518.68, subdivision 2; 518A.40, subdivision 4, by adding a subdivision; 626.556, subdivisions 2, 3, 3c, 4, 10b, 10d, 10e, 10f, 10i; 626.557, subdivisions 4, 9, 12b, 18; 626.5572, subdivisions 2, 4; 626.559, subdivision 1; Laws 2012, chapter 247, article 6, section 2, subdivision 2; proposing coding for new law in Minnesota Statutes, chapters 103I; 119B; 144; 147A; 245A; 256B; 256I; 256L; 256R; proposing coding for new law as Minnesota Statutes, chapter 245G; repealing Minnesota Statutes 2016, sections 103I.005, subdivisions 8, 14, 15; 103I.451; 119B.07; 119B.125, subdivision 5; 119B.16, subdivision 2; 144.0571; 147A.21; 147B.08, subdivisions 1, 2, 3; 147C.40, subdivisions 1, 2, 3, 4; 245A.1915; 245A.192; 245C.11, subdivision 4; 245C.16, subdivision 3; 245C.17, subdivision 4; 245E.03, subdivision 3; 245E.06, subdivisions 4, 5; 246B.06; 252.41, subdivision 8; 252.451; 254A.02, subdivision 4; 256.9692; 256B.0625, subdivision 25a; 256B.0659, subdivision 22; 256B.4914, subdivision 16; 256B.64; 256B.69, subdivisions 1, 2, 3, 3a, 3b, 4, 4b, 5, 5a, 5b, 5c, 5d, 5f, 5g, 5h, 5i, 5j, 5k, 6, 6a, 6b, 6d, 7, 8, 9, 9a, 9c, 9d, 9e, 10, 11, 16, 17, 18, 19, 20, 21, 22, 23, 25, 26, 27, 28, 29, 30, 31, 32a, 33, 34, 35; 256C.23, subdivision 3; 256C.25, subdivision 2; Minnesota Rules, parts 3400.0185, subpart 5; 5600.2500; 9503.0145, subpart 6; 9530.6405, subparts 1, 1a, 2, 3, 4, 5, 6, 7, 7a, 8, 9, 10, 11, 12, 13, 14, 14a, 15, 15a, 16, 17, 17a, 17b, 17c, 18, 20, 21; 9530.6410; 9530.6415; 9530.6420; 9530.6422; 9530.6425; 9530.6430; 9530.6435; 9530.6440; 9530.6445; 9530.6450; 9530.6455; 9530.6460;

9530.6465; 9530.6470; 9530.6475; 9530.6480; 9530.6485; 9530.6490; 9530.6495; 9530.6500; 9530.6505.

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

ARTICLE 1

COMMUNITY SUPPORTS

Section 1. Minnesota Statutes 2016, section 245A.03, subdivision 7, is amended to read:

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

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

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

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

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

(5) new foster care licenses or community residential setting licenses determined to be needed by the commissioner for the transition of people from personal care assistance to the home and community-based services.~~:~~ ;

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

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

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

(7) new foster care licenses or community residential setting licenses determined to be needed by the commissioner for people receiving services under chapter 245D while residing in an unlicensed setting before May 1, 2017, and for which a license is required, as determined by the commissioner. The exception is available until June 30, 2018. This exception is available when:

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

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

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

(c) When an adult resident served by the program moves out of a foster home that is not the primary residence of the license holder according to section 256B.49, subdivision 15, paragraph (f), or the adult community residential setting, the county shall immediately inform the Department of Human Services Licensing Division. The department shall decrease the statewide licensed capacity for adult foster care settings where the physical location is not the primary residence of the license holder, or for adult community residential settings, if the voluntary changes described in paragraph (e) are not sufficient to meet the savings required by reductions in licensed bed capacity under Laws 2011, First Special Session

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

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

(e) A resource need determination process, managed at the state level, using the available reports required by section 144A.351, and other data and information shall be used to determine where the reduced capacity required under paragraph (c) will be implemented. The commissioner shall consult with the stakeholders described in section 144A.351, and employ a variety of methods to improve the state's capacity to meet long-term care service needs within budgetary limits, including seeking proposals from service providers or lead agencies to change service type, capacity, or location to improve services, increase the independence of residents, and better meet needs identified by the long-term care services reports and statewide data and information. By February 1, 2013, and August 1, 2014, and each following year, the commissioner shall provide information and data on the overall capacity of licensed long-term care services, actions taken under this subdivision to manage

statewide long-term care services and supports resources, and any recommendations for change to the legislative committees with jurisdiction over health and human services budget.

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

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

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

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

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

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

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

stipulated in the statement of intended use required under Minnesota Rules, part 2960.3000, subpart 4;

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

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

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

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

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

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

(1) intervention services, including:

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

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

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

(2) in-home support services, including:

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

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

(iii) semi-independent living services;

(3) residential supports and services, including:

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

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

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

(4) day services, including:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 4. Minnesota Statutes 2016, section 256B.0625, subdivision 6a, is amended to read:

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

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

Sec. 5. Minnesota Statutes 2016, section 256B.0625, subdivision 7, is amended to read:

Subd. 7. **Home care nursing.** Medical assistance covers home care nursing services in a recipient's home. Recipients who are authorized to receive home care nursing services in their home may use approved hours outside of the home during hours when normal life activities take them outside of their home. To use home care nursing services at school, the recipient or responsible party must provide written authorization in the care plan identifying the chosen provider and the daily amount of services to be used at school. Medical assistance does not cover home care nursing services for residents of a hospital, nursing facility, intermediate care facility, or a health care facility licensed by the commissioner of health, ~~except as authorized in section 256B.64 for ventilator-dependent recipients in hospitals or~~ unless a resident who is otherwise eligible is on leave from the facility and the facility either pays for the home care nursing services or forgoes the facility per diem for the leave days that home care nursing services are used. Total hours of service and payment allowed for services outside the home cannot exceed that which is otherwise allowed in an in-home setting according to sections 256B.0651 and 256B.0654 . All home care nursing services must be provided according to the limits established under sections 256B.0651, 256B.0653, and 256B.0654. Home care nursing services may not be reimbursed if the nurse is the family foster care provider of a recipient who is under age 18, unless allowed under section 256B.0654, subdivision 4.

Sec. 6. Minnesota Statutes 2016, section 256B.0651, subdivision 17, is amended to read:

Subd. 17. **Recipient protection.** (a) Providers of home care services must provide each recipient with a copy of the home care bill of rights under section 144A.44 at least 30 days prior to terminating services to a recipient, if the termination results from provider sanctions ~~under section 256B.064~~ imposed by the commissioner, such as a payment withhold, a suspension of participation, or a notice of termination of participation. If a home care provider determines it is unable to continue providing services to a recipient, the provider must notify the recipient, the recipient's responsible party, and the commissioner 30 days prior to terminating services to the recipient because of an action ~~under section 256B.064~~ taken by the commissioner, and must assist the commissioner and lead agency in supporting the recipient in transitioning to another home care provider of the recipient's choice.

(b) In the event of a payment withhold from a home care provider, a suspension of participation, or a notice of termination of participation of a home care provider ~~under~~

~~section 256B.064~~ imposed by the commissioner, the commissioner may inform the Office of Ombudsman for Long-Term Care and the lead agencies for all recipients with active service agreements with the provider. At the commissioner's request, the lead agencies must contact recipients to ensure that the recipients are continuing to receive needed care, and that the recipients have been given free choice of provider if they transfer to another home care provider. In addition, the commissioner or the commissioner's delegate may directly notify recipients who receive care from the provider that payments have been withheld or that the ~~provider's~~ provider has been notified of a suspension or termination of participation in medical assistance ~~has been suspended or terminated~~, if the commissioner determines that notification is necessary to protect the welfare of the recipients. For purposes of this subdivision, "lead agencies" means counties, tribes, and managed care organizations.

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

Sec. 7. Minnesota Statutes 2016, section 256B.0652, subdivision 4, is amended to read:

Subd. 4. **Home health services.** Home health services including skilled nurse visits and home health aide visits must be authorized by the commissioner or the commissioner's designee. Authorization must be based on medical necessity and cost-effectiveness when compared with other care options. The commissioner must receive the request for authorization of skilled nurse visits and home health aide visits, including qualifying documentation of the face-to-face encounter as specified in section 256B.0653, subdivision 7, within 20 working days of the start of service. When home health services are used in combination with personal care and home care nursing, the cost of all home care services shall be considered for cost-effectiveness.

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

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

256B.0653 HOME HEALTH ~~AGENCY~~ SERVICES.

Subdivision 1. **Scope.** This section applies to home health ~~agency~~ services including home health aide, skilled nursing visits, physical therapy, occupational therapy, respiratory therapy, and speech-language pathology therapy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) Home care therapies must be:

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

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

(3) assessed by an appropriate therapist; and

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

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

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

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

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

(2) the following skilled nurse visits:

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

(ii) administering or assisting with medication administration, including injections, prefilling syringes for injections, or oral medication setup of an adult recipient, when, as determined and documented by the registered nurse, the need can be met by an available

pharmacy or the recipient or a family member is physically and mentally able to self-administer or prefill a medication;

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

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

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

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

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

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

and

(5) home health services without documentation of a face-to-face encounter according to subdivision 7.

Subd. 7. **Face-to-face encounter.** (a) A face-to-face encounter by a provider must be completed for all home health services, regardless of whether the service requires prior authorization. The face-to-face encounter may occur through telemedicine according to section 256B.0625, subdivision 3b. The encounter must be related to the primary reason the recipient requires home health services and must occur within 90 days before service begins or within 30 days after service begins. The face-to-face encounter may be conducted by a practitioner licensed in Minnesota to practice a profession described in section 214.01, subdivision 2:

(1) a physician;

(2) a nurse practitioner or clinical nurse specialist;

(3) a certified nurse midwife;

(4) a physician assistant; or

(5) for a recipient admitted to home health service immediately after an acute or postacute stay, the attending recipient's acute or postacute physician.

(b) A practitioner described in paragraph (a), clauses (2) to (5), performing the face-to-face encounter must communicate the clinical findings to the ordering physician. The clinical findings must be documented in the recipient's medical record.

(c) To ensure clinical correlation between the face-to-face encounter and the associated home health services, the ordering physician must:

(1) document that the face-to-face encounter related to the primary reason the recipient requires home health services occurred within the required time frames;

(2) indicate the practitioner who conducted the face-to-face encounter; and

(3) indicate the date of the face-to-face encounter.

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

Sec. 9. Minnesota Statutes 2016, section 256B.0659, subdivision 11, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(10) be limited to providing and being paid for up to ~~275~~ 310 hours per month of personal care assistance services regardless of the number of recipients being served or the number of personal care assistance provider agencies enrolled with. The number of hours worked per day shall not be disallowed by the department unless in violation of the law.

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

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

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

Sec. 10. Minnesota Statutes 2016, section 256B.0915, subdivision 1, is amended to read:

Subdivision 1. **Authority.** (a) The commissioner is authorized to apply for a home and community-based services waiver for the elderly, authorized under section 1915(c) of the Social Security Act, in order to obtain federal financial participation to expand the availability

of services for persons who are eligible for medical assistance. The commissioner may apply for additional waivers or pursue other federal financial participation which is advantageous to the state for funding home care services for the frail elderly who are eligible for medical assistance. The provision of waivered services to elderly and disabled medical assistance recipients must comply with the criteria for service definitions and provider standards approved in the waiver.

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

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

Sec. 11. Minnesota Statutes 2016, section 256B.092, subdivision 4, is amended to read:

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

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

(c) Home and community-based resources for all recipients shall be managed by the county of financial responsibility within an allowable reimbursement average established for each county. Payments for home and community-based services provided to individual recipients shall not exceed amounts authorized by the county of financial responsibility.

For specifically identified former residents of nursing facilities, the commissioner shall be responsible for authorizing payments and payment limits under the appropriate home and community-based service program. Payment is available under this subdivision only for persons who, if not provided these services, would require the level of care provided in an intermediate care facility for persons with developmental disabilities.

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

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

Sec. 12. Minnesota Statutes 2016, section 256B.49, subdivision 11, is amended to read:

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

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

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

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

(4) obtain federal financial participation.

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

(c) The commissioner shall provide interested persons serving on agency advisory committees, task forces, the Centers for Independent Living, and others who request to be on a list to receive, notice of, and an opportunity to comment on, at least 30 days before any effective dates, (1) any substantive changes to the state's disability services program manual, or (2) changes or amendments to the federally approved applications for home and community-based waivers, prior to their submission to the federal Centers for Medicare and Medicaid Services.

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

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

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

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

Sec. 13. Minnesota Statutes 2016, section 256B.4912, is amended by adding a subdivision to read:

Subd. 11. **Annual data submission.** (a) As determined by the commissioner, a provider of home and community-based services for the elderly under section 256B.0915, home and community-based services for people with developmental disabilities under section 256B.092, and home and community-based services for people with disabilities under section 256B.49 shall submit data to the commissioner on the following:

(1) wages of workers;

(2) hours worked;

(3) benefits paid and accrued;

(4) staff retention rates;

(5) amount of overtime paid;

(6) amount of travel time paid;

(7) vacancy rates; and

(8) other related data requested by the commissioner.

(b) The commissioner may adjust reporting requirements for a self-employed worker.

(c) This subdivision also applies to a provider of personal care assistance services under section 256B.0625, subdivision 19a; community first services and supports under section 256B.85; consumer support grants under section 256.476; nursing services and home health services under section 256B.0625, subdivision 6a; home care nursing services under section 256B.0625, subdivision 7; or day training and habilitation services for residents of

intermediate care facilities for persons with developmental disabilities under section 256B.501.

(d) A provider shall submit the data annually on a date specified by the commissioner. The commissioner shall give a provider at least 30 calendar days to submit the data. If a provider fails to timely submit the requested data, medical assistance reimbursement may be delayed.

(e) Individually identifiable data submitted to the commissioner in this section are considered private data on an individual, as defined by section 13.02, subdivision 12.

(f) The commissioner shall analyze data annually for workforce assessments and how the data impact service access.

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

Sec. 14. Minnesota Statutes 2016, section 256B.4913, subdivision 4a, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 15. Minnesota Statutes 2016, section 256B.4913, is amended by adding a subdivision to read:

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

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

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

Sec. 16. Minnesota Statutes 2016, section 256B.4914, subdivision 2, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) for day services under subdivision 7:

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

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

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

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

(D) after December 31, 2017, 15 minute units must be used for fewer than six hours of time spent providing direct services and transportation;

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

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

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

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

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

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

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

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

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

Sec. 17. Minnesota Statutes 2016, section 256B.4914, subdivision 3, is amended to read:

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

(1) 24-hour customized living;

(2) adult day care;

(3) adult day care bath;

(4) behavioral programming;

(5) companion services;

(6) customized living;

(7) day training and habilitation;

(8) housing access coordination;

(9) independent living skills;

(10) in-home family support;

(11) night supervision;

(12) personal support;

(13) prevocational services;

(14) residential care services;

(15) residential support services;

(16) respite services;

(17) structured day services;

~~(18) supported employment services;~~

~~(19)~~ (18) supported living services;

~~(20)~~ (19) transportation services; ~~and~~

(20) independent living skills specialist services;

(21) individualized home supports;

(22) employment exploration services;

(23) employment development services;

(24) employment support services; and

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

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

Sec. 18. Minnesota Statutes 2016, section 256B.4914, subdivision 5, is amended to read:

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

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

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

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

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

(3) for residential asleep-overnight staff, the wage will be $7.66 per hour, except in a family foster care setting, the wage is $2.80 per hour;

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

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

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

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

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

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

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

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

(12) for individualized home supports, 40 percent of the median wage for social worker (SOC code 21-1029); 30 percent of the median wage for social and human services assistant (SOC code 21-1093); and 30 percent of the median wage for community and social service specialist (SOC code 21-1099);

~~(11)~~ (13) for services authorized through December 31, 2017, for supported employment staff, 20 percent of the median wage for nursing ~~aide~~ assistant (SOC code ~~31-1012~~ 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(14) effective January 1, 2018, for employment support services staff, 50 percent rehabilitation counselor (SOC code 21-1015); and 50 percent community and social services specialist (SOC code 21-1099);

(15) for employment exploration services staff, 20 percent rehabilitation counselor (SOC code 21-1015); 50 percent social and human services assistant (SOC code 21-1093); and 30 percent community and social services specialist (SOC code 21-1099);

(16) for employment development services staff, 50 percent education, guidance, school, and vocational counselors (SOC code 21-1012); and 50 percent community and social services specialist (SOC code 21-1099);

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

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

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

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

~~(16)~~ (21) for supervisory staff, the basic wage is $17.43 per hour with exception of the supervisor of behavior analyst and behavior specialists, which must be $30.75 per hour;

~~(17)~~ (22) for registered nurse, the basic wage is $30.82 per hour; and

~~(18)~~ (23) for licensed practical nurse, the basic wage is $18.64 per hour.

(b) Component values for residential support services are:

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

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

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

(4) general administrative support ratio: 13.25 percent;

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

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

(c) Component values for family foster care are:

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

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

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

(4) general administrative support ratio: 3.3 percent;

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

(6) absence factor: 1.7 percent.

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

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

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

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

(4) program plan support ratio: 5.6 percent;

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

(6) general administrative support ratio: 13.25 percent;

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

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

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

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

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

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

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

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

(6) general administrative support ratio: 13.25 percent;

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

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

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

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

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

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

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

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

(6) general administrative support ratio: 13.25 percent;

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

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

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

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

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

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

(4) general administrative support ratio: 13.25 percent;

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

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

(h) On July 1, 2017, the commissioner shall update the base wage index in paragraph (a) based on the wage data by standard occupational code (SOC) from the Bureau of Labor Statistics available on December 31, 2016. The commissioner shall publish these updated values and load them into the rate management system. This adjustment occurs every five years. For adjustments in 2021 and beyond, the commissioner shall use the data available on December 31 of the calendar year five years prior.

(i) On July 1, 2017, the commissioner shall update the framework components in paragraphs ~~(b) to (g)~~ (d), clause (5); (e), clause (5); and (f), clause (5); subdivision 6, clauses (8) and (9); and subdivision 7, clauses (10), (16), and (17), for changes in the Consumer Price Index. The commissioner will adjust these values higher or lower by the percentage change in the Consumer Price Index-All Items, United States city average (CPI-U) from January 1, 2014, to January 1, 2017. The commissioner shall publish these updated values and load them into the rate management system. This adjustment occurs every five years.

For adjustments in 2021 and beyond, the commissioner shall use the data available on January 1 of the calendar year four years prior and January 1 of the current calendar year.

(j) The commissioner must ensure that wage values and component values in subdivisions 5 to 9 reflect the cost to provide a service. As determined by the commissioner, a provider enrolled to provide services with rates determined under this section must submit business cost data to the commissioner in concurrence with the five-year provider revalidation cycle. Reporting elements include, but are not limited to:

(1) worker wage costs;

(2) benefits paid;

(3) supervisor wage costs;

(4) executive wage costs;

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

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

(7) administrative costs paid;

(8) program costs paid;

(9) transportation costs paid;

(10) vacancy rates; and

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

(k) A provider must submit cost component data with provider revalidation and reenrollment required under section 256B.04, subdivision 22. If a provider fails to submit required reporting data, the commissioner may disenroll the provider.

(l) The commissioner shall conduct a random audit of data submitted under paragraph (j) to ensure data accuracy.

(m) The commissioner shall analyze cost documentation in paragraph (j) and submit recommendations on component value and inflationary factor adjustments to the chairs and ranking minority members of the legislative committees with jurisdiction over human services every four years beginning January 1, 2020. The commissioner shall make recommendations in conjunction with reports submitted to the legislature according to subdivision 10, paragraph (e).

(n) In this subdivision, if Bureau of Labor Statistics occupational codes or Consumer Price Index items are unavailable in the future, the commissioner shall recommend codes or items to update and replace missing component values.

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

Sec. 19. Minnesota Statutes 2016, section 256B.4914, subdivision 6, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(f) Beginning January 1, 2018, for foster care and supportive living services provided in a corporate setting and with rates calculated in this section, the number of days authorized must not exceed 350 days in an annual service span.

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

Sec. 20. Minnesota Statutes 2016, section 256B.4914, subdivision 8, is amended to read:

Subd. 8. **Payments for unit-based services with programming.** Payments for unit-based services with programming, including behavior programming, housing access coordination,

in-home family support, independent living skills training, independent living skills specialist services, individualized home supports, hourly supported living services, employment exploration services, employment development services, and ~~supported~~ employment support services provided to an individual outside of any day or residential service plan must be calculated as follows, unless the services are authorized separately under subdivision 6 or 7:

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

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

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

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

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

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

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

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

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

(10) this is the subtotal rate;

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

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

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

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

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

Sec. 21. Minnesota Statutes 2016, section 256B.4914, subdivision 10, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) service utilization;

(3) county and tribal allocation changes; and

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

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

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

~~(j)~~ (h) When the available shared staffing hours in a residential setting are insufficient to meet the needs of an individual who enrolled in residential services after January 1, 2014, or insufficient to meet the needs of an individual with a service agreement adjustment

described in section 256B.4913, subdivision 4a, paragraph (f), then individual staffing hours shall be used.

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

Sec. 22. Minnesota Statutes 2016, section 256B.85, subdivision 16, is amended to read:

Subd. 16. **Support workers requirements.** (a) Support workers shall:

(1) enroll with the department as a support worker after a background study under chapter 245C has been completed and the support worker has received a notice from the commissioner that the support worker:

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

(ii) is disqualified, but has received a set-aside of the disqualification under section 245C.22;

(2) have the ability to effectively communicate with the participant or the participant's representative;

(3) have the skills and ability to provide the services and supports according to the participant's CFSS service delivery plan and respond appropriately to the participant's needs;

(4) complete the basic standardized CFSS training as determined by the commissioner before completing enrollment. The training must be available in languages other than English and to those who need accommodations due to disabilities. CFSS support worker training must include successful completion of the following training components: basic first aid, vulnerable adult, child maltreatment, OSHA universal precautions, basic roles and responsibilities of support workers including information about basic body mechanics, emergency preparedness, orientation to positive behavioral practices, orientation to responding to a mental health crisis, fraud issues, time cards and documentation, and an overview of person-centered planning and self-direction. Upon completion of the training components, the support worker must pass the certification test to provide assistance to participants;

(5) complete employer-directed training and orientation on the participant's individual needs;

(6) maintain the privacy and confidentiality of the participant; and

(7) not independently determine the medication dose or time for medications for the participant.

(b) The commissioner may deny or terminate a support worker's provider enrollment and provider number if the support worker:

(1) does not meet the requirements in paragraph (a);

(2) fails to provide the authorized services required by the employer;

(3) has been intoxicated by alcohol or drugs while providing authorized services to the participant or while in the participant's home;

(4) has manufactured or distributed drugs while providing authorized services to the participant or while in the participant's home; or

(5) has been excluded as a provider by the commissioner of human services, or by the United States Department of Health and Human Services, Office of Inspector General, from participation in Medicaid, Medicare, or any other federal health care program.

(c) A support worker may appeal in writing to the commissioner to contest the decision to terminate the support worker's provider enrollment and provider number.

(d) A support worker must not provide or be paid for more than ~~275~~ 310 hours of CFSS per month, regardless of the number of participants the support worker serves or the number of agency-providers or participant employers by which the support worker is employed. The department shall not disallow the number of hours per day a support worker works unless it violates other law.

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

Sec. 23. Minnesota Statutes 2016, section 256C.21, is amended to read:

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

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

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

Sec. 24. Minnesota Statutes 2016, section 256C.23, subdivision 1, is amended to read:

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

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

Sec. 25. Minnesota Statutes 2016, section 256C.23, is amended by adding a subdivision to read:

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

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

Sec. 26. Minnesota Statutes 2016, section 256C.23, subdivision 2, is amended to read:

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

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

Sec. 27. Minnesota Statutes 2016, section 256C.23, is amended by adding a subdivision to read:

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

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

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

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

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

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

Sec. 28. Minnesota Statutes 2016, section 256C.233, subdivision 1, is amended to read:

Subdivision 1. **Deaf and Hard-of-Hearing Services Division.** The ~~commissioners~~ commissioner of human services~~, education, employment and economic development, and health~~ shall create ~~a distinct and separate~~ an organizational unit to be known as the Deaf

and Hard-of-Hearing Services Division to address the developmental, social, ~~educational, and occupational~~ mental health, communication access, and human service needs of persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing ~~persons~~ through a statewide network of ~~collaborative~~ services and by ~~coordinating the promulgation of~~ implementing public policies, regulations, legislation, services, and programs affecting persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing ~~persons~~. ~~An interdepartmental management team shall advise the activities of the Deaf and Hard-of-Hearing Services Division.~~ The commissioner of human services shall ~~coordinate the work of the interagency management team and~~ receive legislative appropriations for the division.

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

Sec. 29. Minnesota Statutes 2016, section 256C.233, subdivision 2, is amended to read:

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

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

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

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

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

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

Sec. 30. Minnesota Statutes 2016, section 256C.233, subdivision 4, is amended to read:

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

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

Sec. 31. Minnesota Statutes 2016, section 256C.24, is amended to read:

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

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

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

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

(i) teaching communication strategies and coping skills;

(ii) offering guidance and problem solving assistance;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 32. Minnesota Statutes 2016, section 256C.25, subdivision 1, is amended to read:

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

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

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

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

Sec. 33. Minnesota Statutes 2016, section 256C.261, is amended to read:

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

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

The commissioner shall award grants for the purposes of:

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

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

(b) The commissioner may make grants:

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

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

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

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

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

Sec. 34. Minnesota Statutes 2016, section 256C.30, is amended to read:

256C.30 DUTIES OF HUMAN SERVICES COMMISSIONER.

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

(b) The grant agreements must provide for:

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

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

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

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

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

Sec. 35. **FEDERAL WAIVER AMENDMENTS.**

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

services. The commissioner shall submit all necessary waiver amendments by October 1, 2017.

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

Sec. 36. **TRANSPORTATION STUDY.**

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

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

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

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

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

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

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

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

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

Sec. 37. **RATE INCREASE FOR SELF-DIRECTED WORKFORCE NEGOTIATIONS.**

(a) The commissioner of human services shall:

(1) increase reimbursement rates, grants, or allocations by 3.09 percent for services provided on or after July 1, 2017;

(2) increase reimbursement rates, grants, or allocations by 0.1 percent for services provided on or after July 1, 2018; and

(3) increase the reimbursement rates, grants, or allocations by an additional ten percent for services provided on or after July 1, 2018, for service recipients with complex needs, defined as recipients with eligibility for 12 or more hours of personal care assistance services per day according to Minnesota Statutes, section 256B.0652.

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

EFFECTIVE DATE. This section is effective if the labor agreement between the state and SEIU Healthcare Minnesota according to Laws 2013, chapter 128, article 2, is ratified by the legislature. The commissioner of human services shall notify the revisor of statutes when ratification occurs.

Sec. 38. **FEDERAL WAIVER REQUESTS.**

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

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

Sec. 39. **REPEALER.**

(a) Minnesota Statutes 2016, sections 252.451; 256B.4914, subdivision 16; 256C.23, subdivision 3; and 256C.25, subdivision 2, are repealed.

(b) Minnesota Statutes 2016, section 252.41, subdivision 8, is repealed.

(c) Minnesota Statutes 2016, section 256B.64, is repealed.

EFFECTIVE DATE. Paragraph (a) is effective the day following final enactment. Paragraph (b) is effective when sections 2, 3, and 16 become effective. The commissioner of human services shall notify the revisor of statutes when sections 2, 3, and 16 are effective. Paragraph (c) is effective July 1, 2017.

ARTICLE 2

HOUSING

Section 1. **[256B.051] HOUSING SUPPORT SERVICES.**

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

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

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

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

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

(e) "Individual with a disability" means:

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

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

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

(g) "Segregated setting" means:

(1) a registered housing with services establishment under chapter 144D;

(2) a licensed board and lodge facility;

(3) a licensed boarding care facility;

(4) a licensed adult foster care;

(5) intensive residential treatment (IRTs); or

(6) a supervised living facility.

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

(1) is 18 years of age or older;

(2) is enrolled in medical assistance;

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

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

(5) has housing instability evidenced by:

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

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

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

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

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

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

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

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

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

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

(b) Housing transition services are defined as:

(1) tenant screening and housing assessment;

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

(3) identifying resources to cover one-time moving expenses;

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

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

(6) developing a housing support crisis plan.

(c) Housing and tenancy sustaining services include:

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

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

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

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

(5) assistance with housing recertification process;

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

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

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

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

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

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

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

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

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

EFFECTIVE DATE. (a) Subdivisions 1 to 6 are contingent upon federal approval and not effective until nine months after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

(b) Subdivision 7 is contingent upon federal approval of subdivisions 1 to 6 and not effective until ten months after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 2. Minnesota Statutes 2016, section 256D.44, subdivision 4, is amended to read:

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

(1) a physician certifies that the absence is not expected to continue for more than three months;

(2) a physician certifies that the recipient will be able to return to independent living; and

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

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

Sec. 3. Minnesota Statutes 2016, section 256D.44, subdivision 5, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(b)~~ (c) Payment for nonrecurring special needs must be allowed for necessary home repairs or necessary repairs or replacement of household furniture and appliances using the payment standard of the AFDC program in effect on July 16, 1996, for these expenses, as long as other funding sources are not available.

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

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

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

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

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

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

(iii) home and community-based waiver recipients living in their own home or rented or leased apartment ~~which is not owned, operated, or controlled by a provider of service not related by blood or marriage, unless allowed under paragraph (g)~~.

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

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

~~(g) Notwithstanding this subdivision, to access housing and services as provided in paragraph (f), the recipient may choose housing that may be owned, operated, or controlled by the recipient's service provider. When housing is controlled by the service provider, the individual may choose the individual's own service provider as provided in section 256B.49, subdivision 23, clause (3). When the housing is controlled by the service provider, the service provider shall implement a plan with the recipient to transition the lease to the recipient's name. Within two years of signing the initial lease, the service provider shall transfer the lease entered into under this subdivision to the recipient. In the event the landlord denies this transfer, the commissioner may approve an exception within sufficient time to ensure the continued occupancy by the recipient. This paragraph expires June 30, 2016.~~

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

Sec. 4. Minnesota Statutes 2016, section 256I.03, subdivision 8, is amended to read:

Subd. 8. **Supplementary services.** "Supplementary services" means housing support services provided to ~~residents of group residential housing providers~~ individuals in addition to room and board including, but not limited to, oversight and up to 24-hour supervision, medication reminders, assistance with transportation, arranging for meetings and appointments, and arranging for medical and social services.

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

Sec. 5. Minnesota Statutes 2016, section 256I.04, subdivision 1, is amended to read:

Subdivision 1. **Individual eligibility requirements.** An individual is eligible for and entitled to a ~~group residential~~ housing support payment to be made on the individual's behalf if the agency has approved the ~~individual's residence in a group residential~~ setting where

the individual will receive housing ~~setting~~ support and the individual meets the requirements in paragraph (a) or (b).

(a) The individual is aged, blind, or is over 18 years of age and disabled as determined under the criteria used by the title II program of the Social Security Act, and meets the resource restrictions and standards of section 256P.02, and the individual's countable income after deducting the (1) exclusions and disregards of the SSI program, (2) the medical assistance personal needs allowance under section 256B.35, and (3) an amount equal to the income actually made available to a community spouse by an elderly waiver participant under the provisions of sections 256B.0575, paragraph (a), clause (4), and 256B.058, subdivision 2, is less than the monthly rate specified in the agency's agreement with the provider of ~~group residential~~ housing support in which the individual resides.

(b) The individual meets a category of eligibility under section 256D.05, subdivision 1, paragraph (a), clauses (1), (3), (5) to (9), and (14), and paragraph (b), if applicable, and the individual's resources are less than the standards specified by section 256P.02, and the individual's countable income as determined under section 256P.06, less the medical assistance personal needs allowance under section 256B.35 is less than the monthly rate specified in the agency's agreement with the provider of ~~group residential~~ housing support in which the individual resides.

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

Sec. 6. Minnesota Statutes 2016, section 256I.04, subdivision 2d, is amended to read:

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

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

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

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

Sec. 7. Minnesota Statutes 2016, section 256I.04, subdivision 2g, is amended to read:

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

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

Sec. 8. Minnesota Statutes 2016, section 256I.04, subdivision 3, is amended to read:

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

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

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

(3) notwithstanding the provisions of subdivision 2a, for up to 190 supportive housing units in Anoka, Dakota, Hennepin, or Ramsey County for homeless adults with a mental illness, a history of substance abuse, or human immunodeficiency virus or acquired immunodeficiency syndrome. For purposes of this section, "homeless adult" means a person who is living on the street or in a shelter or discharged from a regional treatment center, community hospital, or residential treatment program and has no appropriate housing

available and lacks the resources and support necessary to access appropriate housing. At least 70 percent of the supportive housing units must serve homeless adults with mental illness, substance abuse problems, or human immunodeficiency virus or acquired immunodeficiency syndrome who are about to be or, within the previous six months, has been discharged from a regional treatment center, or a state-contracted psychiatric bed in a community hospital, or a residential mental health or chemical dependency treatment program. If a person meets the requirements of subdivision 1, paragraph (a), and receives a federal or state housing subsidy, the ~~group residential~~ housing support rate for that person is limited to the supplementary rate under section 256I.05, subdivision 1a, and is determined by subtracting the amount of the person's countable income that exceeds the MSA equivalent rate from the ~~group residential~~ housing support supplementary service rate. A resident in a demonstration project site who no longer participates in the demonstration program shall retain eligibility for a ~~group residential~~ housing support payment in an amount determined under section 256I.06, subdivision 8, using the MSA equivalent rate. Service funding under section 256I.05, subdivision 1a, will end June 30, 1997, if federal matching funds are available and the services can be provided through a managed care entity. If federal matching funds are not available, then service funding will continue under section 256I.05, subdivision 1a;

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

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

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

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

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

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

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

Sec. 9. Minnesota Statutes 2016, section 256I.05, subdivision 1a, is amended to read:

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

due to a primary diagnosis of mental illness or chemical dependency and shall apply for a waiver if it is determined to be cost-effective.

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

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

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

Sec. 10. Minnesota Statutes 2016, section 256I.05, subdivision 1c, is amended to read:

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

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

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

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

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

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

(f) Until June 30, 1994, an agency may increase by up to five percent the total rate paid for recipients of assistance under sections 256D.01 to 256D.21 or 256D.33 to 256D.54 who reside in residences that are licensed by the commissioner of health as a boarding care home, but are not certified for the purposes of the medical assistance program. However, an increase under this clause must not exceed an amount equivalent to 65 percent of the 1991 medical assistance reimbursement rate for nursing home resident class A, in the geographic grouping in which the facility is located, as established under Minnesota Rules, parts 9549.0051 to 9549.0058.

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

Sec. 11. Minnesota Statutes 2016, section 256I.05, subdivision 1e, is amended to read:

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

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

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

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

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

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

(2) operates a 62-bed facility; and

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

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

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

Sec. 12. Minnesota Statutes 2016, section 256I.05, subdivision 1j, is amended to read:

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

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

Sec. 13. Minnesota Statutes 2016, section 256I.05, subdivision 1m, is amended to read:

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

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

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

Sec. 14. Minnesota Statutes 2016, section 256I.05, subdivision 8, is amended to read:

Subd. 8. **State participation.** For a ~~resident of a group residence~~ person who is eligible under section 256I.04, subdivision 1, paragraph (b), state participation in the ~~group residential~~ housing support payment is determined according to section 256D.03, subdivision 2. For a ~~resident of a group residence~~ person who is eligible under section 256I.04, subdivision 1, paragraph (a), state participation in the ~~group residential~~ housing support rate is determined according to section 256D.36.

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

Sec. 15. Minnesota Statutes 2016, section 256I.06, subdivision 2, is amended to read:

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

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

Sec. 16. Minnesota Statutes 2016, section 256I.06, subdivision 8, is amended to read:

Subd. 8. **Amount of ~~group residential~~ housing support payment.** (a) The amount of a ~~group residential housing~~ room and board payment to be made on behalf of an eligible individual is determined by subtracting the individual's countable income under section 256I.04, subdivision 1, for a whole calendar month from the ~~group residential housing charge~~ room and board rate for that same month. The ~~group residential~~ housing ~~charge~~ support payment is determined by multiplying the ~~group residential~~ housing support rate times the period of time the individual was a resident or temporarily absent under section 256I.05, subdivision 1c, paragraph (d).

(b) For an individual with earned income under paragraph (a), prospective budgeting must be used to determine the amount of the individual's payment for the following six-month period. An increase in income shall not affect an individual's eligibility or payment amount until the month following the reporting month. A decrease in income shall be effective the first day of the month after the month in which the decrease is reported.

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

Sec. 17. **[256I.09] COMMUNITY LIVING INFRASTRUCTURE.**

Each calendar year, the commissioner shall allocate funding to agencies for: (1) outreach to locate and engage people who are homeless or residing in institutions or facilities to screen for basic needs and assist with referral to community living resources, (2) housing resource specialist staff to provide technical assistance and consultation on housing and related support service resources for persons with both disabilities and low income, or (3) administration and monitoring activities related to housing support funds. The commissioner shall allocate funding according to indicators of need, such as poverty rates and housing cost burden. An agency may partner with another agency. The commissioner may adjust allocations to partnered agencies to reflect regional coordination.

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

Sec. 18. **REVISOR'S INSTRUCTION.**

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

subpart headnotes; and in other terminology necessary as a result of the enactment of this section.

Column A	Column B	Column C
144A.071, subdivision 4d	group residential housing	housing support under chapter 256I
201.061, subdivision 3	group residential housing	setting authorized to provide housing support
244.052, subdivision 4c	group residential housing facility	licensed setting authorized to provide housing support under section 256I.04
245.466, subdivision 7	under group residential housing	by housing support under chapter 256I
245.466, subdivision 7	from group residential housing	from housing support
245.4661, subdivision 6	group residential housing	housing support under chapter 256I
245C.10, subdivision 11	group residential housing or supplementary services	housing support
256.01, subdivision 18	group residential housing	housing support under chapter 256I
256.017, subdivision 1	group residential housing	housing support
256.98, subdivision 8	group residential housing	housing support under chapter 256I
256B.49, subdivision 15	group residential housing	housing support under chapter 256I
256B.4914, subdivision 10	group residential housing rate 3 costs	housing support rate 3 costs under chapter 256I
256B.501, subdivision 4b	group residential housing	housing support
256B.77, subdivision 12	residential services covered under the group residential housing program	housing support services under chapter 256I
256D.44, subdivision 2	group residential housing facility	setting authorized to provide housing support
256G.01, subdivision 3	group residential housing	housing support under chapter 256I
256I.01	Group Residential Housing	Housing Support
256I.02	Group Residential Housing	Housing Support
256I.03, subdivision 2	"Group residential housing"	"Room and board"
256I.03, subdivision 2	Group residential housing	The room and board
256I.03, subdivision 3	"Group residential housing"	"Housing support"
256I.03, subdivision 6	group residential housing	room and board
256I.03, subdivisions 7 and 9	group residential housing	housing support
256I.04, subdivisions 1a, 1b, 1c, and 2	group residential housing	housing support

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

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

ARTICLE 3

CONTINUING CARE

Section 1. Minnesota Statutes 2016, section 144.0724, subdivision 6, is amended to read:

Subd. 6. **Penalties for late or nonsubmission.** (a) A facility that fails to complete or submit an assessment according to subdivisions 4 and 5 for a RUG-IV classification within seven days of the time requirements listed in the Long-Term Care Facility Resident Assessment Instrument User's Manual is subject to a reduced rate for that resident. The reduced rate shall be the lowest rate for that facility. The reduced rate is effective on the day of admission for new admission assessments, on the ARD for significant change in status assessments, or on the day that the assessment was due for all other assessments and continues in effect until the first day of the month following the date of submission and acceptance of the resident's assessment.

(b) If loss of revenue due to penalties incurred by a facility for any period of 92 days are equal to or greater than ~~1.0~~ 0.1 percent of the total operating costs on the facility's most recent annual statistical and cost report, a facility may apply to the commissioner of human services for a reduction in the total penalty amount. The commissioner of human services, in consultation with the commissioner of health, may, at the sole discretion of the commissioner of human services, limit the penalty for residents covered by medical assistance to ~~15~~ ten days.

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

Sec. 2. Minnesota Statutes 2016, section 144A.071, subdivision 4d, is amended to read:

Subd. 4d. **Consolidation of nursing facilities.** (a) The commissioner of health, in consultation with the commissioner of human services, may approve a request for consolidation of nursing facilities which includes the closure of one or more facilities and the upgrading of the physical plant of the remaining nursing facility or facilities, the costs of which exceed the threshold project limit under subdivision 2, clause (a). The commissioners shall consider the criteria in this section, section 144A.073, and section ~~256B.437~~ 256R.40, in approving or rejecting a consolidation proposal. In the event the commissioners approve the request, the commissioner of human services shall calculate an external fixed costs rate adjustment according to clauses (1) to (3):

(1) the closure of beds shall not be eligible for a planned closure rate adjustment under section ~~256B.437, subdivision 6~~ 256R.40, subdivision 5;

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

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

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

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

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

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

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

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

(6) the savings from not paying planned closure rate adjustments that the facilities would otherwise be eligible for under section ~~256B.437~~ 256R.40; and

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

(c) For purposes of the calculation in paragraph (a), clause (3), the estimated medical assistance resident days of the remaining facility or facilities shall be computed assuming 95 percent occupancy multiplied by the historical percentage of medical assistance resident days of the remaining facility or facilities, as reported on the facility's or facilities' most

recent nursing facility statistical and cost report filed before the plan of closure is submitted, multiplied by 365.

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

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

(1) submit an application for closure according to section ~~256B.437, subdivision 3~~ 256R.40, subdivision 2; and

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

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

EFFECTIVE DATE. This section is effective for consolidations occurring after July 1, 2017.

Sec. 3. Minnesota Statutes 2016, section 144D.03, is amended by adding a subdivision to read:

Subd. 1b. **Fee for data collection; assisted living.** At the time for the annual registration under subdivision 1, the commissioner shall assess an annual fee on each establishment with an assisted living designation as defined in chapter 144G to pay the commissioner of human services for costs related to collecting data from residents on quality of life and quality of care. The revenue from the fee shall be deposited in the general fund. The fee is nonrefundable. The fee for each establishment shall be $28.60 multiplied by the total maximum resident capacity.

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

Sec. 4. Minnesota Statutes 2016, section 144G.02, subdivision 2, is amended to read:

Subd. 2. **Authority of commissioner.** (a) The commissioner, upon receipt of information that may indicate the failure of a housing with services establishment, the arranged home

care provider, an assisted living client, or an assisted living client's representative to comply with a legal requirement to which one or more of the entities may be subject, shall make appropriate referrals to other governmental agencies and entities having jurisdiction over the subject matter. The commissioner may also make referrals to any public or private agency the commissioner considers available for appropriate assistance to those involved.

(b) In addition to the authority with respect to licensed home care providers under section 144A.45 and with respect to housing with services establishments under chapter 144D, the commissioner shall have standing to bring an action for injunctive relief in the district court in the district in which a housing with services establishment is located to compel the housing with services establishment or the arranged home care provider to meet the requirements of this chapter or other requirements of the state or of any county or local governmental unit to which the establishment or arranged home care provider is otherwise subject. Proceedings for securing an injunction may be brought by the commissioner through the attorney general or through the appropriate county attorney. The sanctions in this section do not restrict the availability of other sanctions.

(c) The commissioner, in consultation with the commissioner of human services, shall survey establishment residents to gather data on resident quality of life and quality of care.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 5. Minnesota Statutes 2016, section 245D.03, subdivision 1, is amended to read:

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

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

(1) in-home and out-of-home respite care services as defined in section 245A.02, subdivision 15, and under the brain injury, community alternative care, community access for disability inclusion, developmental disability, and elderly waiver plans, excluding out-of-home respite care provided to children in a family child foster care home licensed under Minnesota Rules, parts 2960.3000 to 2960.3100, when the child foster care license holder complies with the requirements under section 245D.06, subdivisions 5, 6, 7, and 8,

or successor provisions; and section 245D.061 or successor provisions, which must be stipulated in the statement of intended use required under Minnesota Rules, part 2960.3000, subpart 4;

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

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

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

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

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

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

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

(1) intervention services, including:

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

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

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

(2) in-home support services, including:

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

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

(iii) semi-independent living services;

(3) residential supports and services, including:

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

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

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

(4) day services, including:

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

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

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

(5) supported employment as defined under the brain injury, developmental disability, and community access for disability inclusion waiver plans.

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

Sec. 6. Minnesota Statutes 2016, section 256.975, subdivision 7, is amended to read:

Subd. 7. **Consumer information and assistance and long-term care options counseling; Senior LinkAge Line.** (a) The Minnesota Board on Aging shall operate a statewide service to aid older Minnesotans and their families in making informed choices about long-term care options and health care benefits. Language services to persons with limited English language skills may be made available. The service, known as Senior LinkAge Line, shall serve older adults as the designated Aging and Disability Resource Center under United States Code, title 42, section 3001, the Older Americans Act Amendments of 2006 in partnership with the Disability Linkage Line under section 256.01, subdivision 24, and must be available during business hours through a statewide toll-free number and the Internet. The Minnesota Board on Aging shall consult with, and when appropriate work through, the area agencies on aging counties, and other entities that serve

aging and disabled populations of all ages, to provide and maintain the telephone infrastructure and related support for the Aging and Disability Resource Center partners which agree by memorandum to access the infrastructure, including the designated providers of the Senior LinkAge Line and the Disability Linkage Line.

(b) The service must provide long-term care options counseling by assisting older adults, caregivers, and providers in accessing information and options counseling about choices in long-term care services that are purchased through private providers or available through public options. The service must:

(1) develop and provide for regular updating of a comprehensive database that includes detailed listings in both consumer- and provider-oriented formats that can provide search results down to the neighborhood level;

(2) make the database accessible on the Internet and through other telecommunication and media-related tools;

(3) link callers to interactive long-term care screening tools and make these tools available through the Internet by integrating the tools with the database;

(4) develop community education materials with a focus on planning for long-term care and evaluating independent living, housing, and service options;

(5) conduct an outreach campaign to assist older adults and their caregivers in finding information on the Internet and through other means of communication;

(6) implement a messaging system for overflow callers and respond to these callers by the next business day;

(7) link callers with county human services and other providers to receive more in-depth assistance and consultation related to long-term care options;

(8) link callers with quality profiles for nursing facilities and other home and community-based services providers developed by the commissioners of health and human services;

(9) develop an outreach plan to seniors and their caregivers with a particular focus on establishing a clear presence in places that seniors recognize and:

(i) place a significant emphasis on improved outreach and service to seniors and their caregivers by establishing annual plans by neighborhood, city, and county, as necessary, to address the unique needs of geographic areas in the state where there are dense populations of seniors;

(ii) establish an efficient workforce management approach and assign community living specialist staff and volunteers to geographic areas as well as aging and disability resource center sites so that seniors and their caregivers and professionals recognize the Senior LinkAge Line as the place to call for aging services and information;

(iii) recognize the size and complexity of the metropolitan area service system by working with metropolitan counties to establish a clear partnership with them, including seeking county advice on the establishment of local aging and disabilities resource center sites; and

(iv) maintain dashboards with metrics that demonstrate how the service is expanding and extending or enhancing its outreach efforts in dispersed or hard to reach locations in varied population centers;

(10) incorporate information about the availability of housing options, as well as registered housing with services and consumer rights within the MinnesotaHelp.info network long-term care database to facilitate consumer comparison of services and costs among housing with services establishments and with other in-home services and to support financial self-sufficiency as long as possible. Housing with services establishments and their arranged home care providers shall provide information that will facilitate price comparisons, including delineation of charges for rent and for services available. The commissioners of health and human services shall align the data elements required by section 144G.06, the Uniform Consumer Information Guide, and this section to provide consumers standardized information and ease of comparison of long-term care options. The commissioner of human services shall provide the data to the Minnesota Board on Aging for inclusion in the MinnesotaHelp.info network long-term care database;

(11) provide long-term care options counseling. Long-term care options counselors shall:

(i) for individuals not eligible for case management under a public program or public funding source, provide interactive decision support under which consumers, family members, or other helpers are supported in their deliberations to determine appropriate long-term care choices in the context of the consumer's needs, preferences, values, and individual circumstances, including implementing a community support plan;

(ii) provide Web-based educational information and collateral written materials to familiarize consumers, family members, or other helpers with the long-term care basics, issues to be considered, and the range of options available in the community;

(iii) provide long-term care futures planning, which means providing assistance to individuals who anticipate having long-term care needs to develop a plan for the more distant future; and

(iv) provide expertise in benefits and financing options for long-term care, including Medicare, long-term care insurance, tax or employer-based incentives, reverse mortgages, private pay options, and ways to access low or no-cost services or benefits through volunteer-based or charitable programs;

(12) using risk management and support planning protocols, provide long-term care options counseling under clause (13) to current residents of nursing homes deemed appropriate for discharge by the commissioner~~, former residents of nursing homes who were discharged to community settings, and older adults who request service after consultation with the Senior LinkAge Line under clause (13). The Senior LinkAge Line shall also receive referrals from the residents or staff of nursing homes.~~ who meet a profile that demonstrates that the consumer is either at risk of readmission to a nursing home or hospital, or would benefit from long-term care options counseling to age in place. The Senior LinkAge Line shall identify and contact residents or patients deemed appropriate ~~for discharge~~ by developing targeting criteria and creating a profile in consultation with the commissioner ~~who~~. The commissioner shall provide designated Senior LinkAge Line contact centers with a list of current or former nursing home residents or people discharged from a hospital or for whom Medicare home care has ended, that meet the criteria as being appropriate for ~~discharge planning~~ long-term care options counseling through a referral via a secure Web portal. Senior LinkAge Line shall provide these residents, if they indicate a preference to receive long-term care options counseling, with initial assessment and, if appropriate, a referral to:

(i) long-term care consultation services under section 256B.0911;

(ii) designated care coordinators of contracted entities under section 256B.035 for persons who are enrolled in a managed care plan; or

(iii) the long-term care consultation team for those who are eligible for relocation service coordination due to high-risk factors or psychological or physical disability; and

(13) develop referral protocols and processes that will assist certified health care homes, Medicare home care, and hospitals to identify at-risk older adults and determine when to refer these individuals to the Senior LinkAge Line for long-term care options counseling under this section. The commissioner is directed to work with the commissioner of health to develop protocols that would comply with the health care home designation criteria and protocols available at the time of hospital discharge or the end of Medicare home care. The commissioner shall keep a record of the number of people who choose long-term care options counseling as a result of this section.

(c) Nursing homes shall provide contact information to the Senior LinkAge Line for residents identified in paragraph (b), clause (12), to provide long-term care options counseling pursuant to paragraph (b), clause (11). The contact information for residents shall include all information reasonably necessary to contact residents, including first and last names, permanent and temporary addresses, telephone numbers, and e-mail addresses.

(d) The Senior LinkAge Line shall determine when it is appropriate to refer a consumer who receives long-term care options counseling under paragraph (b), clause (12) or (13), and who uses an unpaid caregiver to the self-directed caregiver service under subdivision 12.

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

Sec. 7. Minnesota Statutes 2016, section 256.975, is amended by adding a subdivision to read:

Subd. 12. **Self-directed caregiver grants.** Beginning on July 1, 2019, the Minnesota Board on Aging shall administer self-directed caregiver grants to support at risk family caregivers of older adults or others eligible under the Older Americans Act of 1965, United States Code, title 42, chapter 35, sections 3001 to 3058ff, to sustain family caregivers in the caregivers' roles so older adults can remain at home longer. The board shall give priority to consumers referred under section 256.975, subdivision 7, paragraph (d).

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

Sec. 8. Minnesota Statutes 2016, section 256B.431, subdivision 10, is amended to read:

Subd. 10. **Property rate adjustments and construction projects.** A nursing facility completing a construction project that is eligible for a rate adjustment under section 256B.434, subdivision 4f, and that was not approved through the moratorium exception process in section 144A.073 must request from the commissioner a property-related payment rate adjustment. ~~If the request is made within 60 days after the construction project's completion date,~~ The effective date of the rate adjustment is the first of the month of January or July, whichever occurs immediately following the construction project's completion date and submission of the provider's rate adjustment request. ~~If the request is made more than 60 days after the completion date, the rate adjustment is effective on the first of the month following the request.~~ The commissioner shall provide a rate notice reflecting the allowable costs within 60 days after receiving all the necessary information to compute the rate adjustment. No sooner than the effective date of the rate adjustment for the construction project, a nursing facility may adjust its rates by the amount anticipated to be allowed. Any

amounts collected from private pay residents in excess of the allowable rate must be repaid to private pay residents with interest at the rate used by the commissioner of revenue for the late payment of taxes and in effect on the date the rate increase is effective. Construction projects with completion dates within one year of the completion date associated with the property rate adjustment request and phased projects with project completion dates within three years of the last phase of the phased project must be aggregated for purposes of the minimum thresholds in subdivisions 16 and 17, and the maximum threshold in section 144A.071, subdivision 2. "Construction project" and "project construction costs" have the meanings given them in Minnesota Statutes, section 144A.071, subdivision 1a.

EFFECTIVE DATE. This section is effective for projects completed after January 1, 2018.

Sec. 9. Minnesota Statutes 2016, section 256B.431, subdivision 16, is amended to read:

Subd. 16. **Major additions and replacements; equity incentive.** For rate years beginning after June 30, 1993, if a nursing facility acquires capital assets in connection with a project approved under the moratorium exception process in section 144A.073 or in connection with an addition to or replacement of buildings, attached fixtures, or land improvements for which the total historical cost of those capital asset additions exceeds the lesser of $150,000 or ten percent of the most recent appraised value, the nursing facility shall be eligible for an equity incentive payment rate as in paragraphs (a) to (d). This computation is separate from the determination of the nursing facility's rental rate. An equity incentive payment rate as computed under this subdivision is limited to one in a 12-month period.

(a) An eligible nursing facility shall receive an equity incentive payment rate equal to the allowable historical cost of the capital asset acquired, minus the allowable debt directly identified to that capital asset, multiplied by the equity incentive factor as described in paragraphs (b) and (c), and divided by the nursing facility's occupancy factor under subdivision 3f, paragraph (c). This amount shall be added to the nursing facility's total payment rate and shall be effective the same day as the incremental increase in paragraph (d) or subdivision 17. The allowable historical cost of the capital assets and the allowable debt shall be determined as provided in Minnesota Rules, parts 9549.0010 to 9549.0080, and this section.

(b) The equity incentive factor shall be determined under clauses (1) to (4):

(1) divide the initial allowable debt in paragraph (a) by the initial historical cost of the capital asset additions referred to in paragraph (a), then cube the quotient,

(2) subtract the amount calculated in clause (1) from the number one,

(3) determine the difference between the rental factor and the lesser of two percentage points above the posted yield for standard conventional fixed rate mortgages of the Federal Home Loan Mortgage Corporation as published in the Wall Street Journal and in effect on the first day of the month the debt or cost is incurred, or 16 percent,

(4) multiply the amount calculated in clause (2) by the amount calculated in clause (3).

(c) The equity incentive payment rate shall be limited to the term of the allowable debt in paragraph (a), not greater than 20 years nor less than ten years. If no debt is incurred in acquiring the capital asset, the equity incentive payment rate shall be paid for ten years. The sale of a nursing facility under subdivision 14 shall terminate application of the equity incentive payment rate effective on the date provided in subdivision 14, paragraph (f), for the sale.

(d) A nursing facility with an addition to or a renovation of its buildings, attached fixtures, or land improvements meeting the criteria in this subdivision and not receiving the property-related payment rate adjustment in subdivision 17, shall receive the incremental increase in the nursing facility's rental rate as determined under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section. The incremental increase shall be added to the nursing facility's property-related payment rate. The effective date of this incremental increase shall be the first day of the month of January or July, whichever occurs immediately following the ~~month in~~ date on which the addition or replacement is completed.

EFFECTIVE DATE. This section is effective for additions or replacements completed after January 1, 2018.

Sec. 10. Minnesota Statutes 2016, section 256B.431, subdivision 30, is amended to read:

Subd. 30. **Bed layaway and delicensure.** (a) For rate years beginning on or after July 1, 2000, a nursing facility reimbursed under this section which has placed beds on layaway shall, for purposes of application of the downsizing incentive in subdivision 3a, paragraph (c), and calculation of the rental per diem, have those beds given the same effect as if the beds had been delicensed so long as the beds remain on layaway. At the time of a layaway, a facility may change its single bed election for use in calculating capacity days under Minnesota Rules, part 9549.0060, subpart 11. The property payment rate increase shall be effective the first day of the month of January or July, whichever occurs immediately following the ~~month~~ date in which the layaway of the beds becomes effective under section 144A.071, subdivision 4b.

(b) For rate years beginning on or after July 1, 2000, notwithstanding any provision to the contrary under section 256B.434, a nursing facility reimbursed under that section which has placed beds on layaway shall, for so long as the beds remain on layaway, be allowed to:

(1) aggregate the applicable investment per bed limits based on the number of beds licensed immediately prior to entering the alternative payment system;

(2) retain or change the facility's single bed election for use in calculating capacity days under Minnesota Rules, part 9549.0060, subpart 11; and

(3) establish capacity days based on the number of beds immediately prior to the layaway and the number of beds after the layaway.

The commissioner shall increase the facility's property payment rate by the incremental increase in the rental per diem resulting from the recalculation of the facility's rental per diem applying only the changes resulting from the layaway of beds and clauses (1), (2), and (3). If a facility reimbursed under section 256B.434 completes a moratorium exception project after its base year, the base year property rate shall be the moratorium project property rate. The base year rate shall be inflated by the factors in section 256B.434, subdivision 4, paragraph (c). The property payment rate increase shall be effective the first day of the month of January or July, whichever occurs immediately following the ~~month~~ date in which the layaway of the beds becomes effective.

(c) If a nursing facility removes a bed from layaway status in accordance with section 144A.071, subdivision 4b, the commissioner shall establish capacity days based on the number of licensed and certified beds in the facility not on layaway and shall reduce the nursing facility's property payment rate in accordance with paragraph (b).

(d) For the rate years beginning on or after July 1, 2000, notwithstanding any provision to the contrary under section 256B.434, a nursing facility reimbursed under that section, which has delicensed beds after July 1, 2000, by giving notice of the delicensure to the commissioner of health according to the notice requirements in section 144A.071, subdivision 4b, shall be allowed to:

(1) aggregate the applicable investment per bed limits based on the number of beds licensed immediately prior to entering the alternative payment system;

(2) retain or change the facility's single bed election for use in calculating capacity days under Minnesota Rules, part 9549.0060, subpart 11; and

(3) establish capacity days based on the number of beds immediately prior to the delicensure and the number of beds after the delicensure.

The commissioner shall increase the facility's property payment rate by the incremental increase in the rental per diem resulting from the recalculation of the facility's rental per diem applying only the changes resulting from the delicensure of beds and clauses (1), (2), and (3). If a facility reimbursed under section 256B.434 completes a moratorium exception project after its base year, the base year property rate shall be the moratorium project property rate. The base year rate shall be inflated by the factors in section 256B.434, subdivision 4, paragraph (c). The property payment rate increase shall be effective the first day of the month of January or July, whichever occurs immediately following the ~~month~~ date in which the delicensure of the beds becomes effective.

(e) For nursing facilities reimbursed under this section or section 256B.434, any beds placed on layaway shall not be included in calculating facility occupancy as it pertains to leave days defined in Minnesota Rules, part 9505.0415.

(f) For nursing facilities reimbursed under this section or section 256B.434, the rental rate calculated after placing beds on layaway may not be less than the rental rate prior to placing beds on layaway.

(g) A nursing facility receiving a rate adjustment as a result of this section shall comply with section ~~256B.47, subdivision 2~~ 256R.06, subdivision 5.

(h) A facility that does not utilize the space made available as a result of bed layaway or delicensure under this subdivision to reduce the number of beds per room or provide more common space for nursing facility uses or perform other activities related to the operation of the nursing facility shall have its property rate increase calculated under this subdivision reduced by the ratio of the square footage made available that is not used for these purposes to the total square footage made available as a result of bed layaway or delicensure.

EFFECTIVE DATE. This section is effective for layaways occurring after July 1, 2017.

Sec. 11. Minnesota Statutes 2016, section 256B.434, subdivision 4, is amended to read:

Subd. 4. **Alternate rates for nursing facilities.** Effective for the rate years beginning on and after January 1, 2018, a nursing facility's ~~case mix~~ property payment ~~rates~~ rate for the second and subsequent years of a facility's contract under this section are the previous rate year's ~~contract~~ property payment ~~rates~~ rate plus an inflation adjustment ~~and, for facilities reimbursed under this section or section 256B.431, an adjustment to include the cost of any~~

~~increase in Health Department licensing fees for the facility taking effect on or after July 1, 2001~~. The index for the inflation adjustment must be based on the change in the Consumer Price Index-All Items (United States City average) (CPI-U) forecasted by the ~~commissioner of management and budget's national economic consultant~~ Reports and Forecasts Division of the Department of Human Services, as forecasted in the fourth quarter of the calendar year preceding the rate year. The inflation adjustment must be based on the 12-month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined. ~~For the rate years beginning on July 1, 1999, July 1, 2000, July 1, 2001, July 1, 2002, July 1, 2003, July 1, 2004, July 1, 2005, July 1, 2006, July 1, 2007, July 1, 2008, October 1, 2009, and October 1, 2010, this paragraph shall apply only to the property-related payment rate. For the rate years beginning on October 1, 2011, October 1, 2012, October 1, 2013, October 1, 2014, October 1, 2015, January 1, 2016, and January 1, 2017, the rate adjustment under this paragraph shall be suspended. Beginning in 2005, adjustment to the property payment rate under this section and section 256B.431 shall be effective on October 1. In determining the amount of the property-related payment rate adjustment under this paragraph, the commissioner shall determine the proportion of the facility's rates that are property-related based on the facility's most recent cost report.~~

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

Sec. 12. Minnesota Statutes 2016, section 256B.434, subdivision 4f, is amended to read:

Subd. 4f. **Construction project rate adjustments effective October 1, 2006.** (a) Effective October 1, 2006, facilities reimbursed under this section may receive a property rate adjustment for construction projects exceeding the threshold in section 256B.431, subdivision 16, and below the threshold in section 144A.071, subdivision 2, clause (a). For these projects, capital assets purchased shall be counted as construction project costs for a rate adjustment request made by a facility if they are: (1) purchased within 24 months of the completion of the construction project; (2) purchased after the completion date of any prior construction project; and (3) are not purchased prior to July 14, 2005. Except as otherwise provided in this subdivision, the definitions, rate calculation methods, and principles in sections 144A.071 and 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080, shall be used to calculate rate adjustments for allowable construction projects under this subdivision and section 144A.073. Facilities completing construction projects between October 1, 2005, and October 1, 2006, are eligible to have a property rate adjustment effective October 1, 2006. Facilities completing projects after October 1, 2006, are eligible for a property rate adjustment effective on the first day of the month following the completion date. Facilities completing projects after January 1, 2018, are eligible for a property rate

adjustment effective on the first day of the month of January or July, whichever occurs immediately following the completion date.

(b) Notwithstanding subdivision 18, as of July 14, 2005, facilities with rates set under section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080, that commenced a construction project on or after October 1, 2004, and do not have a contract under subdivision 3 by September 30, 2006, are eligible to request a rate adjustment under section 256B.431, subdivision 10, through September 30, 2006. If the request results in the commissioner determining a rate adjustment is allowable, the rate adjustment is effective on the first of the month following project completion. These facilities shall be allowed to accumulate construction project costs for the period October 1, 2004, to September 30, 2006.

(c) Facilities shall be allowed construction project rate adjustments no sooner than 12 months after completing a previous construction project. Facilities must request the rate adjustment according to section 256B.431, subdivision 10.

(d) Capacity days shall be computed according to Minnesota Rules, part 9549.0060, subpart 11. For rate calculations under this section, the number of licensed beds in the nursing facility shall be the number existing after the construction project is completed and the number of days in the nursing facility's reporting period shall be 365.

(e) The value of assets to be recognized for a total replacement project as defined in section 256B.431, subdivision 17d, shall be computed as described in clause (1). The value of assets to be recognized for all other projects shall be computed as described in clause (2).

(1) Replacement-cost-new limits under section 256B.431, subdivision 17e, and the number of beds allowed under subdivision 3a, paragraph (c), shall be used to compute the maximum amount of assets allowable in a facility's property rate calculation. If a facility's current request for a rate adjustment results from the completion of a construction project that was previously approved under section 144A.073, the assets to be used in the rate calculation cannot exceed the lesser of the amount determined under sections 144A.071, subdivision 2, and 144A.073, subdivision 3b, or the actual allowable costs of the construction project. A current request that is not the result of a project under section 144A.073 cannot exceed the limit under section 144A.071, subdivision 2, paragraph (a). Applicable credits must be deducted from the cost of the construction project.

(2)(i) Replacement-cost-new limits under section 256B.431, subdivision 17e, and the number of beds allowed under section 256B.431, subdivision 3a, paragraph (c), shall be

used to compute the maximum amount of assets allowable in a facility's property rate calculation.

(ii) The value of a facility's assets to be compared to the amount in item (i) begins with the total appraised value from the last rate notice a facility received when its rates were set under section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080. This value shall be indexed by the factor in section 256B.431, subdivision 3f, paragraph (a), for each rate year the facility received an inflation factor on its property-related rate when its rates were set under this section. The value of assets listed as previous capital additions, capital additions, and special projects on the facility's base year rate notice and the value of assets related to a construction project for which the facility received a rate adjustment when its rates were determined under this section shall be added to the indexed appraised value.

(iii) The maximum amount of assets to be recognized in computing a facility's rate adjustment after a project is completed is the lesser of the aggregate replacement-cost-new limit computed in (i) minus the assets recognized in (ii) or the actual allowable costs of the construction project.

(iv) If a facility's current request for a rate adjustment results from the completion of a construction project that was previously approved under section 144A.073, the assets to be added to the rate calculation cannot exceed the lesser of the amount determined under sections 144A.071, subdivision 2, and 144A.073, subdivision 3b, or the actual allowable costs of the construction project. A current request that is not the result of a project under section 144A.073 cannot exceed the limit stated in section 144A.071, subdivision 2, paragraph (a). Assets disposed of as a result of a construction project and applicable credits must be deducted from the cost of the construction project.

(f) For construction projects approved under section 144A.073, allowable debt may never exceed the lesser of the cost of the assets purchased, the threshold limit in section 144A.071, subdivision 2, or the replacement-cost-new limit less previously existing capital debt.

(g) For construction projects that were not approved under section 144A.073, allowable debt is limited to the lesser of the threshold in section 144A.071, subdivision 2, for such construction projects or the applicable limit in paragraph (e), clause (1) or (2), less previously existing capital debt. Amounts of debt taken out that exceed the costs of a construction project shall not be allowed regardless of the use of the funds.

For all construction projects being recognized, interest expense and average debt shall be computed based on the first 12 months following project completion. "Previously existing

capital debt" means capital debt recognized on the last rate determined under section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080, and the amount of debt recognized for a construction project for which the facility received a rate adjustment when its rates were determined under this section.

For a total replacement project as defined in section 256B.431, subdivision 17d, the value of previously existing capital debt shall be zero.

(h) In addition to the interest expense allowed from the application of paragraph (f), the amounts allowed under section 256B.431, subdivision 17a, paragraph (a), clauses (2) and (3), will be added to interest expense.

(i) The equity portion of the construction project shall be computed as the allowable assets in paragraph (e), less the average debt in paragraph (f). The equity portion must be multiplied by 5.66 percent and the allowable interest expense in paragraph (f) must be added. This sum must be divided by 95 percent of capacity days to compute the construction project rate adjustment.

(j) For projects that are not a total replacement of a nursing facility, the amount in paragraph (i) is adjusted for nonreimbursable areas and then added to the current property payment rate of the facility.

(k) For projects that are a total replacement of a nursing facility, the amount in paragraph (i) becomes the new property payment rate after being adjusted for nonreimbursable areas. Any amounts existing in a facility's rate before the effective date of the construction project for equity incentives under section 256B.431, subdivision 16; capital repairs and replacements under section 256B.431, subdivision 15; or refinancing incentives under section 256B.431, subdivision 19, shall be removed from the facility's rates.

(l) No additional equipment allowance is allowed under Minnesota Rules, part 9549.0060, subpart 10, as the result of construction projects under this section. Allowable equipment shall be included in the construction project costs.

(m) Capital assets purchased after the completion date of a construction project shall be counted as construction project costs for any future rate adjustment request made by a facility under section 144A.071, subdivision 2, clause (a), if they are purchased within 24 months of the completion of the future construction project.

(n) In subsequent rate years, the property payment rate for a facility that results from the application of this subdivision shall be the amount inflated in subdivision 4.

(o) Construction projects are eligible for an equity incentive under section 256B.431, subdivision 16. When computing the equity incentive for a construction project under this subdivision, only the allowable costs and allowable debt related to the construction project shall be used. The equity incentive shall not be a part of the property payment rate and not inflated under subdivision 4. Effective October 1, 2006, all equity incentives for nursing facilities reimbursed under this section shall be allowed for a duration determined under section 256B.431, subdivision 16, paragraph (c).

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

Sec. 13. Minnesota Statutes 2016, section 256B.50, subdivision 1b, is amended to read:

Subd. 1b. **Filing an appeal.** To appeal, the provider shall file with the commissioner a written notice of appeal; the appeal must be postmarked or received by the commissioner within 60 days of the publication date ~~the determination of the payment rate was mailed or personally received by a provider, whichever is earlier~~ printed on the rate notice. The notice of appeal must specify each disputed item; the reason for the dispute; the total dollar amount in dispute for each separate disallowance, allocation, or adjustment of each cost item or part of a cost item; the computation that the provider believes is correct; the authority in statute or rule upon which the provider relies for each disputed item; the name and address of the person or firm with whom contacts may be made regarding the appeal; and other information required by the commissioner.

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

Sec. 14. Minnesota Statutes 2016, section 256R.02, subdivision 4, is amended to read:

Subd. 4. **Administrative costs.** "Administrative costs" means the identifiable costs for administering the overall activities of the nursing home. These costs include salaries and wages of the administrator, assistant administrator, business office employees, security guards, and associated fringe benefits and payroll taxes, fees, contracts, or purchases related to business office functions, licenses, and permits except as provided in the external fixed costs category, employee recognition, travel including meals and lodging, all training except as specified in subdivision 17, voice and data communication or transmission, office supplies, property and liability insurance and other forms of allowable insurance not designated to other areas, personnel recruitment, legal services, accounting services, management or business consultants, data processing, information technology, Web site, central or home office costs, business meetings and seminars, postage, fees for professional organizations,

subscriptions, security services, advertising, board of directors fees, working capital interest expense, and bad debts and bad debt collection fees.

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

Sec. 15. Minnesota Statutes 2016, section 256R.02, subdivision 18, is amended to read:

Subd. 18. **Employer health insurance costs.** "Employer health insurance costs" means premium expenses for group coverage ~~and reinsurance,~~; actual expenses incurred for self-insured plans, including reinsurance; and employer contributions to employee health reimbursement and health savings accounts. Premium and expense costs and contributions are allowable for (1) all employees and (2) the spouse and dependents of employees who meet the definition of full-time employees under the federal Affordable Care Act, Public Law 111-148.

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

Sec. 16. Minnesota Statutes 2016, section 256R.10, is amended by adding a subdivision to read:

Subd. 7. **Not specified allowed costs.** When the cost category for allowed cost items or services is not specified in this chapter or the provider reimbursement manual, the commissioner, in consultation with stakeholders, shall determine the cost category for the allowed cost item or service.

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

Sec. 17. **[256R.18] REPORT BY COMMISSIONER OF HUMAN SERVICES.**

Beginning January 1, 2019, the commissioner shall provide to the house of representatives and senate committees with jurisdiction over nursing facility payment rates a biennial report on the effectiveness of the reimbursement system in improving quality, restraining costs, and any other features of the system as determined by the commissioner.

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

Sec. 18. Minnesota Statutes 2016, section 256R.40, subdivision 5, is amended to read:

Subd. 5. **Planned closure rate adjustment.** (a) The commissioner shall calculate the amount of the planned closure rate adjustment available under subdivision 6 according to clauses (1) to (4):

(1) the amount available is the net reduction of nursing facility beds multiplied by $2,080;

(2) the total number of beds in the nursing facility or facilities receiving the planned closure rate adjustment must be identified;

(3) capacity days are determined by multiplying the number determined under clause (2) by 365; and

(4) the planned closure rate adjustment is the amount available in clause (1), divided by capacity days determined under clause (3).

(b) A planned closure rate adjustment under this section is effective on the first day of the month of January or July, whichever occurs immediately following completion of closure of the facility designated for closure in the application and becomes part of the nursing facility's external fixed payment rate.

(c) Upon the request of a closing facility, the commissioner must allow the facility a closure rate adjustment as provided under section 144A.161, subdivision 10.

(d) A facility that has received a planned closure rate adjustment may reassign it to another facility that is under the same ownership at any time within three years of its effective date. The amount of the adjustment is computed according to paragraph (a).

(e) If the per bed dollar amount specified in paragraph (a), clause (1), is increased, the commissioner shall recalculate planned closure rate adjustments for facilities that delicense beds under this section on or after July 1, 2001, to reflect the increase in the per bed dollar amount. The recalculated planned closure rate adjustment is effective from the date the per bed dollar amount is increased.

EFFECTIVE DATE. This section is effective for closures occurring after July 1, 2017.

Sec. 19. Minnesota Statutes 2016, section 256R.41, is amended to read:

256R.41 SINGLE-BED ROOM INCENTIVE.

(a) Beginning July 1, 2005, the operating payment rate for nursing facilities reimbursed under this chapter shall be increased by 20 percent multiplied by the ratio of the number of new single-bed rooms created divided by the number of active beds on July 1, 2005, for each bed closure that results in the creation of a single-bed room after July 1, 2005. The commissioner may implement rate adjustments for up to 3,000 new single-bed rooms each year. For eligible bed closures for which the commissioner receives a notice from a facility ~~during a calendar quarter~~ that a bed has been delicensed and a new single-bed room has been established, the rate adjustment in this paragraph shall be effective on either the first

day of the ~~second~~ month ~~following that calendar quarter~~ of January or July, whichever occurs immediately following the date of the bed delicensure.

(b) A nursing facility is prohibited from discharging residents for purposes of establishing single-bed rooms. A nursing facility must submit documentation to the commissioner in a form prescribed by the commissioner, certifying the occupancy status of beds closed to create single-bed rooms. In the event that the commissioner determines that a facility has discharged a resident for purposes of establishing a single-bed room, the commissioner shall not provide a rate adjustment under paragraph (a).

EFFECTIVE DATE. This section is effective for closures occurring after July 1, 2017.

Sec. 20. Minnesota Statutes 2016, section 256R.47, is amended to read:

256R.47 RATE ADJUSTMENT FOR CRITICAL ACCESS NURSING FACILITIES.

(a) The commissioner, in consultation with the commissioner of health, may designate certain nursing facilities as critical access nursing facilities. The designation shall be granted on a competitive basis, within the limits of funds appropriated for this purpose.

(b) The commissioner shall request proposals from nursing facilities every two years. Proposals must be submitted in the form and according to the timelines established by the commissioner. In selecting applicants to designate, the commissioner, in consultation with the commissioner of health, and with input from stakeholders, shall develop criteria designed to preserve access to nursing facility services in isolated areas, rebalance long-term care, and improve quality. To the extent practicable, the commissioner shall ensure an even distribution of designations across the state.

(c) The commissioner shall allow the benefits in clauses (1) to (5) for nursing facilities designated as critical access nursing facilities:

(1) partial rebasing, with the commissioner allowing a designated facility operating payment rates being the sum of up to 60 percent of the operating payment rate determined in accordance with section 256R.21, subdivision 3, and at least 40 percent, with the sum of the two portions being equal to 100 percent, of the operating payment rate that would have been allowed had the facility not been designated. The commissioner may adjust these percentages by up to 20 percent and may approve a request for less than the amount allowed;

(2) enhanced payments for leave days. Notwithstanding section 256R.43, upon designation as a critical access nursing facility, the commissioner shall limit payment for leave days to 60 percent of that nursing facility's total payment rate for the involved resident,

and shall allow this payment only when the occupancy of the nursing facility, inclusive of bed hold days, is equal to or greater than 90 percent;

(3) two designated critical access nursing facilities, with up to 100 beds in active service, may jointly apply to the commissioner of health for a waiver of Minnesota Rules, part 4658.0500, subpart 2, in order to jointly employ a director of nursing. The commissioner of health shall consider each waiver request independently based on the criteria under Minnesota Rules, part 4658.0040;

(4) the minimum threshold under section 256B.431, subdivision 15, paragraph (e), shall be 40 percent of the amount that would otherwise apply; and

(5) the quality-based rate limits under section 256R.23, subdivisions 5 to 7, apply to designated critical access nursing facilities.

(d) Designation of a critical access nursing facility is for a period of two years, after which the benefits allowed under paragraph (c) shall be removed. Designated facilities may apply for continued designation.

(e) This section is suspended and no state or federal funding shall be appropriated or allocated for the purposes of this section from January 1, 2016, to December 31, ~~2017~~ 2019.

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

Sec. 21. Minnesota Statutes 2016, section 256R.49, subdivision 1, is amended to read:

Subdivision 1. **Rate adjustments for compensation-related costs.** (a) ~~Operating payment rates of all nursing facilities that are reimbursed under this chapter shall be increased effective for rate years beginning on and after October 1, 2014, to address changes in compensation costs for nursing facility employees paid less than $14 per hour in accordance with this section.~~ Rate increases provided under this section before October 1, 2016, expire effective January 1, 2018, and rate increases provided on or after October 1, 2016, expire effective January 1, 2019.

(b) Nursing facilities that receive approval of the applications in subdivision 2 must receive rate adjustments according to subdivision 4. The rate adjustments must be used to pay compensation costs for nursing facility employees paid less than $14 per hour.

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

Sec. 22. Minnesota Statutes 2016, section 626.557, subdivision 4, is amended to read:

Subd. 4. **Reporting.** (a) Except as provided in paragraph (b), a mandated reporter shall immediately make ~~an oral~~ a report to the common entry point. ~~The common entry point may accept electronic reports submitted through a Web-based reporting system established by the commissioner. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports.~~ To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under sections 144.291 to 144.298, to the extent necessary to comply with this subdivision.

(b) A boarding care home that is licensed under sections 144.50 to 144.58 and certified under Title 19 of the Social Security Act, a nursing home that is licensed under section 144A.02 and certified under Title 18 or Title 19 of the Social Security Act, or a hospital that is licensed under sections 144.50 to 144.58 and has swing beds certified under Code of Federal Regulations, title 42, section 482.66, may submit a report electronically to the common entry point instead of submitting an oral report. The report may be a duplicate of the initial report the facility submits electronically to the commissioner of health to comply with the reporting requirements under Code of Federal Regulations, title 42, section 483.13. The commissioner of health may modify these reporting requirements to include items required under paragraph (a) that are not currently included in the electronic reporting form.

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

Sec. 23. Minnesota Statutes 2016, section 626.557, subdivision 9, is amended to read:

Subd. 9. **Common entry point designation.** (a) ~~Each county board shall designate a common entry point for reports of suspected maltreatment, for use until the commissioner of human services establishes a common entry point. Two or more county boards may jointly designate a single common entry point.~~ The commissioner of human services shall ~~establish~~ operate a common entry point ~~effective July 1, 2015~~. The common entry point is the unit responsible for receiving the report of suspected maltreatment under this section.

(b) The common entry point must be available 24 hours per day to take calls from reporters of suspected maltreatment. The common entry point shall use a standard intake form that includes:

(1) the time and date of the report;

(2) the name~~, address, and telephone number of the person reporting;~~ and identifying and contact information for the alleged victim and the alleged perpetrator;

(3) the name and contact information for the reporter, the initial reporter, witnesses, and other relevant people;

(4) the basis of vulnerability for the alleged victim;

~~(3)~~ (5) the time, date, and location of the incident;

~~(4) the names of the persons involved, including but not limited to, perpetrators, alleged victims, and witnesses;~~

~~(5)~~ (6) whether there ~~was a~~ is an immediate safety risk ~~of imminent danger~~ to the alleged victim;

~~(6)~~ (7) a description of the suspected maltreatment;

~~(7) the disability, if any, of the alleged victim;~~

~~(8) the relationship of the alleged perpetrator to the alleged victim;~~

~~(9)~~ (8) whether a facility was involved and, if so, which agency licenses the facility;

(9) actions taken to protect the alleged victim;

(10) ~~any action taken~~ required notifications and referrals made by the common entry point; and

~~(11) whether law enforcement has been notified;~~

~~(12)~~ (11) whether the reporter wishes to receive notification of the ~~initial and final reports; and~~ disposition.

~~(13) if the report is from a facility with an internal reporting procedure, the name, mailing address, and telephone number of the person who initiated the report internally.~~

(c) The common entry point is not required to complete each item on the form prior to dispatching the report to the appropriate lead investigative agency.

(d) The common entry point shall immediately report to a law enforcement agency any incident in which there is reason to believe a crime has been committed.

(e) If a report is initially made to a law enforcement agency or a lead investigative agency, those agencies shall take the report on the appropriate common entry point intake forms and immediately forward a copy to the common entry point.

(f) The common entry point staff must receive training on how to screen and dispatch reports efficiently and in accordance with this section.

(g) The commissioner of human services shall maintain a centralized database for the collection of common entry point data, lead investigative agency data including maltreatment report disposition, and appeals data. The common entry point shall have access to the centralized database and must log the reports into the database and immediately identify and locate prior reports of abuse, neglect, or exploitation.

(h) When appropriate, the common entry point staff must refer calls that do not allege the abuse, neglect, or exploitation of a vulnerable adult to other organizations that might resolve the reporter's concerns.

(i) A common entry point must be operated in a manner that enables the commissioner of human services to:

(1) track critical steps in the reporting, evaluation, referral, response, disposition, and investigative process to ensure compliance with all requirements for all reports;

(2) maintain data to facilitate the production of aggregate statistical reports for monitoring patterns of abuse, neglect, or exploitation;

(3) serve as a resource for the evaluation, management, and planning of preventative and remedial services for vulnerable adults who have been subject to abuse, neglect, or exploitation;

(4) set standards, priorities, and policies to maximize the efficiency and effectiveness of the common entry point; and

(5) track and manage consumer complaints related to the common entry point.

(j) ~~The commissioners of human services and health shall collaborate on the creation of a system for referring reports to the lead investigative agencies. This system~~ The common entry point shall enable the commissioner of human services to track critical steps in the reporting, evaluation, referral, response, disposition, investigation, notification, determination, and appeal processes.

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

Sec. 24. Minnesota Statutes 2016, section 626.557, subdivision 12b, is amended to read:

Subd. 12b. **Data management.** (a) In performing any of the duties of this section as a lead investigative agency, the county social service agency shall maintain appropriate records. Data collected by the county social service agency under this section are welfare

data under section 13.46. Notwithstanding section 13.46, subdivision 1, paragraph (a), data under this paragraph that are inactive investigative data on an individual who is a vendor of services are private data on individuals, as defined in section 13.02. The identity of the reporter may only be disclosed as provided in paragraph (c).

Data maintained by the common entry point are confidential data on individuals or protected nonpublic data as defined in section 13.02. Notwithstanding section 138.163, the common entry point shall maintain data for three calendar years after date of receipt and then destroy the data unless otherwise directed by federal requirements.

(b) The commissioners of health and human services shall prepare an investigation memorandum for each report alleging maltreatment investigated under this section. County social service agencies must maintain private data on individuals but are not required to prepare an investigation memorandum. During an investigation by the commissioner of health or the commissioner of human services, data collected under this section are confidential data on individuals or protected nonpublic data as defined in section 13.02. Upon completion of the investigation, the data are classified as provided in clauses (1) to (3) and paragraph (c).

(1) The investigation memorandum must contain the following data, which are public:

(i) the name of the facility investigated;

(ii) a statement of the nature of the alleged maltreatment;

(iii) pertinent information obtained from medical or other records reviewed;

(iv) the identity of the investigator;

(v) a summary of the investigation's findings;

(vi) statement of whether the report was found to be substantiated, inconclusive, false, or that no determination will be made;

(vii) a statement of any action taken by the facility;

(viii) a statement of any action taken by the lead investigative agency; and

(ix) when a lead investigative agency's determination has substantiated maltreatment, a statement of whether an individual, individuals, or a facility were responsible for the substantiated maltreatment, if known.

The investigation memorandum must be written in a manner which protects the identity of the reporter and of the vulnerable adult and may not contain the names or, to the extent possible, data on individuals or private data listed in clause (2).

(2) Data on individuals collected and maintained in the investigation memorandum are private data, including:

(i) the name of the vulnerable adult;

(ii) the identity of the individual alleged to be the perpetrator;

(iii) the identity of the individual substantiated as the perpetrator; and

(iv) the identity of all individuals interviewed as part of the investigation.

(3) Other data on individuals maintained as part of an investigation under this section are private data on individuals upon completion of the investigation.

(c) After the assessment or investigation is completed, the name of the reporter must be confidential. The subject of the report may compel disclosure of the name of the reporter only with the consent of the reporter or upon a written finding by a court that the report was false and there is evidence that the report was made in bad faith. This subdivision does not alter disclosure responsibilities or obligations under the Rules of Criminal Procedure, except that where the identity of the reporter is relevant to a criminal prosecution, the district court shall do an in-camera review prior to determining whether to order disclosure of the identity of the reporter.

(d) Notwithstanding section 138.163, data maintained under this section by the commissioners of health and human services must be maintained under the following schedule and then destroyed unless otherwise directed by federal requirements:

(1) data from reports determined to be false, maintained for three years after the finding was made;

(2) data from reports determined to be inconclusive, maintained for four years after the finding was made;

(3) data from reports determined to be substantiated, maintained for seven years after the finding was made; and

(4) data from reports which were not investigated by a lead investigative agency and for which there is no final disposition, maintained for three years from the date of the report.

(e) The commissioners of health and human services shall annually publish on their Web sites the number and type of reports of alleged maltreatment involving licensed facilities reported under this section, the number of those requiring investigation under this section, and the resolution of those investigations. On a biennial basis, the commissioners of health

and human services shall jointly report the following information to the legislature and the governor:

(1) the number and type of reports of alleged maltreatment involving licensed facilities reported under this section, the number of those requiring investigations under this section, the resolution of those investigations, and which of the two lead agencies was responsible;

(2) trends about types of substantiated maltreatment found in the reporting period;

(3) if there are upward trends for types of maltreatment substantiated, recommendations for addressing and responding to them;

(4) efforts undertaken or recommended to improve the protection of vulnerable adults;

(5) whether and where backlogs of cases result in a failure to conform with statutory time frames and recommendations for reducing backlogs if applicable;

(6) recommended changes to statutes affecting the protection of vulnerable adults; and

(7) any other information that is relevant to the report trends and findings.

(f) Each lead investigative agency must have a record retention policy.

(g) The common entry point, a lead investigative ~~agencies~~ agency, a county agency or its designee, a prosecuting ~~authorities~~ authority, ~~and~~ a law enforcement ~~agencies~~ agency, a state licensing board, a federal agency, a state agency, and a tribe may exchange not public data, as defined in section 13.02, if the agency or authority ~~requesting~~ providing the data determines that the data are pertinent and necessary to ~~the requesting agency in initiating, furthering, or completing~~ provide adult protective services or to initiate, further, or complete an investigation under this section. Data collected under this section must be made available to prosecuting authorities and law enforcement officials, local county agencies, and licensing agencies investigating the alleged maltreatment under this section. The lead investigative agency shall exchange not public data with the vulnerable adult maltreatment review panel established in section 256.021 if the data are pertinent and necessary for a review requested under that section. Notwithstanding section 138.17, upon completion of the review, not public data received by the review panel must be destroyed.

(h) Each lead investigative agency shall keep records of the length of time it takes to complete its investigations.

(i) A lead investigative agency may notify other affected parties and their authorized representative if the lead investigative agency has reason to believe maltreatment has occurred

and determines the information will safeguard the well-being of the affected parties or dispel widespread rumor or unrest in the affected facility.

(j) Under any notification provision of this section, where federal law specifically prohibits the disclosure of patient identifying information, a lead investigative agency may not provide any notice unless the vulnerable adult has consented to disclosure in a manner which conforms to federal requirements.

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

Sec. 25. Minnesota Statutes 2016, section 626.557, subdivision 18, is amended to read:

Subd. 18. **Outreach.** The commissioner of human services shall maintain ~~an aggressive~~ a program to educate those required to report, as well as the general public, about the requirements of this section using a variety of media. ~~The commissioner of human services shall print and make available the form developed under subdivision 9.~~

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

Sec. 26. Minnesota Statutes 2016, section 626.5572, subdivision 2, is amended to read:

Subd. 2. **Abuse.** "Abuse" means:

(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:

(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;

(2) the use of drugs to injure or facilitate crime as defined in section 609.235;

(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and

(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.

A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.

(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:

(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;

(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening; or

(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult~~; and~~.

~~(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.~~

(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.

(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

(e) For purposes of this section, a vulnerable adult is not abused for the sole reason that the vulnerable adult or a person with authority to make health care decisions for the vulnerable adult under sections 144.651, 144A.44, chapter 145B, 145C or 252A, or section 253B.03 or 524.5-313, refuses consent or withdraws consent, consistent with that authority and within the boundary of reasonable medical practice, to any therapeutic conduct, including any care, service, or procedure to diagnose, maintain, or treat the physical or mental condition of the vulnerable adult or, where permitted under law, to provide nutrition and hydration parenterally or through intubation. This paragraph does not enlarge or diminish rights otherwise held under law by:

(1) a vulnerable adult or a person acting on behalf of a vulnerable adult, including an involved family member, to consent to or refuse consent for therapeutic conduct; or

(2) a caregiver to offer or provide or refuse to offer or provide therapeutic conduct.

(f) For purposes of this section, a vulnerable adult is not abused for the sole reason that the vulnerable adult, a person with authority to make health care decisions for the vulnerable adult, or a caregiver in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the vulnerable adult in lieu of medical care, provided that this is consistent with the prior practice or belief of the vulnerable adult or with the expressed intentions of the vulnerable adult.

(g) For purposes of this section, a vulnerable adult is not abused for the sole reason that the vulnerable adult, who is not impaired in judgment or capacity by mental or emotional dysfunction or undue influence, engages in consensual sexual contact with:

(1) a person, including a facility staff person, when a consensual sexual personal relationship existed prior to the caregiving relationship; or

(2) a personal care attendant, regardless of whether the consensual sexual personal relationship existed prior to the caregiving relationship.

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

Sec. 27. Minnesota Statutes 2016, section 626.5572, subdivision 4, is amended to read:

Subd. 4. **Caregiver.** "Caregiver" means an individual or facility who has responsibility for the care of a vulnerable adult as a result of ~~a family relationship, or who has~~ an assumed responsibility for all or a portion of the care of a vulnerable adult voluntarily, by contract, or by agreement.

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

ARTICLE 4

HEALTH CARE

Section 1. Minnesota Statutes 2016, section 13.69, subdivision 1, is amended to read:

Subdivision 1. **Classifications.** (a) The following government data of the Department of Public Safety are private data:

(1) medical data on driving instructors, licensed drivers, and applicants for parking certificates and special license plates issued to physically disabled persons;

(2) other data on holders of a disability certificate under section 169.345, except that (i) data that are not medical data may be released to law enforcement agencies, and (ii) data necessary for enforcement of sections 169.345 and 169.346 may be released to parking enforcement employees or parking enforcement agents of statutory or home rule charter cities and towns;

(3) Social Security numbers in driver's license and motor vehicle registration records, except that Social Security numbers must be provided to the Department of Revenue for purposes of tax administration, the Department of Labor and Industry for purposes of workers' compensation administration and enforcement, the Department of Human Services

for purposes of recovery of Minnesota health care program benefits paid, and the Department of Natural Resources for purposes of license application administration; and

(4) data on persons listed as standby or temporary custodians under section 171.07, subdivision 11, except that the data must be released to:

(i) law enforcement agencies for the purpose of verifying that an individual is a designated caregiver; or

(ii) law enforcement agencies who state that the license holder is unable to communicate at that time and that the information is necessary for notifying the designated caregiver of the need to care for a child of the license holder.

The department may release the Social Security number only as provided in clause (3) and must not sell or otherwise provide individual Social Security numbers or lists of Social Security numbers for any other purpose.

(b) The following government data of the Department of Public Safety are confidential data: data concerning an individual's driving ability when that data is received from a member of the individual's family.

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

Sec. 2. Minnesota Statutes 2016, section 256.01, is amended by adding a subdivision to read:

Subd. 18f. **Asset verification system.** The commissioner shall implement the Asset Verification System (AVS) according to Public Law 110-252, title VII, section 7001(d), to verify assets for or renewing an individual applying for health care benefits under section 256B.055, subdivisions 7 and 7b.

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

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

Subd. 3a. **Prepaid health plan appeals.** (a) All prepaid health plans under contract to the commissioner under chapter 256B must provide for a complaint system according to section 62D.11. When a prepaid health plan denies, reduces, or terminates a health service or denies a request to authorize a previously authorized health service, the prepaid health plan must notify the recipient of the right to file a complaint or an appeal. The notice must include the name and telephone number of the ombudsman and notice of the recipient's right to request a hearing under paragraph (b). Recipients may request the assistance of the

ombudsman in the complaint system process. The prepaid health plan must issue a written resolution of the complaint to the recipient within 30 days after the complaint is filed with the prepaid health plan. A recipient is ~~not~~ required to exhaust the complaint system procedures in order to request a hearing under paragraph (b).

(b) Recipients enrolled in a prepaid health plan under chapter 256B may contest a prepaid health plan's denial, reduction, or termination of health services, a prepaid health plan's denial of a request to authorize a previously authorized health service, or the prepaid health plan's written resolution of a complaint by submitting a written request for a hearing according to subdivision 3. A state human services judge shall conduct a hearing on the matter and shall recommend an order to the commissioner of human services. The commissioner need not grant a hearing if the sole issue raised by a recipient is the commissioner's authority to require mandatory enrollment in a prepaid health plan in a county where prepaid health plans are under contract with the commissioner. The state human services judge may order a second medical opinion from ~~the prepaid health plan or may order a second medical opinion from~~ a nonprepaid health plan provider at the expense of the ~~prepaid health plan~~ Department of Human Services. Recipients may request the assistance of the ombudsman in the appeal process.

(c) In the written request for a hearing to appeal from a prepaid health plan's denial, reduction, or termination of a health service, a prepaid health plan's denial of a request to authorize a previously authorized service, or the prepaid health plan's written resolution to a complaint, a recipient may request an expedited hearing. If an expedited appeal is warranted, the state human services judge shall hear the appeal and render a decision within a time commensurate with the level of urgency involved, based on the individual circumstances of the case.

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

Sec. 4. Minnesota Statutes 2016, section 256.962, subdivision 5, is amended to read:

Subd. 5. **Incentive program.** Beginning January 1, 2008, the commissioner shall establish an incentive program for organizations and licensed insurance producers under chapter 60K that directly identify and assist potential enrollees in filling out and submitting an application. For each applicant who is successfully enrolled in MinnesotaCare or medical assistance, the commissioner, within the available appropriation, shall pay the organization or licensed insurance producer a ~~$25~~ $70 application assistance bonus. The organization or licensed insurance producer may provide an applicant a gift certificate or other incentive upon enrollment.

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

Sec. 5. Minnesota Statutes 2016, section 256.962, is amended by adding a subdivision to read:

Subd. 9. **Department of Corrections.** By January 1, 2018, the commissioner, in consultation with the commissioner of the Department of Corrections, shall develop and implement a process to improve access to health care coverage by offering application assistance to people transitioning from incarceration in a facility operated by the Department of Corrections to the community.

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

Sec. 6. Minnesota Statutes 2016, section 256.9686, subdivision 8, is amended to read:

Subd. 8. **Rate year.** "Rate year" means a calendar year from January 1 to December 31. Effective with the 2012 base year, rate year means a state fiscal year from July 1 to June 30.

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

Sec. 7. Minnesota Statutes 2016, section 256.969, subdivision 1, is amended to read:

Subdivision 1. **Hospital cost index.** (a) The hospital cost index shall be the change in the Centers for Medicare and Medicaid Services Inpatient Hospital Market Basket. The commissioner shall use the indices as forecasted for the midpoint of the prior rate year to the midpoint of the current rate year.

(b) Except as authorized under this section, for fiscal years beginning on or after July 1, 1993, the commissioner of human services shall not provide automatic annual inflation adjustments for hospital payment rates under medical assistance.

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

Sec. 8. Minnesota Statutes 2016, section 256.969, subdivision 2b, is amended to read:

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

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

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

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

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

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

(c) Effective for discharges occurring on and after November 1, 2014, payment rates for hospital inpatient services provided by hospitals located in Minnesota or the local trade area, except for the hospitals paid under the methodologies described in paragraph (a), clauses (2) and (3), shall be rebased, incorporating cost and payment methodologies in a manner similar to Medicare. The base year for the rates effective November 1, 2014, shall be calendar year 2012. The rebasing under this paragraph shall be budget neutral, ensuring that the total aggregate payments under the rebased system are equal to the total aggregate payments that were made for the same number and types of services in the base year. Separate budget neutrality calculations shall be determined for payments made to critical access hospitals and payments made to hospitals paid under the DRG system. Only the rate increases or decreases under subdivision 3a or 3c that applied to the hospitals being rebased during the entire base period shall be incorporated into the budget neutrality calculation.

(d) For discharges occurring on or after November 1, 2014, through the next rebasing that occurs, the rebased rates under paragraph (c) that apply to hospitals under paragraph (a), clause (4), shall include adjustments to the projected rates that result in no greater than a five percent increase or decrease from the base year payments for any hospital. Any adjustments to the rates made by the commissioner under this paragraph and paragraph (e) shall maintain budget neutrality as described in paragraph (c).

(e) For discharges occurring on or after November 1, 2014, through the next two rebasing ~~that occurs~~ periods the commissioner may make additional adjustments to the rebased rates,

and when evaluating whether additional adjustments should be made, the commissioner shall consider the impact of the rates on the following:

(1) pediatric services;

(2) behavioral health services;

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

(4) transplant services;

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

(6) outlier admissions;

(7) low-volume providers; and

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

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

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

(2) for critical access hospitals, payment rates for discharges between November 1, 2014, and June 30, 2015, shall be set to the same rate of payment that applied for discharges on October 31, 2014;

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

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

(g) The commissioner shall validate the rates effective November 1, 2014, by applying the rates established under paragraph (c), and any adjustments made to the rates under paragraph (d) or (e), to hospital claims paid in calendar year 2013 to determine whether the

total aggregate payments for the same number and types of services under the rebased rates are equal to the total aggregate payments made during calendar year 2013.

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

(i) Effective for discharges occurring on or after July 1, 2015, inpatient payment rates for critical access hospitals located in Minnesota or the local trade area shall be determined using a new cost-based methodology. The commissioner shall establish within the methodology tiers of payment designed to promote efficiency and cost-effectiveness. Payment rates for hospitals under this paragraph shall be set at a level that does not exceed the total cost for critical access hospitals as reflected in base year cost reports. Until the next rebasing that occurs, the new methodology shall result in no greater than a five percent decrease from the base year payments for any hospital, except a hospital that had payments that were greater than 100 percent of the hospital's costs in the base year shall have their rate set equal to 100 percent of costs in the base year. The rates paid for discharges on and after July 1, 2016, covered under this paragraph shall be increased by the inflation factor in subdivision 1, paragraph (a). The new cost-based rate shall be the final rate and shall not be settled to actual incurred costs. Hospitals shall be assigned a payment tier based on the following criteria:

(1) hospitals that had payments at or below 80 percent of their costs in the base year shall have a rate set that equals 85 percent of their base year costs;

(2) hospitals that had payments that were above 80 percent, up to and including 90 percent of their costs in the base year shall have a rate set that equals 95 percent of their base year costs; and

(3) hospitals that had payments that were above 90 percent of their costs in the base year shall have a rate set that equals 100 percent of their base year costs.

(j) The commissioner may refine the payment tiers and criteria for critical access hospitals to coincide with the next rebasing under paragraph (h). The factors used to develop the new methodology may include, but are not limited to:

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

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

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

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

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

(6) geographic location.

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

Sec. 9. Minnesota Statutes 2016, section 256.969, subdivision 3a, is amended to read:

Subd. 3a. **Payments.** (a) Acute care hospital billings under the medical assistance program must not be submitted until the recipient is discharged. However, the commissioner shall establish monthly interim payments for inpatient hospitals that have individual patient lengths of stay over 30 days regardless of diagnostic category. Except as provided in section 256.9693, medical assistance reimbursement for treatment of mental illness shall be reimbursed based on diagnostic classifications. Individual hospital payments established under this section and sections 256.9685, 256.9686, and 256.9695, in addition to third-party and recipient liability, for discharges occurring during the rate year shall not exceed, in aggregate, the charges for the medical assistance covered inpatient services paid for the same period of time to the hospital. Services that have rates established under subdivision ~~11 or~~ 12, must be limited separately from other services. After consulting with the affected hospitals, the commissioner may consider related hospitals one entity and may merge the payment rates while maintaining separate provider numbers. The operating and property base rates per admission or per day shall be derived from the best Medicare and claims data available when rates are established. The commissioner shall determine the best Medicare and claims data, taking into consideration variables of recency of the data, audit disposition,

settlement status, and the ability to set rates in a timely manner. The commissioner shall notify hospitals of payment rates 30 days prior to implementation. The rate setting data must reflect the admissions data used to establish relative values. The commissioner may adjust base year cost, relative value, and case mix index data to exclude the costs of services that have been discontinued by ~~the~~ October 1 of the year preceding the rate year or that are paid separately from inpatient services. Inpatient stays that encompass portions of two or more rate years shall have payments established based on payment rates in effect at the time of admission unless the date of admission preceded the rate year in effect by six months or more. In this case, operating payment rates for services rendered during the rate year in effect and established based on the date of admission shall be adjusted to the rate year in effect by the hospital cost index.

(b) For fee-for-service admissions occurring on or after July 1, 2002, the total payment, before third-party liability and spenddown, made to hospitals for inpatient services is reduced by .5 percent from the current statutory rates.

(c) In addition to the reduction in paragraph (b), the total payment for fee-for-service admissions occurring on or after July 1, 2003, made to hospitals for inpatient services before third-party liability and spenddown, is reduced five percent from the current statutory rates. Mental health services within diagnosis related groups 424 to 432 or corresponding APR-DRGs, and facilities defined under subdivision 16 are excluded from this paragraph.

(d) In addition to the reduction in paragraphs (b) and (c), the total payment for fee-for-service admissions occurring on or after August 1, 2005, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 6.0 percent from the current statutory rates. Mental health services within diagnosis related groups 424 to 432 or corresponding APR-DRGs, and facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after January 1, 2006, to reflect this reduction.

(e) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for fee-for-service admissions occurring on or after July 1, 2008, through June 30, 2009, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 3.46 percent from the current statutory rates. Mental health services with diagnosis related groups 424 to 432 or corresponding APR-DRGs, and facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after January 1, 2009, through June 30, 2009, to reflect this reduction.

(f) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for fee-for-service admissions occurring on or after July 1, 2009, through June 30, 2011, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 1.9 percent from the current statutory rates. Mental health services with diagnosis related groups 424 to 432 or corresponding APR-DRGs, and facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after July 1, 2009, through June 30, 2011, to reflect this reduction.

(g) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for fee-for-service admissions occurring on or after July 1, 2011, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 1.79 percent from the current statutory rates. Mental health services with diagnosis related groups 424 to 432 or corresponding APR-DRGs, and facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after July 1, 2011, to reflect this reduction.

(h) In addition to the reductions in paragraphs (b), (c), (d), (f), and (g), the total payment for fee-for-service admissions occurring on or after July 1, 2009, made to hospitals for inpatient services before third-party liability and spenddown, is reduced one percent from the current statutory rates. Facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after October 1, 2009, to reflect this reduction.

(i) In addition to the reductions in paragraphs (b), (c), (d), (g), and (h), the total payment for fee-for-service admissions occurring on or after July 1, 2011, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 1.96 percent from the current statutory rates. Facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after January 1, 2011, to reflect this reduction.

(j) Effective for discharges on and after November 1, 2014, from hospitals paid under subdivision 2b, paragraph (a), clauses (1) and (4), the rate adjustments in this subdivision must be incorporated into the rebased rates established under subdivision 2b, paragraph (c), and must not be applied to each claim.

(k) Effective for discharges on and after July 1, 2015, from hospitals paid under subdivision 2b, paragraph (a), clauses (2) and (3), the rate adjustments in this subdivision must be incorporated into the rates and must not be applied to each claim.

(l) Effective for discharges on and after July 1, 2017, from hospitals paid under subdivision 2b, paragraph (a), clause (2), the rate adjustments in this subdivision must be incorporated into the rates and must not be applied to each claim.

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

Sec. 10. Minnesota Statutes 2016, section 256.969, subdivision 3c, is amended to read:

Subd. 3c. **~~Rateable~~ Ratable reduction and readmissions reduction.** (a) The total payment for fee for service admissions occurring on or after September 1, 2011, to October 31, 2014, made to hospitals for inpatient services before third-party liability and spenddown, is reduced ten percent from the current statutory rates. Facilities defined under subdivision 16, long-term hospitals as determined under the Medicare program, children's hospitals whose inpatients are predominantly under 18 years of age, and payments under managed care are excluded from this paragraph.

(b) Effective for admissions occurring during calendar year 2010 and each year after, the commissioner shall calculate a readmission rate for admissions to all hospitals occurring within 30 days of a previous discharge using data from the Reducing Avoidable Readmissions Effectively (RARE) campaign. The commissioner may adjust the readmission rate taking into account factors such as the medical relationship, complicating conditions, and sequencing of treatment between the initial admission and subsequent readmissions.

(c) Effective for payments to all hospitals on or after July 1, 2013, through October 31, 2014, the reduction in paragraph (a) is reduced one percentage point for every percentage point reduction in the overall readmissions rate between the two previous calendar years to a maximum of five percent.

(d) The exclusion from the rate reduction in paragraph (a) shall apply to a hospital located in Hennepin County with a licensed capacity of 1,700 beds as of September 1, 2011, for admissions of children under 18 years of age occurring on or after September 1, 2011, through August 31, 2013, but shall not apply to payments for admissions occurring on or after September 1, 2013, through October 31, 2014.

(e) Effective for discharges on or after November 1, 2014, from hospitals paid under subdivision 2b, paragraph (a), clauses (1) and (4), the rate adjustments in this subdivision must be incorporated into the rebased rates established under subdivision 2b, paragraph (c), and must not be applied to each claim.

(f) Effective for discharges on and after July 1, 2015, from hospitals paid under subdivision 2b, paragraph (a), clauses (2) and (3), the rate adjustments in this subdivision must be incorporated into the rates and must not be applied to each claim.

(g) Effective for discharges on and after July 1, 2017, from hospitals paid under subdivision 2b, paragraph (a), clause (2), the rate adjustments in this subdivision must be incorporated into the rates and must not be applied to each claim.

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

Sec. 11. Minnesota Statutes 2016, section 256.969, subdivision 4b, is amended to read:

Subd. 4b. **Medical assistance cost reports for services.** (a) A hospital that meets one of the following criteria must annually submit to the commissioner medical assistance cost reports within six months of the end of the hospital's fiscal year:

(1) a hospital designated as a critical access hospital that receives medical assistance payments; ~~or~~

(2) a Minnesota hospital or out-of-state hospital located within a Minnesota local trade area that receives a disproportionate population adjustment under subdivision 9; or

(3) a Minnesota hospital that is a licensed children's hospital.

For purposes of this subdivision, local trade area has the meaning given in subdivision 17.

(b) The commissioner shall suspend payments to any hospital that fails to submit a report required under this subdivision. Payments must remain suspended until the report has been filed with and accepted by the commissioner.

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

Sec. 12. Minnesota Statutes 2016, section 256.969, subdivision 8, is amended to read:

Subd. 8. **Unusual length of stay experience.** (a) The commissioner shall establish day outlier thresholds for each diagnostic category established under subdivision 2 at two standard deviations beyond the mean length of stay. Payment for the days beyond the outlier threshold shall be in addition to the operating and property payment rates per admission established under subdivisions 2 and 2b. Payment for outliers shall be at 70 percent of the allowable operating cost, after adjustment by the case mix index, hospital cost index, relative values and the disproportionate population adjustment. The outlier threshold for neonatal and burn diagnostic categories shall be established at one standard deviation beyond the mean length

of stay, and payment shall be at 90 percent of allowable operating cost calculated in the same manner as other outliers. A hospital may choose an alternative to the 70 percent outlier payment that is at a minimum of 60 percent and a maximum of 80 percent if the commissioner is notified in writing of the request by October 1 of the year preceding the rate year. The chosen percentage applies to all diagnostic categories except burns and neonates. The percentage of allowable cost that is unrecognized by the outlier payment shall be added back to the base year operating payment rate per admission.

(b) Effective for admissions and transfers occurring on and after November 1, 2014, the commissioner shall establish payment rates for outlier payments that are based on Medicare methodologies.

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

Sec. 13. Minnesota Statutes 2016, section 256.969, subdivision 8c, is amended to read:

Subd. 8c. **Hospital residents.** (a) For discharges occurring on or after November 1, 2014, payments for hospital residents shall be made as follows:

(1) payments for the first 180 days of inpatient care shall be the APR-DRG system plus any outliers; and

(2) payment for all medically necessary patient care subsequent to the first 180 days shall be reimbursed at a rate computed by multiplying the statewide average cost-to-charge ratio by the usual and customary charges.

(b) For discharges occurring on or after July 1, 2017, payment for hospital residents shall be equal to the payments under subdivision 8, paragraph (b).

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

Sec. 14. Minnesota Statutes 2016, section 256.969, subdivision 9, is amended to read:

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

(1) for a hospital with a medical assistance inpatient utilization rate above the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian

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

(2) for a hospital with a medical assistance inpatient utilization rate above one standard deviation above the mean, the adjustment must be determined by multiplying the adjustment that would be determined under clause (1) for that hospital by 1.1. The commissioner shall report annually on the number of hospitals likely to receive the adjustment authorized by this paragraph. The commissioner shall specifically report on the adjustments received by public hospitals and public hospital corporations located in cities of the first class.

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

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

(d) Effective July 1, 2015, disproportionate share hospital (DSH) payments shall be paid in accordance with a new methodology using 2012 as the base year. Annual payments made under this paragraph shall equal the total amount of payments made for 2012. A licensed children's hospital shall receive only a single DSH factor for children's hospitals. Other DSH factors may be combined to arrive at a single factor for each hospital that is eligible for DSH payments. The new methodology shall make payments only to hospitals located in Minnesota and include the following factors:

(1) a licensed children's hospital with at least 1,000 fee-for-service discharges in the base year shall receive a factor of 0.868. A licensed children's hospital with less than 1,000 fee-for-service discharges in the base year shall receive a factor of 0.7880;

(2) a hospital that has in effect for the initial rate year a contract with the commissioner to provide extended psychiatric inpatient services under section 256.9693 shall receive a factor of 0.0160;

(3) a hospital that has received payment from the fee-for-service program for at least 20 transplant services in the base year shall receive a factor of 0.0435;

(4) a hospital that has a medical assistance utilization rate in the base year between 20 percent up to one standard deviation above the statewide mean utilization rate shall receive a factor of 0.0468;

(5) a hospital that has a medical assistance utilization rate in the base year that is at least one standard deviation above the statewide mean utilization rate but is less than three standard deviations above the mean shall receive a factor of 0.2300; and

(6) a hospital that has a medical assistance utilization rate in the base year that is at least three standard deviations above the statewide mean utilization rate shall receive a factor of 0.3711.

(e) Any payments or portion of payments made to a hospital under this subdivision that are subsequently returned to the commissioner because the payments are found to exceed the hospital-specific DSH limit for that hospital shall be redistributed, proportionate to the number of fee-for-service discharges, to other DSH-eligible ~~nonchildren's~~ non-children's hospitals that have a medical assistance utilization rate that is at least one standard deviation above the mean.

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

Sec. 15. Minnesota Statutes 2016, section 256.969, subdivision 12, is amended to read:

Subd. 12. **Rehabilitation hospitals and distinct parts.** (a) Units of hospitals that are recognized as rehabilitation distinct parts by the Medicare program shall have separate provider numbers under the medical assistance program for rate establishment and billing purposes only. These units shall also have operating payment rates and the disproportionate population adjustment, if allowed by federal law, established separately from other inpatient hospital services.

(b) The commissioner shall establish separate relative values under subdivision 2 for rehabilitation hospitals and distinct parts as defined by the Medicare program. Effective for discharges occurring on and after November 1, 2014, the commissioner, to the extent possible, shall replicate the existing payment rate methodology under the new diagnostic classification system. The result must be budget neutral, ensuring that the total aggregate payments under the new system are equal to the total aggregate payments made for the same number and types of services in the base year, calendar year 2012.

(c) For individual hospitals that did not have separate medical assistance rehabilitation provider numbers or rehabilitation distinct parts in the base year, hospitals shall provide the information needed to separate rehabilitation distinct part cost and claims data from other inpatient service data.

(d) Effective with discharges on or after July 1, 2017, payment to rehabilitation hospitals shall be established under subdivision 2d, paragraph (a), clause (4).

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

Sec. 16. **[256B.0371] ADMINISTRATION OF DENTAL SERVICES.**

Subdivision 1. **Contract for dental administration services.** (a) The commissioner shall contract with up to two dental administrators to administer dental services for all recipients of medical assistance and MinnesotaCare.

(b) The dental administrator must provide administrative services including, but not limited to:

(1) provider recruitment, contracting, and assistance;

(2) recipient outreach and assistance;

(3) utilization management and review for medical necessity of dental services;

(4) dental claims processing, including submission of encounter claims to the department;

(5) coordination with other services;

(6) management of fraud and abuse;

(7) monitoring of access to dental services;

(8) performance measurement;

(9) quality improvement and evaluation requirements; and

(10) management of third party liability requirements.

(c) A payment to a contracted dental provider shall be at the rates established under section 256B.76.

EFFECTIVE DATE. This section is effective January 1, 2019.

Sec. 17. Minnesota Statutes 2016, section 256B.04, subdivision 21, is amended to read:

Subd. 21. **Provider enrollment.** (a) The commissioner shall enroll providers and conduct screening activities as required by Code of Federal Regulations, title 42, section 455, subpart

E, including database checks, unannounced pre- and post-enrollment site visits, fingerprinting, and criminal background studies. A provider providing services from multiple locations must enroll each location separately. The commissioner may deny a provider's incomplete application for enrollment if a provider fails to respond to the commissioner's request for additional information within 60 days of the request.

(b) The commissioner must revalidate each provider under this subdivision at least once every five years. The commissioner may revalidate a personal care assistance agency under this subdivision once every three years. The commissioner shall conduct revalidation as follows:

(1) provide 30-day notice of revalidation due date to include instructions for revalidation and a list of materials the provider must submit to revalidate;

(2) notify the provider that fails to completely respond within 30 days of any deficiencies and allow an additional 30 days to comply; and

(3) give 60-day notice of termination and immediately suspend a provider's ability to bill for failure to remedy any deficiencies within the 30-day time period. The provider shall have no right to appeal suspension of ability to bill.

(c) The commissioner shall require that an individual rendering care to a recipient for the following covered services enroll as an individual provider and be identified on claims:

(1) adult rehabilitative mental health services according to section 256B.0623;

(2) autism early intensive behavioral intervention benefits according to section 256B.0949;

(3) home and community-based waiver services, consumer directed community supports; and

(4) qualified professionals supervising personal care assistant services according to section 256B.0659.

(d) The commissioner may suspend a provider's ability to bill for a failure to comply with any individual provider requirements or conditions of participation until the provider comes into compliance. The commissioner's decision to suspend the provider is not subject to an administrative appeal.

(e) Notwithstanding any other provision to the contrary, all correspondence and notifications, including notifications of termination and other actions, shall be delivered

electronically to a provider's MN-ITS mailbox. For a provider that does not have a MN-ITS account and mailbox, notice shall be sent by first class mail.

(f) If the commissioner or the Centers for Medicare and Medicaid Services determines that a provider is designated "high-risk," the commissioner may withhold payment from providers within that category upon initial enrollment for a 90-day period. The withholding for each provider must begin on the date of the first submission of a claim.

~~(b)~~ (g) An enrolled provider that is also licensed by the commissioner under chapter 245A, or is licensed as a home care provider by the Department of Health under chapter 144A and has a home and community-based services designation on the home care license under section 144A.484, must designate an individual as the entity's compliance officer. The compliance officer must:

(1) develop policies and procedures to assure adherence to medical assistance laws and regulations and to prevent inappropriate claims submissions;

(2) train the employees of the provider entity, and any agents or subcontractors of the provider entity including billers, on the policies and procedures under clause (1);

(3) respond to allegations of improper conduct related to the provision or billing of medical assistance services, and implement action to remediate any resulting problems;

(4) use evaluation techniques to monitor compliance with medical assistance laws and regulations;

(5) promptly report to the commissioner any identified violations of medical assistance laws or regulations; and

(6) within 60 days of discovery by the provider of a medical assistance reimbursement overpayment, report the overpayment to the commissioner and make arrangements with the commissioner for the commissioner's recovery of the overpayment.

The commissioner may require, as a condition of enrollment in medical assistance, that a provider within a particular industry sector or category establish a compliance program that contains the core elements established by the Centers for Medicare and Medicaid Services.

~~(c)~~ (h) The commissioner may revoke the enrollment of an ordering or rendering provider for a period of not more than one year, if the provider fails to maintain and, upon request from the commissioner, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by such provider, when the commissioner has identified a pattern of a lack of documentation. A pattern means a failure

to maintain documentation or provide access to documentation on more than one occasion. Nothing in this paragraph limits the authority of the commissioner to sanction a provider under the provisions of section 256B.064.

~~(d)~~ (i) The commissioner shall terminate or deny the enrollment of any individual or entity if the individual or entity has been terminated from participation in Medicare or under the Medicaid program or Children's Health Insurance Program of any other state.

~~(e)~~ (j) As a condition of enrollment in medical assistance, the commissioner shall require that a provider designated "moderate" or "high-risk" by the Centers for Medicare and Medicaid Services or the commissioner permit the Centers for Medicare and Medicaid Services, its agents, or its designated contractors and the state agency, its agents, or its designated contractors to conduct unannounced on-site inspections of any provider location. The commissioner shall publish in the Minnesota Health Care Program Provider Manual a list of provider types designated "limited," "moderate," or "high-risk," based on the criteria and standards used to designate Medicare providers in Code of Federal Regulations, title 42, section 424.518. The list and criteria are not subject to the requirements of chapter 14. The commissioner's designations are not subject to administrative appeal.

~~(f)~~ (k) As a condition of enrollment in medical assistance, the commissioner shall require that a high-risk provider, or a person with a direct or indirect ownership interest in the provider of five percent or higher, consent to criminal background checks, including fingerprinting, when required to do so under state law or by a determination by the commissioner or the Centers for Medicare and Medicaid Services that a provider is designated high-risk for fraud, waste, or abuse.

~~(g)~~ (l)(1) Upon initial enrollment, reenrollment, and notification of revalidation, all durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) medical suppliers meeting the durable medical equipment provider and supplier definition in clause (3), operating in Minnesota and receiving Medicaid funds must purchase a surety bond that is annually renewed and designates the Minnesota Department of Human Services as the obligee, and must be submitted in a form approved by the commissioner. For purposes of this clause, the following medical suppliers are not required to obtain a surety bond: a federally qualified health center, a home health agency, the Indian Health Service, a pharmacy, and a rural health clinic.

(2) At the time of initial enrollment or reenrollment, durable medical equipment providers and suppliers defined in clause (3) must purchase a surety bond of $50,000. If a revalidating provider's Medicaid revenue in the previous calendar year is up to and including $300,000,

the provider agency must purchase a surety bond of $50,000. If a revalidating provider's Medicaid revenue in the previous calendar year is over $300,000, the provider agency must purchase a surety bond of $100,000. The surety bond must allow for recovery of costs and fees in pursuing a claim on the bond.

(3) "Durable medical equipment provider or supplier" means a medical supplier that can purchase medical equipment or supplies for sale or rental to the general public and is able to perform or arrange for necessary repairs to and maintenance of equipment offered for sale or rental.

~~(h)~~ (m) The Department of Human Services may require a provider to purchase a surety bond as a condition of initial enrollment, reenrollment, reinstatement, or continued enrollment if: (1) the provider fails to demonstrate financial viability, (2) the department determines there is significant evidence of or potential for fraud and abuse by the provider, or (3) the provider or category of providers is designated high-risk pursuant to paragraph ~~(a)~~ (e) and as per Code of Federal Regulations, title 42, section 455.450. The surety bond must be in an amount of $100,000 or ten percent of the provider's payments from Medicaid during the immediately preceding 12 months, whichever is greater. The surety bond must name the Department of Human Services as an obligee and must allow for recovery of costs and fees in pursuing a claim on the bond. This paragraph does not apply if the provider currently maintains a surety bond under the requirements in section 256B.0659 or 256B.85.

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

Sec. 18. Minnesota Statutes 2016, section 256B.04, subdivision 22, is amended to read:

Subd. 22. **Application fee.** (a) The commissioner must collect and retain federally required nonrefundable application fees to pay for provider screening activities in accordance with Code of Federal Regulations, title 42, section 455, subpart E. The enrollment application must be made under the procedures specified by the commissioner, in the form specified by the commissioner, and accompanied by an application fee described in paragraph (b), or a request for a hardship exception as described in the specified procedures. Application fees must be deposited in the provider screening account in the special revenue fund. Amounts in the provider screening account are appropriated to the commissioner for costs associated with the provider screening activities required in Code of Federal Regulations, title 42, section 455, subpart E. The commissioner ~~shall conduct screening activities as required by Code of Federal Regulations, title 42, section 455, subpart E, and as otherwise provided by law, to include database checks, unannounced pre- and postenrollment site visits, fingerprinting, and criminal background studies. The commissioner must revalidate~~

~~all providers under this subdivision at least once every five years~~ must revalidate all personal care assistance agencies under this subdivision at least once every three years.

(b) The application fee under this subdivision is $532 for the calendar year 2013. For calendar year 2014 and subsequent years, the fee:

(1) is adjusted by the percentage change to the Consumer Price Index for all urban consumers, United States city average, for the 12-month period ending with June of the previous year. The resulting fee must be announced in the Federal Register;

(2) is effective from January 1 to December 31 of a calendar year;

(3) is required on the submission of an initial application, an application to establish a new practice location, an application for reenrollment when the provider is not enrolled at the time of application of reenrollment, or at revalidation when required by federal regulation; and

(4) must be in the amount in effect for the calendar year during which the application for enrollment, new practice location, or reenrollment is being submitted.

(c) The application fee under this subdivision cannot be charged to:

(1) providers who are enrolled in Medicare or who provide documentation of payment of the fee to, and enrollment with, another state, unless the commissioner is required to rescreen the provider;

(2) providers who are enrolled but are required to submit new applications for purposes of reenrollment;

(3) a provider who enrolls as an individual; and

(4) group practices and clinics that bill on behalf of individually enrolled providers within the practice who have reassigned their billing privileges to the group practice or clinic.

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

Sec. 19. Minnesota Statutes 2016, section 256B.055, subdivision 2, is amended to read:

Subd. 2. **Subsidized foster children.** Medical assistance may be paid for a child eligible for or receiving foster care maintenance payments under Title IV-E of the Social Security Act, United States Code, title 42, sections 670 to 676, and to any child who is not title IV-E eligible but who is determined eligible for foster care or kinship assistance under chapter 256N.

EFFECTIVE DATE. This section is effective January 1, 2019, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 20. Minnesota Statutes 2016, section 256B.055, subdivision 7, is amended to read:

Subd. 7. **~~Aged, blind, or disabled persons~~ Age 65 or older.** ~~(a)~~ Medical assistance may be paid for a person who is age 65 or older and meets the categorical eligibility requirements of the Supplemental Security Income program or, who would meet those requirements except for excess income or assets, and who meets the other eligibility requirements of this section.

~~(b) Following a determination that the applicant is not aged or blind and does not meet any other category of eligibility for medical assistance and has not been determined disabled by the Social Security Administration, applicants under this subdivision shall be referred to the commissioner's state medical review team for a determination of disability.~~

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

Sec. 21. Minnesota Statutes 2016, section 256B.055, is amended by adding a subdivision to read:

Subd. 7b. **Persons who are blind or who have been determined disabled.** (a) Medical assistance may be paid for a person who meets the categorical eligibility requirements of the Supplemental Security Income program or who would meet those requirements except for excess income or assets and who meets the other eligibility requirements of this section.

(b) Following a determination that the applicant is not blind and does not meet any other category of eligibility for medical assistance and has not been determined disabled by the Social Security Administration, an applicant under this subdivision shall be referred to the commissioner's state medical review team for a determination of disability.

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

Sec. 22. Minnesota Statutes 2016, section 256B.056, subdivision 1b, is amended to read:

Subd. 1b. **~~Aged, blind, and disabled~~ Age 65 or older income methodology.** The $20 general income disregard allowed under the Supplemental Security Income program is included in the standard and shall not be allowed as a deduction from income for a person eligible under section 256B.055, ~~subdivisions~~ subdivision 7~~, 7a, and 12~~.

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

Sec. 23. Minnesota Statutes 2016, section 256B.056, is amended by adding a subdivision to read:

Subd. 1e. **Income methodology for persons who are blind or who have been determined disabled.** The $20 general income disregard allowed under the Supplemental Security Income program is included in the standard and shall not be allowed as a deduction from income for a person eligible under section 256B.055, subdivisions 7a, 7b, and 12.

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

Sec. 24. Minnesota Statutes 2016, section 256B.056, subdivision 3b, is amended to read:

Subd. 3b. **Treatment of trusts.** (a) A "medical assistance qualifying trust" is a revocable or irrevocable trust, or similar legal device, established on or before August 10, 1993, by a person or the person's spouse under the terms of which the person receives or could receive payments from the trust principal or income and the trustee has discretion in making payments to the person from the trust principal or income. Notwithstanding that definition, a medical assistance qualifying trust does not include: (1) a trust set up by will; (2) a trust set up before April 7, 1986, solely to benefit a person with a developmental disability living in an intermediate care facility for persons with developmental disabilities; or (3) a trust set up by a person with payments made by the Social Security Administration pursuant to the United States Supreme Court decision in Sullivan v. Zebley, 110 S. Ct. 885 (1990). The maximum amount of payments that a trustee of a medical assistance qualifying trust may make to a person under the terms of the trust is considered to be available assets to the person, without regard to whether the trustee actually makes the maximum payments to the person and without regard to the purpose for which the medical assistance qualifying trust was established.

(b) ~~Except as provided in paragraphs (c) and (d),~~ Trusts established after August 10, 1993, are treated according to ~~section 13611(b) of the Omnibus Budget Reconciliation Act of 1993 (OBRA), Public Law 103-66~~ United States Code, title 42, section 1396p(d).

(c) For purposes of paragraph (d), a pooled trust means a trust established under United States Code, title 42, section 1396p(d)(4)(C).

(d) A beneficiary's interest in a pooled trust is considered an available asset unless the trust provides that upon the death of the beneficiary or termination of the trust during the beneficiary's lifetime, whichever is sooner, the department receives any amount, up to the amount of medical assistance benefits paid on behalf of the beneficiary, remaining in the beneficiary's trust account after a deduction for reasonable administrative fees and expenses,

and an additional remainder amount. The retained remainder amount of the subaccount must not exceed ten percent of the account value at the time of the beneficiary's death or termination of the trust, and must only be used for the benefit of disabled individuals who have a beneficiary interest in the pooled trust.

(e) Trusts may be established on or after December 12, 2016, by a person who has been determined to be disabled, according to United States Code, title 42, section 1396p(d)(4)(A), as amended by section 5007 of the 21st Century Cures Act, Public Law 114-255.

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

Sec. 25. Minnesota Statutes 2016, section 256B.056, subdivision 3c, is amended to read:

Subd. 3c. **Asset limitations for families and children.** (a) A household of two or more persons must not own more than $20,000 in total net assets, and a household of one person must not own more than $10,000 in total net assets. In addition to these maximum amounts, an eligible individual or family may accrue interest on these amounts, but they must be reduced to the maximum at the time of an eligibility redetermination. The value of assets that are not considered in determining eligibility for medical assistance for families and children is the value of those assets excluded under the AFDC state plan as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law 104-193, with the following exceptions:

(1) household goods and personal effects are not considered;

(2) capital and operating assets of a trade or business up to $200,000 are not considered~~, except that a bank account that contains personal income or assets, or is used to pay personal expenses, is not considered a capital or operating asset of a trade or business~~;

(3) one motor vehicle is excluded for each person of legal driving age who is employed or seeking employment;

(4) assets designated as burial expenses are excluded to the same extent they are excluded by the Supplemental Security Income program;

(5) court-ordered settlements up to $10,000 are not considered;

(6) individual retirement accounts and funds are not considered;

(7) assets owned by children are not considered; and

(8) effective July 1, 2009, certain assets owned by American Indians are excluded as required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public

Law 111-5. For purposes of this clause, an American Indian is any person who meets the definition of Indian according to Code of Federal Regulations, title 42, section 447.50.

~~The assets specified in clause (2) must be disclosed to the local agency at the time of application and at the time of an eligibility redetermination, and must be verified upon request of the local agency.~~

(b) Beginning January 1, 2014, this subdivision applies only to parents and caretaker relatives who qualify for medical assistance under subdivision 5.

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

Sec. 26. Minnesota Statutes 2016, section 256B.056, subdivision 3d, is amended to read:

Subd. 3d. **Reduction of excess assets for people age 65 or older.** For people age 65 or older, assets in excess of the limits in ~~subdivisions~~ subdivision 3 ~~to 3c~~ may be reduced to allowable limits as follows:

(a) Assets may be reduced in any of the three calendar months before the month of application in which the applicant seeks coverage by paying bills for health services that are incurred in the retroactive period for which the applicant seeks eligibility, starting with the oldest bill. After assets are reduced to allowable limits, eligibility begins with the next dollar of MA-covered health services incurred in the retroactive period. Applicants reducing assets under this subdivision who also have excess income shall first spend excess assets to pay health service bills and may meet the income spenddown on remaining bills.

(b) Assets may be reduced beginning the month of application by paying bills for health services that are incurred during the period specified in Minnesota Rules, part 9505.0090, subpart 2, that would otherwise be paid by medical assistance. After assets are reduced to allowable limits, eligibility begins with the next dollar of medical assistance covered health services incurred in the period. Applicants reducing assets under this subdivision who also have excess income shall first spend excess assets to pay health service bills and may meet the income spenddown on remaining bills.

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

Sec. 27. Minnesota Statutes 2016, section 256B.056, is amended by adding a subdivision to read:

Subd. 3f. **Reduction of excess assets for people under age 65.** (a) For a person younger than 65 years of age, assets in excess of the limits in subdivision 3 or 3c may be reduced to allowable limits according to this subdivision.

(b) A person's assets may be reduced in any of the three calendar months before the month of application in which the person seeks coverage by:

(1) designating burial funds up to $1,500 for each applicant, the applicant's spouse, and the applicant's medical assistance-eligible dependent child; and

(2) paying bills for health services that are incurred in the retroactive period for which the person seeks eligibility, starting with the oldest bill. After assets are reduced to allowable limits, eligibility begins with the next dollar of medical assistance-covered health services incurred in the retroactive period. An applicant reducing assets under this subdivision who also has excess income shall first spend excess assets to pay health services bills and may meet the income spenddown on remaining bills.

(c) A person's assets may be reduced beginning the month of application by:

(1) paying bills for health services that are incurred during the period specified in Minnesota Rules, part 9505.0090, subpart 2, that would otherwise be paid by medical assistance; and

(2) using any means other than a transfer of assets for less than fair market value defined in section 256B.0595, subdivision 1, paragraph (b).

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

Sec. 28. Minnesota Statutes 2016, section 256B.057, subdivision 9, is amended to read:

Subd. 9. **Employed persons with disabilities.** (a) Medical assistance may be paid for a person who is employed and who:

(1) but for excess earnings or assets, meets the definition of disabled under the Supplemental Security Income program;

(2) meets the asset limits in paragraph (d); and

(3) pays a premium and other obligations under paragraph (e).

(b) For purposes of eligibility, there is a $65 earned income disregard. To be eligible for medical assistance under this subdivision, a person must have more than $65 of earned income. Earned income must have Medicare, Social Security, and applicable state and federal taxes withheld. The person must document earned income tax withholding. Any spousal income or assets shall be disregarded for purposes of eligibility and premium determinations.

(c) After the month of enrollment, a person enrolled in medical assistance under this subdivision who:

(1) is temporarily unable to work and without receipt of earned income due to a medical condition, as verified by a physician; or

(2) loses employment for reasons not attributable to the enrollee, and is without receipt of earned income may retain eligibility for up to four consecutive months after the month of job loss. To receive a four-month extension, enrollees must verify the medical condition or provide notification of job loss. All other eligibility requirements must be met and the enrollee must pay all calculated premium costs for continued eligibility.

(d) For purposes of determining eligibility under this subdivision, a person's assets must not exceed $20,000, excluding:

(1) all assets excluded under section 256B.056;

(2) retirement accounts, including individual accounts, 401(k) plans, 403(b) plans, Keogh plans, and pension plans;

(3) medical expense accounts set up through the person's employer; and

(4) spousal assets, including spouse's share of jointly held assets.

(e) All enrollees must pay a premium to be eligible for medical assistance under this subdivision, except as provided under clause (5).

(1) An enrollee must pay the greater of a $35 premium or the premium calculated based on the person's gross earned and unearned income and the applicable family size using a sliding fee scale established by the commissioner, which begins at one percent of income at 100 percent of the federal poverty guidelines and increases to 7.5 percent of income for those with incomes at or above 300 percent of the federal poverty guidelines.

(2) Annual adjustments in the premium schedule based upon changes in the federal poverty guidelines shall be effective for premiums due in July of each year.

(3) All enrollees who receive unearned income must pay one-half of one percent of unearned income in addition to the premium amount, except as provided under clause (5).

(4) Increases in benefits under title II of the Social Security Act shall not be counted as income for purposes of this subdivision until July 1 of each year.

(5) Effective July 1, 2009, American Indians are exempt from paying premiums as required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public

Law 111-5. For purposes of this clause, an American Indian is any person who meets the definition of Indian according to Code of Federal Regulations, title 42, section 447.50.

(f) A person's eligibility and premium shall be determined by the local county agency. Premiums must be paid to the commissioner. All premiums are dedicated to the commissioner.

(g) Any required premium shall be determined at application and redetermined at the enrollee's six-month income review or when a change in income or household size is reported. Enrollees must report any change in income or household size within ten days of when the change occurs. A decreased premium resulting from a reported change in income or household size shall be effective the first day of the next available billing month after the change is reported. Except for changes occurring from annual cost-of-living increases, a change resulting in an increased premium shall not affect the premium amount until the next six-month review.

(h) Premium payment is due upon notification from the commissioner of the premium amount required. Premiums may be paid in installments at the discretion of the commissioner.

(i) Nonpayment of the premium shall result in denial or termination of medical assistance unless the person demonstrates good cause for nonpayment. ~~Good cause exists if the requirements specified in Minnesota Rules, part 9506.0040, subpart 7, items B to D, are met~~ "Good cause" means an excuse for the enrollee's failure to pay the required premium when due because the circumstances were beyond the enrollee's control or not reasonably foreseeable. The commissioner shall determine whether good cause exists based on the weight of the supporting evidence submitted by the enrollee to demonstrate good cause. Except when an installment agreement is accepted by the commissioner, all persons disenrolled for nonpayment of a premium must pay any past due premiums as well as current premiums due prior to being reenrolled. Nonpayment shall include payment with a returned, refused, or dishonored instrument. The commissioner may require a guaranteed form of payment as the only means to replace a returned, refused, or dishonored instrument.

(j) For enrollees whose income does not exceed 200 percent of the federal poverty guidelines and who are also enrolled in Medicare, the commissioner shall reimburse the enrollee for Medicare part B premiums under section 256B.0625, subdivision 15, paragraph (a).

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

Sec. 29. Minnesota Statutes 2016, section 256B.059, subdivision 6, is amended to read:

Subd. 6. **Temporary application.** (a) During the period in which rules against spousal impoverishment are temporarily applied according to section 2404 of the Patient Protection Affordable Care Act, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, this section applies to an institutionalized spouse:

(1) applying for home and community-based waivers under sections 256B.092, 256B.093, and 256B.49 on or after June 1, 2016;

(2) enrolled in home and community-based waivers under sections 256B.092, 256B.093, and 256B.49 before June 1, 2016, based on an application submitted on or after January 1, 2014; or

(3) applying for services under section 256B.85 upon the effective date of that section.

(b) During the applicable period of paragraph (a), the definition of "institutionalized spouse" in subdivision 1, paragraph (f), also includes an institutionalized spouse referenced in paragraph (a).

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

Sec. 30. Minnesota Statutes 2016, section 256B.0625, is amended by adding a subdivision to read:

Subd. 1b. **Medical necessity criteria for inpatient hospital treatment.** (a) The medical review agent shall determine whether:

(1) a recipient's admission is medically necessary;

(2) the inpatient hospital services provided to the recipient were medically necessary;

(3) the recipient's continued stay was or will be medically necessary; and

(4) all medically necessary inpatient hospital services were provided to the recipient.

(b) The medical review agent shall determine the medical necessity of inpatient hospital services and inpatient psychiatric treatment services based on a review of the recipient's medical condition and records in conjunction with an industry-standard, evidence-based clinical decision tool to ensure consistent and optimal application of medical appropriateness criteria.

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

Sec. 31. Minnesota Statutes 2016, section 256B.0625, subdivision 3a, is amended to read:

Subd. 3a. **~~Sex reassignment~~ Gender confirmation surgery.** ~~Sex reassignment~~ Gender confirmation surgery is ~~not~~ covered when medically necessary.

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

Sec. 32. Minnesota Statutes 2016, section 256B.0625, subdivision 18h, is amended to read:

Subd. 18h. **Managed care.** (a) The following subdivisions ~~do not~~ apply to managed care plans and county-based purchasing plans:

(1) subdivision 17, paragraphs ~~(d) to (k)~~ (a), (b), (h), and (n);

(2) subdivision ~~18e~~ 18; and

(3) subdivision ~~18g~~ 18a.

(b) A nonemergency medical transportation provider must comply with the operating standards for special transportation service defined in sections 174.29 to 174.30 and Minnesota Rules, chapter 8840, and in consultation with the Minnesota Department of Transportation. Publicly operated transit systems, volunteers, and not-for-hire vehicles are exempt from the requirements in this paragraph.

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

Sec. 33. Minnesota Statutes 2016, section 256B.0625, subdivision 30, is amended to read:

Subd. 30. **Other clinic services.** (a) Medical assistance covers rural health clinic services, federally qualified health center services, nonprofit community health clinic services, and public health clinic services. Rural health clinic services and federally qualified health center services mean services defined in United States Code, title 42, section 1396d(a)(2)(B) and (C). Payment for rural health clinic and federally qualified health center services shall be made according to applicable federal law and regulation.

(b) A federally qualified health center that is beginning initial operation shall submit an estimate of budgeted costs and visits for the initial reporting period in the form and detail required by the commissioner. A federally qualified health center that is already in operation shall submit an initial report using actual costs and visits for the initial reporting period. Within 90 days of the end of its reporting period, a federally qualified health center shall submit, in the form and detail required by the commissioner, a report of its operations, including allowable costs actually incurred for the period and the actual number of visits

for services furnished during the period, and other information required by the commissioner. Federally qualified health centers that file Medicare cost reports shall provide the commissioner with a copy of the most recent Medicare cost report filed with the Medicare program intermediary for the reporting year which support the costs claimed on their cost report to the state.

(c) In order to continue cost-based payment under the medical assistance program according to paragraphs (a) and (b), a federally qualified health center or rural health clinic must apply for designation as an essential community provider within six months of final adoption of rules by the Department of Health according to section 62Q.19, subdivision 7. For those federally qualified health centers and rural health clinics that have applied for essential community provider status within the six-month time prescribed, medical assistance payments will continue to be made according to paragraphs (a) and (b) for the first three years after application. For federally qualified health centers and rural health clinics that either do not apply within the time specified above or who have had essential community provider status for three years, medical assistance payments for health services provided by these entities shall be according to the same rates and conditions applicable to the same service provided by health care providers that are not federally qualified health centers or rural health clinics.

(d) Effective July 1, 1999, the provisions of paragraph (c) requiring a federally qualified health center or a rural health clinic to make application for an essential community provider designation in order to have cost-based payments made according to paragraphs (a) and (b) no longer apply.

(e) Effective January 1, 2000, payments made according to paragraphs (a) and (b) shall be limited to the cost phase-out schedule of the Balanced Budget Act of 1997.

(f) Effective January 1, 2001, each federally qualified health center and rural health clinic may elect to be paid either under the prospective payment system established in United States Code, title 42, section 1396a(aa), or under an alternative payment methodology consistent with the requirements of United States Code, title 42, section 1396a(aa), and approved by the Centers for Medicare and Medicaid Services. The alternative payment methodology shall be 100 percent of cost as determined according to Medicare cost principles.

(g) For purposes of this section, "nonprofit community clinic" is a clinic that:

(1) has nonprofit status as specified in chapter 317A;

(2) has tax exempt status as provided in Internal Revenue Code, section 501(c)(3);

(3) is established to provide health services to low-income population groups, uninsured, high-risk and special needs populations, underserved and other special needs populations;

(4) employs professional staff at least one-half of which are familiar with the cultural background of their clients;

(5) charges for services on a sliding fee scale designed to provide assistance to low-income clients based on current poverty income guidelines and family size; and

(6) does not restrict access or services because of a client's financial limitations or public assistance status and provides no-cost care as needed.

(h) Effective for services provided on or after January 1, 2015, all claims for payment of clinic services provided by federally qualified health centers and rural health clinics shall be paid by the commissioner. The commissioner shall determine the most feasible method for paying claims from the following options:

(1) federally qualified health centers and rural health clinics submit claims directly to the commissioner for payment, and the commissioner provides claims information for recipients enrolled in a managed care or county-based purchasing plan to the plan, on a regular basis; or

(2) federally qualified health centers and rural health clinics submit claims for recipients enrolled in a managed care or county-based purchasing plan to the plan, and those claims are submitted by the plan to the commissioner for payment to the clinic.

(i) For clinic services provided prior to January 1, 2015, the commissioner shall calculate and pay monthly the proposed managed care supplemental payments to clinics, and clinics shall conduct a timely review of the payment calculation data in order to finalize all supplemental payments in accordance with federal law. Any issues arising from a clinic's review must be reported to the commissioner by January 1, 2017. Upon final agreement between the commissioner and a clinic on issues identified under this subdivision, and in accordance with United States Code, title 42, section 1396a(bb), no supplemental payments for managed care plan or county-based purchasing plan claims for services provided prior to January 1, 2015, shall be made after June 30, 2017. If the commissioner and clinics are unable to resolve issues under this subdivision, the parties shall submit the dispute to the arbitration process under section 14.57.

(j) The commissioner shall seek a federal waiver, authorized under section 1115 of the Social Security Act, to obtain federal financial participation at the 100 percent federal matching percentage available to facilities of the Indian Health Service or tribal organization

in accordance with section 1905(b) of the Social Security Act for expenditures made to organizations dually certified under Title V of the Indian Health Care Improvement Act, Public Law 94-437, and as a federally qualified health center under paragraph (a) that provides services to American Indian and Alaskan Native individuals eligible for services under this subdivision.

(k) Effective for services provided on or after January 1, 2019, all claims for payment of clinic services provided by federally qualified health centers and rural health clinics shall be paid by the commissioner according to the current prospective payment system described in paragraph (f), or an alternative payment methodology with the following requirements:

(1) each federally qualified health center and rural health clinic must receive a single medical and a single dental organization rate;

(2) the commissioner shall reimburse federally qualified health centers and rural health clinics allowable costs, including direct patient care costs and patient-related support services, based upon Medicare cost principles that apply at the time the alternative payment methodology is calculated;

(3) the 2019 payment rates for federally qualified health centers and rural health clinics:

(i) must be determined using each federally qualified health center's and rural health clinic's Medicare cost reports from 2015 and 2016. A provider must submit the required cost reports to the commissioner within six months of the second base year calendar or fiscal year end. Cost reports must be submitted six months before the quarter in which the base rate will take effect;

(ii) must be according to current Medicare cost principles applicable to federally qualified health centers and rural health clinics at the time of the alternative payment rate calculation without the application of productivity screens and upper payment limits or the Medicare prospective payment system federally qualified health center aggregate mean upper payment limit; and

(iii) must provide for a 60-day appeals process;

(4) the commissioner shall inflate the base year payment rate for federally qualified health centers and rural health clinics to the effective date by using the Bureau of Economic Analysis' personal consumption expenditures medical care inflator;

(5) the commissioner shall establish a statewide trend inflator using 2015-2020 costs replacing the use of the personal consumption expenditures medical care inflator with the 2023 rate calculation forward;

(6) federally qualified health center and rural health clinic payment rates shall be rebased by the commissioner every two years using the methodology described in paragraph (k), clause (3), using the provider's Medicare cost reports from the previous third and fourth years. In nonrebasing years, the commissioner shall adjust using the Medicare economic index until 2023 when the statewide trend inflator is available;

(7) the commissioner shall increase payments by two percent according to Laws 2003, First Special Session chapter 14, article 13C, section 2, subdivision 6. This is an add-on to the rate and must not be included in the base rate calculation;

(8) for federally qualified health centers and rural health clinics seeking a change of scope of services:

(i) the commissioner shall require federally qualified health centers and rural health clinics to submit requests with the commissioner if the change of scope would result in the medical or dental payment rate currently received by the federally qualified health center or rural health clinic increasing or decreasing by at least 2-1/2 percent;

(ii) federally qualified health centers and rural health clinics shall submit the request to the commissioner within seven business days of submission of the scope change to the federal Health Resources Services Administration;

(iii) the effective date of the payment change is the date the Health Resources Services Administration approves the federally qualified health center's or rural health clinic's change of scope request;

(iv) for change of scope requests that do not require Health Resources Services Administration approval, federally qualified health centers and rural health clinics shall submit the request to the commissioner before implementing the change, and the effective date of the change is the date the commissioner receives the request from the federally qualified health center or rural health clinic; and

(v) the commissioner shall provide a response to the federally qualified health center's or rural health clinic's change of scope request within 45 days of submission and provide a final decision regarding approval or disapproval within 120 days of submission. If more information is needed to evaluate the request, this timeline may be waived at the mutual agreement of the commissioner and the federally qualified health center or rural health clinic; and

(9) the commissioner shall establish a payment rate for new federally qualified health center and rural health clinic organizations, considering the following factors:

(i) a comparison of patient caseload of federally qualified health centers and rural health clinics within a 60-mile radius for organizations established outside of the seven-county metropolitan area and within a 30-mile radius for organizations within the seven-county metropolitan area; and

(ii) if comparison is not feasible under item (i), the commissioner may use Medicare cost reports or audited financial statements to establish the base rate.

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

Sec. 34. Minnesota Statutes 2016, section 256B.0625, subdivision 45a, is amended to read:

Subd. 45a. **Psychiatric residential treatment facility services for persons under 21 years of age.** (a) Medical assistance covers psychiatric residential treatment facility services for persons under 21 years of age. Individuals who reach age 21 at the time they are receiving services are eligible to continue receiving services until they no longer require services or until they reach age 22, whichever occurs first.

(b) For purposes of this subdivision, "psychiatric residential treatment facility" means a facility other than a hospital that provides psychiatric services, as described in Code of Federal Regulations, title 42, sections 441.151 to 441.182, to individuals under age 21 in an inpatient setting.

(c) The commissioner shall develop admissions and discharge procedures and establish rates consistent with guidelines from the federal Centers for Medicare and Medicaid Services.

(d) The commissioner shall enroll up to 150 certified psychiatric residential treatment facility services beds at up to six sites. The commissioner shall select psychiatric residential treatment facility services providers through a request for proposals process. Providers of state-operated services may respond to the request for proposals.

(e) An individual who is eligible for mental health treatment services in a psychiatric residential treatment facility is an individual who meets all of the following criteria:

(1) has a certificate of need prior to admission, as determined and approved by the state's medical review agent, to determine medical necessity according to Code of Federal Regulations, title 42, section 441.152;

(2) is younger than 21 years of age at the time of admission. Services may continue until the individual meets criteria for discharge or reaches 22 years of age, whichever occurs first;

(3) has a mental health diagnosis as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders, as well as clinical evidence of severe aggression, or the individual is a risk to self or others;

(4) has functional impairment and a history of difficulty in functioning safely and successfully in the community, school, home, or job; an inability to adequately care for one's physical needs; or caregivers, guardians, or family members are unable to safely fulfill the individual's needs;

(5) requires psychiatric residential treatment under the direction of a physician to improve the individual's condition or prevent further regression so that services will no longer be needed;

(6) has utilized and exhausted other community-based mental health services, or clinical evidence indicates that such services cannot provide the level of care needed; and

(7) has been referred for treatment in a psychiatric residential treatment facility by a qualified mental health professional licensed as defined in section 245.4871, subdivision 27, clauses (1) to (6).

A mental health professional making a referral shall submit documentation to the state's medical review agent containing all information necessary to determine eligibility for admission, including a standard diagnostic assessment completed within 180 days of the individual's admission. Documentation shall include evidence of family participation in the individual's treatment planning and signed consent for services.

(f) The commissioner shall establish a statewide per diem rate for psychiatric residential treatment facility services for individuals 21 years of age or younger. The rate for a provider must not exceed the rate charged by that provider for the same service to other payers. Except as provided in paragraph (c), payment will not be made to more than one entity for each individual for services provided under this section on a given day. Rates are set prospectively for the annual rate period. A provider is required to submit annual cost reports on a uniform cost reporting form. A submitted cost report is used to inform the rate-setting process. The cost reporting shall be done according to federal requirements for Medicare cost reports.

(g) "Actual cost" means costs that are allowable, allocable, reasonable, and consistent with federal reimbursement requirements in Code of Federal Regulations, title 48, chapter 1, part 31, relating to for-profit entities, and the Office of Management and Budget Circular Number A-122, relating to nonprofit entities. The following are included in the rate:

(1) development of the individual plan of care, review of the individual plan of care every 30 days, and discharge planning by required members of the treatment team according to Code of Federal Regulations, title 42, sections 441.155 to 441.156;

(2) any services provided by a psychiatrist or physician for development of an individual plan of care, conducting a review of the individual plan of care every 30 days, and discharge planning by required members of the treatment team according to Code of Federal Regulations, title 42, sections 441.155 to 441.156;

(3) active treatment seven days per week, which includes individual, family, and group therapy provided by licensed mental health professionals;

(4) individual therapy, provided a minimum of twice per week;

(5) family engagement activities, provided a minimum of once per week;

(6) consultation with other professionals including case managers, primary care professionals, community-based mental health providers, school staff, or other support planners;

(7) coordination of educational services between local and resident school districts and the facility;

(8) 24-hour nursing;

(9) direct care and supervision, supportive services for daily living and safety, and positive behavior management;

(10) lab and pharmacy related to the diagnosed condition of youth and an individualized plan of care;

(11) costs necessary for licensure and accreditation, meeting all staffing standards for participation, meeting all service standards for participation, meeting all requirements for active treatment, maintaining medical records, conducting utilization review, meeting inspection of care, and discharge planning; and

(12) payment for room and board provided by facilities meeting all accreditation and licensing requirements for participation.

(h) Facilities may submit claims for payment outside of the per diem for professional services arranged by and provided at the facility by an appropriately licensed professional who is enrolled as a provider with Minnesota health care programs. Arranged services shall be billed by the facility on a separate claim, and the facility shall be responsible for payment

to the provider. These services must be included in the individual plan of care and require prior authorization by the state's medical review agent:

(1) physician or psychiatric services outside of the development of the individual plan of care, review of the individual plan of care every 30 days, and discharge planning by required members of the treatment team;

(2) psychological testing;

(3) neuropsychological testing;

(4) health and physical medical consults;

(5) occupational therapy;

(6) physical therapy; and

(7) speech therapy.

(i) Medical assistance covers therapeutic and hospital leave days, provided the recipient was not discharged from the psychiatric residential treatment facility (PRTF) and is expected to return to the PRTF. A reserved bed must be held for a recipient on hospital leave or therapeutic leave.

(j) A therapeutic leave day to home shall be for the purposes of preparing for discharge and reintegration and shall be included in the individual plan of care. The state will reimburse 75 percent of the per diem rate for a reserve bed day while the recipient is on therapeutic leave. A therapeutic leave visit may not exceed three days per visit without prior authorization.

(k) A hospital leave day shall be a day when a recipient requires admission to a hospital for medical or acute psychiatric care and is temporarily absent from the psychiatric residential treatment facility. The state shall reimburse 50 percent of the per diem rate for a reserve bed day while the recipient is receiving medical or psychiatric care in a hospital.

(l) Medicaid shall reimburse for concurrent services as approved by the commissioner to support continuity of care and successful discharge from the facility. "Concurrent services" means services provided by another entity or provider while the individual is admitted to a psychiatric residential treatment facility. Payment for concurrent services may be limited and require prior authorization by the state's medical review agent. Concurrent services may include targeted case management, assertive community treatment, clinical care consultation, team consultation, and treatment planning.

(m) Payment rates under this subdivision shall not include the costs of providing:

(1) educational services;

(2) acute medical care or specialty services for other medical conditions;

(3) dental services; and

(4) pharmacy drug costs for other medical conditions;

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

Sec. 35. Minnesota Statutes 2016, section 256B.0625, subdivision 57, is amended to read:

Subd. 57. **Payment for Part B Medicare crossover claims.** (a) Effective for services provided on or after January 1, 2012, medical assistance payment for an enrollee's cost-sharing associated with Medicare Part B is limited to an amount up to the medical assistance total allowed, when the medical assistance rate exceeds the amount paid by Medicare.

(b) Excluded from this limitation are payments for mental health services and payments for dialysis services provided to end-stage renal disease patients. The exclusion for mental health services does not apply to payments for physician services provided by psychiatrists and advanced practice nurses with a specialty in mental health.

(c) Excluded from this limitation are payments to federally qualified health centers, Indian Health Services, and rural health clinics.

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

Sec. 36. Minnesota Statutes 2016, section 256B.0659, subdivision 21, is amended to read:

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

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

(2) proof of surety bond coverage for each location providing services. Upon new enrollment, or if the provider's Medicaid revenue in the previous calendar year is up to and including $300,000, the provider agency must purchase a surety bond of $50,000. If the Medicaid revenue in the previous year is over $300,000, the provider agency must purchase a surety bond of $100,000. The surety bond must be in a form approved by the commissioner,

must be renewed annually, and must allow for recovery of costs and fees in pursuing a claim on the bond;

(3) proof of fidelity bond coverage in the amount of $20,000 for each business location providing service;

(4) proof of workers' compensation insurance coverage identifying the business address where PCA services are provided from;

(5) proof of liability insurance coverage identifying the business address where PCA services are provided from and naming the department as a certificate holder;

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

~~(7)~~ (6) a copy of the personal care assistance provider agency's written policies and procedures including: hiring of employees; training requirements; service delivery; and employee and consumer safety including process for notification and resolution of consumer grievances, identification and prevention of communicable diseases, and employee misconduct;

~~(8)~~ (7) copies of all other forms the personal care assistance provider agency uses in the course of daily business including, but not limited to:

(i) a copy of the personal care assistance provider agency's time sheet if the time sheet varies from the standard time sheet for personal care assistance services approved by the commissioner, and a letter requesting approval of the personal care assistance provider agency's nonstandard time sheet;

(ii) the personal care assistance provider agency's template for the personal care assistance care plan; and

(iii) the personal care assistance provider agency's template for the written agreement in subdivision 20 for recipients using the personal care assistance choice option, if applicable;

~~(9)~~ (8) a list of all training and classes that the personal care assistance provider agency requires of its staff providing personal care assistance services;

~~(10)~~ (9) documentation that the personal care assistance provider agency and staff have successfully completed all the training required by this section;

~~(11)~~ (10) documentation of the agency's marketing practices;

~~(12)~~ (11) disclosure of ownership, leasing, or management of all residential properties that is used or could be used for providing home care services;

~~(13)~~ (12) documentation that the agency will use the following percentages of revenue generated from the medical assistance rate paid for personal care assistance services for employee personal care assistant wages and benefits: 72.5 percent of revenue in the personal care assistance choice option and 72.5 percent of revenue from other personal care assistance providers. The revenue generated by the qualified professional and the reasonable costs associated with the qualified professional shall not be used in making this calculation; and

~~(14)~~ (13) effective May 15, 2010, documentation that the agency does not burden recipients' free exercise of their right to choose service providers by requiring personal care assistants to sign an agreement not to work with any particular personal care assistance recipient or for another personal care assistance provider agency after leaving the agency and that the agency is not taking action on any such agreements or requirements regardless of the date signed.

(b) Personal care assistance provider agencies shall provide the information specified in paragraph (a) to the commissioner at the time the personal care assistance provider agency enrolls as a vendor or upon request from the commissioner. The commissioner shall collect the information specified in paragraph (a) from all personal care assistance providers beginning July 1, 2009.

(c) All personal care assistance provider agencies shall require all employees in management and supervisory positions and owners of the agency who are active in the day-to-day management and operations of the agency to complete mandatory training as determined by the commissioner before submitting an application for enrollment of the agency as a provider. All personal care assistance provider agencies shall also require qualified professionals to complete the training required by subdivision 13 before submitting an application for enrollment of the agency as a provider. Employees in management and supervisory positions and owners who are active in the day-to-day operations of an agency who have completed the required training as an employee with a personal care assistance provider agency do not need to repeat the required training if they are hired by another agency, if they have completed the training within the past three years. By September 1, 2010, the required training must be available with meaningful access according to title VI of the Civil Rights Act and federal regulations adopted under that law or any guidance from the United States Health and Human Services Department. The required training must be available online or by electronic remote connection. The required training must provide for competency testing. Personal care assistance provider agency billing staff shall complete

training about personal care assistance program financial management. This training is effective July 1, 2009. Any personal care assistance provider agency enrolled before that date shall, if it has not already, complete the provider training within 18 months of July 1, 2009. Any new owners or employees in management and supervisory positions involved in the day-to-day operations are required to complete mandatory training as a requisite of working for the agency. Personal care assistance provider agencies certified for participation in Medicare as home health agencies are exempt from the training required in this subdivision. When available, Medicare-certified home health agency owners, supervisors, or managers must successfully complete the competency test.

(d) All surety bonds, fidelity bonds, workers compensation insurance, and liability insurance required by this subdivision must be maintained continuously. After initial enrollment, a provider must submit proof of bonds and required coverages at any time at the request of the commissioner. Services provided while there are lapses in coverage are not eligible for payment. Lapses in coverage may result in sanctions, including termination. The commissioner shall send instructions and a due date to submit the requested information to the personal care assistance provider agency.

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

Sec. 37. Minnesota Statutes 2016, section 256B.0755, subdivision 1, is amended to read:

Subdivision 1. **Implementation.** (a) The commissioner shall develop and authorize a demonstration project to test alternative and innovative ~~health care delivery systems~~ integrated health partnerships, including accountable care organizations that provide services to a specified patient population for an agreed-upon total cost of care or risk/gain sharing payment arrangement. The commissioner shall develop a request for proposals for participation in the demonstration project in consultation with hospitals, primary care providers, health plans, and other key stakeholders.

(b) In developing the request for proposals, the commissioner shall:

(1) establish uniform statewide methods of forecasting utilization and cost of care for the appropriate Minnesota public program populations, to be used by the commissioner for the ~~health care delivery system~~ integrated health partnership projects;

(2) identify key indicators of quality, access, patient satisfaction, and other performance indicators that will be measured, in addition to indicators for measuring cost savings;

(3) allow maximum flexibility to encourage innovation and variation so that a variety of provider collaborations are able to become ~~health care delivery systems~~ integrated health partnerships;

(4) encourage and authorize different levels and types of financial risk;

(5) encourage and authorize projects representing a wide variety of geographic locations, patient populations, provider relationships, and care coordination models;

(6) encourage projects that involve close partnerships between the ~~health care delivery system~~ integrated health partnership and counties and nonprofit agencies that provide services to patients enrolled with the ~~health care delivery system~~ integrated health partnership, including social services, public health, mental health, community-based services, and continuing care;

(7) encourage projects established by community hospitals, clinics, and other providers in rural communities;

(8) identify required covered services for a total cost of care model or services considered in whole or partially in an analysis of utilization for a risk/gain sharing model;

(9) establish a mechanism to monitor enrollment;

(10) establish quality standards for the delivery system demonstrations; and

(11) encourage participation of privately insured population so as to create sufficient alignment in demonstration systems.

(c) To be eligible to participate in the demonstration project, ~~a health care delivery system~~ an integrated health partnership must:

(1) provide required covered services and care coordination to recipients enrolled in the health care delivery system;

(2) establish a process to monitor enrollment and ensure the quality of care provided;

(3) in cooperation with counties and community social service agencies, coordinate the delivery of health care services with existing social services programs;

(4) provide a system for advocacy and consumer protection; and

(5) adopt innovative and cost-effective methods of care delivery and coordination, which may include the use of allied health professionals, telemedicine, patient educators, care coordinators, and community health workers.

(d) ~~A health care delivery system~~ An integrated health partnership demonstration may be formed by the following groups of providers of services and suppliers if they have established a mechanism for shared governance:

(1) professionals in group practice arrangements;

(2) networks of individual practices of professionals;

(3) partnerships or joint venture arrangements between hospitals and health care professionals;

(4) hospitals employing professionals; and

(5) other groups of providers of services and suppliers as the commissioner determines appropriate.

A managed care plan or county-based purchasing plan may participate in this demonstration in collaboration with one or more of the entities listed in clauses (1) to (5).

~~A health care delivery system~~ An integrated health partnership may contract with a managed care plan or a county-based purchasing plan to provide administrative services, including the administration of a payment system using the payment methods established by the commissioner for ~~health care delivery systems~~ integrated health partnerships.

(e) The commissioner may require ~~a health care delivery system~~ an integrated health partnership to enter into additional third-party contractual relationships for the assessment of risk and purchase of stop loss insurance or another form of insurance risk management related to the delivery of care described in paragraph (c).

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

Sec. 38. Minnesota Statutes 2016, section 256B.0755, subdivision 2, is amended to read:

Subd. 2. **Enrollment.** (a) Individuals eligible for medical assistance or MinnesotaCare shall be eligible for enrollment in ~~a health care delivery system~~ an integrated health partnership.

(b) Eligible applicants and recipients may enroll in ~~a health care delivery system~~ an integrated health partnership if a system serves the county in which the applicant or recipient resides. If more than one ~~health care delivery system~~ integrated health partnership serves a county, the applicant or recipient shall be allowed to choose among the ~~delivery systems~~ integrated health partnerships. The commissioner may assign an applicant or recipient to ~~a health care delivery system~~ an integrated health partnership if ~~a health care delivery system~~

an integrated health partnership is available and no choice has been made by the applicant or recipient.

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

Sec. 39. Minnesota Statutes 2016, section 256B.0755, subdivision 3, is amended to read:

Subd. 3. **Accountability.** (a) ~~Health care delivery systems~~ Integrated health partnerships must accept responsibility for the quality of care based on standards established under subdivision 1, paragraph (b), clause (10), and the cost of care or utilization of services provided to its enrollees under subdivision 1, paragraph (b), clause (1).

(b) ~~A health care delivery system~~ An integrated health partnership may contract and coordinate with providers and clinics for the delivery of services and shall contract with community health clinics, federally qualified health centers, community mental health centers or programs, county agencies, and rural clinics to the extent practicable.

(c) ~~A health care delivery system~~ An integrated health partnership must indicate how it will coordinate with other services affecting its patients' health, quality of care, and cost of care that are provided by other providers, county agencies, and other organizations in the local service area. The ~~health care delivery system~~ integrated health partnership must indicate how it will engage other providers, counties, and organizations, including county-based purchasing plans, that provide services to patients of the ~~health care delivery system~~ integrated health partnership on issues related to local population health, including applicable local needs, priorities, and public health goals. The ~~health care delivery system~~ integrated health partnership must describe how local providers, counties, organizations, including county-based purchasing plans, and other relevant purchasers were consulted in developing the application to participate in the demonstration project.

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

Sec. 40. Minnesota Statutes 2016, section 256B.0755, subdivision 4, is amended to read:

Subd. 4. **Payment system.** (a) In developing a payment system for ~~health care delivery systems~~ integrated health partnerships, the commissioner shall establish a total cost of care benchmark or a risk/gain sharing payment model to be paid for services provided to the recipients enrolled in ~~a health care delivery system~~ an integrated health partnership.

(b) The payment system may include incentive payments to ~~health care delivery systems~~ integrated health partnerships that meet or exceed annual quality and performance targets realized through the coordination of care.

(c) An amount equal to the savings realized to the general fund as a result of the demonstration project shall be transferred each fiscal year to the health care access fund.

(d) The payment system may include population-based payments to integrated health partnerships that incorporate payment for care coordination. Any integrated health partnership participant certified as a health care home under section 256B.0751 that agrees to a payment method that includes population-based payments for care coordination is not eligible to receive a health care home payment or care coordination fee authorized under section 62U.03 or 256B.0753, subdivision 1, or in-reach care coordination under section 256B.0625, subdivision 56, for any medical assistance or MinnesotaCare beneficiaries enrolled or attributed to the integrated health partnership under this demonstration.

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

Sec. 41. Minnesota Statutes 2016, section 256B.0755, subdivision 7, is amended to read:

Subd. 7. **Expansion.** The commissioner shall expand the demonstration project to include additional medical assistance and MinnesotaCare enrollees, and shall seek participation of Medicare in demonstration projects. The commissioner shall seek to include participation of privately insured persons and Medicare recipients in the ~~health care delivery~~ integrated health partnership demonstration. As part of the demonstration expansion, the commissioner may procure the services of the ~~health care delivery systems~~ integrated health partnerships authorized under this section by geographic area, to supplement or replace the services provided by managed care plans operating under section 256B.69.

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

Sec. 42. Minnesota Statutes 2016, section 256B.0943, subdivision 9, is amended to read:

Subd. 9. **Service delivery criteria.** (a) In delivering services under this section, a certified provider entity must ensure that:

(1) each individual provider's caseload size permits the provider to deliver services to both clients with severe, complex needs and clients with less intensive needs. The provider's caseload size should reasonably enable the provider to play an active role in service planning, monitoring, and delivering services to meet the client's and client's family's needs, as specified in each client's individual treatment plan;

(2) site-based programs, including day treatment programs, provide staffing and facilities to ensure the client's health, safety, and protection of rights, and that the programs are able to implement each client's individual treatment plan; and

(3) a day treatment program is provided to a group of clients by a multidisciplinary team under the clinical supervision of a mental health professional. The day treatment program must be provided in and by: (i) an outpatient hospital accredited by the Joint Commission on Accreditation of Health Organizations and licensed under sections 144.50 to 144.55; (ii) a community mental health center under section 245.62; or (iii) an entity that is certified under subdivision 4 to operate a program that meets the requirements of section 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475. The day treatment program must stabilize the client's mental health status while developing and improving the client's independent living and socialization skills. The goal of the day treatment program must be to reduce or relieve the effects of mental illness and provide training to enable the client to live in the community. The program must be available year-round at least three to five days per week, two or three hours per day, unless the normal five-day school week is shortened by a holiday, weather-related cancellation, or other districtwide reduction in a school week. A child transitioning into or out of day treatment must receive a minimum treatment of one day a week for a two-hour time block. The two-hour time block must include at least one hour of patient and/or family or group psychotherapy. The remainder of the structured treatment program may include patient and/or family or group psychotherapy, and individual or group skills training, if included in the client's individual treatment plan. Day treatment programs are not part of inpatient or residential treatment services. When a day treatment group that meets the minimum group size requirement temporarily falls below the minimum group size because of a member's temporary absence, medical assistance covers a group session conducted for the group members in attendance. A day treatment program may provide fewer than the minimally required hours for a particular child during a billing period in which the child is transitioning into, or out of, the program.

(b) To be eligible for medical assistance payment, a provider entity must deliver the service components of children's therapeutic services and supports in compliance with the following requirements:

(1) patient and/or family, family, and group psychotherapy must be delivered as specified in Minnesota Rules, part 9505.0372, subpart 6. Psychotherapy to address the child's underlying mental health disorder must be documented as part of the child's ongoing treatment. A provider must deliver, or arrange for, medically necessary psychotherapy, unless the child's parent or caregiver chooses not to receive it. When a provider delivering other services to a child under this section deems it not medically necessary to provide psychotherapy to the child for a period of 90 days or longer, the provider entity must

document the medical reasons why psychotherapy is not necessary. When a provider determines that a child needs psychotherapy but psychotherapy cannot be delivered due to a shortage of licensed mental health professionals in the child's community, the provider must document the lack of access in the child's medical record;

(2) individual, family, or group skills training must be provided by a mental health professional or a mental health practitioner who is delivering services that fall within the scope of the provider's practice and is supervised by a mental health professional who accepts full professional responsibility for the training. Skills training is subject to the following requirements:

(i) a mental health professional, clinical trainee, or mental health practitioner shall provide skills training;

(ii) skills training delivered to a child or the child's family must be targeted to the specific deficits or maladaptations of the child's mental health disorder and must be prescribed in the child's individual treatment plan;

(iii) the mental health professional delivering or supervising the delivery of skills training must document any underlying psychiatric condition and must document how skills training is being used in conjunction with psychotherapy to address the underlying condition;

(iv) skills training delivered to the child's family must teach skills needed by parents to enhance the child's skill development, to help the child utilize daily life skills taught by a mental health professional, clinical trainee, or mental health practitioner, and to develop or maintain a home environment that supports the child's progressive use of skills;

(v) group skills training may be provided to multiple recipients who, because of the nature of their emotional, behavioral, or social dysfunction, can derive mutual benefit from interaction in a group setting, which must be staffed as follows:

(A) one mental health professional or one clinical trainee or mental health practitioner under supervision of a licensed mental health professional must work with a group of three to eight clients; or

(B) two mental health professionals, two clinical trainees or mental health practitioners under supervision of a licensed mental health professional, or one mental health professional or clinical trainee and one mental health practitioner must work with a group of nine to 12 clients;

(vi) a mental health professional, clinical trainee, or mental health practitioner must have taught the psychosocial skill before a mental health behavioral aide may practice that skill with the client; and

(vii) for group skills training, when a skills group that meets the minimum group size requirement temporarily falls below the minimum group size because of a group member's temporary absence, the provider may conduct the session for the group members in attendance;

(3) crisis assistance to a child and family must include development of a written plan that anticipates the particular factors specific to the child that may precipitate a psychiatric crisis for the child in the near future. The written plan must document actions that the family should be prepared to take to resolve or stabilize a crisis, such as advance arrangements for direct intervention and support services to the child and the child's family. Crisis assistance must include preparing resources designed to address abrupt or substantial changes in the functioning of the child or the child's family when sudden change in behavior or a loss of usual coping mechanisms is observed, or the child begins to present a danger to self or others;

(4) mental health behavioral aide services must be medically necessary treatment services, identified in the child's individual treatment plan and individual behavior plan, which are performed minimally by a paraprofessional qualified according to subdivision 7, paragraph (b), clause (3), and which are designed to improve the functioning of the child in the progressive use of developmentally appropriate psychosocial skills. Activities involve working directly with the child, child-peer groupings, or child-family groupings to practice, repeat, reintroduce, and master the skills defined in subdivision 1, paragraph (t), as previously taught by a mental health professional, clinical trainee, or mental health practitioner including:

(i) providing cues or prompts in skill-building peer-to-peer or parent-child interactions so that the child progressively recognizes and responds to the cues independently;

(ii) performing as a practice partner or role-play partner;

(iii) reinforcing the child's accomplishments;

(iv) generalizing skill-building activities in the child's multiple natural settings;

(v) assigning further practice activities; and

(vi) intervening as necessary to redirect the child's target behavior and to de-escalate behavior that puts the child or other person at risk of injury.

To be eligible for medical assistance payment, mental health behavioral aide services must be delivered to a child who has been diagnosed with an emotional disturbance or a mental illness, as provided in subdivision 1, paragraph (a). The mental health behavioral aide must implement treatment strategies in the individual treatment plan and the individual behavior plan as developed by the mental health professional, clinical trainee, or mental health practitioner providing direction for the mental health behavioral aide. The mental health behavioral aide must document the delivery of services in written progress notes. Progress notes must reflect implementation of the treatment strategies, as performed by the mental health behavioral aide and the child's responses to the treatment strategies;

(5) direction of a mental health behavioral aide must include the following:

(i) ongoing face-to-face observation of the mental health behavioral aide delivering services to a child by a mental health professional or mental health practitioner for at least a total of one hour during every 40 hours of service provided to a child; and

(ii) immediate accessibility of the mental health professional, clinical trainee, or mental health practitioner to the mental health behavioral aide during service provision;

(6) mental health service plan development must be performed in consultation with the child's family and, when appropriate, with other key participants in the child's life by the child's treating mental health professional or clinical trainee or by a mental health practitioner and approved by the treating mental health professional. Treatment plan drafting consists of development, review, and revision by face-to-face or electronic communication. The provider must document events, including the time spent with the family and other key participants in the child's life to review, revise, and sign the individual treatment plan. Notwithstanding Minnesota Rules, part 9505.0371, subpart 7, medical assistance covers service plan development before completion of the child's individual treatment plan. Service plan development is covered only if a treatment plan is completed for the child. If upon review it is determined that a treatment plan was not completed for the child, the commissioner shall recover the payment for the service plan development; and

(7) to be eligible for payment, a diagnostic assessment must be complete with regard to all required components, including multiple assessment appointments required for an extended diagnostic assessment and the written report. Dates of the multiple assessment appointments must be noted in the client's clinical record.

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

Sec. 43. Minnesota Statutes 2016, section 256B.15, subdivision 1, is amended to read:

Subdivision 1. **Policy and applicability.** (a) It is the policy of this state that individuals or couples, either or both of whom participate in the medical assistance program, use their own assets to pay their share of the cost of their care during or after their enrollment in the program according to applicable federal law and the laws of this state. The following provisions apply:

(1) subdivisions 1c to 1k shall not apply to claims arising under this section which are presented under section 525.313;

(2) the provisions of subdivisions 1c to 1k expanding the interests included in an estate for purposes of recovery under this section give effect to the provisions of United States Code, title 42, section 1396p, governing recoveries, but do not give rise to any express or implied liens in favor of any other parties not named in these provisions;

(3) the continuation of a recipient's life estate or joint tenancy interest in real property after the recipient's death for the purpose of recovering medical assistance under this section modifies common law principles holding that these interests terminate on the death of the holder;

(4) all laws, rules, and regulations governing or involved with a recovery of medical assistance shall be liberally construed to accomplish their intended purposes;

(5) a deceased recipient's life estate and joint tenancy interests continued under this section shall be owned by the remainderpersons or surviving joint tenants as their interests may appear on the date of the recipient's death. They shall not be merged into the remainder interest or the interests of the surviving joint tenants by reason of ownership. They shall be subject to the provisions of this section. Any conveyance, transfer, sale, assignment, or encumbrance by a remainderperson, a surviving joint tenant, or their heirs, successors, and assigns shall be deemed to include all of their interest in the deceased recipient's life estate or joint tenancy interest continued under this section; and

(6) the provisions of subdivisions 1c to 1k continuing a recipient's joint tenancy interests in real property after the recipient's death do not apply to a homestead owned of record, on the date the recipient dies, by the recipient and the recipient's spouse as joint tenants with a right of survivorship. Homestead means the real property occupied by the surviving joint tenant spouse as their sole residence on the date the recipient dies and classified and taxed to the recipient and surviving joint tenant spouse as homestead property for property tax purposes in the calendar year in which the recipient dies. For purposes of this exemption, real property the recipient and their surviving joint tenant spouse purchase solely with the

proceeds from the sale of their prior homestead, own of record as joint tenants, and qualify as homestead property under section 273.124 in the calendar year in which the recipient dies and prior to the recipient's death shall be deemed to be real property classified and taxed to the recipient and their surviving joint tenant spouse as homestead property in the calendar year in which the recipient dies. The surviving spouse, or any person with personal knowledge of the facts, may provide an affidavit describing the homestead property affected by this clause and stating facts showing compliance with this clause. The affidavit shall be prima facie evidence of the facts it states.

(b) For purposes of this section, "medical assistance" includes the medical assistance program under this chapter, the general assistance medical care program formerly codified under chapter 256D, and alternative care for nonmedical assistance recipients under section 256B.0913.

(c) For purposes of this section, ~~beginning January 1, 2010,~~ "medical assistance" does not include Medicare cost-sharing benefits in accordance with United States Code, title 42, section 1396p.

(d) All provisions in this subdivision, and subdivisions 1d, 1f, 1g, 1h, 1i, and 1j, related to the continuation of a recipient's life estate or joint tenancy interests in real property after the recipient's death for the purpose of recovering medical assistance, are effective only for life estates and joint tenancy interests established on or after August 1, 2003. For purposes of this paragraph, medical assistance does not include alternative care.

EFFECTIVE DATE. This section is effective the day following final enactment and applies retroactively to estate claims pending on or after July 1, 2016, and to the estates of people who died on or after July 1, 2016.

Sec. 44. Minnesota Statutes 2016, section 256B.15, subdivision 1a, is amended to read:

Subd. 1a. **Estates subject to claims.** (a) If a person receives medical assistance hereunder, on the person's death, if single, or on the death of the survivor of a married couple, either or both of whom received medical assistance, or as otherwise provided for in this section, the amount paid for medical assistance as limited under subdivision 2 for the person and spouse shall be filed as a claim against the estate of the person or the estate of the surviving spouse in the court having jurisdiction to probate the estate or to issue a decree of descent according to sections 525.31 to 525.313.

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

(1) the person's probate estate;

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

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

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

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

(c) For the purpose of this section and recovery in a surviving spouse's estate for medical assistance paid for a predeceased spouse, the estate must consist of all of the legal title and interests the deceased individual's predeceased spouse had in jointly owned or marital property at the time of the spouse's death, as defined in subdivision 2b, and the proceeds of those interests, that passed to the deceased individual or another individual, a survivor, an heir, or an assign of the predeceased spouse through a joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement. A deceased recipient who, at death, owned the property jointly with the surviving spouse shall have an interest in the entire property.

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

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

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

~~(2)~~ (1) the person resided in a medical institution for six months or longer, received services under this chapter, and, at the time of institutionalization or application for medical

assistance, whichever is later, the person could not have reasonably been expected to be discharged and returned home, as certified in writing by the person's treating physician. For purposes of this section only, a "medical institution" means a skilled nursing facility, intermediate care facility, intermediate care facility for persons with developmental disabilities, nursing facility, or inpatient hospital;

~~(3)~~ (2) the person received general assistance medical care services under the program formerly codified under chapter 256D; ~~or~~

~~(4)~~ (3) the person was 55 years of age or older and received medical assistance services ~~on or after January 1, 2014,~~ that consisted of nursing facility services, home and community-based services, or related hospital and prescription drug benefits.

(f) The claim shall be considered an expense of the last illness of the decedent for the purpose of section 524.3-805. Notwithstanding any law or rule to the contrary, a state or county agency with a claim under this section must be a creditor under section 524.6-307. Any statute of limitations that purports to limit any county agency or the state agency, or both, to recover for medical assistance granted hereunder shall not apply to any claim made hereunder for reimbursement for any medical assistance granted hereunder. Notice of the claim shall be given to all heirs and devisees of the decedent, and to other persons with an ownership interest in the real property owned by the decedent at the time of the decedent's death, whose identity can be ascertained with reasonable diligence. The notice must include procedures and instructions for making an application for a hardship waiver under subdivision 5; time frames for submitting an application and determination; and information regarding appeal rights and procedures. Counties are entitled to one-half of the nonfederal share of medical assistance collections from estates that are directly attributable to county effort. Counties are entitled to ten percent of the collections for alternative care directly attributable to county effort.

EFFECTIVE DATE. This section is effective the day following final enactment and applies retroactively to estate claims pending on or after July 1, 2016, and to the estates of people who died on or after July 1, 2016.

Sec. 45. Minnesota Statutes 2016, section 256B.15, subdivision 2, is amended to read:

Subd. 2. **Limitations on claims.** ~~(a) For services rendered prior to January 1, 2014, the claim shall include only the total amount of medical assistance rendered after age 55 or during a period of institutionalization described in subdivision 1a, paragraph (e), and the total amount of general assistance medical care rendered under the program formerly codified under chapter 256D, and shall not include interest.~~

~~(b) For services rendered on or after January 1, 2014,~~ (a) The claim shall include only:

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

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

(3) the total amount of general assistance medical care rendered under the program formerly codified under chapter 256D.

The claim shall not include interest. For the purposes of this section, "home and community-based services" has the same meaning it has when used in United States Code, title 42, section 1396p(b)(1)(B)(i), and includes the alternative care program under section 256B.0913 even for periods when alternative care services receive only state funding.

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

EFFECTIVE DATE. This section is effective the day following final enactment and applies retroactively to estate claims pending on or after July 1, 2016, and to the estates of people who died on or after July 1, 2016.

Sec. 46. Minnesota Statutes 2016, section 256B.199, is amended to read:

256B.199 ~~PAYMENTS REPORTED BY GOVERNMENTAL ENTITIES~~ FEDERAL MATCHING FUNDS.

~~(a) The commissioner shall apply for federal matching funds for the expenditures in paragraphs (b) and (c).~~

~~(b)~~ The commissioner shall apply for federal matching funds for certified public expenditures ~~as follows:~~ for the

~~(1)~~ Hennepin County ~~, Hennepin County Medical Center, Ramsey County, and Regions Hospital shall report quarterly to the commissioner beginning June 1, 2007, payments made during the second previous quarter that may qualify for reimbursement under federal law;~~ Mental Health Center.

~~(2) based on these reports, the commissioner shall apply for federal matching funds; and~~

~~(3) by May 1 of each year, beginning May 1, 2007, the commissioner shall inform the nonstate entities listed in paragraph (a) of the amount of federal disproportionate share hospital payment money expected to be available in the current federal fiscal year.~~

~~(c) For the period from April 1, 2009, to September 30, 2010, the commissioner shall apply for additional federal matching funds available as disproportionate share hospital payments under the American Recovery and Reinvestment Act of 2009. These funds shall be made available as the state share of payments. The entities required to report certified public expenditures under paragraph (b), clause (1), shall report additional certified public expenditures as necessary under this paragraph.~~

~~(d) For services provided on or after September 1, 2011, the commissioner shall apply for additional federal matching funds available as disproportionate share hospital payments under the MinnesotaCare program. A hospital may elect on an annual basis to not be a disproportionate share hospital for purposes of this paragraph, if the hospital does not qualify for a payment under section 256.969, subdivision 9, paragraph (a).~~

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

Sec. 47. Minnesota Statutes 2016, section 256B.75, is amended to read:

256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.

(a) For outpatient hospital facility fee payments for services rendered on or after October 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge, or (2) 32 percent above the rate in effect on June 30, 1992, except for those services for

which there is a federal maximum allowable payment. Effective for services rendered on or after January 1, 2000, payment rates for nonsurgical outpatient hospital facility fees and emergency room facility fees shall be increased by eight percent over the rates in effect on December 31, 1999, except for those services for which there is a federal maximum allowable payment. Services for which there is a federal maximum allowable payment shall be paid at the lower of (1) submitted charge, or (2) the federal maximum allowable payment. Total aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare upper limit. If it is determined that a provision of this section conflicts with existing or future requirements of the United States government with respect to federal financial participation in medical assistance, the federal requirements prevail. The commissioner may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial participation resulting from rates that are in excess of the Medicare upper limitations.

(b) Notwithstanding paragraph (a), payment for outpatient, emergency, and ambulatory surgery hospital facility fee services for critical access hospitals designated under section 144.1483, clause (9), shall be paid on a cost-based payment system that is based on the cost-finding methods and allowable costs of the Medicare program. Effective for services provided on or after July 1, 2015, rates established for critical access hospitals under this paragraph for the applicable payment year shall be the final payment and shall not be settled to actual costs. Effective for services delivered on or after the first day of the hospital's fiscal year ending in 2016, the rate for outpatient hospital services shall be computed using information from each hospital's Medicare cost report as filed with Medicare for the year that is two years before the year that the rate is being computed. Rates shall be computed using information from Worksheet C series until the department finalizes the medical assistance cost reporting process for critical access hospitals. After the cost reporting process is finalized, rates shall be computed using information from Title XIX Worksheet D series. The outpatient rate shall be equal to ancillary cost plus outpatient cost, excluding costs related to rural health clinics and federally qualified health clinics, divided by ancillary charges plus outpatient charges, excluding charges related to rural health clinics and federally qualified health clinics.

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

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

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

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

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

Sec. 48. Minnesota Statutes 2016, section 256B.76, subdivision 1, is amended to read:

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

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

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

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

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

(c) Effective for services rendered on or after July 1, 2009, payment rates for physician and professional services shall be reduced by five percent, except that for the period July 1, 2009, through June 30, 2010, payment rates shall be reduced by 6.5 percent for the medical assistance and general assistance medical care programs, over the rates in effect on June 30, 2009. This reduction and the reductions in paragraph (d) do not apply to office or other outpatient visits, preventive medicine visits and family planning visits billed by physicians, advanced practice nurses, or physician assistants in a family planning agency or in one of the following primary care practices: general practice, general internal medicine, general pediatrics, general geriatrics, and family medicine. This reduction and the reductions in paragraph (d) do not apply to federally qualified health centers, rural health centers, and Indian health services. Effective October 1, 2009, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment reduction described in this paragraph.

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

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

(f) Effective for services rendered on or after September 1, 2014, payment rates for physician and professional services, including physical therapy, occupational therapy, speech pathology, and mental health services shall be increased by five percent from the rates in effect on August 31, 2014. In calculating this rate increase, the commissioner shall not include in the base rate for August 31, 2014, the rate increase provided under section

256B.76, subdivision 7. This increase does not apply to federally qualified health centers, rural health centers, and Indian health services. Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

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

(h) Any ratables effective before July 1, 2015, do not apply to autism early intensive intervention benefits described in section 256B.0949.

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

Sec. 49. Minnesota Statutes 2016, section 256B.76, subdivision 2, is amended to read:

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

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

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

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

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

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

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

(f) Effective for dental services rendered on or after October 1, 2010, by a state-operated dental clinic, payment shall be paid on a reasonable cost basis that is based on the Medicare principles of reimbursement. This payment shall be effective for services rendered on or

after January 1, 2011, to recipients enrolled in managed care plans or county-based purchasing plans.

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

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

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

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

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

~~(l)~~ (k) Effective for services provided on or after January 1, 2017, through December 31, 2018, the commissioner shall increase payment rates by 9.65 percent for dental services provided outside of the seven-county metropolitan area. This increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, or Indian health services. Effective January 1, 2017, through December 31, 2018, payments to managed care plans and county-based purchasing plans under sections 256B.69 and 256B.692 shall reflect the payment increase described in this paragraph.

(l) Effective for services rendered on or after January 1, 2019, payment rates for dental services shall be increased by 54 percent. This increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, and Indian health services when an encounter rate is paid.

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

Sec. 50. Minnesota Statutes 2016, section 256B.76, subdivision 4, is amended to read:

Subd. 4. **Critical access dental providers.** (a) The commissioner shall increase reimbursements to dentists and dental clinics deemed by the commissioner to be critical access dental providers. For dental services rendered on or after July 1, 2016, the commissioner shall increase reimbursement by 37.5 percent above the reimbursement rate that would otherwise be paid to the critical access dental provider, except as specified under paragraph (b). The commissioner shall pay the managed care plans and county-based purchasing plans in amounts sufficient to reflect increased reimbursements to critical access dental providers as approved by the commissioner.

(b) For dental services rendered on or after July 1, 2016, by a dental clinic or dental group that meets the critical access dental provider designation under paragraph (d), clause (4), and is owned and operated by a health maintenance organization licensed under chapter 62D, the commissioner shall increase reimbursement by 35 percent above the reimbursement rate that would otherwise be paid to the critical access provider.

(c) Critical access dental payments made under paragraph (a) or (b) for dental services provided by a critical access dental provider to an enrollee of a managed care plan or county-based purchasing plan must not reflect any capitated payments or cost-based payments from the managed care plan or county-based purchasing plan. The managed care plan or county-based purchasing plan must base the additional critical access dental payment on the amount that would have been paid for that service had the dental provider been paid according to the managed care plan or county-based purchasing plan's fee schedule that applies to dental providers that are not paid under a capitated payment or cost-based payment.

(d) The commissioner shall designate the following dentists and dental clinics as critical access dental providers:

(1) nonprofit community clinics that:

(i) have nonprofit status in accordance with chapter 317A;

(ii) have tax exempt status in accordance with the Internal Revenue Code, section 501(c)(3);

(iii) are established to provide oral health services to patients who are low income, uninsured, have special needs, and are underserved;

(iv) have professional staff familiar with the cultural background of the clinic's patients;

(v) charge for services on a sliding fee scale designed to provide assistance to low-income patients based on current poverty income guidelines and family size;

(vi) do not restrict access or services because of a patient's financial limitations or public assistance status; and

(vii) have free care available as needed;

(2) federally qualified health centers, rural health clinics, and public health clinics;

(3) hospital-based dental clinics owned and operated by a city, county, or former state hospital as defined in section 62Q.19, subdivision 1, paragraph (a), clause (4);

(4) a dental clinic or dental group owned and operated by a nonprofit corporation in accordance with chapter 317A with more than 10,000 patient encounters per year with patients who are uninsured or covered by medical assistance or MinnesotaCare;

(5) a dental clinic owned and operated by the University of Minnesota or the Minnesota State Colleges and Universities system; and

(6) private practicing dentists if:

(i) the dentist's office is located within the seven-county metropolitan area and more than 50 percent of the dentist's patient encounters per year are with patients who are uninsured or covered by medical assistance or MinnesotaCare; or

(ii) the dentist's office is located outside the seven-county metropolitan area and more than 25 percent of the dentist's patient encounters per year are with patients who are uninsured or covered by medical assistance or MinnesotaCare.

(e) The program established under this subdivision expires January 1, 2019. No payments under this subdivision shall be made for dates of service on and after January 1, 2019.

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

Sec. 51. Minnesota Statutes 2016, section 256B.76, is amended by adding a subdivision to read:

Subd. 8. **Payment for certain preventive medical visits.** (a) Payment for certain preventive medical visits rendered on or after July 1, 2017, shall be increased by five percent, unless otherwise limited by state or federal regulations. This rate increase is not applicable to federally qualified health centers, rural health centers, Indian health services, other cost-based rates, rates that are negotiated with the county, or rates that are established by the federal government. This rate increase under this subdivision does not apply to managed care.

(b) For purposes of paragraph (a), preventive medical visits shall be limited to preventive medicine visits when provided by a physician, advanced practice registered nurse, or physician assistant.

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

Sec. 52. Minnesota Statutes 2016, section 256B.761, is amended to read:

256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES.

(a) Effective for services rendered on or after July 1, 2001, payment for medication management provided to psychiatric patients, outpatient mental health services, day treatment services, home-based mental health services, and family community support services shall be paid at the lower of (1) submitted charges, or (2) 75.6 percent of the 50th percentile of 1999 charges.

(b) Effective July 1, 2001, the medical assistance rates for outpatient mental health services provided by an entity that operates: (1) a Medicare-certified comprehensive outpatient rehabilitation facility; and (2) a facility that was certified prior to January 1, 1993, with at least 33 percent of the clients receiving rehabilitation services in the most recent calendar year who are medical assistance recipients, will be increased by 38 percent, when those services are provided within the comprehensive outpatient rehabilitation facility and provided to residents of nursing facilities owned by the entity.

(c) The commissioner shall establish three levels of payment for mental health diagnostic assessment, based on three levels of complexity. The aggregate payment under the tiered rates must not exceed the projected aggregate payments for mental health diagnostic

assessment under the previous single rate. The new rate structure is effective January 1, 2011, or upon federal approval, whichever is later.

(d) In addition to rate increases otherwise provided, the commissioner may restructure coverage policy and rates to improve access to adult rehabilitative mental health services under section 256B.0623 and related mental health support services under section 256B.021, subdivision 4, paragraph (f), clause (2). For state fiscal years 2015 and 2016, the projected state share of increased costs due to this paragraph is transferred from adult mental health grants under sections 245.4661 and 256E.12. The transfer for fiscal year 2016 is a permanent base adjustment for subsequent fiscal years. Payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the rate changes described in this paragraph.

(e) Any ratables effective before July 1, 2015, do not apply to autism early intensive intervention benefits described in section 256B.0949.

(f) Effective for services provided on or after July 1, 2017, payments for outpatient mental health services shall be increased by five percent. This rate increase is not applicable to federally qualified health centers, rural health centers, Indian health services, other cost-based rates, rates that are negotiated with the county, or rates that are established by the federal government. This rate increase does not apply to managed care.

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

Sec. 53. **[256B.7625] REIMBURSEMENT FOR EVIDENCE-BASED PUBLIC HEALTH NURSE HOME VISITS.**

Prenatal and postpartum follow-up home visits provided by public health nurses or registered nurses supervised by a public health nurse using evidence-based models shall be paid $140 per visit. Evidence-based postpartum follow-up home visits must be administered by home visiting programs that meet the United States Department of Health and Human Services criteria for evidence-based models and are identified by the commissioner of health as eligible to be implemented under the maternal, infant, and early childhood home visiting program. Home visits shall be targeted at mothers and the mothers' children beginning with prenatal visits through three years of age.

EFFECTIVE DATE. This section is effective for services provided on or after January 1, 2018.

Sec. 54. Minnesota Statutes 2016, section 256B.766, is amended to read:

256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.

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

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

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

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

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

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

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

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

(i) Effective for services provided on or after July 1, 2015, the following categories of durable medical equipment shall be individually priced items: enteral nutrition and supplies, customized and other specialized tracheostomy tubes and supplies, electric patient lifts, and durable medical equipment repair and service. This paragraph does not apply to medical supplies and durable medical equipment subject to a volume purchase contract, products subject to the preferred diabetic testing supply program, and items provided to dually eligible recipients when Medicare is the primary payer for the item. The commissioner shall not apply any medical assistance rate reductions to durable medical equipment as a result of Medicare competitive bidding.

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

(1) payment rates for durable medical equipment, prosthetics, orthotics, or supplies that were subject to the Medicare competitive bid that took effect in January of 2009 shall be increased by 9.5 percent; and

(2) payment rates for durable medical equipment, prosthetics, orthotics, or supplies on the medical assistance fee schedule, whether or not subject to the Medicare competitive bid

that took effect in January of 2009, shall be increased by 2.94 percent, with this increase being applied after calculation of any increased payment rate under clause (1).

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

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

Sec. 55. **[256B.90] LONG-ACTING REVERSIBLE CONTRACEPTIVE ACCESS GRANTS.**

Subdivision 1. **Purpose.** The commissioner of human services shall coordinate and implement a long-acting reversible contraceptive access grant program to reduce rapid repeat births and improve birth outcomes for adolescents enrolled in medical assistance.

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

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

(c) "Long-acting reversible contraceptive" means a method of contraception, including an intrauterine device or a subdermal contraceptive implant, that provides effective contraception for an extended period of time without requiring user action.

(d) "Manufacturer" means the manufacturer of the long-acting reversible contraceptive defined in section 151.01, subdivision 14a.

(e) "Provider" means a hospital or clinic provider enrolled in Minnesota health care programs.

Subd. 3. **Grants.** (a) The commissioner shall adopt and implement a preferred long-acting reversible contraceptive list by March 1, 2018. The commissioner shall employ competitive bidding and negotiation with manufacturers under the provisions of chapter 16C to develop the preferred long-acting reversible contraceptive list. To be included on the list, the manufacturer must offer a price for the long-acting reversible contraceptive that is no more than the payment rate established in section 256B.0625, subdivision 13e, minus the federal Medicaid drug rebate pursuant to the Social Security Act, title XIX, section 1927.

(b) The commissioner shall award through a competitive process contracts for grants to providers to purchase long-acting reversible contraceptives on the preferred long-acting reversible contraceptive list at the negotiated manufacturer price. The long-acting reversible contraceptives purchased through the grant program shall be made available to medical assistance enrollees receiving services from the participating provider.

(c) A provider receiving long-acting reversible contraceptive access grants must document the use of the contraceptives and work with the commissioner to track and analyze outcomes.

(d) The cost of long-acting reversible contraceptives purchased with grant funds shall not be billed to medical assistance.

(e) The commissioner shall submit a 1115(a) demonstration waiver request to the Centers for Medicaid and Medicare Services to make available administrative funding at the 90 percent federal matching rate for the long-acting reversible contraceptive access grant program, as authorized by United States Code, title 42, section 1903, paragraph (a), clause (5).

(f) The grants shall be available by July 1, 2018, or upon federal approval of the 1115(a) demonstration project, whichever is later.

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

Sec. 56. Minnesota Statutes 2016, section 256L.03, subdivision 1, is amended to read:

Subdivision 1. **Covered health services.** (a) "Covered health services" means the health services reimbursed under chapter 256B, with the exception of special education services, home care nursing services, adult dental care services other than services covered under section 256B.0625, subdivision 9, orthodontic services, nonemergency medical transportation services, personal care assistance and case management services, and nursing home or intermediate care facilities services.

(b) No public funds shall be used for coverage of abortion under MinnesotaCare except where the life of the female would be endangered or substantial and irreversible impairment of a major bodily function would result if the fetus were carried to term; or where the pregnancy is the result of rape or incest.

(c) Covered health services shall be expanded as provided in this section.

(d) For the purposes of covered health services under this section, "child" means an individual younger than 19 years of age.

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

Sec. 57. Minnesota Statutes 2016, section 256L.03, subdivision 1a, is amended to read:

Subd. 1a. **Children; MinnesotaCare health care reform waiver.** Children are eligible for coverage of all services that are eligible for reimbursement under the medical assistance program according to chapter 256B, except special education services and that abortion services under MinnesotaCare shall be limited as provided under subdivision 1. Children are exempt from the provisions of subdivision 5, regarding co-payments. Children who are lawfully residing in the United States but who are not "qualified noncitizens" under title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Public Law 104-193, Statutes at Large, volume 110, page 2105, are eligible for coverage of all services provided under the medical assistance program according to chapter 256B.

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

Sec. 58. Minnesota Statutes 2016, section 256L.03, subdivision 5, is amended to read:

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

~~(1) $3 per prescription for adult enrollees;~~

~~(2) $25 for eyeglasses for adult enrollees;~~

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

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

~~(5) a family deductible equal to $2.75 per month per family and adjusted annually by the percentage increase in the medical care component of the CPI-U for the period of September to September of the preceding calendar year, rounded to the next-higher five cent increment.~~

~~(b) Paragraph (a) does~~ (a) Co-payments, coinsurance, and deductibles do not apply to children under the age of 21 and to American Indians as defined in Code of Federal Regulations, title 42, section ~~447.51~~ 600.5.

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

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

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

~~(f)~~ (b) The commissioner shall ~~increase~~ adjust co-payments, coinsurance, and deductibles for covered services in a manner sufficient to ~~reduce~~ maintain the actuarial value of the benefit to 94 percent. The cost-sharing changes described in this paragraph do not apply to eligible recipients or services exempt from cost-sharing under state law. The cost-sharing changes described in this paragraph shall not be implemented prior to January 1, 2016.

~~(g)~~ (c) The cost-sharing changes authorized under paragraph ~~(f)~~ (b) must satisfy the requirements for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations, title 42, sections 600.510 and 600.520.

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

Sec. 59. Minnesota Statutes 2016, section 256L.04, is amended by adding a subdivision to read:

Subd. 2b. **Federal waiver.** The commissioner of human services shall apply for a federal waiver to allow the state to permit a person who has access to employer-sponsored health insurance through a spouse or parent that is deemed minimum essential coverage under Code of Federal Regulations, title 26, section 1.36B-2, and the portion of the annual premium the person pays for employee and dependent coverage exceeds the required contribution percentage in Code of Federal Regulations, title 26, section 1.36B-2, to enroll in the MinnesotaCare program, if the person meets all eligibility requirements, except for section 256L.07, subdivision 2, paragraph (a).

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

Sec. 60. Minnesota Statutes 2016, section 256L.05, is amended by adding a subdivision to read:

Subd. 3d. **Coverage for gap months.** (a) Notwithstanding subdivision 3, MinnesotaCare coverage may be made available beginning the first day of the month of application for a new applicant who meets all MinnesotaCare eligibility requirements or beginning the first day of the month in which an applicant enrolled in medical assistance or a qualified health plan offered through MNsure under chapter 62V is eligible for MinnesotaCare due to a change in circumstances.

(b) For an applicant required to pay a premium, coverage under paragraph (a) is available if:

(1) the first premium payment for coverage according to subdivision 3 is received within 30 days of the premium billing; and

(2) the premiums for coverage under paragraph (a) are paid in full within 30 days of the premium billing.

EFFECTIVE DATE. This section is effective January 1, 2019.

Sec. 61. Minnesota Statutes 2016, section 256L.11, subdivision 7, is amended to read:

Subd. 7. **Critical access dental providers.** (a) Effective for dental services provided to MinnesotaCare enrollees on or after July 1, 2016, the commissioner shall increase payment rates to dentists and dental clinics deemed by the commissioner to be critical access providers under section 256B.76, subdivision 4, by 32.5 percent above the payment rate that would otherwise be paid to the provider, except for a dental clinic or dental group described in section 256B.76, subdivision 4, paragraph (b), in which the commissioner shall increase the payment rate by 30 percent above the payment rate that would otherwise be paid to the provider. The commissioner shall pay the prepaid health plans under contract with the commissioner amounts sufficient to reflect this rate increase. The prepaid health plan must pass this rate increase to providers who have been identified by the commissioner as critical access dental providers under section 256B.76, subdivision 4.

(b) The program established under this subdivision expires January 1, 2019. No payments under this subdivision shall be made for dates of service on and after January 1, 2019.

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

Sec. 62. Minnesota Statutes 2016, section 256L.15, subdivision 2, is amended to read:

Subd. 2. **Sliding fee scale; monthly individual or family income.** (a) The commissioner shall establish a sliding fee scale to determine the percentage of monthly individual or family income that households at different income levels must pay to obtain coverage through the MinnesotaCare program. The sliding fee scale must be based on the enrollee's monthly individual or family income.

(b) Beginning January 1, 2014, MinnesotaCare enrollees shall pay premiums according to the premium scale specified in paragraph (d).

(c) Paragraph (b) does not apply to:

(1) children 20 years of age or younger; and

(2) individuals with household incomes below 35 percent of the federal poverty guidelines.

(d) The following premium scale is established for each individual in the household who is 21 years of age or older and enrolled in MinnesotaCare:

Federal Poverty Guideline Greater than or Equal to	**Less than**	**Individual Premium Amount**
35%	55%	$4
55%	80%	$6
80%	90%	$8
90%	100%	$10
100%	110%	$12
110%	120%	$14
120%	130%	$15
130%	140%	$16
140%	150%	$25
150%	160%	~~$29~~ $37
160%	170%	~~$33~~ $44
170%	180%	~~$38~~ $52
180%	190%	~~$43~~ $61
190%	200%	~~$50~~ $71
200%		$80

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

Sec. 63. **[256L.29] MINNESOTACARE BUY-IN OPTION.**

Subdivision 1. **Request for federal authority and program establishment.** (a) The commissioner of human services shall seek all necessary federal authority to establish a program that allows individuals who are determined eligible for enrollment in a qualified health plan with or without advance premium tax credits and cost-sharing reductions according to the requirements of Code of Federal Regulations, title 45, section 155.305, paragraphs (a), (f), and (g), to purchase coverage in the MinnesotaCare program pursuant to this section (MinnesotaCare buy-in option), instead of purchasing a qualified health plan through MNsure, as defined in section 62V.02.

(b) The commissioner shall also seek all necessary federal authority to:

(1) allow individuals who qualify under paragraph (a) and who choose to purchase the MinnesotaCare buy-in option to use advance premium tax credits and cost-sharing reductions, if eligible, to purchase this option;

(2) permit the MinnesotaCare buy-in option to be offered through MNsure as a coverage option and to be compared with qualified health plans offered through MNsure;

(3) allow the commissioner to use any surplus funds in the basic health plan trust fund under section 16A.724, subdivision 3, for purposes of establishing a special revenue account that will serve as a reserve to support the payment of claims and liabilities and other financial needs for the MinnesotaCare program as described in section 256L.04, and the MinnesotaCare buy-in option as described in this section; and

(4) maintain program requirements and funding mechanisms to the MinnesotaCare program that provides coverage to individuals eligible under section 256L.04.

(c) The commissioner is exempt from the requirements in chapter 16C to contract for actuarial services that satisfy the waiver submission requirements under this subdivision. The commissioner may utilize existing contracts to satisfy the waiver submission requirements of this subdivision.

Subd. 2. **Program establishment and criteria.** (a) The commissioner shall establish a program consistent with this section to offer plans developed for the MinnesotaCare buy-in option through the MNsure Web site, as defined in section 62V.02, subdivision 13, and contract with vendors to provide these services, consistent with sections 256L.12 and 256L.121.

(b) The commissioner shall coordinate administration of the MinnesotaCare buy-in option with the MinnesotaCare program, as described in section 256L.04, to maximize

efficiency and improve continuity of care for enrollees. The commissioner shall seek to implement mechanisms to ensure the long-term financial sustainability of MinnesotaCare and mitigate any adverse financial impacts to the state and MNsure. These mechanisms must address issues related to minimizing adverse selection, the state financial risk and contribution, and negative impacts to premiums in the individual and group health insurance market both inside and outside of MNsure.

(c) The MinnesotaCare buy-in option shall include, at a minimum, the following:

(1) establishment of an annual per-enrollee premium rate similar to the average rate paid by the state to contractors under sections 256L.12 and 256L.121;

(2) establishment of a benefit set similar to the benefits covered under section 256L.03;

(3) limiting enrollment of eligible individuals to the same annual open and special enrollment periods established for MNsure as defined in Code of Federal Regulations, title 45, sections 155.410 and 155.420;

(4) establishment of two plans to be offered in MNsure with actuarial values of 70 percent and 80 percent;

(5) a cost allocation methodology to reimburse MNsure operations in lieu of the premium withhold for qualified health plans under section 62V.05; and

(6) establishment of mechanisms that mitigate the fiscal impact to the state budget.

(d) Individuals who are determined eligible for enrollment in a qualified health plan with or without advance payments of the premium tax credit and cost-sharing reductions according to Code of Federal Regulations, title 45, section 155.305, paragraphs (a), (f), and (g), are eligible to purchase and enroll in a plan established under this section through MNsure, instead of purchasing a qualified health plan as defined under section 62V.02.

(e) Individuals who are eligible under this section, and whose income is less than or equal to 400 percent of the federal poverty guidelines, may qualify for advance premium tax credits and cost-sharing reductions to purchase a plan established under this section.

(f) There shall be no state subsidy to individuals eligible for the MinnesotaCare buy-in option.

(g) The MinnesotaCare buy-in option established under this section shall be considered the MinnesotaCare program for purposes of the requirements for health maintenance organizations under section 62D.04, subdivision 5, and providers under section 256B.0644.

(h) The commissioner shall have authority to accept and expend all federal funds made available under this section upon federal approval.

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

Sec. 64. **RATE-SETTING ANALYSIS REPORT.**

The commissioner of human services shall conduct a comprehensive analysis report of the current rate-setting methodology for outpatient, professional, and physician services that do not have a cost-based, federally mandated, or contracted rate. The report shall include recommendations for changes to the existing fee schedule that utilizes the Resource-Based Relative Value System (RBRVS), and alternate payment methodologies for services that do not have relative values, to simplify the fee for service medical assistance rate structure and to improve consistency and transparency. In developing the report, the commissioner shall consult with outside experts in Medicaid financing. The commissioner shall provide a report on the analysis to the chairs of the legislative committees with jurisdiction over health and human services finance by November 1, 2019.

Sec. 65. **REPEALER.**

Minnesota Statutes 2016, sections 256.9692; 256B.0625, subdivision 25a; and 256B.0659, subdivision 22, are repealed.

ARTICLE 5

MANAGED CARE

Section 1. **[256B.68] MANAGED CARE.**

Subdivision 1. **Purpose.** (a) The commissioner of human services shall utilize managed care as an effective mechanism to ensure that all eligible individuals receive necessary health care in a coordinated fashion while containing costs. Each individual who is eligible for medical assistance must participate in managed care unless the individual meets the exclusion criteria in subdivision 9.

(b) If allowed by the commissioner, a managed care organization (MCO) may contract with an insurer, health care provider, nonprofit health service plan corporation, or the commissioner, to provide insurance or similar protection against the cost of care provided by the managed care organization or to provide coverage against the risks incurred by the managed care organization under this section. The recipients enrolled with a managed care

organization are a permissible group under group insurance laws and sections 62C.01 to 62C.23. Under this type of contract, the insurer or corporation may make benefit payments to a participating provider for services rendered or to be rendered to a beneficiary. Any insurer or nonprofit health service plan corporation licensed to conduct business in the state is authorized to provide insurance or similar protection.

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

(b) "Abuse" means provider practices that are inconsistent with sound fiscal, business, beneficiary, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

(c) "Access" means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans.

(d) "Actuary" means an individual who meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the practice standards established by the Actuarial Standards Board. For purposes of this section, actuary refers to an individual who is acting on behalf of the state when used in reference to the development and certification of capitation rates.

(e) "Actuarial sound capitation rates" means actuarially sound capitation rates projected to provide for all reasonable, appropriate, and attainable costs required under the terms of the contract and for the operation of the MCO for the time period and the populations covered under the terms of the contract.

(f) "Actuarially sound principles" means generally accepted actuarial principles and practices applied to determine aggregate utilization patterns, appropriate for the population and services to be covered, and have been certified by an actuary.

(g) "Adverse benefit determination" means:

(1) denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;

(2) reduction, suspension, or termination of a previously authorized service;

(3) denial, in whole or in part, of payment for a service;

(4) failure to provide services in a timely manner, as defined by the commissioner;

(5) failure of an MCO to act within the time frames provided in Code of Federal Regulations, title 42, section 438.408(b)(1) and (2), regarding the standard resolution of grievances and appeals;

(6) For an enrollee of a rural area with only one MCO, the denial of an enrollee's request to exercise the enrollee's right, under Code of Federal Regulations, title 42, section 438.52(b)(2)(ii), to obtain services outside the network; or

(7) denial of an enrollee's request to dispute a financial liability, including cost sharing, co-payments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

(h) "Appeal" means a review by an MCO of an adverse benefit determination.

(i) "Base amount" means the starting amount, calculated according to Code of Federal Regulations, title 42, section 438.6(d)(2), available for pass-through payments to hospitals in a contract year subject to the schedule in Code of Federal Regulations, title 42, section 438.6(d)(3).

(j) "Beneficiary" means a person that is eligible for medical assistance benefits as defined in sections 256B.055, 256B.056, and 256B.06. For purposes of this section, beneficiary and recipient have the same meaning.

(k) "Budget neutral" means a standard for any risk-sharing mechanism that recognizes both higher and lower expected costs among contracted MCOs under a managed care program and does not create a net aggregate gain or loss across all payments under the managed care program.

(l) "Capitation Payment" means a monthly payment made by the commissioner to an MCO on behalf of each beneficiary enrolled in a contract and based on the actuarially sound capitation rate for the provision of services under the state plan. The commissioner must make the payment regardless of whether the particular beneficiary receives services during the period covered by the payment.

(m) "Choice counseling" means the provision of information and services designed to assist a beneficiary in making enrollment decision, including answering questions and identifying factors to consider when choosing a managed care plan. Choice counseling does not include making recommendations for or against enrollment into a specific MCO.

(n) "Cold-call marketing" means any unsolicited personal contact or communication by the MCO with a Medicaid beneficiary who is not enrolled in that MCO that can reasonably be interpreted as intended to influence the beneficiary to enroll in that particular MCO's Medicaid product, or to not enroll in or to disenroll from another MCO's Medicaid product.

(o) "Commissioner" means the commissioner of the Department of Human Services.

(p) "Comprehensive risk contract" means a risk contract between the commissioner and an MCO that covers comprehensive services, including inpatient hospital services and any three or more of the following services:

(1) outpatient hospital services;

(2) rural health clinic services;

(3) Federally Qualified Health Center (FQHC) services;

(4) other laboratory and x-ray services;

(5) nursing facility services;

(6) early and periodic screening, diagnostic, and treatment (EPSDT) services;

(7) family planning services;

(8) physician services; or

(9) home health services.

(q) "Cost sharing" means any co-payment, coinsurance, deductible, or other similar charge.

(r) "Credibility adjustment" means an adjustment to the minimum lost ratio (MLR) for a partially credible MCO to account for the difference between the actual and target MLRs that may be due to a random statistical variation.

(s) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in jeopardizing the health of the individual or in the case of a pregnant women, seriously impairing bodily functions, or serious dysfunction of a body organ or part.

(t) "Emergency services" means covered inpatient and outpatient services that are:

(1) furnished by a qualified provider under Code of Federal Regulations, title 42; and

(2) needed to evaluate or stabilize an emergency medical condition.

(u) "Enrollee" means a medical assistance or MinnesotaCare person who is currently enrolled in an MCO.

(v) "Enrollee encounter data" means the information relating to the receipt of any item or service by an enrollee under a contract between the commissioner and an MCO that is subject to Code of Federal Regulations, title 42, sections 438.242 and 438.818.

(w) "External quality review (EQR)" means the analysis and evaluation by an EQRO of the aggregated information on quality, timeliness, and access to the health care services that an MCO or the MCO's contractor furnish to medical assistance managed care enrollees.

(x) "External quality review organization (EQRO)" means an organization that meets the competence and independence requirements in Code of Federal Regulations, title 42, section 438.354, and performs external quality review, other EQR-related activities in Code of Federal Regulations, title 42, section 438.358, or both.

(y) "Fraud" means an intentional deception or misrepresentation by a person with the knowledge that the deception may result in unauthorized benefit to the person or another person. Fraud includes any act that constitutes health care fraud under federal or state law.

(z) "Full credibility" means a standard for which the experience of an MCO for the calculation of an MLR with a minimal chance that the difference between the actual and target medical loss ratio is not statistically significant. An MCO is assigned full creditability must not receive a creditability adjustment to an MCO's MLR.

(aa) "Grievance" means an expression of dissatisfaction about any matter other than an adverse benefit determination. A grievance includes but is not limited to the quality of care or services provided; and aspects of interpersonal relationships, including rudeness of a provider or employee; or failure to respect the enrollee's rights regardless of whether an action is requested; or an enrollee's right to dispute an extension of time proposed by the MCO to make an authorization decision.

(bb) "Grievance and appeal system" means the processes an MCO implements to handle appeals of an adverse benefit determination and grievances and the processes to collect and track information about grievances.

(cc) "Health care services" means all medical assistance provided by an MCO under contract with the state Medicaid agency in any setting, including but not limited to medical care, behavioral health care, and long-term services and supports.

(dd) "Incentive arrangement" means any payment mechanism under which an MCO may receive additional funds over and above the capitation rates an MCO was paid for meeting targets in the contract.

(ee) "Indian" means any individual defined in United States Code, title 25, section 1603(13), 1603(28), or 1679(a), or who was determined eligible as Indian, according to Code of Federal Regulations, title 42, section 136.12. Indian also means the individual is a member of a federally recognized tribe or resides in an urban center and is:

(1) a member of a tribe, band, or other organized group of Indians, including tribes, bands, groups terminated since 1940 and tribes recognized now or in the future by the state in which they reside, or who is a descendant, in the first or second degree, of any such member;

(2) an Eskimo or Aleut or other Alaska native;

(3) considered by the Secretary of the Interior to be an Indian for any purpose; or

(4) considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including a California Indian, Eskimo, Aleut, or other Alaska native.

(ff) "Indian Health Care Provider" or "HCP" means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act, United States Code, title 25, section 1603.

(gg) "Limited English proficient" or "LEP" means potential enrollees and enrollees who do not speak English as the individual's primary language and who have a limited ability to read, write, speak, or understand English may be LEP and may be eligible to receive language assistance for a particular type of service, benefit, or encounter.

(hh) "Long-term services and supports" or "LTSS" means services and supports provided to a beneficiary of any age who has functional limitations or chronic illnesses that primarily support the ability of the beneficiary to live or work in a setting of the beneficiary's choice, including the beneficiary's home, a work site, a provider owned or controlled residential setting, a nursing facility, or other institutional setting.

(ii) "Managed care organization" or "MCO" means an entity that has, or is seeking to qualify for, a comprehensive, and that is:

(1) a federally qualified health maintenance organization (HMO) that meets the advance directives requirements of Code of Federal Regulations, title 42, sections 489.100 to 489.104; or

(2) any public or private entity that meets the advance directives requirements and:

(i) makes the services the entity provides to medical assistance enrollees as accessible, including timeliness, amount, duration, and scope of services as services provided to other medical assistance beneficiaries in the area served by the entity; and

(ii) meets the solvency standards of Code of Federal Regulations, title 42, section 438.116. A participating entity must meet the requirements of this section and section 256B.692.

(jj) "Marketing" means any communication from an MCO to a Medicaid beneficiary who is not enrolled in that MCO, that can reasonably be interpreted as intended to influence the beneficiary to enroll in a particular MCO, or to not enroll or to disenroll from another MCO. Marketing does not include communications about the qualified health plan to a Medicaid beneficiary from the issuer of a qualified health plan, as defined in Code of Federal Regulations, title 45, section 155.20.

(kk) "Marketing materials" means materials that:

(1) are produced in any medium, by or on behalf of an MCO; and

(2) can reasonably be interpreted as intended to market the MCO to potential enrollees.

(ll) "Medical loss ratio" or "MLR" means a basic financial measurement used in the Affordable Care Act to provide value to enrollees. If an insurer uses 80 cents out of every premium dollar to pay its enrollees' medical claims and activities that improve the quality of care, the company has a medical loss ratio of 80 percent. A medical loss ratio of 80 percent indicates that the insurer is using the remaining 20 cents of each premium dollar to pay overhead expenses, such as marketing, profits, salaries, administrative costs, and agent commissions.

(mm) "Member months" means the number of months an enrollee or a group of enrollees is covered by an MCO over a specified period of time, such as a year.

(nn) "Market loss ratio" or "MLR reporting year" means the period of 12 months consistent with the rating period selected by the commissioner.

(oo) "Network provider" means any provider, group of providers, entity with a network provider agreement with an MCO, or a subcontractor, and that receives Medicaid funding directly or indirectly to order, refer, or render covered services as a result of the commissioner's contract with an MCO. A network provider is not a subcontractor by virtue of the network provider agreement.

(pp) "No credibility" means a standard for which the experience of an MCO is determined to be insufficient for the calculation of an MLR. An MCO that is assigned no credibility must not be measured against any MLR requirements.

(qq) "Outcomes" means changes in patient health, functional status, satisfaction, or goal achievement that result from health care or supportive services.

(rr) "Overpayment" means any payment made by an MCO to a network provider that the provider is not entitled to receive, or any payment to an MCO from the commissioner that the MCO is not entitled to receive under title XIX of the Social Security Act.

(ss) "Pass-through payment" means any amount required by the commissioner to be added to the contracted payment rates, and considered in calculating the actuarially sound capitation rate, between the MCO and a hospital, physician, or nursing facility that is not for the following purposes:

(1) specific service or benefit provided to a specific enrollee covered under the contract;

(2) a provider payment methodology permitted under Code of Federal Regulations, title 42, sections 438.6(c)(1)(i) to (iii),

(3) for services and enrollees covered under a contract;

(4) a subcapitated payment arrangement for a specific set of services and enrollees covered under the contract;

(5) Graduate Medical Education (GME) payments; or

(6) Federally Qualified Health Clinic (FQHC) or Rural Health Clinic (RHC) wrap around payments.

(tt) "Partial credibility" means a standard for which the experience of an MCO is determined to be sufficient for the calculation of an MLR but with a non-negligible chance that the difference between the actual and target medical loss ratios is statistically significant. An MCO that is assigned partial credibility must receive a credibility adjustment to an MCO's MLR.

(uu) "Participating entity" means a health carrier as defined in section 62A.01, subdivision 2; a county-based purchasing plan established under section 256B.692; an accountable care organization or other entity operating a health care delivery system demonstration project authorized under section 256B.0755; an entity operating a county integrated health care delivery network pilot project authorized under section 256B.0756; or a network of health care providers established to offer services under MinnesotaCare.

(vv) "Prevalent" means a non-English language determined to be spoken by a significant number or percentage of potential enrollees and enrollees that are limited English proficient.

(ww) "Primary care" means all health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician, gynecologist, pediatrician, or other licensed practitioner as authorized by the Minnesota medical assistance program, to the extent that providing the services is legally authorized in the state in which the practitioner furnishes services.

(xx) "Potential enrollee" means a medical assistance or MinnesotaCare person who is subject to mandatory enrollment, or for medical assistance only may voluntarily elect to enroll in an MCO, but is not yet an enrollee of an MCO.

(yy) "Provider" means any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the state in which the provider delivers services.

(zz) "Post-stabilization care services" means covered services, related to an emergency medical condition that are provided after an enrollee is stabilized to maintain the stabilized condition, or according to Code of Federal Regulations, title 42, section 438.114(e).

(aaa) "Quality" means the degree that an MCO increases the likelihood of desired outcomes of an MCO's enrollees through:

(1) an MCO's structural and operational characteristics;

(2) the provision of services that are consistent with current professional, evidence-based knowledge; and

(3) interventions for performance improvement.

(bbb) "Rate cell" means a set of mutually exclusive categories of enrollees that is defined by one or more characteristics to determine the capitation rate and make a capitation payment. Characteristics may include age, gender, eligibility category, and region or geographic area. Each enrollee should be categorized in one of the rate cells for each unique set of mutually exclusive benefits under the contract.

(ccc) "Readily accessible" means electronic information and services which comply with modern accessibility standards, including section 508 guidelines, section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions.

(ddd) "Risk adjustment" is a methodology to account for the health status of an enrollee via relative risk factors when predicting or explaining costs of services covered under the contract for defined populations or for evaluating retrospectively the experience of the MCOs contracted with the commissioner.

(eee) "Risk contract" means a contract between the commissioner and an MCO in which the contractor:

(1) assumes risk for the cost of the services covered under the contract; and

(2) incurs loss if the cost of furnishing the services exceeds the payments under the contract.

(fff) "Risk corridor" means a risk-sharing mechanism in which the commissioner and MCOs may share in profits and losses under the contract outside of a predetermined threshold amount.

(ggg) "Rural area" means any county designated as "micro," "rural," or "County with Extreme Access Considerations" in the Medicare Advantage Health Services Delivery (HSD) Reference file for the applicable calendar year.

(hhh) "State fair hearing" means the process set forth in subpart E of Code of Federal Regulations, title 42, section 431.

(iii) "Subcontractor" means an individual or entity that has a contract with an MCO that relates directly or indirectly to the performance of the MCO's obligations under an MCO's contract with the commissioner.

(jjj) "Validation" means the review of information, data, and procedures to determine the extent that information, data, and procedures are accurate, reliable, free from bias, and according to standards for data collection and analysis.

(kkk) "Withhold arrangement" means any payment mechanism under which a portion of a capitation rate is withheld from an MCO, and a portion or all of the withheld amount must be paid to the MCO for meeting targets specified in the contract. An arrangement that withholds a portion of a capitation rate for noncompliance with general operational requirements are a penalty and not a withhold arrangement.

Subd. 3. **Service area.** Managed care shall be offered in each county in Minnesota.

Subd. 4. **Procurement for managed care.** (a) The commissioner, when implementing managed care within a county or a group of counties that have elected county-based purchasing, must comply with applicable state laws in chapter 16C, and Code of Federal Regulations, title 45, part 75. These counties shall participate in the procurement according to this section. The commissioner shall procure for managed care contracts, at a minimum of every five years according to section 16B.98, subdivision 5, and may conduct a statewide procurement or procure for a limited number of counties within a specified region.

(b) The commissioner shall coordinate the procurement of MinnesotaCare to the extent practicable with medical assistance according to this subdivision.

(c) The commissioner may consider a request from the county or group of counties representing county-based purchasing to exclude price in the evaluation criteria. The commissioner shall ensure that the payment made by the commissioner to any managed care plan in these counties does not exceed payments that would otherwise be paid to any other managed care organization providing medical assistance services for the same county, region, or population. The procurement shall also consider the unique nature of the county or group of counties in county-based purchasing and evaluate the responders on provider network access, coordination, and integration with county services for the provision of health care and other local community-based services.

(d) The counties must be included in the process of development, and issuance of the request for proposals to provide services to eligible individuals within the proposed county. Counties must be given reasonable opportunity to make recommendations regarding the development, issuance, and changes needed in the request for proposals before publication. The recommendations must reflect neutrality towards all potential responders and be reasonably related to the performance of managed care organization functions and within the scope of the medical assistance benefit set. The commissioner must provide counties the opportunity to review and score each responder's proposal based on the identification of the counties' community needs under chapters 145A and 256E and county advocacy activities. The counties shall consider the respondent's ability to fully and adequately deliver required health care services, offer an adequate provider network, provide care coordination with county services, and serve special populations, including enrollees with language and cultural needs.

(e) As part of the procurement process, a county may seek county board recommendations based on the county's review and score of each proposal. A county board's recommendations must be submitted to the commissioner for consideration in the overall decision of the managed care organization selection process.

(f) All county and state staff serving as evaluators of the proposals must sign a confidentiality agreement that complies with the conflict of interest requirements in sections 15.43, 43A.48, 16C.04, and 256B.0914.

(g) All responders seeking a contract to provide health care services under this section are subject to the prohibition against conflict of interest in section 256B.0914, and must

comply with all applicable prohibitions and requirements for safeguards regarding conflict of interest in Code of Federal Regulations, title 42, section 438.58.

(h) Before the commissioner implements a new managed care program, or when an MCO provides services to a new eligibility group, or contracting with a new MCO, the commissioner shall conduct a readiness review according to Code of Federal Regulations, title 42, section 438.66(d). The readiness review must be conducted at least three months before the program implementation effective date and with sufficient time to ensure a smooth transition and receive Centers for Medicare and Medicaid approval.

(i) The commissioner shall provide a written report under section 3.195 to the chairs of the legislative committees having jurisdiction over human services if a procurement results in a significant change of new contracted entities, population shifts, new eligibility groups, or a change in the number of contracted entities. The report shall be provided 60 days following the effective date of the change.

(j) If a county board or counties and the commissioner cannot reach agreement regarding the selection of participating managed care organizations in that county or counties, the commissioner shall resolve the dispute after considering the recommendation of a three-person mediation panel. The panel shall be composed of three panelists: one designee of the president of the Association of Minnesota Counties, one designee of the commissioner of human services, and one designee selected jointly by the designee of the commissioner of human services and the designee of the Association of Minnesota Counties. Within a reasonable period of time before the hearing, the panelists must be provided all documents and information relevant to the mediation. The parties to the mediation must be given 30 days' notice of a hearing before the mediation panel.

(k) A contract between the commissioner and a managed care organization is exempt from the set-aside and preference provisions of section 16C.16, subdivision 6.

Subd. 5. **Competitive bidding.** (a) For managed care contracts, the commissioner may utilize a competitive price bidding program for nonelderly, nondisabled adults and children in medical assistance and MinnesotaCare. The managed care program must allow a minimum of two managed care organizations in each county that is identified as a metropolitan statistical area (MSA).

(b) The pilot programs operating in Hennepin County and Ramsey County under section 256B.0756 are exempt from competitive bid.

Subd. 6. **Enrollment.** (a) For populations required to enroll in a managed care organization, the commissioner must ensure that an eligible beneficiary has a choice between

two managed care organizations. For an eligible beneficiary residing in a rural area, the commissioner may limit a rural area beneficiary to a single managed care organization. For a beneficiary living in a rural county with a single managed care organization, the rural beneficiary:

(1) must be allowed to choose from at least two primary care providers; and

(2) is permitted to obtain services from any provider according to Code of Federal Regulations, title 42, section 438.52(b).

(b) The commissioner, in consultation with the tribal governments, shall develop a plan for tribes to assist in the enrollment process for American Indian beneficiaries enrolled in managed care under this section. This plan shall address how tribes shall be included in ensuring the coordination of care for American Indian beneficiaries by Indian Health Care Providers.

(c) Each person who is eligible for medical assistance must participate in managed care unless the person:

(1) meets the exclusion criteria listed in subdivision 8;

(2) is 65 years of age or older and eligible for Medicare and elects to enroll in the Minnesota Senior Health Options program.

(3) is 18 to 64 years of age and certified disabled, and does not opt out, is enrolled in the Special Needs Basic Care Program.

(d) A state plan that requires medical assistance beneficiaries to enroll in MCOs must comply with Code of Federal Regulations, title 42, section 438.50, unless the commissioner received federal waiver authority.

(e) The enrollment system must comply with Code of Federal Regulations, title 42, section 438.54, as applicable to mandatory, voluntary, and passive enrollments. For a potential enrollee that does not select an MCO during the period allowed by the commissioner, the commissioner must have a default enrollment process for assigning the potential enrollee to an MCO and must consider priority enrollment and existing provider-beneficiary relationships. The MCO must not be subject to an intermediate sanction in Code of Federal Regulations, title 42, section 438.702(a)(4), and the MCO's capacity to accept new enrollment.

(1) The commissioner may consider additional reasonable criteria to conduct the default process including the previous plan assignment of the beneficiary, quality assurance and improvement performance, procurement evaluation elements, accessibility of provider

offices for people with disabilities, if appropriate, and other reasonable criteria that support the objectives of the managed care program.

(2) The commissioner must send a confirmation of the enrollee's managed care enrollment to the enrollee within five calendar days of the date enrollment is processed by the commissioner. The confirmation must clearly explain the enrollee's right to disenroll within 90 days from the effective date of enrollment.

(3) The commissioner must provide an informational notice to each potential enrollee who may enroll in an MCO. The notice must include the MCOs that are available to the potential enrollee, how to select an MCO, explain the implications of making or not making an active choice, explain the length of enrollment period and the disenrollment policies, and comply with Code of Federal Regulations, title 42, sections 438.10 and 438.206.

Subd. 7. **Prohibition against enrollment discrimination.** (a) The commissioner shall ensure, through its contracts with the managed care organizations, compliance with all federal and state anti-discrimination laws and regulations. A managed care organization that contracts with the commissioner cannot discriminate or use any policy that has the effect of discriminating against people on the basis of medical condition, health status, receipt of health care services, claims experience, medical history, genetic information, disability, including mental or physical impairment, marital status, age, race, color, religion, creed, national origin, sex, including sex stereotypes and gender identity, sexual orientation, political beliefs, or public assistance status.

(b) The managed care organization must accept an individual eligible for enrollment in the order that the individual applied or are assigned up to the limits set by the contract. The commissioner may limit the number of enrollees in the MCO if in the commissioner's judgment the MCO is unable to demonstrate the capacity to serve additional enrollees.

Subd. 8. **Enrollment exclusions.** (a) The commissioner shall exclude the following persons from enrollment in managed care:

(1) a child who is receiving medical assistance through adoption assistance according to section 256B.055, subdivision 1, is eligible to enroll in managed care on a voluntary basis;

(2) a person under 65 years of age that is eligible for medical assistance because of blindness or disability as determined by the Social Security Administration or the medical review team, except as permitted under subdivision 74;

(3) a beneficiary who has private health care coverage through a health maintenance organization (HMO) certified under chapter 62D. A beneficiary with this coverage may enroll in managed care on a voluntary basis if the private HMO is the same as the managed care organization the recipient will select under managed care;

(4) a beneficiary who is eligible for medical assistance by spending down excess income for medical expenses other than the nursing facility per diem expense, exceptions apply under specific managed care programs;

(5) a beneficiary who receives benefits under the Refugee Assistance Program, established under United States Code, title 8, section 1522(e);

(6) a child who is determined to be severely emotionally disturbed (SED) and eligible to receive mental health targeted case management services according to section 245.4881, is eligible to enroll in managed care on a voluntary basis;

(7) an adult who is determined to be seriously and persistently mentally ill, according to section 256B.0625, subdivision 20, and eligible to receive mental health targeted case management services according to section 245.4711, is eligible to enroll in managed care on a voluntary basis;

(8) a beneficiary eligible for medical assistance through the breast and cervical cancer control program according to section 256B.057, subdivision 10;

(9) a beneficiary with cost-effective employer-sponsored private health insurance or a beneficiary enrolled in a non-Medicare individual health plan determined to be cost-effective according to section 256B.0625, subdivision 15;

(10) a beneficiary who, before enrollment, is a resident of a state institution. A beneficiary already enrolled in managed care who enter state institutions must remain enrolled if the beneficiary's placement was approved by an MCO, including court ordered placements for services covered under an MCO contract;

(11) a beneficiary who, at the time of enrollment, has a terminal communicable disease which may exceed six months, and has an established relationship with a primary physician who is not a network provider in any of the managed care organizations and the physician certifies that disruption of the physician-patient relationship is likely to result in the patient becoming noncompliant with medication or other health services;

(12) a beneficiary who, at the time of enrollment, has a terminal illness with a medical prognosis of six months or less life expectancy and has a permanent relationship with a primary physician who is not a network provider in any of the managed care organizations;

(13) beneficiaries who are Qualified Medicare Beneficiaries (QMB) as defined in section 1905(p) of the Social Security Act, United States Code, section 1396d(p), and not eligible for medical assistance;

(14) beneficiaries who are Specified Low-Income Medicare Beneficiaries (SLMB) as defined in section 1905(p) of the Social Security Act, United States Code, title 42, sections 1396a(a)(10)(E)(iii) and 1396d(p), and not eligible for medical assistance;

(15) beneficiaries who are Qualified Working Disabled Adults (QWD) as defined in United States Code, title 42, section 1396d(s), and not eligible for medical assistance;

(16) a beneficiary receiving care and services from a nonprofit center established to serve victims of torture;

(17) a beneficiary who receives emergency medical assistance under section 256B.06, subdivision 4;

(18) a recipient eligible for the Minnesota family planning program (MFPP) under section 256B.78;

(19) a beneficiary participating in the navigator pilot under section 254B.13; and

(20) a beneficiary participating in the continuum of care pilot under section 254B.14.

(b) Unless a newborn is determined to be excluded from managed care enrollment for any reason identified in this section, the newborn who is determined eligible for and receiving medical assistance must be enrolled in managed care retroactively from the birth month in the same MCO as the mother, if applicable. For a birth reported within 90 days of birth there will be continuous managed care enrollment from the birth month. For a birth reported after 90 days from the birth month, enrollment will be the next available month following the month that the birth was reported.

Subd. 9. **Disenrollment.** (a) The commissioner shall establish procedures for when a beneficiary may disenroll or change the beneficiary's MCO. The effective date of an approved disenrollment must be no later than the first day of the second month following the month that the beneficiary requests disenrollment.

(b) A beneficiary may disenroll for cause at any time. Cause for disenrollment includes:

(1) the enrollee moves outside of the MCO service area;

(2) the MCO does not, because of moral or religious objections, cover the service the enrollee seeks;

(3) the enrollee needs related services to be performed at the same time and not all related services are available within the provider network; and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk;

(4) an enrollee that uses MLTSS, the enrollee would have to change the enrollee's residential, institutional, or employment supports provider based on that provider's change in status from an in-network to an out-of-network provider with the MCO and, as a result, would experience a disruption in the enrollee's residence or employment; or

(5) reasons such as poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced with the enrollee's care needs.

(c) A beneficiary may disenroll without cause at the following times:

(1) within 90 days following the date of the beneficiary's initial enrollment into a new managed care organization or 90 days following the date the commissioner sends the beneficiary notice of the enrollment, whichever is later;

(2) in a county where there is a single plan, a beneficiary may change the beneficiary's primary care clinic on a monthly basis;

(3) at least once every 12 months following the beneficiary's initial enrollment;

(4) upon automatic reenrollment, if the temporary loss of medical assistance eligibility caused the beneficiary to miss the beneficiary's annual health plan selection opportunity;

(5) if the commissioner imposes the intermediate sanction in Code of Federal Regulations, title 42, section 438.702(a)(4);

(6) if a managed care organization ends participation for any reason, a beneficiary enrolled with that organization must select a new managed care organization but may change managed care organizations without cause once more within the first 60 days after enrollment with the second managed care organization;

(7) because of substantial travel time or local agency error;

(8) the beneficiary elects to change MCOs within 120 days following notice of a material modification of an MCO's provider network; or

(9) the beneficiary has a change in major medical program.

Subd. 10. **Consumer safeguards.** The commissioner shall ensure safeguards against conflict of interest of an individual who has responsibilities relating to the enrollment processes.

Subd. 11. **Transition services.** (a) The commissioner must have a transition of care policy for managed care that ensures a beneficiary has continued access to medical assistance services during the following transition periods:

(1) moving from FFS to enrollment in an MCO;

(2) changing from one MCO to another MCO;

(3) the beneficiary's MCO contract is terminated; and

(4) the beneficiary is disenrolled from managed care for any reason other than ineligibility for Medicaid.

(b) The commissioner's transition of care policy must ensure:

(1) that a beneficiary has access to services consistent with the access the beneficiary previously had and is permitted to retain the beneficiary's current provider for a period of up to 120 days if that provider is not in the MCO network;

(2) within the transition period the beneficiary is referred to appropriate a provider of services that are in the MCO's network;

(3) the commissioner, in the case of FFS, or the MCO that was previously serving the enrollee, fully and timely complies with requests for historical utilization data from the new MCO according to federal and state law;

(4) the enrollee's new provider is able to obtain copies of the enrollee's medical records, as appropriate and consistent with state and federal law.

(5) access to other necessary procedures as specified by the Centers for Medicare and Medicaid to ensure continued access to services to prevent serious detriment to the enrollee's health or reduce the risk of hospitalization or institutionalization; and

(6) that the policy is be publicly available to enrollees and potential enrollees on how to access continued services during transition.

Subd. 12. **Beneficiary support system.** (a) The commissioner shall have a beneficiary support system that provides support to a beneficiary both before and after enrollment in a managed care organization.

(b) A state beneficiary support system must:

(1) provide choice counseling for each potential enrollee, including an enrollee who disenrolled from an MCO;

(2) assist each enrollee in understanding managed care;

(3) provide an access point for complaints and concerns about MCO enrollment, covered services, and other related matters;

(4) provide education on enrollee's grievance and appeal rights within the MCO, the state fair hearing process, enrollee rights and responsibilities, and additional resources outside of the MCO;

(5) assist, if request, navigating the grievance and appeal process within the MCO and appealing adverse benefit determinations by the MCO to a state fair hearing. The beneficiary support system may not provide representation to the enrollee at a state fair hearing but may refer an enrollee to legal representation sources;

(6) perform outreach to a beneficiary or an authorized representative and be accessible in multiple formats including telephone, internet, in-person, and via auxiliary aids and services if requested; and

(7) review and oversee LTSS program data to guide the state Medicaid agency on identification, remediation, and resolution of systemic issues.

(c) Federal financial participation is available only if:

(1) costs must be supported by an allocation methodology that appears in the state's approved Public Assistance Cost Allocation Plan in Code of Federal Regulations, title 42, section 433.34; and

(2) costs do not duplicate payment for activities that are already offered or should be provided by other entities or paid by other programs.

(d) The commissioner may designate a county coordinator to assist the department in educating beneficiaries about selecting an MCO and providing necessary enrollment information.

Subd. 13. **Network adequacy.** (a) The commissioner shall develop and enforce time and distance standards for provider types in clauses (1) to (9) that are covered under the managed care organization contract with the commissioner and who is permitted to have varying standards for the same provider type based on geographic areas:

(1) primary care, adult and pediatric;

(2) obstetrician/gynecologist;

(3) adult and pediatric behavioral health, including mental health and substance use disorder;

(4) specialist, adult and pediatric;

(5) hospital;

(6) pharmacy;

(7) pediatric dental;

(8) LTSS providers that the enrollee travels to the provider; and for providers traveling to an enrollee's home, the commissioner may set alternative standards; and

(9) additional provider types as determined by the commissioner or the Centers for Medicare and Medicaid if the commissioner promotes the objectives of the Medicaid program.

(b) In developing network standards for the providers in paragraph (a), the commissioner must consider the elements in Code of Federal Regulations, title 42, section 438.68(c).

(c) The commissioner may allow an exception to any of the provider-specific network standards. The exception must be identified in the MCO contract and be based, at a minimum, on the number of providers practicing that specialty in the managed care organization's service area. The commissioner must monitor enrollee access to the provider on an ongoing basis and report those findings to the Centers for Medicare and Medicaid in the managed care program assessment report according to Code of Federal Regulations, title 42, section 438.68(d)(2).

(d) The commissioner must publish on the department's Web site the network adequacy standards developed according to this section. The network adequacy standards must also be made available, upon request, at no cost to an enrollee with a disability in an alternate format or through the provision of auxiliary aids and services.

Subd. 14. **Provider selection.** (a) The commissioner must ensure that a contract with an MCO requires the MCO to have written policies and procedures for selection and retention of network providers and that the policies and procedures satisfy Code of Federal Regulations, title 42, section 438.214.

(b) The commissioner shall require an MCO to adopt a uniform credentialing and recredentialing process and comply with the process consistent with state regulations and current NCQA Standards and Guidelines for the Accreditation of Health Plans. The MCO must follow the process for acute, primary care, behavioral, substance use, and LTSS providers. For organizational providers, including hospitals, and Medicare certified home health care agencies, an MCO shall adopt a uniform credentialing and recredentialing process and comply with that process consistent with state regulations.

(c) An MCO serving a county with a nonprofit community clinic or community health services agency must contract with the clinic or agency to provide services to a client who chooses to receive services from the clinic or agency, if the clinic or agency agrees to payment rates that are competitive with rates paid to other health plan providers for the same or similar services. For purposes of this subdivision, "nonprofit community clinic" includes, but is not limited to, a community mental health center as defined in sections 245.62 and 256B.0625, subdivision 5.

(d) An MCO may not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of the provider's license or certification under applicable state law, solely on the basis of that license or certification. If an MCO declines to include provider or groups of providers in an MCO's network, the MCO must give written notice of the MCO's decision. An MCO is:

(1) not required to contract with a provider beyond the amount necessary to meet the needs of an MCO's enrollees;

(2) not prohibited from using different reimbursement amounts for different specialties or different practitioners in the same specialty; and

(3) allowed to establish measures designed to maintain quality of services and control costs.

(e) The MCO may not employ or contract with a provider excluded from participation in federal health care programs under the Social Security Act, United States Code, section 1128 or 1128A.

Subd. 15. **Provider screening and enrollment.** (a) The commissioner, through the commissioner's contract with the MCOs, must ensure all network providers are enrolled with the Medicaid agency as a medical assistance provider and must comply with the provider disclosure, screening, and enrollment requirements of part 455. A provider network is not required to render services to a fee-for-service beneficiary.

(b) An MCO may execute a network provider agreement pending the outcome of the medical assistance provider enrollment process up to 120 days. An MCO must terminate the network provider upon notification that the network provider cannot be enrolled or upon expiration of the 120-day period and must notify each affected enrollee.

Subd. 16. **Network and payment requirements for Indian health care providers.** (a) Medical assistance shall cover health care services provided at Indian health services facilities and facilities operated by a tribe or tribal organization under funding authorized under

United states Code, title 25, sections 450f to 450n, or title III of the Indian Self-Determination and Education Assistance Act, Public Law 93-638, if services would otherwise be covered under section 256B.0625. A payment for services provided under this subdivision shall be made on a fee-for-service basis, and may, at the option of the tribe or tribal organization, be made according to rates authorized under sections 256.969, subdivision 16, and 256B.0625, subdivision 34.

(b) For an American Indian that enrolled in managed care, the commissioner must require an MCO to ensure timely access to services available under the contract from IHCP providers for an enrollee who is eligible to receive services. Timely access to services includes:

(1) an MCO demonstrating it has sufficient Indian Health Care Providers (IHCP) participating in the provider network;

(2) an IHCP, whether in the network or not, must be paid:

(i) at a rate negotiated between the MCO and the IHCP; and

(ii) at a rate not less than the level and amount of payment that the MCO would pay for the services to a participating provider that is not an IHCP;

(3) making payment to all IHCPs in an MCO's network in a timely manner as required for payment to practitioners in individual or group practices according to Code of Federal Regulations, title 42, sections 447.45 and 447.46;

(4) permitting an Indian enrolled in an MCO to choose an IHCP as the enrollee's primary care provider participating as a network provider as long as the provider has the capacity to provide the services;

(5) permitting an Indian enrollee to obtain services covered under the contract from out of network IHCPs for whom the enrollee is otherwise eligible to receive services; and

(6) permitting an out-of-network IHCP to refer an Indian enrollee to a network provider.

(c) In a state where timely access to covered services cannot be assured due to few or no IHCPs, the MCO must be considered to have met the requirements of this section, if the Indian enrollee is permitted access to an out of state IHCP or deemed to have good cause for disenrollment.

(d) When an IHCP is enrolled in medical assistance as a FQHC but not a participating provider with the MCO, the IHCP must be paid an amount equal to the amount the MCO would pay an FQHC within an MCO's network including any supplemental payment from

the commissioner to cover the difference in the amount the MCO paid and the amount the IHCP FQHC would receive under FFS.

(e) If an IHCP is not enrolled in medical assistance as a FQHC, regardless of an MCO's participation in an MCO's network, the IHCP has the right to receive the encounter rate published annually in the Federal Register by the IHS or if not published, the amount the IHCP would receive if the services were provided under the commissioner's plan's FFS methodology.

(f) When the amount an ICHP receives from an MCO is less than the encounter rate, the commissioner must pay a supplemental payment to the IHCP to cover the difference.

Subd. 17. **MCO subcontractual relationships.** (a) The commissioner shall ensure that all managed care organizations maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of an MCO's contract with the commissioner. If an MCO chooses to delegate any of an MCO's responsibilities to a subcontractor, an MCO must execute a valid contract between the MCO and an MCO's subcontractor. The contract must be in writing and must specify:

(1) the delegated activities or obligations, and related reporting responsibilities;

(2) the subcontractor must perform the delegated activities and reporting responsibilities specified, according to the MCO's contract obligations; and

(3) the subcontractor must comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provision.

(b) The contract must either provide for revocation of the delegation of activities or obligations, or specify other remedies and sanctions if the commissioner or the MCO determines that the subcontractor failed to perform satisfactorily.

(c) The commissioner, Centers for Medicare and Medicaid, Department of Health and Human Services inspector general, comptroller general, or a designee has the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the MCO's contract with the commissioner.

(d) The subcontractor will make available, for purposes of an audit, the subcontractor's premises, physical facilities, equipment, books, records, contracts, and computer or other electronic systems relating to the subcontractor's medical assistance enrollees. The right to

audit exists ten years from the final date of the contract or from the date of completion of any audit, whichever is later.

(e) If the commissioner, Centers for Medicare and Medicaid, or Department of Health and Human Services inspector general determines that there is a reasonable possibility of fraud or similar risk, the commissioner, Centers for Medicare and Medicaid, or Department of Health and Human Services inspector general may inspect, evaluate, and audit the subcontractor at any time.

Subd. 18. **Information requirements for enrollees and potential enrollees.** (a) All required information to enrollees and potential enrollees must be provided in a manner and format that is easily understood and readily accessible. The information must be available through the beneficiary support system, the department's Web site, and may link to individual MCO Web sites with the required information including, at a minimum, the enrollee handbook, the provider directory, and drug formulary.

(b) The commissioner must ensure that MCOs provide each enrollee with:

(1) an enrollee handbook, using the model provided by the department, within a reasonable time after receiving notice of the beneficiary's enrollment. The handbook must include information on benefits provided, how and where to access benefits, cost sharing, how transportation is provided, and must, at a minimum, address other information required by Code of Federal Regulations, title 42, section 438.10(g);

(2) a provider directory that must include the provider's name, group affiliation, street address, telephone number, Web site, specialty if applicable, whether the provider accepts new enrollees, the provider's cultural and linguistic capabilities as identified in Code of Federal Regulations, title 42, section 438.10(h), and whether the provider's office accommodates people with disabilities. A provider directory must be provided for the following provider types, physicians, specialists, hospitals, pharmacies, behavioral health providers, and LTSS providers, as appropriate;

(3) a formulary that includes both generic and name brand medications that are covered and each medication tier;

(4) written notice of termination of a contracted provider, within 15 calendar days after receipt or issuance of the termination notice, to each enrollee who received and the enrollee's primary care from, or was seen on a regular basis by, the terminated provider; and

(5) the MCO's physician incentive plan, upon enrollee request.

(c) The commissioner must provide the following information to each potential enrollee to ensure an enrollee has sufficient information to make an informed selection on:

(1) basic features of managed care;

(2) whether a populations is excluded from enrollment, subject to mandatory enrollment, or free to enroll voluntarily. For mandatory and voluntary populations, the length of the enrollment period and all disenrollment opportunities available to the enrollee;

(3) the service area covered by each MCO;

(4) covered benefits, including benefits provided by the MCO and benefits provided directly by the commissioner;

(5) the provider directory and drug formulary;

(6) cost sharing;

(7) requirements for adequate access to network services, including network adequacy standards;

(8) an MCO's responsibility for coordination of enrollee care;

(9) quality and performance indicators, including enrollee satisfaction for each MCO, if available; and

(10) information about the potential enrollee's right to disenroll according to Code of Federal Regulations, title 42, section 438.56.

(d) The commissioner and MCO must provide materials electronically to potential enrollees and enrollees unless the enrollee requests the information in paper form. An enrollee must be informed that the information is available in paper form without charge upon request and must be provided within five business days of the request and mailed to the enrollee's mailing address. Information provided electronically for potential enrollees and enrollees must:

(1) be readily accessible;

(2) be placed in a prominent location on the commissioner's and MCO's Web site and in a format that has the capability to be retained and printed;

(3) if provided to the enrollee through e-mail, the MCO receive the enrollee's agreement before providing the information by e-mail;

(4) satisfy the requirements for content and language requirements according to Code of Federal Regulations, title 42, section 438.10(d); and

(5) inform the enrollee that the information is available on the Web site and includes the applicable URL address in order to access the information. An enrollee with a disability who cannot access the information online is provided auxiliary aids and services upon request at no cost.

Subd. 19. **Language and accessibility standards.** (a) Managed care contracts entered into under sections 256B.69 and 256L.12 must require MCOs to provide language assistance, auxiliary aids and services, to ensure meaningful access to an MCO's programs and services, according to title VI of the Civil Rights Act, section 1557 of the Affordable Care Act, and any other federal regulations or guidance from the United States Department of Health and Human Services.

(b) The commissioner must establish a methodology to identify the prevalent non-English languages spoken by enrollees and potential enrollees throughout Minnesota and in each MCO's service area.

(c) The commissioner shall ensure that oral interpretation is provided in all languages and written interpretation is provided in each prevalent non-English language and are available to both enrollees and potential enrollees free of charge. Oral interpretation services include the use of auxiliary aids, TTY/TDY, and American sign language.

(d) Written materials that target potential enrollees must include "taglines" in an 18-point font that explains the availability of interpretation services, and includes the toll-free telephone number for the department's beneficiary support system.

(e) All written materials, including a provider directory, enrollee handbook, an appeal and grievance notice, and denial and termination notice, must:

(1) be easily understood;

(2) use at least 12-point font size;

(3) be available in alternative formats and through the provision of auxiliary aids and services that consider the special needs of the beneficiary, including a beneficiary with a disability or limited English proficiency;

(4) include taglines in an 18-point font that explains the availability of interpreter services and how to request auxiliary aids and services, including the provision of the materials in alternative formats and the TTY/TDY telephone number of the MCO's customer service unit; and

(5) notify a beneficiary on how to access the oral interpretation services, written translations, and the auxiliary aids and services.

Subd. 20. **Enrollee communication.** (a) The commissioner shall ensure, through contracts with the MCOs, that the MCOs:

(1) submit all marketing materials to the commissioner for approval before distribution;

(2) distribute marketing materials to an MCO's entire service area and as otherwise permitted by contract;

(3) comply with the information requirements in Code of Federal Regulations, title 42, section 438.10;

(4) does not seek to influence enrollment with the sale or offering of any private insurance;

(5) does not directly, or indirectly, engage in door-to-door, telephone, e-mail, texting, or other cold-call marketing activities;

(6) marketing materials are accurate, do not mislead, confuse, or defraud a beneficiary or the department.

Subd. 21. **State monitoring.** (a) The commissioner must establish a monitoring system that addresses all aspects of managed care programs including each MCO's performance according to Code of Federal Regulations, title 42, section 438.66(b).

(b) The commissioner must use data identified in Code of Federal Regulations, title 45, section 438.66(c), collected from its monitoring activities to improve the performance of its managed care program.

(c) The commissioner is responsible to assess the readiness of each MCO with which it contracts as follows:

(1) before implementing a managed care program, whether an MCO is voluntary or mandatory; or

(2) if the specific MCO has not previously contracted with the commissioner; or

(3) if an MCO currently contracting with the commissioner provides or arranges for the provision of covered benefits to new eligibility groups.

(d) The commissioner shall conduct a readiness review of each MCO that contracts with the commissioner within the timelines and receives the Centers for Medicare and Medicaid approval of the resulting contract or amendment.

(e) The commissioner's readiness review must assess the areas defined in Code of Federal Regulations, title 42, section 438.66(d), for the MCO's ability and capacity to perform satisfactorily in each area.

(f) Annually, no later than 180 days after the contract year, the commissioner must submit a report on each managed care program administered by the commissioner regardless of the authority that the program operates under, following the release of the Centers for Medicare and Medicaid guidance. The report:

(1) must provide assessment of the operation of the managed care program in the areas identified in Code of Federal Regulations, title 42, section 438.66(e)(2);

(2) may be substituted with the commissioner's obligation to report under the commissioner's waiver authority for managed care program;

(3) must be posted on the department's Web site;

(4) must be provided to the Medical Care Advisory Committee according to Code of Federal Regulations, title 42, section 431.12;

(5) must be provided to the stakeholder consultation group according to Code of Federal Regulations, section 438.70, to the extent the managed care program includes LTSS.

(g) The commissioner must have in effect safeguards against conflict of interest on behalf of state and local officers and employees and agents of the state who have responsibilities relating to MCO contracts. The safeguards must be at least as effective as the safeguards specified in section 27 of the Office of Federal Procurement Policy Act, United States Code, title 41, section 423. The commissioner must comply with Code of Federal Regulations, title 42, section 438.58, and section 1902(a)(4)(c) of the Social Security Act applicable to contracting officers, employees, or independent contractors

Subd. 22. **Enrollee rights and protections.** (a) The commissioner shall ensure that each MCO, an MCO's employees, and contracted providers comply with applicable federal and state laws that pertain to an enrollee's rights and that each MCO's employees and contracted providers:

(1) receive information according to Code of Federal Regulations, title 42, section 438.10;

(2) be treated with respect and with due consideration for the enrollee's dignity and privacy;

(3) receive information on available treatment options and alternatives, presented in a manner appropriate to the beneficiary's condition and ability to understand;

(4) participate in decisions regarding the enrollee's health care, including the right to refuse treatment;

(5) be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other federal regulations on the use of restraints and seclusion;

(6) receive a copy of the enrollee's medical records, and request that the records be corrected, according to Code of Federal Regulations, title 45, sections 164.524 and 164.526;

(7) receive health care services according to Code of Federal Regulations, title 42, sections 438.206 to 438.210.

(b) The commissioner shall ensure that each enrollee is free to exercise the enrollee's rights, and that the exercise of the enrollee's rights does not adversely affect the way the MCO, the MCO's network providers, or the state Medicaid agency treats the enrollee.

(c) The commissioner shall ensure that the MCO complies with all federal and state antidiscrimination laws and regulations. An MCO that contracts with the commissioner cannot discriminate or use any policy that has the effect of discriminating against people on the basis of medical condition, health status, receipt of health care services, claims experience, medical history, genetic information, disability, including mental or physical impairment, marital status, age, race, color, religion, creed, national origin, sex, including sex stereotypes and gender identity, sexual orientation, political beliefs, or public assistance status.

(d) The commissioner must ensure, through contracts with the MCO, that for medical records and any other health and enrollment information that identifies a particular enrollee, each MCO uses and discloses individually identifiable health information according to the privacy requirements in Code of Federal Regulations, title 45, parts 160 and 164, subparts A and E, to the extent that these requirements are applicable.

Subd. 23. **Liability for payment.** (a) The commissioner shall require that the MCO ensure the enrollee is held harmless of payment liability for covered services provided to the enrollee, if:

(1) MCO debt in the event of insolvency;

(2) lack of payment to the MCO;

(3) lack of payment to the provider by the MCO or the commissioner for services furnished under a contract, referral, or other arrangement; or

(4) payments for services covered under the contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the enrollee would owe if the MCO covered the services directly.

(b) An MCO may limit any reimbursement an MCO may be required to pay to a provider for services to a beneficiary not enrolled in the MCO.

(c) An MCO must comply with the standards for claims settlement under section 72A.201, subdivisions 4, 5, 7, and 8, if contracting with other health care and social service practitioners to provide services to enrollees. An MCO must pay a clean claim, as defined in Code of Federal Regulations, title 42, section 447.45(b), within 30 business days of the date of acceptance of the claim.

Subd. 24. **Cost sharing.** (a) The commissioner may impose cost sharing according to Code of Federal Regulations, title 42, sections 447.50 through 447.57, and may set limits or waive the cost sharing for specific population groups.

(b) The commissioner must exempt from cost sharing an American Indian who receives or has received an item or service furnished by Indian Health Services 638 facilities, IHCP, or through referral under contract health services according to Code of Federal Regulations, title 42, section 447.56(a)(1)(x).

Subd. 25. **Provider enrollee communications.** (a) The commissioner shall ensure the managed care organizations do not prohibit, or otherwise restrict, an MCO provider, who is acting within the lawful scope of the provider's practice, from advising or advocating on behalf of the enrollee regarding:

(1) the enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

(2) any information the enrollee needs to decide among all relevant treatment options;

(3) the risks, benefits, and consequences of treatment or nontreatment; or

(4) the enrollee's right to participate in decisions regarding the enrollee's health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

(b) The commissioner must ensure that the MCO inform enrollees of how and where to obtain any services excluded by MCOs on the basis of moral or religious grounds. The enrollee notification must satisfy the requirements in Code of Federal Regulations, title 42, section 438.102(b).

Subd. 26. **Stakeholder and enrollee engagement.** (a) The commissioner shall establish a stakeholder group to solicit the views of beneficiaries, individuals representing beneficiaries, providers, and other stakeholders to provide advice on managed care programs for persons using LTSS. The stakeholder group shall provide advice on:

(1) design and implementation efforts;

(2) consumer protections; and

(3) oversight of the LTSS program, including quality assurance measures, data collection and reporting, and evaluation of costs, quality, and results.

(b) Each MCO under contract shall establish and maintain an enrollee advisory committee that includes a representative sample of the LTSS population and other individuals representing this population.

Subd. 27. **Covered services.** (a) The commissioner must ensure that all services covered under the state plan are available and accessible to each enrollee of the MCOs. The MCO shall authorize and arrange for the provision of all medically necessary health services, and unless otherwise specified by law or contract, the MCO is exempt from the commissioner's authorization requirements.

(b) An MCO's provider network must meet the standards developed by the commissioner according to Code of Federal Regulations, title 42, section 438.68, and an MCO must meet the following requirements:

(1) maintain and monitor a network of appropriate providers that are supported by written agreements and sufficient to provide adequate access to all services covered under the contract for each enrollee;

(2) provide female enrollees with direct access to a women's health specialist that provides women's routine and preventive health services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist;

(3) provide for a second medical opinion from a network provider unless otherwise not available within the network or required by state law, at no cost to the enrollee;

(4) adequately and timely provide covered services for an enrollee out of network for as long as the MCO provider network is unable to provide them;

(5) require an out-of-network provider coordinate with the MCO for payment and ensure that the cost to the enrollee is no greater than the cost would be if the services were furnished within the MCO's network;

(6) provide to the commissioner the MCO's documented process for credentialing and recredentialing of the MCO's network providers according to Code of Federal Regulations, title 42, section 438.206(b)(6); and

(7) ensure that the MCO's network includes sufficient family planning providers for timely access to covered services.

(c) The commissioner shall ensure through contracts that the managed care organization is responsible for payment of emergency and post stabilization services. The MCO must cover and pay for emergency services regardless of whether the provider is within the managed care organizations network.

(d) The MCO may not deny payment for treatment obtained:

(1) by an enrollee with an emergency medical condition as defined in subdivision 2; or

(2) by an enrollee who was instructed to seek emergency services by a representative of the MCO.

The MCO may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms or refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the MCO of the enrollee's screening and treatment within ten calendar days of presentation for emergency services.

(e) An enrollee who has an emergency medical condition must not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the enrollee.

(f) The attending emergency physician, or provider treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the MCO for coverage and payment. Post stabilization care services are covered and paid for by the MCO in accordance with the provisions in Code of Federal Regulations, title 42, section 422.113(c).

(g) The commissioner must have methods to promote access and delivery of services in a culturally competent manner to each beneficiary, including a beneficiary with limited English proficiency, diverse cultural and ethnic background, disability, and regardless of gender, sexual orientation, or gender identity. The commissioner must ensure a beneficiary has access to covered services that are delivered in a manner that meets the beneficiary's needs.

(h) The commissioner must ensure, through contracts, that each MCO meets the standards for timely access, cultural competency, and accessibility according to Code of Federal Regulations, title 42, section 438.206(c).

Subd. 28. **Adequate capacity and services assurances.** (a) The MCO must provide supporting documentation that an MCO has the capacity to serve the expected enrollment in an MCO's service area according to Code of Federal Regulations, title 42, section 438.207(c), and ensure the commissioner that the MCO:

(1) offers an appropriate range of preventive, primary care, specialty services, and LTSS; and

(2) maintains a network of providers that is sufficient in number, mix, and geographic distribution.

(b) After reviewing the MCO's submitted documentation the commissioner must submit an assurance of compliance to the Centers for Medicare and Medicaid that the MCO meets the requirements for availability of services according to Code of Federal Regulations, title 42, sections 438.68 and 438.206. The submission to the Centers for Medicare and Medicaid must include an analysis that supports the assurance of the adequacy of the network for each contracted MCO's provider network. The Centers for Medicare and Medicaid may request all documentation collected by the commissioner from the MCO.

Subd. 29. **Coordination of services and continuity of care.** (a) For each MCO that serves an enrollee who is also enrolled in and receives Medicare benefits from a Medicare advantage organization, the commissioner shall determine to what extent the MCO meets the identification, assessment, and treatment planning provisions in this section for a dually eligible enrollee.

(b) The MCO must implement procedures to deliver care to and coordinate services for each MCO enrollee, including the following:

(1) an ongoing source of care appropriate to the enrollee's needs and a person or entity formally designated as primarily responsible for coordinating the services;

(2) coordination of the services the MCO furnishes to the enrollee between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays;

(3) coordination with any covered services the enrollee receives through a different managed care organization or on a fee-for-service basis; and

(4) coordination with the services the enrollee receives from community and social support providers.

(c) The MCO must make a best effort to conduct an initial screening within 90 days of enrollment for each enrollee.

(d) The MCO must share with the commissioner or another MCO serving the enrollee the results of any identification and assessment of the enrollee's needs to prevent duplicating activities.

(e) The MCO shall ensure that each provider furnishing services to an enrollee maintains and shares an enrollee health record and in the process of coordinating care protecting each enrollee's privacy according to Code of Federal Regulations, title 45, parts 160 and 164.

Subd. 30. **Additional services for enrollees with special health care needs or who need LTSS.** (a) The commissioner, or the commissioner's designee, must implement mechanisms to identify persons who need LTSS or persons with special health care needs to MCOs. The mechanisms must be identified in the commissioner's quality strategy.

(b) The MCO must implement mechanisms to assess each identified enrollee needing LTSS or having special health care needs that require a course of treatment or regular care monitoring using appropriate providers or individuals for the assessment.

(c) The MCO must produce a treatment or service plan for an enrollee who requires LTSS and, if the commissioner requires, for an enrollee with special health care needs. The treatment or service plan must:

(1) be developed by an appropriate individual of LTSS services, with enrollee participation, and with each provider caring for the enrollee;

(2) be developed by a person trained in person-centered planning using a person-centered process and plan as defined in Code of Federal Regulations, title 42, section 441.301(c)(1) and (2);

(3) be approved by the MCO, in a timely manner, if approval is required by the MCO;

(4) comply with any applicable state quality assurance and utilization review standards; and

(5) be reviewed and revised upon reassessment of functional need, at least annually, or if the enrollee's circumstances or needs change significantly, or at the request of the enrollee according to Code of Federal Regulations, title 42, section 441.301(c)(3).

(d) The MCO must have a mechanism to allow an enrollee with special health care needs to directly access a specialist, through a standing referral or approved number of visits, as appropriate for the enrollee's condition and identified needs.

Subd. 31. **Coverage and authorization of services.** (a) The commissioner must ensure that all contracts with the MCOs identify, define, and specify the amount, duration, and scope of each covered service and are furnished in an amount, duration, and scope that is no less than what is provided under FFS Medicaid.

(b) The MCO must ensure that the covered services are sufficient in amount, duration, or scope to reasonably achieve the purpose for the services and must not arbitrarily deny or reduce the amount, duration, or scope solely because of diagnosis, type of illness, or condition of the enrollee.

(c) The commissioner shall permit the MCO to limit a service based on criteria applied under the state plan, including but not limited to medical necessity or utilization control if the service meets the criteria in Code of Federal Regulations, title 42, section 438.210(a)(4).

(d) The commissioner shall identify in the MCO contract what constitutes medically necessary services that:

(1) are no more restrictive than those used in medical assistance, including quantitative and nonquantitative treatment limits, as indicated in state statutes and regulations, the state plan, or other state policies and procedures;

(2) address the extent to which the MCO is responsible for covering services that address the criteria in Code of Federal Regulations, title 42, section 438.210(a)(5)(ii).

(e) The commissioner must ensure the MCO contract requires the MCO and an MCO's subcontractors to have and follow written policies and procedures on processing requests for initial and continuing authorization of services. The MCO must:

(1) ensure consistent application of review criteria for authorization decisions;

(2) consult with the requesting provider for medical services, if appropriate;

(3) authorize LTSS based on an enrollee's current needs assessment and consistent with the person-centered service plan; and

(4) notify the requesting provider and the enrollee of any decision of the MCO to deny a service authorization or to authorize the service in an amount, duration, or scope that is less than requested.

(f) Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, by an individual who has appropriate expertise in addressing the enrollee's medical behavioral health or long-term services and support needs.

(g) The MCO contract must include time frames for standard authorizations that are ten business days following the receipt of the request and no later than 72 hours of a receipt for an expedited authorization. For both standard and expedited authorizations the MCO may extend the time frame 14 additional calendar days, if the enrollee or a provider requests an extension. Upon a request from the commissioner the MCO must justify the need for additional information and how the extension is in the enrollee's best interest.

(h) For all covered outpatient drug authorization decisions, provide notice within 24 hours of a request according to section 1927(d)(5)(A) of the Social Security Act.

(i) The contract must ensure that compensation to an individual or entity that conducts utilization management activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to an enrollee.

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

Subd. 32. **Prescription drugs.** The commissioner may exclude or modify coverage for prescription drugs from the prepaid managed care contracts entered into under this section to increase savings to the commissioner by collecting additional prescription drug rebates. The contracts must maintain incentives for the managed care plan to manage drug costs and utilization and may require that the managed care plans maintain an open drug formulary. To manage drug costs and utilization, a contract must authorize the managed care organizations to use preferred drug lists and prior authorization. This subdivision is contingent on federal approval of the managed care contract changes and the collection of additional prescription drug rebates. A contracted MCO must comply with the standards in section 1927 of the Social Security Act.

Subd. 33. **Additional and in lieu of services.** (a) An MCO may choose to provide services in addition to services required under the terms of the contract. If an MCO chooses

to provide an enrollee eligible for medical assistance with additional services, the cost of the additional services cannot be included in determining the capitated payment rate.

(b) An MCO may provide any service necessary to comply with the Mental Health Parity Act, Code of Federal Regulations, title 42, section 438.910.

(c) An MCO may cover services or settings that are in lieu of services and settings covered under the state plan as follows:

(1) medically appropriate and cost-effective substitute for the covered service or setting under the state plan;

(2) the enrollee is not required by the MCO to use the alternative service or setting;

(3) authorized and identified in the MCO contract and must be offered to enrollees at the option of the MCO; and

(4) the utilization and actual cost of the in lieu of service is considered in developing the component of the capitation rates that represents the covered date plan service.

Subd. 34. **Prohibition of additional payments for services covered under the MCO contract.** The commissioner must ensure that no payment is made to a network provider other than by the MCO for services covered under the MCO's contract with the commissioner, except when payments by the commissioner are required to be made according to title XIX of the Social Security Act, or if the commissioner makes direct payments to network providers for graduate medical education costs approved under the state plan.

Subd. 35. **Quality assessment and performance improvement program.** (a) The commissioner must require the managed care organizations to establish and implement an ongoing comprehensive quality assessment and performance improvement program for the services furnished to medical assistance enrollees according to Code of Federal Regulations, title 42, section 438.330(b).

(b) The commissioner shall ensure that the MCO conduct performance improvement projects that focus on both clinical and nonclinical measures, designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction and must meet the elements in Code of Federal Regulations, title 42, section 438.330(d)(2).

(c) The commissioner may permit an MCO exclusively serving dual eligible enrollees to substitute a Medicare Advantage organization quality improvement project for one or more of the required performance improvement projects.

(d) The commissioner, or the Centers for Medicare and Medicaid, may identify standard performance measures including measures relating to quality of life, rebalancing, and community integration activities for enrollees receiving long term services and supports.

(e) The MCOs must annually measure and report on the MCO's performance using the standard measures as required by the commissioner and submit the data to the commissioner to calculate the MCO's performance.

(f) The commissioner shall review annually the impact and the effectiveness of the quality assessment and performance improvement program of each MCO, outcomes and trended results of the MCO performance improvement projects, and identify the results of any efforts to support community integration for an enrollee using LTSS.

(g) The commissioner shall ensure, through contracts with MCOs, that each MCO adopt practice guidelines that satisfy Code of Federal Regulations, title 42, section 438.236(b), and disseminate the guidelines to each affected provider and upon request, to an enrollee or potential enrollee.

Subd. 36. **MCO health information system.** (a) The commissioner shall ensure the MCOs maintain a health information system that collects, analyzes, integrates, and reports data. The systems must provide information on areas including but not limited to utilizations, claims, grievances and appeals, and enrollments and disenrollments.

(b) The commissioner shall require each MCO to collect data elements necessary to enable the mechanized claims processing retrieval systems operated by the commissioner according to section 1903(r)(1)(f) of the Social Security Act.

(c) Collect data on enrollee and provider characteristics and on all services furnished to enrollees through an encounter data system or other methods as specified by the commissioner. The MCO must ensure that data received from a provider is accurate and complete, verifying the accuracy and timeliness of the reported data and screening the data for completeness, logic, and consistency.

(d) Collecting data from a provider in a standardized format to the extent feasible and appropriate, including secure information exchanges and technologies utilized for medical assistance quality improvement and care coordination efforts.

(e) Make all collected data available to the commissioner and upon request to the Centers for Medicare and Medicaid.

(f) The commissioner must ensure through contract with MCOs that an MCO provides for:

(1) collection and maintenance of sufficient enrollee encounter data to identify the provider who delivers any items or services to enrollees;

(2) submission of enrollee encounter data to the commissioner at a frequency and level of detail to be specified by the Centers for Medicare and Medicaid and the commissioner, based on program administration, oversight, and program integrity needs;

(3) submission of all enrollee encounter data to the commissioner that satisfies Code of Federal Regulations, title 42, section 438.818. Federal financial participation is available if the commissioner meets the requirements for providing enrollee encounter data to the Centers for Medicare and Medicaid.

(4) specifications for submitting encounter data to the commissioner in standardized ASC X12 N837 and NCPDP formats, and the ASC X12 N8355 format.

(g) The commissioner must establish procedures and quality assurance protocols to review and validate the encounter data collected, maintained, and submitted to the commissioner, and is a complete and accurate representation of the services provided to enrollees under the contract between the commissioner and MCO.

Subd. 37. **Accreditation status of MCOs.** (a) Each MCO shall notify the commissioner whether the MCO was accredited by a private independent accrediting entity. The MCO must authorize the accrediting entity to provide the commissioner with a copy of the MCO's most recent accreditation review. The accreditation review must include:

(1) the accreditation status, survey type, and level, if applicable;

(2) accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings; and

(3) the expiration date of the accreditation.

(b) Annually, the commissioner must make available on the department's Web site whether an MCO was accredited, and if applicable, the name of the accrediting entity, accreditation program, and accreditation level.

Subd. 38. **Quality rating system.** (a) The commissioner shall adopt and implement a Medicaid managed care quality rating system developed by the Centers for Medicare and Medicaid within three years of the date of a final notice being published in the Federal Register. The commissioner may submit a request to the Centers for Medicare and Medicaid to use an alternative Medicaid managed care quality rating system that utilizes different performance measures or applies a different methodology from that published in the Federal Register provided that:

(1) the ratings generated by the alternative Medicaid managed care quality rating system must yield information regarding the MCO performance that is substantially comparable to the information yielded by the Centers for Medicare and Medicaid system published in the Federal Register; and

(2) the commissioner receives the Centers for Medicare and Medicaid approval, before implementing, the quality rating system or modifications.

(b) Before submitting for the Centers for Medicare and Medicaid approval, the commissioner:

(1) must obtain input from the Medical Care Advisory Committee; and

(2) provide an opportunity for public comment of at least 30 days on the proposed alternative Medicaid managed care quality rating system or modification; and

(3) must document in the commissioner's request for approval comments received from the public and the Medical Care Advisory Committee and explain any revisions made in response to comments and rationale for comments not accepted.

(c) Once the quality rating system has been implemented, each year the commissioner must collect data from each MCO and issue an annual quality rating for each MCO based on the data collected, using the quality rating system that was adopted. Annually, the commissioner must prominently display the quality rating given by the commissioner to each MCO on the department's Web site.

Subd. 39. **State-managed care quality strategy.** (a) The commissioner must draft and implement a written quality strategy for accessing and improving the quality of health care and services provided by the MCOs. At a minimum, the quality strategy must include the following:

(1) the commissioner's defined network adequacy and availability of services standards for MCOs and examples of evidence-based clinical practice guidelines;

(2) the goals and objectives for continuous quality improvement that are measurable and consider the health status of all populations in Minnesota served by the MCO;

(3) a description of:

(i) the quality metrics and performance targets used in measuring the performance and improvement of each MCO;

(ii) the quality measures and performance outcomes that must be annually published on the department's Web site; and

(iii) the performance improvement projects including a description of any interventions the commissioner proposes to improve access, quality, or timeliness of care for enrollees;

(4) annual, external independent reviews, of the quality outcomes and timelines of, and access to, the services covered by an MCO;

(5) a description of the transition of care policy;

(6) the commissioner's plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status, and must provide this demographic information to the MCO at the time of enrollment;

(7) appropriate use of intermediate sanctions imposed on a managed care organization;

(8) the mechanisms implemented to identify persons who need LTSS or persons with special health care needs; and

(9) information related to nonduplication of the external quality review activities found in Code of Federal Regulations, title 42, section 438.360(c).

(b) In drafting or revising the quality strategy, the commissioner must:

(1) make the strategy available for public comment before submitting to the Centers for Medicare and Medicaid for review;

(2) obtain input from the Medical Care Advisory Committee, beneficiaries, and other stakeholders; and

(3) if an Indian enrolls in the MCO, consult with the tribes according to the tribal consultation policy;

(4) review and update the quality strategy as needed, but no less than once every three years;

(5) evaluate the effectiveness of the quality strategy conducted within the previous three years;

(6) make the results of the review available on the department's Web site;

(7) must consider the recommendations from the External Quality Review Organization for improving the quality of health care services furnished by the MCO;

(8) submit a copy of the initial strategy to the Centers for Medicare and Medicaid for comment and feedback before adopting the initial strategy as final;

(9) a copy of the revised strategy whenever significant changes are made; and

(10) make the final quality strategy available on the department's Web site.

Subd. 40. **External quality reviews.** (a) The commissioner shall ensure that an annual external quality review (EQR) is conducted of each managed care organization by an external quality review organization (EQRO) that satisfies Code of Federal Regulations, title 42, section 438.354.

(1) The commissioner must contract with one EQRO to conduct the EQR and may contract with the same EQRO or other EQROs to perform other EQR-related activities. The information provided to the EQRO for the EQRO's review is obtained according to Code of Federal Regulations, title 42, section 438.352.

(2) The EQRO is permitted to use subcontractors that must meet the requirements for independence, but the EQRO is accountable for and must oversee all subcontractor functions.

(3) The commissioner must follow an open, competitive procurement process according to state and federal law for any contract with an EQRO.

(b) The commissioner, the commissioner's agent, or an EQRO may perform the mandatory and optional EQR activities. The following mandatory EQR-related activities must be performed for each MCO:

(1) using the preceding 12 months, validation of performance improvement projects, performance measures, and network adequacy, including compliance with a sufficient number of IHCPs that ensure timely access to services from these providers, if Indians are enrolled; and

(2) review of the MCO's compliance with Code of Federal Regulations, title 42, Subpart D and section 438.330 for the preceding three years.

(c) The commissioner may elect to incorporate any optional activity listed in Code of Federal Regulations, title 42, section 438.358(c) in the EQR. The commissioner may grant the EQRO permission to provide technical assistance to the MCOs related to the mandatory and optional activities included in the EQR.

(e) The commissioner may use information from a Medicare or private accreditation review of an MCO to provide information for the annual EQR instead of conducting one or more of the mandatory EQR activities to avoid duplication. This information must satisfy Code of Federal Regulations, title 42, section 438.360(a)(1) to (3), to meet the nonduplication standard.

(f) The commissioner must ensure that all information is furnished to the EQRO for analysis and inclusion in the EQR technical report.

(g) The commissioner may accept the data, correspondence, information, and findings pertaining to the MCO's compliance with a Medicare quality review if the conditions in Code of Federal Regulations, title 42, section 438.362, are met in lieu of performing an EQR.

(h) The commissioner must obtain from each MCO that the commissioner exempts from EQR the most recent Medicare review findings or Medicare information from a private national accrediting organization that the Centers for Medicare and Medicaid approves and recognizes for Medicare Advantage Organization deeming.

(i) The commissioner must contract with a qualified EQRO to produce an annual EQR technical report that satisfies Code of Federal Regulations, title 42, section 438.364. The content of the final EQR report may be revised if there is evidence of error or omission. The commissioner must post the final technical report to the department's Web site by April 30 of each year. The technical report must summarize findings on access and quality of care and must make copies of the information available upon request and available in alternative formats. Information in the report may not disclose the identity or other protected health information of any enrollee.

Subd. 41. **Appeals and grievance system.** (a) Each MCO must have a grievance and appeals system for enrollees. An enrollee may file a grievance and request an appeal with the MCO. The MCO may only offer one level of appeal to enrollees. An enrollee may request a state fair hearing only after receiving written notice of resolution on the enrollee's appeal from the MCO, or after the enrollee was deemed to have exhausted the MCO's appeals process, meaning the MCO has failed to adhere to the notice and timing requirements. An enrollee is not allowed to request a state fair hearing based on the MCO's resolution of a grievance.

(b) With the enrollee's written consent, the provider or authorized representative may file an appeal or grievance or request a state fair hearing on behalf of an enrollee. When the term enrollee is used throughout Code of Federal Regulations, title 42, sections 438.400 to 438.424, it includes providers and authorized representatives with the exception that providers cannot request continuation of benefits.

(c) The commissioner may offer and arrange for an external medical review if the review:

(1) is at the enrollee's option and the review must not be required before or used as a deterrent to proceed to a state fair hearing;

(2) is independent of the department and MCO;

(3) is offered to the enrollee at no cost to the enrollee; and

(4) does not extend any time frame for resolution and does not disrupt the continuation of benefits.

(d) An enrollee may file a grievance at any time either orally or in writing with the MCO.

(e) An enrollee must file an appeal with the MCO within 60 calendar days from the date on the adverse benefit determination notice. An enrollee may file an appeal with the MCO orally or in writing. Unless the enrollee requested an expedited appeal, the enrollee must follow an oral appeal with a written, signed appeal.

Subd. 42. **Timely and adequate notice of adverse benefit determination.** (a) An MCO must give enrollees timely and adequate notice of an adverse benefit determination in writing consistent this section and Code of Federal Regulations, title 42, section 438.10.

(b) The adverse benefit determination notice must contain the following:

(1) the adverse benefit determination the MCO made or intends to make;

(2) the reasons for the adverse benefit determination, including but not limited to medical necessity criteria. An enrollee may request, free of charge, reasonable access to and copies of all documents and records relevant to the enrollee's adverse benefit determination;

(3) the enrollee's right to request an appeal of the MCO's adverse benefit determination, including information about exhausting the MCO's one level of appeal and the enrollee's right to request a state fair hearing;

(4) the procedures for exercising the rights specified in this section;

(5) a description of when an appeal can be expedited and how to request an expedited appeal; and

(6) the enrollee's right to have benefits continue pending resolution of the appeal, how to request continued benefits, and the circumstances under which the enrollee may be required to pay for the cost of continued benefits.

(c) The MCO must mail the notice of adverse benefit determination to the enrollee or the enrollee's authorized representative according to the following:

(1) termination, suspension, or reduction of previously authorized covered services, the notice of adverse benefit determination must be mailed at least ten days before the proposed date of termination, suspension, or reduction, unless the MCO satisfies an exception in Code of Federal Regulations, title 42, section 431.213;

(2) denial of payment, at the time of any action affecting the claim; and

(3) a standard service authorization decision that denies or limits services, within ten calendar days from the date the MCO receives the enrollee's request for the service.

(d) If the MCO extends the time frame 14 calendar days, the MCO must:

(1) provide the enrollee written notice of the reason for the decision to extend the time frame and inform the enrollee of the right to file a grievance if the enrollee disagrees with the decision; and

(2) issue and carry out the determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

(e) A service authorization decision not made within the required time frame, constitutes a denial and is an adverse benefit determination by the MCO. For expedited service authorization decisions within 72 hours from the time of the request.

(f) The commissioner must conduct random reviews of each MCO and the MCO's providers or subcontractors delegated for the responsibility of sending the notice of adverse benefit determination to ensure that the MCOs are notifying enrollees in a timely manner.

Subd. 43. **Handling of grievances and appeals.** (a) The MCO must give an enrollee reasonable assistance for filing a grievance or an appeal, including assistance completing required forms and other required procedural steps. The MCO must provide auxiliary aids and services upon request, including interpreter services and toll-free TTY/TTD, and interpreter capability.

(b) The MCO must acknowledge the receipt of each grievance and appeal.

(c) The MCO must ensure that the individuals who make decisions on grievances and appeals are individuals:

(1) who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual;

(2) who have the appropriate clinical expertise in treating the enrollee's condition or disease if deciding:

(i) an appeal of a denial that is based on lack of medical necessity;

(ii) a grievance regarding denial of expedited resolution of an appeal; or

(iii) a grievance or appeal that involves clinical issues; and

(3) who consider all comments, documents, records, and other information submitted by the enrollee or the enrollee's representative without regard to whether the information was submitted or considered in the initial adverse benefit determination.

(d) The MCO must provide that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals to establish the earliest possible filing date for the appeal.

(e) The MCO must provide the enrollee with a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The MCO must provide the enrollee sufficient notice of the time frame for resolution for appeals, including expedited appeals.

(f) The MCO must provide the enrollee and the enrollee's representative with the enrollee's case file, including medical records, other documents, and any new or additional evidence considered, relied upon, or generated by the MCO for the appeal. This information must be provided free of charge and sufficiently in advance of the resolution time frame for appeals.

(g) The MCO must include the following as parties to the appeal:

(1) the enrollee and the enrollee's representative; or

(2) the legal representative of a deceased enrollee's estate.

Subd. 44. **Resolution and notification of grievances and appeals.** (a) The MCO must resolve each grievance and appeal, and provide notice of resolution, as expeditiously as the enrollee's health condition requires within the following time frames:

(1) for grievances, within 90 calendar days from the day the MCO receives the grievance;

(2) for standard appeals, within 30 calendar days from the day the MCO receives the appeal; and

(3) for expedited appeals, within 72 hours from the time the MCO receives the expedited appeal.

(b) The MCO may extend the time frame for standard and expedited appeals by an additional 14 calendar days, if:

(1) the enrollee requests the extension; or

(2) the MCO justifies to the commissioner that there is a need for additional information and that the delay is in the enrollee's interest.

(c) If the extension is not at the request of the enrollee, the MCO must:

(1) make reasonable efforts to give the enrollee prompt oral notice of the delay;

(2) within two calendar days give the enrollee written notice of the decision to extend the time frame and if the enrollee disagrees with that decision inform the enrollee of the right to file a grievance; and

(3) resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

(d) The commissioner must establish the method that the MCO must use to notify the enrollee of the resolution of the grievance, and ensure that the notice meets the information requirements in Code of Federal Regulations, title 42, section 438.10.

(e) For appeals, the MCO must provide written notice of the resolution according to Code of Federal Regulations, title 42, section 438.10.

(f) For expedited appeals, the MCO must provide oral notice of the resolution.

(g) The written notice for appeals must include the results of the resolution process and the date it was completed. For appeals not resolved wholly in favor of the enrollee, the notice must also contain:

(1) instructions on how to request a state fair hearing;

(2) instructions on the right to receive continued benefits during the pending state fair hearing; and

(3) information on when an enrollee must be held liable for the costs of continued benefits.

(h) An enrollee must request a state fair hearing no later than 120 calendar days from the date of the MCO's notice of resolution or when the enrollee is deemed to have exhausted the MCO's appeals process.

(i) The parties to the state fair hearing include the MCO, the enrollee and the enrollee's representative, or the representative of a deceased enrollee's estate.

Subd. 45. **Expedited resolution of appeals.** (a) MCOs must establish and maintain an expedited review process for appeals. When the MCO determines based on the request of an enrollee, or the provider indicates when making an appeal on behalf of the enrollee, that the time frame for a standard appeal could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

(b) The MCO must ensure that no punitive action is taken against a provider who requests an expedited resolution or supports an enrollee's appeal.

(c) If the MCO denies a request for an expedited appeal, the MCO must:

(1) transfer the appeal to the standard time frame for resolution of appeals; and

(2) follow the process for seeking an extension of the standard time frame for resolution of appeals.

Subd. 46. **Provider and subcontractor information.** The MCO is required to provide information about the MCO's grievance and appeals systems to the MCO's providers and subcontractors at the time a contract is entered.

Subd. 47. **Record-keeping requirements.** (a) The commissioner must require MCOs to maintain records of all grievances and appeals and must monitor the information and update and revise the quality strategy accordingly.

(b) A record of each grievance and appeal must contain, at a minimum, information that satisfies Code of Federal Regulations, title 42, section 438.4416(b) and (c).

Subd. 48. **Continuation of benefits.** (a) The MCO must continue the enrollee's benefits if:

(1) the enrollee files a request for an appeal timely and requests continued benefits on or before the later of the following:

(i) within ten calendar days of the MCO sending the notice of the adverse benefit determination; or

(ii) the intended effective date of the MCO's proposed adverse benefit determination;

(2) the appeal involves the termination, suspension, or reduction of previously authorized services;

(3) the services were ordered by an authorized provider; and

(4) the period covered by the original service authorization has not expired.

(b) If the MCO continues or reinstates benefits at the enrollee's request while the appeal or state fair hearing is pending, the benefits must be continued until:

(1) the enrollee withdraws the appeal or request for state fair hearing;

(2) the enrollee fails to request a state fair hearing and continuation of benefits within ten calendar days after the MCO sends the notice of an adverse resolution; or

(3) a state fair hearing office issues a hearing decision adverse to the enrollee.

(c) If the final resolution of the appeal or state fair hearing is adverse to the enrollee, the MCO may, consistent with the policies on recoveries under Code of Federal Regulations, title 42, section 431.230(b), and as specified in the commissioner's contract with the MCO, recover the cost of services furnished to the enrollee while the appeal and state fair hearing was pending.

Subd. 49. **Effectuation of reversed appeal resolutions.** (a) If the MCO or the state fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date the MCO receives notice reversing the MCO's adverse benefit determination.

(b) If the MCO or the state fair hearing officer reverses a decision to deny authorization of service, and the enrollee received the disputed services while the appeal was pending, the MCO or the commissioner must pay according to department policy and regulations.

Subd. 50. **Ombudsperson.** (a) The commissioner shall designate an ombudsperson to advocate for persons required to enroll in an MCO through an appeal and grievance process. The ombudsperson shall advocate for recipients enrolled in an MCO through complaint and appeal procedures and ensure that necessary medical services are provided either by the MCO directly or by referral to appropriate social services. Before enrollment in an MCO, an enrollee is provided information about managed care including the ombudsman person program and the enrollee's right to a resolution of an appeal or grievance. The local agency shall inform a recipient about the ombudsperson program and the recipient right to a resolution of a complaint by the MCO if recipient experiences a problem with the plan or the MCO's providers.

(b) The provider or MCO must respond directly to the managed care ombudspersons and county advocates regarding service delivery and must be accountable to the commissioner regarding contracts with medical assistance funds.

Subd. 51. **Program integrity.** (a) The commissioner must review the ownership and control disclosures submitted by the MCO and any MCO subcontractors.

(b) The commissioner must confirm through routine checks of the Federal databases the identity and determine the exclusion status of the MCO, any subcontractor, and any person with an ownership of five percent or control interest, or who is an agent or managing employee of the MCO. This includes the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the list of Excluded

Individuals/Entities (LEIE), the System for Award Management (SAM), and any other databases that the Centers for Medicare and Medicaid may prescribe. The databases listed in this paragraph must be consulted upon contract initiation and renewal and monthly thereafter. If, upon review of the databases listed in this paragraph, an excluded party is identified, the commissioner must notify the MCO and take action consistent with Code of Federal Regulations, title 42, section 438.610(d).

(c) The commissioner must, at least every three years, conduct, or contract for, an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by each MCO. The commissioner shall receive and investigate information from whistleblowers relating to the integrity of the MCO, subcontractors, or network providers receiving federal funds.

(e) The commissioner shall post on the department's Web site:

(1) the MCO contract;

(2) the documentation required by Code of Federal Regulations, title 42, section 438.207(b), that the commissioner based its certification that the MCO complies with the commissioner's availability and accessibility of services requirements, including the provider network adequacy requirements;

(3) the name and title of any person with an ownership or control interest of the MCO or any MCO subcontractors according to Code of Federal Regulations, title 42, section 455.104; and

(4) a copy of the audit results conducted pursuant to Code of Federal Regulations, title 42, section 438.602(e).

(f) The commissioner must ensure that an MCO is not located outside of the United States and no claims are paid by an MCO to a network provider, out-of-network provider, subcontractor, or financial institution located outside of the United States.

(g) Federal financial participation is only available if the commissioner excludes from the MCO contracts all of the entities listed in Code of Federal Regulations, title 42, section 438.808(b).

Subd. 52. **Data, information, and documentation requirements.** (a) The commissioner must require each MCO to submit the following data:

(1) encounter data according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) security and privacy standards and must be submitted in the format

required by the Medicaid Statistical Information System or a format required by any successor system to the Medicaid Statistical Information System;

(2) data on the basis that the commissioner certifies the actuarial soundness of capitation rates to an MCO according to Code of Federal Regulations, title 42, section 438.4, including base data described in Code of Federal Regulations, title 42, section 438.5(c) that is generated by the MCO;

(3) data on the basis that the commissioner determines MCO compliance with the medical loss ratio requirements;

(4) data on the basis that the commissioner determines that the MCO made adequate provision against the risk of insolvency as required under Code of Federal Regulations, title 42, section 438.116;

(5) documentation, in a format specified by the commissioner according to Code of Federal Regulations, title 42, section 438.207(b), that the MCO complied with the commissioner's requirements for availability and accessibility of services, including the adequacy of the provider network in Code of Federal Regulations, title 42, section 438.206;

(6) information from the MCO on ownership and control interest according to Code of Federal Regulations, title 42, section 455.104, and subcontractors according to Code of Federal Regulations, title 42, section 438.230; and

(7) an annual report of the MCO's recoveries of overpayments.

(b) The commissioner shall require that data submitted under Code of Federal Regulations, title 42, section 438.604, by the MCO must be certified by the MCO's chief executive officer (CEO), chief financial officer (CFO), or an individual who reports directly to the CEO or CFO with delegated authority to sign on their behalf. The certification must include an attestation by the CEO or CFO that the information submitted is based on the CEO's or CFO's knowledge and belief that the data is accurate, complete, and truthful, and must be submitted concurrently with the data.

Subd. 53. **MCO program integrity requirements.** (a) The commissioner must require the MCO, or any MCO subcontractor delegated responsibility for coverage of services and payment of claims, to implement and maintain procedures designed to detect and prevent fraud, waste, and abuse. The MCO must include the procedures in a compliance plan that includes:

(1) written policies, procedures, and standards of conduct that articulate the MCO's commitment to comply with applicable federal and state requirements regarding fraud, waste, and abuse;

(2) the designation of a compliance officer responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and who reports directly to the CEO and the board of directors;

(3) the establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the MCO's compliance program;

(4) a system for training and education for the compliance officer, the MCO's senior management, and employees for federal and state standards and develop a procedure for effective lines of communication between the groups;

(5) enforcement of standards and implementation of procedures for routine internal monitoring and auditing of compliance according to Code of Federal Regulations, title 42, section 438.608(a)(1)(vii), to reduce the potential for recurrence and promote ongoing compliance;

(6) a provision for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the commissioner;

(7) a provision for prompt reporting to the commissioner when the MCO receives information that may affect an enrollee's eligibility;

(8) a provision for notification to the commissioner if the MCO receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including termination of the provider agreement with the MCO;

(9) a provision for a method to verify, on a regular basis, that services represented as delivered by a network provider were received by the enrollees;

(10) for an MCO contract that has an annual payment or receipt of at least $5,000,000, a provision for written policies for all employees of the MCO, or subcontractor, that provides detailed information about the False Claims Act and other federal and state laws described in section 1902(a)(68) of the Social Security Act, including information about rights of employees to be protected as whistleblowers;

(11) a provision for the prompt referral of any potential fraud, waste, or abuse identified by the MCO to the Medicaid Program Integrity Unit, and any potential fraud directly to the Medicaid Fraud Control Unit; and

(12) a provision for the suspension of payments to a network provider that the commissioner determines there is a credible allegation of fraud according to Code of Federal Regulations, title 42, section 455.23.

(b) The commissioner shall ensure that each MCO and any subcontractor:

(1) provides written disclosure of any prohibited affiliation according to Code of Federal Regulations, title 42, section 438.610;

(2) provides written disclosures of information on ownership and control required by Code of Federal Regulations, title 42, section 455.104; and

(3) reports to the commissioner within 60 calendar days when the MCO or subcontractor identifies that capitation payments or other payments were in excess of the amounts specified in the contract.

(c) The commissioner must ensure the MCO contracts specify:

(1) the retention policies for treatment of all overpayments from the MCO to a provider, including the retention policies for the treatment of recoveries of overpayments due to fraud, waste, and abuse;

(2) the process, time frames, and documentation required for reporting the recovery of all overpayments, including situations of recoveries of overpayments to the commissioner where the MCO is not permitted to retain some or all of the recoveries of overpayments; and

(3) the treatment of recoveries does not apply to any amount of recovery to be retained under the False Claims Act or through other investigations.

(d) The commissioner shall ensure each MCO has a mechanism for a network provider to report to the MCO when the MCO has received an overpayment, to return the overpayment to the MCO within 60 calendar days after the date the overpayment was identified, and to notify the MCO in writing of the reason for the overpayment.

(e) The commissioner shall require each MCO to submit an annual report to the commissioner on the MCO's recoveries of overpayments. The commissioner must use the information to set actuarially sound capitation rates.

(f) An MCO may not knowingly have a relationship with any of the types identified in Code of Federal Regulations, title 42, section 438.610(c), if the following occurs:

(1) an individual or entity is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from

participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or

(2) an individual or entity is an affiliate, as defined in Code of Federal Regulations, title 42, section 2.101, of a person described in clause (1).

(g) An MCO may not have a relationship with an individual or entity that is excluded from participation in any federal health care program under section 1128 or 1128A of the Social Security Act.

(h) If the commissioner determines that an MCO fails to comply with paragraphs (f) and (g), the commissioner:

(1) must notify the Centers for Medicare and Medicaid of the MCO's noncompliance;

(2) may continue an existing agreement with the MCO unless the Centers for Medicare and Medicaid directs otherwise; and

(3) may not renew or otherwise extend the duration of an existing agreement with the MCO unless the Centers for Medicare and Medicaid provides a written statement to the commissioner and congress describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliations;

Nothing in this section must be construed to limit or otherwise affect any remedies available under sections 1128, 1128A, or 1128B of the Social Security Act.

Subd. 54. **Sanctions.** (a) The commissioner must establish intermediate sanctions if the commissioner makes a determination that the MCO :

(1) failed to substantially provide medically necessary services to an enrollee that is covered under law or under the contract with the commissioner;

(2) imposed premiums or charges that exceed premiums or charges permitted under medical assistance;

(3) discriminated against an enrollee on the basis of the enrollee's health status or need for health care services, including:

(i) termination of enrollment or refusal to reenroll a beneficiary, except as permitted under medical assistance; or

(ii) any practice that would reasonably be expected to discourage enrollment by a beneficiary whose medical condition or history indicates probable need for substantial future medical services;

(4) misrepresented or falsified information to the Centers for Medicare and Medicaid or the commissioner;

(5) misrepresented or falsified information furnished to an enrollee, potential enrollee, or health care provider;

(6) failed to comply with the requirements for physician incentive plans, as set forth in according to Code of Federal Regulations, title 42, sections 422.208 and 422.210;

(7) the MCO distributed directly, or indirectly through any agent or independent contractor, marketing materials that were not approved by the commissioner or that contained false or materially misleading information; or

(8) the MCO violated any of the other requirements of section 1903(m) or 1932 of the Social Security Act, or any implementing regulations.

(b) Only the sanctions listed in Code of Federal Regulations, title 42, section 438.702(a)(3), (4), and (5), may be imposed.

Subd. 55. **Types of intermediate sanctions.** (a) The commissioner may:

(1) impose civil money penalties according to Code of Federal Regulations, title 42, section 438.704;

(2) appoint of temporary management for an MCO as provided in Code of Federal Regulations, title 42, section 438.706;

(3) grant an enrollee the right to terminate enrollment without cause and notifying the affected enrollee of the enrollee's right to disenroll;

(4) suspend new enrollment, including default enrollment, after the date the Centers for Medicare and Medicaid or the commissioner notifies the MCO of a determination of a violation under sections 1903(m) or 1932 of the Social Security Act; or

(5) suspend payment for a beneficiary enrolled after the effective date of the sanction and until the Centers for Medicare and Medicaid or the commissioner is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

(b) The commissioner may impose additional sanctions for an MCO's noncompliance according to Code of Federal Regulations, title 42, section 438.700.

Subd. 56. **Special rules for temporary management.** (a) The commissioner may impose temporary management of the MCO according to Code of Federal Regulations, title 42, section 438.702(a)(2), only if the commissioner finds through on-site surveys, enrollee or other complaints, financial status, or any other source the following:

(1) continued egregious behavior by the MCO including but not limited to behavior described in Code of Federal Regulations, title 42, section 438.700, or behavior that violates sections 1903(m) and 1932 of the Social Security Act;

(2) there is substantial risk to the enrollee's health; or

(3) the sanction is necessary to ensure the health of the enrollee while improvements are made to remedy the violations or until there is an orderly termination or reorganization of the MCO.

(b) The commissioner must impose temporary management of the MCO, regardless of the imposition of any other sanction, if the commissioner finds that an MCO repeatedly failed to meet substantive requirements of section 1903(m) or 1932 of the Social Security Act or Code of Federal Regulations, title 42, section 438. The commissioner must grant an enrollee the right to terminate enrollment without cause and notify the affected enrollee of the enrollee's right to disenroll.

(c) The commissioner shall not delay imposition of temporary management pending a hearing. Temporary management must remain in place until the commissioner determines that the sanctioned behavior will not recur.

Subd. 57. **Termination of the MCO contract.** The commissioner may terminate an MCO contract and enroll that MCO's enrollees in different MCOs, or provide the enrollee's medical assistance benefits through other options included in the state plan, if the commissioner determines that the MCO failed to either carry out the substantive terms of the MCO's contract or satisfy sections 1932, 1903(m), and 1905(t) of the Social Security Act.

Subd. 58. **Notice of sanction and pretermination.** (a) Except as provided in Code of Federal Regulations, title 42, section 438.706(c), the commissioner, before imposing any intermediate sanctions, must give the affected MCO timely written notice that explains the basis and nature of the sanction and any other appeal rights that the commissioner elects to provide.

(b) Before terminating an MCO contract, the commissioner must provide the MCO:

(1) with a pretermination hearing;

(2) written notice of its intent to terminate, the reason for termination, and the time and place of the hearing; and

(3) written notice of the decision affirming or reversing the proposed termination of the contract.

(c) If the contract is terminated, the commissioner must specify the effective date of the termination and provide the MCO's enrollees notice of the termination and information according to Code of Federal Regulations, title 42, section 438.10, on the enrollee's options for receiving medical assistance services following the effective date of the termination. The MCO's enrollees may be allowed to disenroll immediately without cause.

Subd. 59. **Notice to the Centers for Medicare and Medicaid.** (a) The commissioner must notify the Centers for Medicare and Medicaid in writing if the commissioner imposes or lifts a sanction for a violation of Code of Federal Regulations, title 42, section 438.700.

(b) The notice must be given no later than 30 days after the commissioner imposes or lifts a sanction and must specify the affected MCO, the kind of sanction, and the reason for the commissioner's decision.

Subd. 60. **State plan requirements.** (a) The commissioner must include a plan to monitor MCO violations.

(b) The MCO contract must provide that payments made pursuant to the contract must be denied for a new enrollee if, and for so long as, payment for the enrollee is denied by the Centers for Medicare and Medicaid according to Code of Federal Regulations, title 42, section 438.730(e).

Subd. 61. **Sanctions by the Centers for Medicare and Medicaid.** (a) The commissioner may recommend that the Centers for Medicare and Medicaid impose a denial of payment sanction on an MCO if the commissioner determines that an MCO acted or failed to act according to Code of Federal Regulations, title 42, section 438.700(b)(1) to (6). The commissioner's determination or recommendation to impose the denial of payment sanction becomes the Centers for Medicare and Medicaid's decision for purposes of section 1903(m)(5)(A)and(B) unless the Centers for Medicare and Medicaid rejects it within 15 days.

(b) If the commissioner's determination becomes the Centers for Medicare and Medicaid's decision, the commissioner must:

(1) provide written notice of the nature and basis of the proposed sanction to the MCO;

(2) allow the MCO 15 days from the date the MCO receives the notice to provide evidence that the MCO did not act or failed to act in the manner that is the basis for the recommended sanction;

(c) The initial 15 days may be extended 15 days if:

(1) the MCO submits a written request that includes a credible explanation of why the MCO needs additional time;

(2) the request is received by the Centers for Medicare and Medicaid before the end of the initial period; or

(3) the Centers for Medicare and Medicaid has not determined that the MCO's conduct poses a threat to an enrollee's health or safety.

(d) If the MCO submits a timely response to the notice of sanction, the commissioner must:

(1) conduct an informal reconsideration including review of the evidence by a staff member who did not participate in the original recommendation;

(2) provide the MCO a concise written decision setting forth the factual and legal basis for the decision. The commissioner's decision becomes the Centers for Medicare and Medicaid's decision unless the Centers for Medicare and Medicaid reverses or modifies the decision within 15 days of the date of receipt by the Centers for Medicare and Medicaid. If the Centers for Medicare and Medicaid reverses or modifies the commissioner's decision the commissioner must send the MCO a copy of the Centers for Medicare and Medicaid's decision; and

(3) provide the decision to the Centers for Medicare and Medicaid.

(d) Upon the recommendation of the commissioner, the Centers for Medicare and Medicaid may deny payment to the department for new enrollees of the MCO under section 1903(m)(5)(B)(ii) of the Social Security Act, if:

(1) a Centers for Medicare and Medicaid determination that an MCO has acted or failed to act is affirmed under review;

(2) the Centers for Medicare and Medicaid determination is not timely contested by the MCO; or

(3) the Centers for Medicare and Medicaid's denial of payment for a new enrollee automatically results in a denial of payment to the MCO for the enrollee.

(f) If the MCO does not seek reconsideration, the sanction is effective 15 days following the MCO's notification of the decision to impose the sanction. If the MCO seeks reconsideration, the sanction is effective on the date specified in the Centers for Medicare and Medicaid's reconsideration notice. If the MCO's conduct poses a serious threat to an

enrollee's health or safety, the sanction may be made effective earlier than the date of the commissioner's reconsideration.

(g) If the commissioner sends notice of the sanction to the MCO, the Centers for Medicare and Medicaid must forward a copy of the notice to the Office of Inspector General for consideration of possible civil money penalties according to section 1903(m)(5)(A) of the Social Security Act and Code of Federal Regulations, title 42, section 1003.

Subd. 62. **Managed care rates.** (a) The commissioner shall establish the method and amount of payments for services covered under the managed care contract. The final capitation rate must be:

(1) specifically identified in the applicable contract submitted for Centers for Medicare and Medicaid review and approval;

(2) based solely upon services covered under the state plan and additional services deemed by the commissioner to be necessary to comply with mental health parity requirements; and

(3) adequate to allow the MCO to efficiently deliver covered services to individuals eligible for medical assistance in a manner compliant with contractual requirements.

(b) Payments for elderly waiver services and 180 days of nursing home care may be included in the capitation payments for a beneficiary 65 years of age and older.

Subd. 63. **Actuarial soundness.** (a) Capitation rates for MCOs must be reviewed and approved by the Centers for Medicare and Medicaid as actuarially sound. To be approved by the Centers for Medicare and Medicaid, capitation rates must:

(1) be developed according to the rates standards in Code of Federal Regulations, title 42, section 438.5, and generally accepted actuarial principles and practices. Any proposed differences among capitation rates according to covered populations must be based on valid rate development standards and not based on the rate of federal financial participation associated with the covered populations;

(2) be appropriate for the populations covered and the services furnished under the contract;

(3) meet the requirements on MCOs for availability of services, assurance of adequate capacity and services, and coordination and continuity of care according to Code of Federal Regulations, title 42, sections 438.206, 438.207, and 438.208;

(4) be specific to payments for each rate cell under the contract, and must not cross-subsidize or be cross-subsidized by payments for any other rate cell;

(5) be certified by an independent actuary. The actuary shall certify that the rates were developed according to Code of Federal Regulations, title 42, section 438.3(c)(1)(ii)(e);

(6) meet any special contract provisions according to Code of Federal Regulations, title 42, section 438.6;

(7) be provided to the Centers for Medicare and Medicaid in a format and within a time frame according to Code of Federal Regulations, title 42, section 438.7; and

(8) be developed for the MCO to reasonably achieve a medical loss ratio standard of at least 85 percent for the rate year. The capitation rates may be developed for the MCO to achieve a medical loss ratio greater than 85 percent as long as the capitation rates are adequate for reasonable, appropriate, and attainable nonbenefit costs.

Subd. 64. **Rate development standards.** (a) The commissioner shall establish actuarially sound capitation rates and must:

(1) identify and develop base utilization and price data including validated encounter data and audited financial reports received from the MCOs that demonstrate experience for the populations served by the MCOs, for the three most recent and complete years before the rating period;

(2) develop and apply reasonable trend factors, including cost and utilization, to base data that are developed from actual experience of the Medicaid population or a similar population according to generally accepted actuarial practices and principles;

(3) develop the nonbenefit component of the rate to account for reasonable expenses related to the MCO's administration; taxes; licensing and regulatory fees; contribution to reserves; risk margin; cost of capital and other operational costs associated with the MCO's provision of covered services to beneficiaries;

(4) pay administrative costs to MCOs not to exceed 6.6 percent of total payments made to all MCOs in aggregate across all state public health care programs. The commissioner may reduce or eliminate administrative requirements to meet the administrative cost limit. For purposes of this paragraph, administrative costs do not include premium taxes paid under section 297I.05, subdivision 5, provider surcharges paid under section 256.9657, subdivision 3, or health insurance fees under section 9010 of the Affordable Care Act;

(5) consider investment income and interest earnings as income to the same extent that investment-related expenses are treated as administrative expenditures;

(6) consider the value of cost sharing for rate development purposes, regardless of whether the MCO imposes the cost sharing on the MCO's beneficiary or the cost sharing is collected;

(7) make appropriate and reasonable adjustments to account for changes to the base data, programmatic changes, non-benefit components, and any other adjustment necessary to establish actuarially sound rates. Each adjustment must reasonably support the development of an accurate base data set for purposes of rate setting, reflect the health status of the enrolled population, and be developed in accordance with generally accepted actuarial principles and practices;

(8) consider the MCO's past medical loss ratio in the development of the capitation rates and consider the projected medical loss ratio; and

(9) select a prospective or retrospective risk adjustment methodology that must be developed in a budget-neutral manner consistent with generally accepted actuarial principles and practices.

(b) The base data must be derived from the Medicaid population, or, if data on the Medicaid population is not available, derived from a similar population and adjusted to make the utilization and price data comparable to data from the Medicaid population. Data must be in accordance with actuarial standards for data quality and an explanation of why that specific data is used must be provided in the rate certification. If the commissioner is unable to base the rates on data that are within the three most recent and complete years before the rating period, the commissioner may request an approval for an exception. The request must describe why an exception is necessary and describe the actions that the commissioner intends to take to come comply with.

(c) Notwithstanding paragraph (a), the commissioner shall reduce administrative expenses paid to managed care plans by one-half percent for contracts beginning January 1, 2016, and ending December 31, 2017. To meet the administrative reductions under this paragraph, the commissioner may reduce or eliminate administrative requirements, exclude additional unallowable administrative expenses resulting from the financial audits, and utilize competitive bidding to gain efficiencies through economies of scale from increased enrollment. If the total reduction cannot be achieved through administrative reduction, the commissioner may limit total rate increases on payments to MCOs.

(d) Where reasonably possible, expenses for an administrative item shall be directly allocated so as to assign costs for an item to an individual state public health care program when the cost can be specifically identified with and benefits the individual state public

health care program. For administrative services expensed to the state's public health care programs, managed care organizations must clearly identify and separately record expense items in the MCO's accounting systems in a manner that allows for independent verification of unallowable expenses for purposes of determining payment rates for state public health care programs.

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

(1) charitable contributions made by the managed care organization. Charitable contributions include payments for or to any organization or entity selected by the managed care plan or county-based purchasing plan that is operated for charitable, educational, political, religious, or scientific purposes, that are not related to medical and administrative services covered under state public health care programs;

(2) compensation of individuals within the organization in excess of $200,000 such that the allocation of compensation for an individual across all state public health care programs in total cannot exceed $200,000. For the purposes of this subdivision, compensation includes salaries, bonuses and incentives, other reportable compensation on an IRS 990 form, retirement and other deferred compensation, and nontaxable benefits;

(3) any penalties or fines assessed against the MCO;

(4) any indirect marketing or advertising expenses of the MCO, including but not limited to costs to promote the MCO, costs of facilities used for special events, and costs of displays, demonstrations, donations, and promotional items such as memorabilia, models, gifts, and souvenirs. The commissioner may classify an item listed as an allowable administrative expense for rate-setting purposes, if the commissioner determines that the expense is incidental to an activity related to state public health care programs that is an allowable cost for purposes of rate setting;

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

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

(7) alcoholic beverages and related costs;

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

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

(f) Payments to a quality improvement organization are an allowable administrative expense for rate-setting purposes under this section, to the extent are allocated to a state public health care program and approved by the commissioner.

(g) Within the limit of available appropriations, the commissioner shall work with the commissioner of health to identify and collect data on administrative spending for state public health care programs reported to the commissioner of health by managed care organizations, provided that data are consistent with guidelines and standards for administrative spending that are developed by the commissioner of health, and reported to the legislature under Laws 2008, chapter 364, section 12. Data provided to the commissioner under this subdivision are nonpublic data as defined in section 13.02.

(h) The commissioner, in consultation with an actuary, shall evaluate the regional rate relationships based on actual health plan costs for state public health care programs. The commissioner shall establish, based on the actuary's recommendation, new rate regions that recognize metropolitan areas outside of the seven-county metropolitan area.

Subd. 65. **Payment limits.** (a) The commissioner shall reduce payments and limit future rate increases paid to managed care plans and county-based purchasing plans. The limits in paragraphs (a) to (f) shall be achieved on a statewide aggregate basis by program. The commissioner may use competitive bidding, payment reductions, or other reductions to achieve the reductions and limits in this subdivision.

(b) The commissioner shall reduce payments to managed care organizations as follows:

(1) 2.0 percent for medical assistance elderly basic care. This shall not apply to Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver services;

(2) 2.82 percent for medical assistance families and children;

(3) 10.1 percent for medical assistance adults without children; and

(4) 6.0 percent for MinnesotaCare families and children.

(c) The commissioner shall limit rates paid to managed care plans and county-based purchasing plans for calendar year 2012 to a percentage of the rates in effect on August 31, 2011, as follows:

(1) 98 percent for medical assistance elderly basic care. This shall not apply to Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver services;

(2) 97.18 percent for medical assistance families and children;

(3) 89.9 percent for medical assistance adults without children; and

(4) 94 percent for MinnesotaCare families and children.

(d) Beginning January 1, 2013, to December 31, 2013, the commissioner shall limit the maximum annual trend increases to rates paid to managed care plans and county-based purchasing plans as follows:

(1) 7.5 percent for medical assistance elderly basic care. This shall not apply to Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver services;

(2) 5.0 percent for medical assistance special needs basic care;

(3) 2.0 percent for medical assistance families and children;

(4) 3.0 percent for medical assistance adults without children;

(5) 3.0 percent for MinnesotaCare families and children; and

(6) 3.0 percent for MinnesotaCare adults without children.

(e) The commissioner may limit trend increases to less than the maximum. Beginning July 1, 2014, the commissioner shall limit the maximum annual trend increases to rates paid to managed care plans and county-based purchasing plans as follows for calendar years 2014 and 2015:

(1) 7.5 percent for medical assistance elderly basic care. This shall not apply to Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver services;

(2) 5.0 percent for medical assistance special needs basic care;

(3) 2.0 percent for medical assistance families and children;

(4) 3.0 percent for medical assistance adults without children; (5) 3.0 percent for MinnesotaCare families and children; and

(6) 4.0 percent for MinnesotaCare adults without children. The commissioner may limit trend increases to less than the maximum. For calendar year 2014, the commissioner shall reduce the maximum aggregate trend increases by $47,000,000 in state and federal funds to account for the reductions in administrative expenses in subdivision 15b.

Subd. 66. **Special contract requirements related to payment.** (a) If the commissioner uses risk-sharing mechanisms such as reinsurance, risk corridors, or stop-loss limits, they must be described in the contract, and must be developed according to the rate development standards and generally accepted actuarial principles and practices.

(b) The commissioner may utilize incentive payment arrangements in MCO contracts. The payment may not exceed 105 percent of the approved capitation payments attributable

to the enrollees or services covered by the incentive arrangement and must be considered within actuarial soundness. For all incentive arrangements the contract must provide that the arrangement is:

(1) for a fixed period of time and performance is measured during the rating period in which the incentive arrangement is applied;

(2) not to be renewed automatically;

(3) made available to both public and private contractors under the same terms of performance; and

(4) specified activities, targets, performance measures, or quality-based outcomes in the state's quality strategy.

The incentive payment arrangement must not condition the MCO's participation in the incentive arrangement on entering into or adhering to intergovernmental transfer agreements.

(c) The commissioner must provide that any withholding arrangement must ensure that the capitation payment minus any portion of the withheld funds that is not reasonably achievable is actuarially sound. The total amount of the withheld funds, achievable or not, must be reasonable and take into consideration each MCO's financial operating needs accounting for the size and characteristics of the populations covered under the contract, as well as the MCO's capital reserves, as measured by the risk based capital level, months of claims reserve, or other appropriate measure of reserves. The data, assumptions, and methodologies used to determine the portion of the withhold that is reasonably achievable must be submitted as part of the documentation required by Code of Federal Regulations, title 42, section 438.7(b)(6); for all withhold arrangements the contract must provide that the arrangement is :

(1) for a fixed period of time and performance is measured during the rating period in which the withhold arrangement is applied

(2) not to be renewed automatically;

(3) made available to both public and private contractors under the same terms of performance;

(4) specified activities, targets, performance measures, or quality-based outcomes in the state's quality strategy.

The withhold payment arrangement must not condition the managed care organization's participation in the withhold arrangement on entering into or adhering to intergovernmental transfer agreements;

(d) Each performance target must be quantifiable, objective, measurable, and reasonably attainable. The withheld funds must be returned no sooner than July of the following year if performance targets in the contract are achieved. The commissioner may exclude special demonstration projects under subdivisions 18 and 19. A managed care plan or a county-based purchasing plan under section 256B.692 may include as admitted assets under section 62D.044 any amount withheld under this section that is reasonably expected to be returned.

Subd. 67. **Managed care withhold requirements.** (a) The commissioner shall withhold five percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program pending completion of performance targets. Each performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. Clinical or utilization performance targets and their related criteria must consider evidence-based research and reasonable interventions when available or applicable to the populations served, and must be developed with input from external clinical experts and stakeholders, including managed care plans, county-based purchasing plans, and providers. The managed care or county-based purchasing plan must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance target is accurate. The commissioner shall periodically change the administrative measures used as performance targets in order to improve plan performance across a broader range of administrative services. The performance targets must include measurement of plan efforts to contain spending on health care services and administrative activities. The commissioner may adopt plan-specific performance targets that take into account factors affecting only one plan, including characteristics of the plan's enrollee population. The withheld funds must be returned no sooner than July of the following year if performance targets in the contract are achieved. The commissioner may exclude special demonstration projects under subdivisions 75 and 76.

(b) The commissioner shall include as part of the performance targets described in paragraph (a) a reduction in the health plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each subsequent year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than ten percent of the plan's

emergency department utilization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 75 and 76, compared to the previous measurement year until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

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

The withheld funds shall continue for each consecutive contract period until the plan's emergency room utilization rate for state health care program enrollees is reduced by 25 percent of the plan's emergency room utilization rate for medical assistance and MinnesotaCare enrollees for calendar year 2009. Hospitals shall cooperate with the health plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved.

(c) The commissioner shall include as part of the performance targets described in paragraph (a) a reduction in the plan's hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than five percent of the plan's hospital admission rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 75 and 76, compared to the previous calendar year until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

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

returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

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

(d) The commissioner shall include as part of the performance targets described in paragraph (a) a reduction in the plan's hospitalization admission rates for subsequent hospitalizations within 30 days of a previous hospitalization of a patient regardless of the reason, for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of the subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 75 and 76, of no less than five percent compared to the previous calendar year until the final performance target is reached.

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

The withheld funds must continue for each consecutive contract period until the plan's subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 74 and 75, is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar year 2011. Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that must be returned to the hospitals if the performance target is achieved.

(e) The commissioner shall withhold 4.5 percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than

July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivisions 75 and 76.

(f) The commissioner shall withhold three percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivisions 75 and 76.

(g) The return of the withhold under paragraphs (d)(v) and (d)(vi) is not subject to the requirements of paragraph (d)(i).

Subd. 68. **Medical education and research fund.** (a) The commissioner shall transfer each year to the medical education and research fund established under section 62J.692, an amount specified in this subdivision.

(b) The commissioner shall calculate the following:

(1) an amount equal to the reduction in the prepaid medical assistance payments as specified in this clause. The county medical assistance capitation base rate before plan specific adjustments is reduced 6.3 percent for Hennepin County, two percent for the remaining metropolitan counties, and 1.6 percent for nonmetropolitan Minnesota counties. Nursing facility and elderly waiver payments and demonstration project payments operating under subdivisions 78 and 79 are excluded from this reduction. The amount calculated under this clause shall not be adjusted for periods already paid due to subsequent changes to the capitation payments;

(2) beginning July 1, 2003, $4,314,000 from the capitation rates paid under this section;

(3) beginning July 1, 2002, an additional $12,700,000 from the capitation rates paid under this section; and

(4) beginning July 1, 2003, an additional $4,700,000 from the capitation rates paid under this section.

(c) This subdivision shall be effective upon approval of a federal waiver which allows federal financial participation in the medical education and research fund. The amount specified under paragraph (b) shall not exceed the total amount transferred for fiscal year 2009. Any excess shall first reduce the amounts specified under paragraph (b). Any excess following this reduction shall proportionally reduce the amount specified under paragraph (b).

(d) Of the amount in clause (1), the commissioner shall transfer $21,714,000 each fiscal year to the medical education and research fund.

(e) Of the amount in clause (1), following the transfer under clause (3), the commissioner shall transfer to the medical education research fund $23,936,000 in fiscal years 2012 and 2013 and $49,552,000 in fiscal year 2014 and thereafter.

(f) Beginning July 1, 2002, the capitation rates paid under this section are increased by $12,700,000 per year. Beginning July 1, 2003, the capitation rates paid under this section are increased by $4,700,000 per year.

(g) Beginning July 1, 2009, the capitation rates paid under this section are increased each year by the lesser of $21,714,000 or an amount equal to the difference between the estimated value of the reductions described in clause (1), item (i), and the amount of the limit described in clause (2).

(h) Capitation payments for services provided in the month of June for which payment shall be made no earlier than the first day of the following month and no later than the last day of that month.

(i) The commissioner shall not direct MCO expenditures under the contract, except in the following situations:

(1) implementation of a value-based purchasing model for provider reimbursement, such as pay-for-performance arrangements, bundled payments, or other service payments intended to recognize value or outcomes over volume of services;

(2) participation in a multipayer or medical assistance specific delivery system reform or performance improvement initiative;

(3) implementation of a minimum or maximum fee schedule, or a uniform dollar or percentage increase for network providers that provide a particular service. The maximum fee schedule must allow the MCO the ability to reasonably manage risk and provide discretion in accomplishing the goals of the contract; and

(4) the MCO contract that directs the MCO expenditures under clauses (1) to (3) must be developed according to Code of Federal Regulations, title 42, section 438.5, comply with actuarial soundness, and generally accepted actuarial principles and practices and have written approval from the Centers for Medicare and Medicaid before implementation. To obtain approval the commissioner must demonstrate in writing that the contract arrangements:

(i) are based on the utilization and delivery of services;

(ii) directs expenditures equally, using the same terms of performance for a class of providers providing service under the contract;

(iii) expects to advance at least one of the goals and objectives in the commissioner's quality strategy;

(iv) has an evaluation plan that measures the degree to which the arrangement advances at least one of the goals in the commissioner's quality strategy;

(v) does not condition network provider participation on the network provider entering into or adhering to an intergovernmental transfer agreement; and

(vi) are not renewed automatically; and

(5) for contract arrangements identified in clauses (1) and (2), the commissioner shall:

(i) make participation in the value-based purchasing initiative delivery system reform or performance improvement initiative available, using the same terms of performance, to a class of providers providing services under the contract related to the reform or improvement initiatives;

(ii) use a common set of performance measures across all of the payers and providers;

(iii) not set the amount or frequency of the expenditures; and

(iv) not allow the state to recoup from the MCO any unspent funds allocated for these arrangements.

(j) The commissioner may require MCOs to make pass-through payments to network providers that are hospitals, physicians, and nursing facilities satisfy Code of Federal Regulations, title 42, section 438.6(d), until the commissioner must phase out pass-through payments. Pass-through payments for hospitals may be required under the contract but must be phased out no longer than on the 10-year schedule, beginning with contracts that start on or after July 1, 2017 and ending on July 1, 2027. Pass-through payments for physicians and nursing facilities may be required under the contract but must be phased out no longer than on the 5-year schedule, beginning with contracts that start on or after July 1, 2017 and ending on July 1, 2022.

(k) The commissioner may make a monthly capitation payment to an MCO for an enrollee 21 to 64 years of age receiving inpatient treatment for psychiatric or substance use disorder in an institution for mental diseases for a short term stay of no more than 15 days during the period of the monthly capitation payment. The provision of psychiatric or substance use

disorder treatment in an institution for mental diseases must meet the requirements for in lieu of services in subdivision 33.

Subd. 69. **Rate certification submission.** (a) The commissioner must submit to the Centers for Medicare and Medicaid for review and approval the commissioner's rate certifications at the same time as the commissioner's managed care contracts.

(b) The rate certification must satisfy Code of Federal Regulations, title 42, section 438.7(b) and must:

(1) base data used in the rate setting process;

(2) trend, including changes in the utilization and the price of services;

(3) nonbenefit component of the rate;

(4) adjustments;

(5) prospective and retrospective risk adjustment methodology; and

(6) special contract provisions related to payment.

(c) An actuary must certify the final capitation rates paid per rate cell under each risk contract and document the underlying data, assumptions and methodologies.

(d) The commissioner may pay each MCO a capitation rate under the contract that is different than the capitation rate paid to a different MCO, if each capitation rate per rate cell that is paid is independently developed and set in according to Code of Federal Regulations, title 42, sections 438.4, 438.5, 438.6, and 438.8.

(e) If the commissioner determines that a retroactive adjustment to the capitation rate is necessary, the retroactive adjustment must be supported by a rationale for the adjustment and the data. Assumptions and methodologies used to develop the adjustment must be described with enough detail to allow the Centers for Medicare and Medicaid or an actuary to determine the reasonableness of the adjustment. Any retroactive adjustments must be certified by an actuary in a revised rate certification and submitted to the Centers for Medicare and Medicaid for approval as a contract amendment. All adjustments are subject to timely claim filing requirements.

(f) The commissioner may increase or decrease the capitation rate per rate cell according to Code of Federal Regulations, title 42, sections 438.4(b)(4) and 438.7(c), up to 1.5 percent without submitting a revised rate certification.

(g) The commissioner must, upon request from the Centers for Medicare and Medicaid, provide additional information if the Centers for Medicare and Medicaid determines the

information is pertinent to certification approval. The commissioner must identify whether the additional information is offered by the commissioner, the actuary, or another party.

(h) Each year, within 30 days of the establishment of MCO rates, the commissioner shall submit a report on the certification and how each condition is met by the new payment rates to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance.

Subd. 70. **Medical loss ratio.** (a) The commissioner must ensure through contracts that each MCO calculate and report an MLR for each contract year. The commissioner may mandate a minimum MLR that must be equal to or higher than 85 percent.

(b) The calculation of the MLR in a MLR reporting year is the ratio of the numerator to the denominator. The numerator includes the sum of the MCO's incurred claims, the MCO's expenditures for activities that improve health care quality, and fraud prevention activities. The denominator includes the MCO's adjusted premium revenue minus the MCO's federal, state, and local taxes and licensing and regulatory fees. The MCO must aggregate the data for all eligibility groups covered under the contract unless the commissioner requires separate reporting and a separate MLR calculation for specific populations.

(c) Incurred claims are identified by the expenditures, liabilities, reserves, deductions, and exclusions according to Code of Federal Regulations, title 42, section 438.8(e)(2).

(d) Activities that improve health care quality must be in one category according to Code of Federal Regulations, title 42, section 438.8(e)(3).

(e) Fraud prevention activities include MCO expenditures on activities related to fraud prevention according to Code of Federal Regulations, title 45, section 158.

(f) Premium revenue includes state capitation payments; state-developed onetime payments for specific life events of enrollees; other payments to the MCO according to Code of Federal Regulations, title 42, section 438.6(b)(3); unpaid cost-sharing amounts; and changes to unearned premium reserves, net payments, and receipts related to risk sharing mechanisms.

(g) Taxes, licensing, and regulatory fees identified in Code of Federal Regulations, title 42, section 438.8(f)(3).

(h) The total amount of the denominator for an MCO that is later assumed by another entity must be reported by the assuming MCO for the entire MLR reporting year.

(i) Each expense must be included under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder

fits into a different type of expense, in which case the expense must be prorated between types of expenses. Expenditures that benefit multiple contracts or populations, or contracts other than those being reported must be reported on a pro rata basis. Expenses must be allocated using the methods described in Code of Federal Regulations, title 42, section 438.8(g)(2).

(j) Credibility adjustment means an adjustment to the MLR for a partially credible MCO to account for a difference between the actual and target MLRs that may be due to random statistical variation. The calculation of an MLR is based on the MCO's member months and may be determined as credible, partially credible, or no credibility. An MCO that is assigned no credibility or full credibility to the MCO's MLR calculation must not receive a credibility adjustment.

(k) The commissioner may require the MCO to provide a remittance if the MLR for the MLR reporting year does not meet the minimum MLR standard of 85 percent or higher as set by the commissioner.

(l) The commissioner through contracts must require each MCO to submit a report to the commissioner for each MLR reporting year that includes the information identified in Code of Federal Regulations, title 42, section 438.8(k). The report must be submitted within 12 months of the end of the MLR reporting year. The MCO must require any third-party vendor providing claims adjudication to provide all underlying data associated with MLR reporting to the MCO within 180 days of the end of the MLR reporting year or within 30 days of being requested by the MCO to calculate and validate the accuracy of MLR reporting. The MCO must include an attestation with the MLR report as to the accuracy of the calculation of the MLR.

(m) The commissioner must annually submit to the Centers for Medicare and Medicaid a summary description of the reports received from the MCOs according to Code of Federal Regulations, title 42, section 438.8(k), along with the required rate certification. The summary description must include, at a minimum, the amount of the numerator, the amount of the denominator, the MLR percentage achieved, the number of member months, and any remittances owed by each for the MLR reporting year. If the commissioner requires the MCO to pay remittances through the contract for not meeting the minimum MLR the state must reimburse the Centers for Medicare and Medicaid the federal share, considering differences in the federal matching rate. If a remittance is owed, the commissioner must submit a separate report describing the methodology used to determine the state and federal shares of the remittance with the required report.

(n) The commissioner may exclude a newly contracted MCO from calculating and reporting an MLR for the first year of the MCO's operation. MCOs must be required to comply with the requirements in this section during the next MLR reporting year.

(o) If the commissioner makes a retroactive change to the capitation payments for a MLR reporting year where the report was already submitted to the commissioner, the MCO must recalculate the MLR for all affected by the change and submit a new report meeting the reporting requirements in paragraph (l).

Subd. 71. **Solvency standards.** (a) Each MCO must provide assurances satisfactory to the commissioner showing that the MCO's provision against the risk of insolvency is adequate to ensure that the MCO's medical assistance enrollees are not be liable for the MCO's debts if the MCO becomes insolvent.

(b) The MCO must meet the solvency standards established by the commissioner for private health maintenance organizations, or be licensed or certified by the commissioner as a risk-bearing entity.

Subd. 72. **Managed care financial reporting.** (a) The commissioner shall collect detailed data regarding financials, provider payments, provider rate methodologies, and other data as determined by the commissioner. The commissioner shall set uniform criteria, definitions, and standards for the data to be submitted, and shall require managed care organizations to comply with these criteria, definitions, and standards when submitting data. The commissioner shall ensure that the data collection is implemented in an integrated and coordinated manner that avoids unnecessary duplication of effort. To the extent possible, the commissioner shall use existing data sources and streamline data collection in order to reduce public and private sector administrative costs. Nothing in this subdivision shall allow release of information that is nonpublic data pursuant to section 13.02.

(b) Each MCO must provide quarterly to the commissioner the following information on state public programs, in the form and manner specified by the commissioner:

(1) an income statement by program;

(2) financial statement footnotes;

(3) quarterly profitability by program and population group;

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

(5) received but unpaid claims report by program;

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

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

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

(9) subcapitation expenses by population group;

(10) third-party payments by program;

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

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

(13) medical loss ratios by program;

(14) administrative expenses by category and subcategory by program that reconcile to other state and federal regulatory agencies, including Minnesota Supplement Report #1A;

(15) revenues by program, including investment income;

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

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

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

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

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

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

(18) contribution to reserve, by program.

(c) If a report is published or released based on data provided under this subdivision, the commissioner shall provide the report to MCOs 15 days before the publication or release of the report. MCOs shall have 15 days to review the report and provide comment to the commissioner. The quarterly reports shall be submitted to the commissioner no later than 60 days after the end of the previous quarter, except the fourth-quarter report, which shall be submitted by April 1 of each year. The fourth-quarter report shall include audited financial statements, parent company audited financial statements, an income statement reconciliation report, and any other documentation necessary to reconcile the detailed reports to the audited financial statements.

(d) MCOs shall certify to the commissioner for the purpose of financial reporting for state public health care programs under this subdivision that costs reported for state public health care programs include:

(1) only services covered under the state plan and waivers, and related allowable administrative expenses; and

(2) the dollar value of unallowable and nonstate plan services, including both medical and administrative expenditures, that have been excluded.

Subd. 73. **Financial and data quality assurance audits.** (a) The commissioner shall require, in the request for bids and resulting contracts with MCOs under this section and section 256B.692, that each MCO submit to and fully cooperate with the independent third-party financial audits by the legislative auditor under of the information required under subdivision 70, paragraph (b). Each contract with an MCO under this section or section 256B.692 must provide the commissioner, the legislative auditor, and vendors contracting with the legislative auditor, access to all data required to complete audits under this subdivision.

(b) The legislative auditor shall conduct or contract with vendors to conduct independent third-party financial audits of the information required to be provided by managed care organizations under subdivision 70, paragraph (b). The audits by the vendors shall be conducted as vendor resources permit and according to generally accepted government auditing standards issued by the Government Accountability Office. The contract with the vendors shall be designed and administered to render the independent third-party audits eligible for a federal subsidy, if available. The contract shall require the audits to include a determination of compliance with the Medicaid rate certification process. For purposes of this subdivision, "independent third-party" means a vendor that is independent according to government auditing standards issued by the Government Accountability Office.

(c) Each MCO providing services shall provide to the commissioner biweekly encounter data and claims data for state public health care programs and shall participate in a quality assurance program that verifies the timeliness, completeness, accuracy, and consistency of the data provided. The commissioner shall develop written protocols for the quality assurance program and shall make the protocols publicly available. The commissioner shall contract for an independent third-party audit to evaluate the quality assurance protocols as to the capacity of the protocols to ensure complete and accurate data and to evaluate the commissioner's implementation of the protocols.

(d) Upon completion of the evaluation under paragraph (c), the commissioner shall provide copies of the report to the legislative auditor and the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and financing.

(e) Any actuary under contract with the commissioner to provide actuarial services must meet the independence requirements under the professional code for fellows in the Society of Actuaries and must not have provided actuarial services to an MCO that is under contract with the commissioner during the period in which the actuarial services are being provided. An actuary or actuarial firm meeting the requirements of this paragraph must certify and attest to the rates paid to the MCOs, and the certification and attestation must be auditable.

(f) The commissioner shall conduct or contract for the performance of an audit of state public health care program administrative and medical expenses reported by the MCOs at least every three years. This includes: financial and encounter data reported to the commissioner under subdivision 70, including payments to providers and subcontractors; supporting documentation for expenditures; categorization of administrative and medical expenses; and allocation methods used to attribute administrative expenses to state public health care programs. These audits also must monitor compliance with data and financial report certification requirements established by the commissioner for the purposes of managed care capitation payment rate-setting. The MCOs shall fully cooperate with the audits. The commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by February 1, 2016, and each February 1 thereafter, the number of ad hoc audits conducted in the past calendar year and the results of these audits.

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

Subd. 74. **Prior approval.** (a) Federal financial participation (FFP) is available under a comprehensive risk contract if:

(1) the Centers for Medicare and Medicaid confirmed that the contractor meets the definition of an MCO; and

(2) the MCO contract meets all of the requirements of sections 1903(m)(2)(A) and 1932 of the Social Security Act.

(b) Prior approval by the Centers for Medicare and Medicaid is a condition for FFP under any MCO contract that extends for less than one full year or that has a value equal to or greater than the following threshold amounts:

(1) for 1998, the threshold is $1,000,000; or

(2) for subsequent years, the amount is increased by the percentage increase in the Consumer Price Index.

(c) The commissioner must submit all MCO contracts to the Centers for Medicare and Medicaid for review 90 days before the effective date of the contracts.

Subd. 75. **Standard contract requirements.** (a) Managed care contracts under this section and section 256L.12 shall be entered into or renewed on a calendar year basis.

(b) The commissioner may issue separate contracts with requirements specific to services to medical assistance recipients 65 years of age and older and persons with disabilities 18 to 64 years of age as described in section 256B.055, subdivision 7.

(c) Requirements applicable to managed care programs under chapters 256B and 256L established after the effective date of a contract with the commissioner take effect when the contract is next issued or renewed.

(d) The commissioner shall ensure that contracts with MCOs comply with:

(1) all applicable federal and state laws and regulations, including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Americans with Disabilities Act of 1990 as amended; and section 1557 of the Patient Protection and Affordable Care Act;

(2) conflict of interest safeguards in Code of Federal Regulations, title 42, section 438.58, and with conflict of interest prohibitions for contracting officers, employees, or independent contractors in section 1902(a)(4)(C) of the Social Security Act;

(3) requirements mandating provider identification of provider-preventable conditions as a condition of payment, and the prohibition against payment for provider-preventable conditions in sections 256.969 subdivision 3b, paragraph (c), and 256B.0625 subdivision 3, and Code of Federal Regulations, title 42, sections 434.6(a)(12) and 447.26;

(4) inspections and audits of records and access to facilities according to Code of Federal Regulations, title 42, section 438.3(h);

(5) physician incentive requirements according to Code of Federal Regulations, title 42, sections 422.208 and 422.210;

(6) maintaining policies and procedures for advance directives according to Code of Federal Regulations, title 42, section 422.128. The contract must also provide adult enrollees with written information on advance directive policies, and include a description of applicable state law. The information must reflect changes in state law as soon as possible but no later than 90 days after the effective date of the change;

(7) requirements for subcontracts in Code of Federal Regulations, title 42, section 438.230;

(8) requirements for enrollee's choice of network provider;

(9) annual submission requirements for audited financial reports specific to the medical assistance contract;

(10) parity requirements for mental health and substance use disorders, if applicable;

(11) for LTSS services covered under the contract that could be authorized by a waiver in section 1915(c) of the Social Security Act or a state plan amendment authorized by section 1915(i) or 1915(k) of the Social Security Act must be delivered according to Code of Federal Regulations, title 42, section 441.301(c)(4);

(12) requirements of Code of Federal Regulations, title 42, section 438.3(s), for coverage of outpatient drugs;

(13) responsibility for coordination of benefits for individuals dually eligible for medical assistance and Medicare. MCOs must enter a coordination of benefits agreement with Medicare and participate in the automated claims crossover process; and

(14) enrollee grievance and appeal records requirements in Code of Federal Regulations, title 42, section 438.416, base data requirements in Code of Federal Regulations, title 42, section 438.5(c), MLR reports requirements in Code of Federal Regulations, title 42, 438.8(k), and the data information and documentation requirements in Code of Federal Regulations, title 42, sections 438.604, 438.606, 438.608, and 438.610, for a period of ten years plus the current contract year.

Subd. 76. **Alternative services; elderly and disabled persons.** (a) The commissioner may create alternative integrated delivery systems for acute and long-term care services to

elderly persons and people with disabilities that provide increased coordination, improve access to quality services, and mitigate future cost increases. The commissioner may seek federal authority to combine Medicare and Medicaid capitation payments for the demonstrations and may contract with Medicare-approved special needs plans that are offered by a demonstration provider or by an entity that is directly or indirectly wholly owned or controlled by a demonstration provider to provide Medicaid services. Medicare funds and services shall be administered according to the terms and conditions of the federal contract and demonstration provisions. For the purpose of administering medical assistance funds, demonstrations under this subdivision are subject to subdivisions 1 to 22. All enforcement and rulemaking powers available under chapters 62D, 62M, and 62Q are hereby granted to the commissioner of health with respect to Medicare-approved special needs plans with which the commissioner contracts to provide Medicaid services under this section. An initial open enrollment period may be provided. Persons who disenroll from demonstrations under this subdivision remain subject to Minnesota Rules, parts 9500.1450 to 9500.1464. When a person is enrolled in a health plan under these demonstrations and the health plan's participation is subsequently terminated for any reason, the person shall be provided an opportunity to select a new health plan and shall have the right to change health plans within the first 60 days of enrollment in the second health plan. Persons required to participate in health plans under this section who fail to make a choice of health plan shall not be randomly assigned to health plans under these demonstrations. Notwithstanding section 256L.12, subdivision 5, and Minnesota Rules, part 9505.5220, subpart 1, item A, if adopted, for the purpose of demonstrations under this subdivision, the commissioner may contract with MCOs, including counties, to serve only elderly persons eligible for medical assistance, elderly and disabled persons, or disabled persons only.

(b) Before implementation of a demonstration project for persons with a disability, the commissioner must provide information to appropriate committees of the house of representatives and senate and must involve representatives of affected disability groups in the design of the demonstration projects.

(c) The commissioner, in consultation with the commissioners of commerce and health, may approve and implement programs for all-inclusive care for the elderly (PACE) according to federal laws and regulations governing that program and state laws or rules applicable to participating providers. A PACE provider is not required to be licensed or certified as a health plan company as defined in section 62Q.01, subdivision 4. A person 55 years of age and older who was screened by the county and found eligible for services under the elderly waiver or community access for disability inclusion or who is already eligible for medical

assistance but meets level of care criteria for receipt of waiver services may choose to enroll in the PACE program. Medicare and Medicaid services must be provided according to this subdivision and federal Medicare and Medicaid requirements governing PACE providers and programs. PACE enrollees must receive Medicaid home and community-based services through the PACE provider as an alternative to services for which the person would otherwise be eligible through home and community-based waiver programs and medical assistance. The commissioner shall establish medical assistance rates for PACE providers that do not exceed costs that would have been incurred under fee-for-service or other relevant managed care programs operated by the department.

(d) Costs for home and community-based services for people with disabilities must not exceed costs that would have been incurred under the fee-for-service program. In developing program specifications for expansion of integrated programs, the commissioner shall involve and consult the state-level stakeholder group established in subdivision 75, paragraph (d), including consultation on whether and how to include home and community-based waiver programs. Plans to create alternative integrated delivery systems shall be presented to the chairs of the house of representatives and senate committees with jurisdiction over health and human services policy and finance before implementation.

(e) Notwithstanding section 256B.0621, health plans providing services under this section are responsible for home care targeted case management and relocation targeted case management. Services must be provided according to the terms of the waivers and contracts approved by the federal government.

(f) Except as applicable to the project's operation, the provisions of sections 256.975 and 256B.0911 are waived for the purposes of this section for recipients enrolled in the managed care program for seniors.

(g) The commissioner shall ensure the views of beneficiaries, individuals representing beneficiaries, providers, and other stakeholders are solicited and addressed during the design, implementation, and oversight of the managed LTSS program. The composition of the stakeholder group and frequency of meetings must be sufficient to ensure meaningful stakeholder engagement.

Subd. 77. **Medicare special needs plans; medical assistance basic health care.** (a) The commissioner may contract with demonstration providers and current or former sponsors of qualified Medicare-approved special needs plans, to provide medical assistance basic health care services to persons with disabilities, including those with developmental disabilities. Basic health care services include:

(1) services covered by medical assistance, except for ICF/DD services, home and community-based waiver services, case management for persons with developmental disabilities under section 256B.0625, subdivision 20a, and personal care and certain home care services defined by the commissioner in consultation with the stakeholder group established under paragraph (d); and

(2) risk for up to 100 days of nursing facility services for persons who reside in a noninstitutional setting and home health services related to rehabilitation as defined by the commissioner after consultation with the stakeholder group.

The commissioner may exclude other medical assistance services from the basic health care benefit set. Enrollees in these plans can access any excluded services on the same basis as other medical assistance recipients who have not enrolled.

(b) The commissioner may contract with demonstration providers and current and former sponsors of qualified Medicare special needs plans, to provide basic health care services under medical assistance to persons who are dually eligible for both Medicare and Medicaid and those Social Security beneficiaries eligible for Medicaid but in the waiting period for Medicare. The commissioner shall consult with the stakeholder group under paragraph (d) to develop program specifications for these services. Payment for Medicaid services provided under this subdivision for the months of May and June will be made no earlier than July 1 of the same calendar year.

(c) The commissioner shall enroll a person with a disability in managed care under this section, unless the person chooses to opt out of enrollment. The commissioner shall establish enrollment and opt-out procedures consistent with applicable enrollment procedures under this section.

(d) The commissioner shall establish a state-level stakeholder group to provide advice on managed care programs for persons with disabilities, including both integrated programs and contracts with special needs plans that provide basic health care services as described in paragraphs (a) and (b). The stakeholder group shall provide advice on program expansions under this subdivision and subdivision 18, including:

(1) implementation efforts;

(2) consumer protections; and

(3) program specifications such as quality assurance measures, data collection and reporting, and evaluation of costs, quality, and results.

(e) Each plan under contract to provide medical assistance basic health care services shall establish a local or regional stakeholder group, including representatives of the counties covered by the plan, members, consumer advocates, and providers, for advice on issues that arise in the local or regional area.

(f) The commissioner is prohibited from providing the names of potential enrollees to health plans for marketing purposes. The commissioner shall mail no more than two sets of marketing materials per contract year to potential enrollees on behalf of health plans, at the health plan's request. The marketing materials shall be mailed by the commissioner within 30 days of receipt of these materials from the health plan. The health plans shall cover any costs incurred by the commissioner for mailing marketing materials.

Subd. 78. **Home and community-based waiver services.** (a) For individuals 65 years of age and older enrolled in prepaid managed care programs including demonstration projects authorized under subdivision 74, elderly waiver services shall be covered.

(b) For individuals younger than 65 years of age enrolled in demonstrations authorized under subdivision 18, home and community-based waiver services shall be covered according to the terms and conditions of the federal agreement governing that demonstration project.

Subd. 79. **Nursing home services.** (a) Notwithstanding Minnesota Rules, part 9500.1457, subpart 1, item B, up to 180 days of nursing facility services as defined in section 256B.0625, subdivision 2, which are provided in a nursing facility certified by the Department of Health for services provided and eligible for payment under Medicaid, shall be covered under the managed care program for individuals who are not residing in a nursing facility at the time of enrollment in the managed care program.

(b) For individuals enrolled in the Minnesota senior health options project or in other programs authorized under subdivision 75, nursing facility services shall be covered according to the terms and conditions of the federal agreement governing that demonstration project.

(c) For individuals enrolled in programs authorized under subdivision 75, services in an intermediate care facility for persons with developmental disabilities shall be covered according to the terms and conditions established in the MCO's contract with the commissioner.

Subd. 80. **Additional managed care reporting.** (a) The commissioner shall require MCOs, as a condition of contract, to implement strategies that facilitate access to periodic developmental and social-emotional screenings for children between the ages of one and three years of age. The commissioner shall also ensure children who do not meet milestones

have access to appropriate evaluation and assessment, including treatment recommendations, expected to improve the child's functioning, with the goal of meeting milestones by five years of age.

(b) The following information from encounter data provided to the commissioner shall be reported on the department's public Web site for each MCO annually by July 31 of each year:

(1) the number of children who received a diagnostic assessment;

(2) the total number of children one to six years of age with a diagnosis of autism spectrum disorder who received treatments;

(3) the number of children identified under this paragraph reported by each 12-month age group beginning with age one and ending with age six; and

(4) the types of treatments provided to children identified under this paragraph listed by billing code, including the number of units billed for each child.

(c) Each MCO shall also report any barriers to providing screening, diagnosis, and treatment of children between one and three years of age, any strategies implemented to address barriers, and make recommendations on how to measure and report on the effectiveness of the strategies implemented to facilitate access for the children to provide developmental and social-emotional screening, diagnosis, and treatment as described in paragraph (a).

(d) Each MCO shall submit information as required by the commissioner, including data required for assessing client satisfaction, quality of care, cost, and utilization of services for purposes of project evaluation. The commissioner shall develop methods of data reporting and collection to provide aggregate enrollee information on encounters and outcomes to determine access and quality assurance. Required information shall be specified before the commissioner contracts with an MCO.

(e) Aggregate nonpersonally identifiable health plan encounter data, aggregate spending data for major categories of service as reported to the commissioners of health and commerce under section 62D.08, subdivision 3, clause (a), and criteria for service authorization and service use are public data that the commissioner shall make available and use in public reports. The commissioner shall require each MCO to provide:

(1) encounter data for each service provided, using standard codes and unit of service definitions set by the commissioner, in a form that the commissioner can report by age, eligibility groups, and health plan; and

(2) criteria, written policies, and procedures to determine the medical necessity, appropriateness, and efficacy of a procedure or service required to be disclosed under section 62M.10, subdivision 7, and Code of Federal Regulations, title 42, part 438.210(b)(1), used for each type of service for which authorization is required.

(f) Each MCO shall report to the commissioner the extent that providers employed by or under contract with the MCO use patient-centered decision-making tools or procedures designed to engage patients early in the decision-making process and the steps taken by the MCO to encourage their use.

(g) Each MCO shall submit drug utilization data as specified by the commissioner in the MCO's contract to allow the commissioner to bill drug manufacturers for rebates according to section 1927 of the Social Security Act, in a time frame established by the commissioner. Each MCO shall exclude from this report utilization data for covered outpatient drugs that are subject to discounts under the 340B Drug Pricing Program.

Subd. 81. **Supplemental recovery program.** The commissioner shall conduct a supplemental recovery program for third-party liabilities identified through coordination of benefits not recovered by MCOs for state public health programs. Any third-party liability identified through coordination of benefits and recovered by the commissioner more than eight months after the date an MCO adjudicates a health care claim shall be retained by the commissioner and deposited in the general fund. The commissioner shall establish a mechanism, including a reconciliation process, for MCOs to coordinate third-party liability collections efforts resulting from coordination of benefits under this subdivision with the commissioner to ensure there is no duplication of efforts. The coordination mechanism must be consistent with the reporting requirements in subdivision 70. The commissioner shall share accurate and timely third-party liability data with MCOs.

Subd. 82. **Individualized education program and individualized family service plan services.** The commissioner shall separate out individualized education program (IEP) and individualized family service plan (IFSP) services for children enrolled in the managed care and the MinnesotaCare program. Medical assistance coverage of eligible IEP and IFSP services shall not be included in the capitated services for children enrolled in MCOs through managed care and the MinnesotaCare program. Local school districts shall bill the commissioner for these services, and claims shall be paid on a fee-for-service basis.

Sec. 2. **REPEALER.**

Minnesota Statutes 2016, section 256B.69, subdivisions 1, 2, 3, 3a, 3b, 4, 4b, 5, 5a, 5b, 5c, 5d, 5f, 5g, 5h, 5i, 5j, 5k, 6, 6a, 6b, 6d, 7, 8, 9, 9a, 9c, 9d, 9e, 10, 11, 16, 17, 18, 19, 20, 21, 22, 23, 25, 26, 27, 28, 29, 30, 31, 32a, 33, 34, and 35, are repealed.

Sec. 3. **REVISOR'S INSTRUCTION.**

In Minnesota Statutes and Minnesota Rules, the revisor of statutes, in consultation with the Department of Human Services, shall make necessary cross-reference changes resulting from implementing this article and repealing Minnesota Statutes, section 256B.69.

ARTICLE 6

DIRECT CARE AND TREATMENT

Section 1. Minnesota Statutes 2016, section 246.014, is amended to read:

246.014 SERVICES.

The measure of services are:

(a) The commissioner of human services shall develop and maintain state-operated services in a manner consistent with sections 245.461 and 245.487 and chapters 252, 254A, and 254B. State-operated services shall be provided in coordination with counties and other vendors. State-operated services shall include regional treatment centers, specialized inpatient or outpatient treatment programs, enterprise services, community-based services and programs, community preparation services, consultative services, and other services consistent with the mission of the Department of Human Services. These services ~~shall~~ may include crisis beds, waivered homes, intermediate care facilities, and day training and habilitation facilities. The administrative structure of state-operated services must be statewide in character. The state-operated services staff may deliver services at any location throughout the state.

(b) The commissioner of human services shall create and maintain forensic services programs. Forensic services shall be provided in coordination with counties and other vendors. Forensic services shall include specialized inpatient programs at secure treatment facilities as defined in sections 253B.02, subdivision 18a, and 253D.02, subdivision 13, consultative services, aftercare services, community-based services and programs, transition services, nursing home services, or other services consistent with the mission of the Department of Human Services.

(c) Community preparation services as identified in paragraphs (a) and (b) are defined as specialized inpatient or outpatient services or programs operated outside of a secure environment but are administered by a secured treatment facility.

(d) The commissioner of human services may establish policies and procedures which govern the operation of the services and programs under the direct administrative authority of the commissioner.

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

Sec. 2. Minnesota Statutes 2016, section 246B.05, is amended to read:

246B.05 MINNESOTA SEX OFFENDER PROGRAM; VOCATIONAL WORK PROGRAM OPTION.

Subdivision 1. **Vocational work program option.** The commissioner ~~of human services~~ shall develop a vocational work program for persons admitted to the Minnesota sex offender program. The vocational work program is an extension of therapeutic treatment ~~in order~~ for civilly committed sex offenders to learn valuable work skills ~~and work habits while contributing to their cost of care. The vocational work program may include work maintaining the center or work that is brought to the center by an outside source.~~ training and educational training, and to develop proper work habits and extended treatment services. The industrial and commercial activities authorized by this section are designated Minnesota state industries. The earnings generated from the vocational work program must be deposited into the account created in subdivision 2.

Subd. 2. **Minnesota sex offender program; vocational work program account.** A vocational work program account is created in the state treasury. Money collected by the commissioner ~~of human services~~ for the program under this section must be deposited in this account. Money in the account is appropriated to the commissioner ~~for purposes of this section.~~ to be used for the vocational work program authorized under this section, including the purchase of equipment and raw materials, the payment of salaries and wages, and other necessary expenses as determined by the commissioner. The purchase of a service, material, and commodity used in and held for resale is not subject to the competitive bidding procedures of section 16C.06, but is subject to all other provisions of chapters 16B and 16C. If practical, a purchase must be made from a small targeted group business designated under section 16C.16.

Subd. 3. **Money.** The commissioner has the authority to collect money resulting from the vocational work program for reinvestment within the program.

Subd. 4. **Wages.** Notwithstanding section 177.24 or any other law, the commissioner has the discretion to set the pay rate for an individual participating in the vocational work program. The commissioner has the authority to retain up to 50 percent of a payment made to an individual participating in the vocational work program to reduce state costs associated with operating the Minnesota sex offender program.

Subd. 5. **Status of civilly committed sex offenders.** A civilly committed sex offender participating in the vocational work program is not an employee of the Minnesota sex offender program, the Department of Human Services, or the state, and is not subject to fair labor standards under sections 177.21 to 177.35; workers' compensation under sections 176.011 to 176.862; the Minnesota Human Rights Act under sections 363A.01 to 363A.44; laws governing state employees under chapter 43A; the Public Employment Labor Relations Act under chapter 179A; or the successors to any of these sections and any other laws pertaining to employees and employment.

Subd. 6. **Claims.** A claim or demand arising out of injury to or death of a civilly committed sex offender while the individual is participating in the vocational work program or performing a work assignment maintaining the facility must be presented to, heard by, and determined exclusively by the legislature as provided in section 3.738.

Subd. 7. **Indirect costs and reimbursements.** The commissioner is not required to include indirect costs as defined in section 16A.127 in work activity contracts for a client of the Minnesota sex offender program and is not required to reimburse the general fund for indirect costs related to work activity programs.

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

Sec. 3. Minnesota Statutes 2016, section 246B.10, is amended to read:

246B.10 LIABILITY OF COUNTY; REIMBURSEMENT.

(a) The civilly committed sex offender's county shall pay to the state a portion of the cost of care provided in the Minnesota sex offender program to a civilly committed sex offender who has legally settled in that county. A county's payment must be made from the county's own sources of revenue and payments must equal 25 percent of the cost of care, as determined by the commissioner, for each day or portion of a day, ~~that the~~ for which the civilly committed sex offender ~~spends at the facility~~ receives services, either within a Minnesota sex offender program facility or while on provisional discharge.

(b) If payments received by the state under this chapter exceed 75 percent of the cost of care for an individual admitted to the program after August 1, 2011, the county is responsible for paying the state the remaining amount.

(c) If payments received by the state under this chapter exceeds 90 percent of the cost of care for an individual admitted to the program before August 1, 2011, the county is responsible for paying the state the remaining amount.

(d) The county is not entitled to reimbursement from the civilly committed sex offender, the civilly committed sex offender's estate, or from the civilly committed sex offender's relatives, except as provided in section 246B.07.

EFFECTIVE DATE. This section is effective July 1, 2017. The inclusion of services while on provisional discharge applies to services received on or after July 1, 2017, regardless of the date the civilly committed sex offender was provisionally discharged.

Sec. 4. Minnesota Statutes 2016, section 253B.19, subdivision 1, is amended to read:

Subdivision 1. **Creation.** The Supreme Court shall establish an appeal panel composed of three judges and four alternate judges appointed from among the acting judges of the state. Panel members shall serve for terms of one year each. Only three judges need hear any case. One of the regular three appointed judges shall be designated as the chief judge of the appeal panel. The chief judge is vested with power to fix the time and place of all hearings before the panel, issue all notices, subpoena witnesses, appoint counsel for the patient, if necessary, and supervise and direct the operation of the appeal panel. The chief judge shall designate one of the other judges or an alternate judge to act as chief judge in any case where the chief judge is unable to act. No member of the appeal panel shall take part in the consideration of any case in which that judge committed the patient. ~~The chief justice of the Supreme Court shall determine the compensation of the judges serving on the appeal panel. The compensation shall be in addition to their regular compensation as judges. All compensation and expenses of the appeal panel and all allowable fees and costs of the patient's counsel shall be established and paid by the Department of Human Services.~~

EFFECTIVE DATE. This section is effective July 1, 2017, and applies to all compensation, costs, and expenses incurred on or after July 1, 2017.

Sec. 5. Minnesota Statutes 2016, section 253B.19, is amended by adding a subdivision to read:

Subd. 1b. **Compensation, costs, and expenses.** (a) The chief justice of the Supreme Court shall determine the compensation of the judges serving on the appeal panel. The compensation shall be in addition to the judges' regular compensation as judges.

(b) All compensation and expenses of the appeal panel shall be paid by the judicial branch from judicial branch funds, including the costs of employing law clerks, court reporters, assistant appellate court clerks, and any other staff, and the costs of courtrooms, courtroom technology, and courtroom security.

(c) For proceedings originating pursuant to section 253D.28, all allowable fees and costs of the court-appointed counsel for the committed person, as defined in section 253D.02, subdivision 4, and all allowable fees and costs of a court-appointed examiner shall be established and paid by the judicial branch from judicial branch funds. Allowable fees and costs include expenses associated with an appeal of a judicial appeal panel order.

(d) For proceedings originating from subdivision 2, the Department of Human Services shall reimburse the judicial branch for the compensation and expenses described in paragraph (b). All allowable fees and costs of the court-appointed counsel for the patient, as defined in section 253B.02, subdivision 15, and all allowable fees and costs of a court-appointed examiner shall be established and paid by the Department of Human Services from Department of Human Services funds. Allowable fees and costs include expenses associated with an appeal of a judicial appeal panel order.

EFFECTIVE DATE. This section is effective July 1, 2017, and applies to all compensation, costs, and expenses incurred on or after July 1, 2017.

Sec. 6. **REPEALER.**

Minnesota Statutes 2016, section 246B.06, is repealed.

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

ARTICLE 7

CHILDREN AND FAMILIES SERVICES

Section 1. Minnesota Statutes 2016, section 119B.011, subdivision 6, is amended to read:

Subd. 6. **Child care fund.** "Child care fund" means a program under this chapter providing:

(1) financial assistance for child care to support:

(i) parents engaged in employment, job search, or education and training leading to employment, or an at-home infant child care subsidy; and

(ii) the development and school readiness of children; and

(2) grants to develop, expand, and improve the access and availability of child care services statewide.

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

Sec. 2. Minnesota Statutes 2016, section 119B.011, is amended by adding a subdivision to read:

Subd. 13b. **Homeless.** "Homeless" means a self-declared housing status as defined in the McKinney-Vento Act, United States Code, title 42, section 11302, paragraph (a).

EFFECTIVE DATE. This section is effective December 18, 2017.

Sec. 3. Minnesota Statutes 2016, section 119B.011, is amended by adding a subdivision to read:

Subd. 15b. **Law enforcement authority.** "Law enforcement authority" means a government agency or department within or outside Minnesota with jurisdiction to investigate or bring a civil or criminal action against a child care provider, including a county, city, or district attorney's office, the Attorney General's Office, a human services agency, a United States attorney's office, or a law enforcement agency.

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

Sec. 4. Minnesota Statutes 2016, section 119B.011, is amended by adding a subdivision to read:

Subd. 16a. **Legal nonlicensed related provider.** "Legal nonlicensed related provider" means a legal nonlicensed child care provider under subdivision 16 who cares for children related to the provider and does not care for any child receiving assistance under this chapter who is not related to the provider. For purposes of this subdivision, "related" means the provider is, by marriage, blood relationships, or court decrees, a sibling, grandparent, aunt, or uncle of the child.

EFFECTIVE DATE. This section is effective September 25, 2017.

Sec. 5. Minnesota Statutes 2016, section 119B.011, is amended by adding a subdivision to read:

Subd. 16b. **Legal nonlicensed unrelated provider.** "Legal nonlicensed unrelated provider" means a legal nonlicensed child care provider under subdivision 16 who provides care in Minnesota for at least one child receiving assistance under this chapter who is not related to the provider. For purposes of this subdivision, "related" means the provider is, by marriage, blood relationships, or court decrees, a sibling, grandparent, aunt, or uncle of the child.

EFFECTIVE DATE. This section is effective September 25, 2017.

Sec. 6. Minnesota Statutes 2016, section 119B.011, subdivision 19, is amended to read:

Subd. 19. **Provider.** "Provider" means:

(1) an individual or child care center or facility~~, either licensed or unlicensed,~~ providing licensed legal child care services as defined under section 245A.03; ~~or~~

(2) a license-exempt center required to be certified under chapter 245G;

~~(2)~~ (3) an individual or child care center or facility ~~holding~~ that:

(i) holds a valid child care license issued by another state or a tribe ~~and providing~~;

(ii) provides child care services in the licensing state or in the area under the licensing tribe's jurisdiction~~.~~; and

(iii) is in compliance with federal health and safety requirements as certified by the licensing state or tribe, or as determined by receipt of Child Care Development Block Grant funds in the licensing state; or

(4) a legal nonlicensed child care provider as defined under section 119B.011, subdivision 16, providing legal child care services. A ~~legally unlicensed family~~ legal nonlicensed child care provider must be at least 18 years of age, and not a member of the MFIP assistance unit or a member of the family receiving child care assistance to be authorized under this chapter.

EFFECTIVE DATE. This section is effective September 25, 2017.

Sec. 7. Minnesota Statutes 2016, section 119B.011, is amended by adding a subdivision to read:

Subd. 19c. **Stop payment.** "Stop payment" means canceling a payment that was already issued to a provider.

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

Sec. 8. Minnesota Statutes 2016, section 119B.011, subdivision 20, is amended to read:

Subd. 20. **Transition year families.** "Transition year families" means families who have received MFIP assistance, or who were eligible to receive MFIP assistance after choosing to discontinue receipt of the cash portion of MFIP assistance under section 256J.31, subdivision 12, or families who have received DWP assistance under section 256J.95 for at least ~~three~~ one of the last six months before losing eligibility for MFIP or DWP. Notwithstanding Minnesota Rules, part 3400.0040, subpart 10, and 3400.0090, subpart 2, transition year child care may be used to support employment, approved education or training programs, or job search that meets the requirements of section 119B.10. Transition year child care is not available to families who have been disqualified from MFIP or DWP due to fraud.

EFFECTIVE DATE. This section is effective October 23, 2017.

Sec. 9. Minnesota Statutes 2016, section 119B.011, subdivision 20a, is amended to read:

Subd. 20a. **Transition year extension families.** "Transition year extension families" means families who have completed their transition year of child care assistance under this subdivision and who are eligible for, but on a waiting list for, services under section 119B.03. For purposes of sections 119B.03, subdivision 3, and 119B.05, subdivision 1, clause (2), families participating in extended transition year shall not be considered transition year families. Notwithstanding Minnesota Rules, parts 3400.0040, subpart 10, and 3400.0090, subpart 2, transition year extension child care may be used to support employment, approved education or training programs, or a job search that meets the requirements of section 119B.10 for the length of time necessary for families to be moved from the basic sliding fee waiting list into the basic sliding fee program.

EFFECTIVE DATE. This section is effective October 23, 2017.

Sec. 10. Minnesota Statutes 2016, section 119B.02, subdivision 1, is amended to read:

Subdivision 1. **Child care services.** The commissioner shall develop standards for county and human services boards to provide child care services to enable eligible families to participate in employment, training, or education programs. Within the limits of available appropriations, the commissioner shall distribute money to counties to reduce the costs of child care for eligible families. The commissioner shall adopt rules to govern the program in accordance with this section. The rules must establish a sliding schedule of fees for parents receiving child care services. The rules shall provide that funds received as a lump-sum payment of child support arrearages shall not be counted as income to a family in the month received but shall be prorated over the 12 months following receipt and added to the family income during those months. The commissioner may establish limits on how frequently expedited application processing timelines are used for an applicant who declares that the applicant is homeless. The commissioner may adopt rules to implement changes under this subdivision. The commissioner shall maximize the use of federal money under title I and title IV of Public Law 104-193, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, and other programs that provide federal or state reimbursement for child care services for low-income families who are in education, training, job search, or other activities allowed under those programs. Money appropriated under this section must be coordinated with the programs that provide federal reimbursement for child care services to accomplish this purpose. Federal reimbursement obtained must be allocated to the county that spent money for child care that is federally reimbursable under programs that provide federal reimbursement for child care services. The counties shall use the federal money to expand child care services. The commissioner may adopt rules under chapter 14 to implement and coordinate federal program requirements.

EFFECTIVE DATE. This section is effective December 18, 2017.

Sec. 11. Minnesota Statutes 2016, section 119B.02, subdivision 5, is amended to read:

Subd. 5. **Program integrity.** For child care assistance programs under this chapter, the commissioner shall enforce the requirements for program integrity and fraud prevention investigations under sections 256.046, 256.98, and 256.983 and chapter 245E.

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

Sec. 12. Minnesota Statutes 2016, section 119B.025, subdivision 1, is amended to read:

Subdivision 1. ~~**Factors which must be verified**~~ **Applications.** (a) The county shall verify the following at all initial child care applications using the universal application:

(1) identity of adults;

(2) presence of the minor child in the home, if questionable;

(3) relationship of minor child to the parent, stepparent, legal guardian, eligible relative caretaker, or the spouses of any of the foregoing;

(4) age;

(5) immigration status, if related to eligibility;

(6) Social Security number, if given;

(7) counted income;

(8) spousal support and child support payments made to persons outside the household;

(9) residence; and

(10) inconsistent information, if related to eligibility.

(b) ~~If a family did not use the universal application or child care addendum to apply for child care assistance, the family must complete the universal application or child care addendum at its next eligibility redetermination and the county must verify the factors listed in paragraph (a) as part of that redetermination. Once a family has completed a universal application or child care addendum, the county shall use the redetermination form described in paragraph (c) for that family's subsequent redeterminations. Eligibility must be redetermined at least every six months. A family is considered to have met the eligibility redetermination requirement if a complete redetermination form and all required verifications are received within 30 days after the date the form was due. When the 30th day after the date the form was due falls on a Saturday, Sunday, or legal holiday, the 30-day time period is extended to include the next succeeding day that is not a Saturday, Sunday, or legal holiday. Assistance shall be payable retroactively from the redetermination due date. For a family where at least one parent is under the age of 21, does not have a high school or general equivalency diploma, and is a student in a school district or another similar program that provides or arranges for child care, as well as parenting, social services, career and employment supports, and academic support to achieve high school graduation, the redetermination of eligibility shall be deferred beyond six months, but not to exceed 12 months, to the end of the student's school year. If a family reports a change in an eligibility factor before the family's next regularly scheduled redetermination, the county must recalculate eligibility without requiring verification of any eligibility factor that did not change. Changes must be reported as required by section 256P.07. A change in income occurs on the day the participant received the first payment reflecting the change in income.~~

The county must mail a notice of approval or denial of assistance to the applicant within 30 calendar days after receiving the application. The county may extend the response time by 15 calendar days if the applicant is informed of the extension.

(c) ~~The commissioner shall develop a redetermination form to redetermine eligibility and a change report form to report changes that minimize paperwork for the county and the participant.~~ The county must send a notice of approval or denial of assistance to an applicant who declares that the applicant is homeless and who meets the definition of homeless under section 119B.011, subdivision 13b, within five working days after receiving the application. The county is not required to verify the factors under paragraph (a) before issuing the notice of approval or denial. An applicant must submit proof of eligibility within three months of the date the application was received by the county. If the applicant does not submit the proof of eligibility within three months, the applicant's eligibility ends. The county must send a 15-day adverse action notice to end an applicant's eligibility.

EFFECTIVE DATE. Paragraphs (a) and (b) are effective the day following final enactment. Paragraph (c) is effective December 18, 2017.

Sec. 13. Minnesota Statutes 2016, section 119B.025, is amended by adding a subdivision to read:

Subd. 3. **Redeterminations.** (a) Notwithstanding Minnesota Rules, part 3400.0180, item A, the county shall conduct a redetermination according to paragraphs (b) and (c).

(b) The county shall use the redetermination form developed by the commissioner. The county must verify the factors listed in subdivision 1, paragraph (a), as part of the redetermination.

(c) An applicant's eligibility must be redetermined no more frequently than every 12 months. The following criteria apply:

(1) a family meets the eligibility redetermination requirements if a complete redetermination form and all required verifications are received within 30 days after the date the form was due;

(2) if the 30th day after the date the form was due falls on a Saturday, Sunday, or holiday, the 30-day time period is extended to include the next day that is not a Saturday, Sunday, or holiday. Assistance shall be payable retroactively from the redetermination due date;

(3) for a family where at least one parent is under 21 years of age, does not have a high school degree or general equivalency diploma, and is a student in a school district or another similar program that provides or arranges for child care; parenting, social services, career

and employment supports; and academic support to achieve high school graduation, the redetermination of eligibility may be deferred beyond 12 months, to the end of the student's school year; and

(4) a family and the family's providers must be notified that the family's redetermination is due at least 45 days before the end of the family's 12-month eligibility period.

EFFECTIVE DATE. This section is effective October 23, 2017.

Sec. 14. Minnesota Statutes 2016, section 119B.025, is amended by adding a subdivision to read:

Subd. 4. **Changes in eligibility.** (a) The county shall process a change in eligibility factors according to paragraphs (b) to (g).

(b) A family is subject to the reporting requirements in section 256P.07.

(c) If a family reports a change or a change is known to the agency before the family's regularly scheduled redetermination, the county must act on the change. The commissioner shall establish standards for verifying changes.

(d) A change in income occurs on the day the participant received the first payment reflecting the change in income.

(e) During a family's 12-month eligibility period, if the family's income increases and remains at or below 85 percent of the state median income, adjusted for family size, there is no change to the family's eligibility. The county shall not request verification of the change. The co-payment fee shall not increase during the remaining portion of the family's 12-month eligibility period.

(f) During a family's 12-month eligibility period, if the family's income increases and exceeds 85 percent of the state median income, adjusted for family size, the family is not eligible for child care assistance. The family must be given 15 calendar days to provide verification of the change. If the required verification is not returned or confirms ineligibility, the family's eligibility ends following a subsequent 15-day adverse action notice.

(g) Notwithstanding Minnesota Rules, parts 3400.0040, subpart 3, and 3400.0170, subpart 1, if an applicant or participant reports that employment ended, the agency may accept a signed statement from the applicant or participant as verification that employment ended.

EFFECTIVE DATE. Paragraphs (a) and (b) are effective the day following final enactment. Paragraphs (c) to (g) are effective October 23, 2017.

Sec. 15. Minnesota Statutes 2016, section 119B.03, subdivision 3, is amended to read:

Subd. 3. **Eligible participants.** Families that meet the eligibility requirements under sections ~~119B.07,~~ 119B.09~~,~~ and 119B.10, except MFIP participants, diversionary work program, and transition year families are eligible for child care assistance under the basic sliding fee program. Families enrolled in the basic sliding fee program shall be continued until they are no longer eligible. Child care assistance provided through the child care fund is considered assistance to the parent.

EFFECTIVE DATE. This section is effective December 18, 2017.

Sec. 16. Minnesota Statutes 2016, section 119B.03, subdivision 9, is amended to read:

Subd. 9. **Portability pool.** (a) The commissioner shall establish a pool of up to five percent of the annual appropriation for the basic sliding fee program to provide continuous child care assistance for eligible families who move between Minnesota counties. At the end of each allocation period, any unspent funds in the portability pool must be used for assistance under the basic sliding fee program. If expenditures from the portability pool exceed the amount of money available, the reallocation pool must be reduced to cover these shortages.

(b) To be eligible for portable basic sliding fee assistance, a family that has moved from a county in which it was receiving basic sliding fee assistance to a county with a waiting list for the basic sliding fee program must:

(1) meet the income and eligibility guidelines for the basic sliding fee program; and

(2) notify the new county of residence within 60 days of moving and submit information to the new county of residence to verify eligibility for the basic sliding fee program.

(c) The receiving county must:

(1) accept administrative responsibility for applicants for portable basic sliding fee assistance at the end of the two months of assistance under the Unitary Residency Act;

(2) continue portability pool basic sliding fee assistance ~~for the lesser of six months or~~ until the family is able to receive assistance under the county's regular basic sliding program; and

(3) notify the commissioner through the quarterly reporting process of any family that meets the criteria of the portable basic sliding fee assistance pool.

EFFECTIVE DATE. This section is effective October 23, 2017.

Sec. 17. Minnesota Statutes 2016, section 119B.05, subdivision 1, is amended to read:

Subdivision 1. **Eligible participants.** Families eligible for child care assistance under the MFIP child care program are:

(1) MFIP participants who are employed or in job search and meet the requirements of section 119B.10;

(2) persons who are members of transition year families under section 119B.011, subdivision 20, and meet the requirements of section 119B.10;

(3) families who are participating in employment orientation or job search, or other employment or training activities that are included in an approved employability development plan under section 256J.95;

(4) MFIP families who are participating in work job search, job support, employment, or training activities as required in their employment plan, or in appeals, hearings, assessments, or orientations according to chapter 256J;

(5) MFIP families who are participating in social services activities under chapter 256J as required in their employment plan approved according to chapter 256J;

(6) families who are participating in services or activities that are included in an approved family stabilization plan under section 256J.575;

(7) families who are participating in programs as required in tribal contracts under section 119B.02, subdivision 2, or 256.01, subdivision 2;

(8) families who are participating in the transition year extension under section 119B.011, subdivision 20a; ~~and~~

(9) student parents as defined under section 119B.011, subdivision 19b~~.~~; and

(10) student parents who turn 21 years of age and who continue to meet the other requirements under section 119B.011, subdivision 19b. A student parent continues to be eligible until the student parent is approved for basic sliding fee child care assistance or until the student parent's redetermination, whichever comes first. At the student parent's redetermination, if the student parent was not approved for basic sliding fee child care assistance, a student parent's eligibility ends following a 15-day adverse action notice.

EFFECTIVE DATE. This section is effective October 23, 2017.

Sec. 18. Minnesota Statutes 2016, section 119B.09, subdivision 1, is amended to read:

Subdivision 1. **General eligibility requirements ~~for all applicants for child care assistance.~~** (a) Child care services must be available to families who need child care to find or keep employment or to obtain the training or education necessary to find employment and who:

(1) have household income less than or equal to 67 percent of the state median income, adjusted for family size, at application and redetermination, and meet the requirements of section 119B.05; receive MFIP assistance; and are participating in employment and training services under chapter 256J; or

(2) have household income less than or equal to 47 percent of the state median income, adjusted for family size, at ~~program entry~~ application and less than or equal to 67 percent of the state median income, adjusted for family size, at ~~program exit~~ redetermination.

(b) Child care services must be made available as in-kind services.

(c) All applicants for child care assistance and families currently receiving child care assistance must be assisted and required to cooperate in establishment of paternity and enforcement of child support obligations for all children in the family at application and redetermination as a condition of program eligibility. For purposes of this section, a family is considered to meet the requirement for cooperation when the family complies with the requirements of section 256.741.

(d) All applicants for child care assistance and families currently receiving child care assistance must pay the co-payment fee under section 119B.12, subdivision 2, as a condition of eligibility. The co-payment fee may include additional recoupment fees due to a child care assistance program overpayment.

(e) At application and redetermination, a family must self-certify that the value of the family's assets is less than or equal to $1,000,000 as a condition of eligibility. The commissioner shall establish procedures to determine the value of countable assets when a family self-certifies that the value of the family's assets is greater than $1,000,000. The value of countable assets must be less than or equal to $1,000,000 as a condition of eligibility at application and redetermination.

(f) If a family has one child with a child care authorization and the child turns 13 years of age or the child has a disability and turns 15 years of age, the family remains eligible until the redetermination.

EFFECTIVE DATE. Paragraphs (a) and (c) are effective October 23, 2017. Paragraph (d) is effective the day following final enactment. Paragraph (e) is effective February 26, 2018. Paragraph (f) is effective December 18, 2017.

Sec. 19. Minnesota Statutes 2016, section 119B.09, subdivision 4, is amended to read:

Subd. 4. **Eligibility; annual income; calculation.** (a) Annual income of the applicant family is the current monthly income of the family multiplied by 12 or the income for the 12-month period immediately preceding the date of application, or income calculated by the method which provides the most accurate assessment of income available to the family.

(b) Self-employment income must be calculated based on ~~gross receipts less operating expenses. Income must be recalculated when the family's income changes, but no less often than every six months. For a family where at least one parent is under the age of 21, does not have a high school or general equivalency diploma, and is a student in a school district or another similar program that provides or arranges for child care, as well as parenting, social services, career and employment supports, and academic support to achieve high school graduation, income must be recalculated when the family's income changes, but otherwise shall be deferred beyond six months, but not to exceed 12 months, to the end of the student's school year~~ section 256P.05.

(c) Income changes are processed under section 119B.025, subdivision 4. Included lump sums counted as income under section 256P.06, subdivision 3, must be annualized over 12 months. Income must be verified with documentary evidence. If the applicant does not have sufficient evidence of income, verification must be obtained from the source of the income.

EFFECTIVE DATE. Paragraph (a) is effective the day following final enactment. Paragraph (b) is effective July 30, 2018. Paragraph (c) is effective October 23, 2017.

Sec. 20. Minnesota Statutes 2016, section 119B.09, subdivision 9a, is amended to read:

Subd. 9a. **Child care centers; assistance.** (a) ~~For the purposes of this subdivision, "qualifying child" means a child who is not a child or dependent of an employee of the child care provider.~~ A child care center may receive authorizations for 25 or fewer children who are dependents of the center's employees. If a child care center is authorized for more than 25 children who are dependents of center employees, the county cannot authorize additional dependents of an employee until the number of children falls below 25.

~~(b) Funds distributed under this chapter must not be paid for child care services that are provided for a child or dependent of an employee under paragraph (a) unless at all times at~~

~~least 50 percent of the children for whom the child care provider is providing care are qualifying children under paragraph (a).~~

~~(c) If a child care provider satisfies the requirements for payment under paragraph (b), but the percentage of qualifying children under paragraph (a) for whom the provider is providing care falls below 50 percent, the provider shall have four weeks to raise the percentage of qualifying children for whom the provider is providing care to at least 50 percent before payments to the provider are discontinued for child care services provided for a child who is not a qualifying child.~~

~~(d) This subdivision shall be implemented as follows:~~

~~(1) no later than August 1, 2014, the commissioner shall issue a notice to providers who have been identified as ineligible for funds distributed under this chapter as described in paragraph (b); and~~

~~(2) no later than January 5, 2015, payments to providers who do not comply with paragraph (c) will be discontinued for child care services provided for children who are not qualifying children.~~

~~(e) If a child's authorization for child care assistance is terminated under this subdivision, the county shall send a notice of adverse action to the provider and to the child's parent or guardian, including information on the right to appeal, under Minnesota Rules, part 3400.0185.~~

~~(f)~~ (b) Funds paid to providers during the period of time ~~between the issuance of a notice under paragraph (d), clause (1), and discontinuation of payments under paragraph (d), clause (2),~~ when a center is authorized for more than 25 children who are dependents of center employees must not be treated as overpayments under section 119B.11, subdivision 2a, due to noncompliance with this subdivision.

~~(g)~~ (c) Nothing in this subdivision precludes the commissioner from conducting fraud investigations relating to child care assistance, imposing sanctions, and obtaining monetary recovery as otherwise provided by law.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 21. **[119B.095] CHILD CARE AUTHORIZATIONS.**

Subdivision 1. **General authorization requirements.** (a) When authorizing the amount of child care, the county agency must consider the amount of time the parent reports on the

application or redetermination form that the child attends preschool, a Head Start program, or school while the parent is participating in an authorized activity.

(b) Care must be authorized and scheduled with a provider based on the applicant's or participant's verified activity schedule when:

(1) the family requests care from more than one provider per child;

(2) the family requests care from a legal nonlicensed provider; or

(3) an applicant or participant is employed by any business that is licensed by the Department of Human Services or Medicaid-enrolled as verified through the department's Web site.

(c) If the conditions in paragraph (b) do not apply, the county does not need to verify the applicant's or participant's activity schedule and the amount of child care assistance authorized may be used at times determined by the family.

(d) If the family remains eligible at redetermination, a new authorization with fewer hours, the same hours, or increased hours may be determined.

Subd. 2. **Maintain steady child care authorizations.** (a) Notwithstanding Minnesota Rules, chapter 3400, the amount of child care authorized under section 119B.10 for employment, education, or an MFIP or DWP employment plan shall continue at the same number of hours or more hours until redetermination, including:

(1) when the other parent moves in and is employed or has an education plan under section 119B.10, subdivision 3, or has an MFIP or DWP employment plan; or

(2) when a participant's work hours are reduced or a participant temporarily stops working or attending an approved education program. Temporary changes include, but are not limited to, a medical leave, seasonal employment fluctuations, or a school break between semesters.

(b) The county may increase the amount of child care authorized at any time if the participant verifies the need for increased hours for authorized activities.

(c) The county may reduce the amount of child care authorized if a parent requests a reduction or because of a change in:

(1) the child's school schedule;

(2) the custody schedule; or

(3) the provider's availability.

(d) When a child reaches 13 years of age or a child with a disability reaches 15 years of age, the amount of child care authorized shall continue at the same number of hours or more hours until redetermination.

(e) The amount of child care authorized for a family subject to subdivision 1, paragraph (b), must change when the participant's activity schedule changes. Paragraph (a) does not apply to a family subject to subdivision 1, paragraph (b).

Subd. 3. **Assistance for persons who are homeless.** An applicant who is homeless and is eligible for child care assistance under this chapter is eligible for 60 hours of child care assistance per service period for three months from the date the county receives the application. Additional hours may be authorized as needed based on the applicant's participation in an employment, education, or MFIP or DWP employment plan. To continue receiving child care assistance after the initial three months, the applicant must verify that the applicant meets eligibility and activity requirements for child care assistance under this chapter.

EFFECTIVE DATE. This section is effective December 18, 2017.

Sec. 22. **[119B.097] AUTHORIZATION WITH A SECONDARY PROVIDER.**

(a) If a child uses any combination of the following providers paid by child care assistance, a parent must choose one primary provider and one secondary provider per child that can be paid by child care assistance:

(1) an individual or child care center licensed under chapter 245A;

(2) an individual or child care center or facility holding a valid child care license issued by another state or tribe; or

(3) a child care center exempt from licensing under section 245A.03.

(b) The amount of child care authorized with the secondary provider cannot exceed 20 hours per two-week service period, per child, and the amount of care paid to a child's secondary provider is limited under section 119B.13, subdivision 1. The total amount of child care authorized with both the primary and secondary provider cannot exceed the amount of child care allowed based on the parents' eligible activity schedule, the child's school schedule, and any other factors relevant to the family's child care needs.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 23. Minnesota Statutes 2016, section 119B.10, subdivision 1, is amended to read:

Subdivision 1. **Assistance for persons seeking and retaining employment.** (a) ~~Persons who are seeking employment~~ An applicant who is job searching and who is eligible for child care assistance under this chapter is eligible for 60 hours of child care assistance per service period for three months from the date of eligibility. Job searching at initial application is allowed one time per 12-month period. The applicant must meet employment requirements under paragraph (c) or education requirements under subdivision 3, or have an MFIP or DWP employment plan, to continue receiving child care assistance after the initial three months.

(b) A participant who meets the employment requirements of paragraph (c) or who is attending an approved education or training program under subdivision 3 and who ~~are eligible for~~ is receiving child care assistance under this ~~section are~~ chapter is eligible to receive ~~up to 240~~ an additional ten hours of child care assistance per ~~calendar year~~ service period for job search.

~~(b)~~ (c) At application and redetermination, employed persons who work at least an average of 20 hours and full-time students who work at least an average of ten hours a week and receive at least a minimum wage for all hours worked are eligible for ~~continued~~ child care assistance for employment. For purposes of this section, work-study programs must be counted as employment. An employed person with an MFIP or DWP employment plan shall receive child care assistance as specified in the person's employment plan. Child care assistance during employment must be authorized as provided in paragraphs ~~(c) and~~ (d) and (e).

~~(c)~~ (d) When the person works for an hourly wage and the hourly wage is equal to or greater than the applicable minimum wage, child care assistance shall be provided for the ~~actual~~ hours of employment, break, and mealtime during the employment, and travel time up to two hours per day.

~~(d)~~ (e) When the person does not work for an hourly wage, child care assistance must be provided for the lesser of:

(1) the amount of child care determined by dividing gross earned income or, for a self-employed person, the self-employment income determined under section 256P.05, subdivision 2, by the applicable minimum wage, up to one hour every eight hours for meals and break time, plus up to two hours per day for travel time; or

(2) the amount of child care equal to the actual amount of child care used during employment, including break and mealtime during employment, and travel time up to two hours per day.

EFFECTIVE DATE. Paragraphs (a) to (d) are effective December 18, 2017. Paragraph (e) is effective July 30, 2018.

Sec. 24. Minnesota Statutes 2016, section 119B.10, is amended by adding a subdivision to read:

Subd. 3. **Assistance for persons attending an approved education or training program.** (a) Money for an eligible person according to sections 119B.03, subdivision 3, and 119B.05, subdivision 1, shall be used to reduce child care costs for a student. The county shall not limit the duration of child care subsidies for a person in an employment or educational program unless the person is ineligible for child care funds. Any other limitation must be based on county policies included in the approved child care fund plan.

(b) To be eligible, the student must be in good standing and making satisfactory progress toward the degree. The maximum length of time a student is eligible for child care assistance under the child care fund for education and training is no more than the time necessary to complete the credit requirements for an associate or baccalaureate degree as determined by the educational institution. Time limitations for child care assistance do not apply to basic or remedial educational programs needed for postsecondary education or employment. Basic or remedial educational programs include high school, general equivalency diploma, and English as a second language programs. A program exempt from this time limit must not run concurrently with a postsecondary program.

(c) If a student meets the conditions of paragraphs (a) and (b), child care assistance must be authorized for all hours of class time and credit hours, including independent study and internships, and up to two hours of travel time per day. A postsecondary student shall receive four hours of child care assistance per credit hour for study time and academic appointments per service period.

(d) For an MFIP or DWP participant, child care assistance must be authorized according to the person's approved employment plan. If an MFIP or DWP participant receiving MFIP or DWP child care assistance under this chapter moves to another county, continues to participate in an authorized educational or training program, and remains eligible for MFIP or DWP child care assistance, the participant must receive continued child care assistance from the county responsible for the person's current employment plan under section 256G.07.

(e) If a person with an approved education program under section 119B.03, subdivision 3, or 119B.05, subdivision 1, begins receiving MFIP or DWP assistance, the person continues to receive child care assistance for the approved education program until the person's education is included in an approved MFIP or DWP employment plan or until redetermination, whichever occurs first.

(f) If a person's MFIP or DWP assistance ends and the approved MFIP or DWP employment plan included education, the person continues to be eligible for child care assistance for education under transition year child care assistance until the person's education is included in an approved education plan or until redetermination.

EFFECTIVE DATE. This section is effective December 18, 2017.

Sec. 25. **[119B.105] EXTENDED ELIGIBILITY AND AUTHORIZATION.**

Subdivision 1. **Three-month extended eligibility period.** (a) A family in a situation under paragraph (b) continues to be eligible for up to three months or until the family's redetermination, whichever occurs first, rather than losing eligibility or having the family's eligibility suspended. During extended eligibility, the amount of child care authorized shall continue at the same number or more hours. The family must continue to meet all other eligibility requirements under this chapter.

(b) The family's three-month extended eligibility period applies when:

(1) a participant's employment or education program ends permanently;

(2) the other parent moves in and does not participate in an authorized activity;

(3) a participant's MFIP assistance ends and the participant is not participating in an authorized activity or the participant's participation in an authorized activity is unknown;

(4) a student parent under section 119B.011, subdivision 19b, stops attending school; or

(5) a participant receiving basic sliding fee child care assistance or transition year child care assistance applied for MFIP assistance and is not participating in an authorized activity or the participant's participation in an authorized activity is unknown.

Subd. 2. **Extended eligibility and redetermination.** (a) If the family received three months of extended eligibility and redetermination is not due, to continue receiving child care assistance the participant must be employed or have an education plan which meets the requirements of section 119B.10, subdivision 3, or have an MFIP or DWP employment plan. If child care assistance continues, the amount of child care authorized shall continue

at the same number or more hours until redetermination, unless a condition in section 119B.095, subdivision 2, paragraph (c), applies. A family subject to section 119B.095, subdivision 1, paragraph (b), shall have child care authorized based on a verified activity schedule.

(b) If the family's redetermination occurs before the end of the three-month extended eligibility period to continue receiving child care assistance, the participant must verify that the participant meets eligibility and activity requirements for child care assistance under this chapter. If child care assistance continues, the amount of child care authorized is based on section 119B.10. A family subject to section 119B.095, subdivision 1, paragraph (b), shall have child care authorized based on a verified activity schedule.

EFFECTIVE DATE. This section is effective December 18, 2017.

Sec. 26. Minnesota Statutes 2016, section 119B.11, subdivision 2a, is amended to read:

Subd. 2a. **Recovery of overpayments.** (a) An amount of child care assistance paid to a recipient in excess of the payment due is recoverable by the county agency under paragraphs (b) and (c), even when the overpayment was caused by agency error or circumstances outside the responsibility and control of the family or provider.

(b)(1) An overpayment ~~must be recouped or recovered from the family if the overpayment~~ that benefited the family by causing the family to pay less for child care expenses than the family otherwise would have been required to pay under ~~child care assistance program requirements~~ this chapter must be established and recovered according to clauses (1) to (5), with the following exceptions:

(i) an overpayment estimated to be less than $500 must not be established or collected;

(ii) the portion of an overpayment that occurred more than one year before the date of overpayment determination must not be established or collected; or

(iii) an overpayment designated solely as agency error must not be established or collected.

(2) If the family remains eligible for child care assistance and an overpayment is established, the overpayment must be recovered through recoupment as identified in Minnesota Rules, part 3400.0187, except that the overpayments must be calculated and collected on a service period basis. ~~If the family no longer remains eligible for child care assistance, the county may choose to initiate efforts to recover overpayments from the family for overpayment less than $50. If the overpayment is greater than or equal to $50,~~

(3) If the family is no longer eligible for child care assistance and an overpayment is established, the county shall seek voluntary repayment of the overpayment from the family.

(4) If the county is unable to recoup the overpayment through voluntary repayment, the county shall initiate civil court proceedings to recover the overpayment unless the county's costs to recover the overpayment will exceed the amount of the overpayment.

(5) A family with an outstanding debt under this subdivision is not eligible for child care assistance until:

~~(1)~~ (i) the debt is paid in full; or

~~(2)~~ (ii) satisfactory arrangements are made with the county to retire the debt consistent with the requirements of this chapter and Minnesota Rules, chapter 3400, and the family is in compliance with the arrangements.

(c) The county must recover an overpayment from a provider if the overpayment did not benefit the family by causing it to receive more child care assistance or to pay less for child care expenses than the family otherwise would have been eligible to receive or required to pay under child care assistance program requirements, and benefited the provider by causing the provider to receive more child care assistance than otherwise would have been paid on the family's behalf under child care assistance program requirements. If the provider continues to care for children receiving child care assistance, the overpayment must be recovered through reductions in child care assistance payments for services as described in an agreement with the county. The provider may not charge families using that provider more to cover the cost of recouping the overpayment. If the provider no longer cares for children receiving child care assistance, the county may choose to initiate efforts to recover overpayments of less than $50 from the provider. If the overpayment is greater than or equal to $50, the county shall seek voluntary repayment of the overpayment from the provider. If the county is unable to recoup the overpayment through voluntary repayment, the county shall initiate civil court proceedings to recover the overpayment unless the county's costs to recover the overpayment will exceed the amount of the overpayment. A provider with an outstanding debt under this subdivision is not eligible to care for children receiving child care assistance until:

(1) the debt is paid in full; or

(2) satisfactory arrangements are made with the county to retire the debt consistent with the requirements of this chapter and Minnesota Rules, chapter 3400, and the provider is in compliance with the arrangements.

(d) When both the family and the provider acted together to intentionally cause the overpayment, both the family and the provider are jointly liable for the overpayment regardless of who benefited from the overpayment. The county must recover the overpayment as provided in paragraphs (b) and (c). When the family or the provider is in compliance with a repayment agreement, the party in compliance is eligible to receive child care assistance or to care for children receiving child care assistance despite the other party's noncompliance with repayment arrangements.

(e) A provider overpayment designated as an agency error because of the application of an incorrect maximum rate must not be established or collected. Any other provider overpayment designated as agency error must be established and collected.

(f) Notwithstanding any provision to the contrary in this subdivision, an overpayment must be established and collected if the overpayment was caused in any part by wrongfully obtaining assistance under section 256.98 or by benefits paid while an action is pending appeal under section 119B.16, if on appeal the commissioner finds that the appellant was ineligible for the amount of child are assistance paid.

EFFECTIVE DATE. This section is effective October 23, 2017.

Sec. 27. Minnesota Statutes 2016, section 119B.12, subdivision 2, is amended to read:

Subd. 2. **Parent fee.** A family must be assessed a parent fee for each service period. A family's parent fee must be a fixed percentage of its annual gross income. Parent fees must apply to families eligible for child care assistance under sections 119B.03 and 119B.05. Income must be as defined in section 119B.011, subdivision 15. The fixed ~~percent~~ percentage is based on the relationship of the family's annual gross income to 100 percent of the annual state median income. Parent fees must begin at 75 percent of the poverty level. The minimum parent fees for families between 75 percent and 100 percent of poverty level must be $2 per biweekly period. Parent fees must provide for graduated movement to full payment. At initial application, the parent fee is established for the family's 12-month eligibility period. At redetermination, if the family remains eligible, the parent fee is recalculated and is established for the next 12-month eligibility period. A parent fee shall not increase during the 12-month eligibility period. Payment of part or all of a family's parent fee directly to the family's child care provider on behalf of the family by a source other than the family shall not affect the family's eligibility for child care assistance, and the amount paid shall be excluded from the family's income. Child care providers who accept third-party payments must maintain family specific documentation of payment source, amount, and time period covered by the payment.

EFFECTIVE DATE. This section is effective October 23, 2017.

Sec. 28. Minnesota Statutes 2016, section 119B.125, subdivision 1b, is amended to read:

Subd. 1b. **Training required.** (a) ~~Effective November 1, 2011, prior to~~ Before initial authorization as required in subdivision 1, a legal nonlicensed ~~family~~ child care provider must complete pediatric first aid and CPR training and provide the verification of the pediatric first aid and CPR training to the county. The training documentation must have valid effective dates as of the date the registration request is submitted to the county~~.~~ and the training must have been provided by an individual approved to provide first aid and CPR instruction and have included CPR techniques for infants and children.

(b) A legal nonlicensed ~~family child care providers with an authorization effective before November 1, 2011, must be notified of the requirements before October 1, 2011, or at authorization, and must meet the requirements upon renewal of an authorization that occurs on or after January 1, 2012~~ related provider must:

(1) complete training on abusive head trauma before being authorized for a child through four years of age;

(2) complete training on reducing the risk of sudden unexpected infant death before being authorized for a child younger than 12 months old; and

(3) meet the training requirements by September 30, 2017, if authorized for a child before July 1, 2017.

(c) A legal nonlicensed unrelated provider must:

(1) complete training on abusive head trauma before being authorized for a child through four years of age;

(2) complete training on reducing the risk of sudden unexpected infant death before being authorized for a child younger than 12 months old;

(3) complete a child care provider orientation class, or equivalent training approved by the commissioner, within 90 days after initial authorization. The commissioner must develop the child care provider orientation class, which must include training on maintaining health, safety, and fire standards; and

(4) meet the training requirements and complete a child care provider orientation class by September 30, 2017, if authorized to care for a child before July 1, 2017.

(d) Upon each reauthorization ~~after the authorization period when the initial first aid and CPR training requirements are met,~~ a legal nonlicensed ~~family child care~~ unrelated

provider must ~~provide verification of at least eight hours of additional training listed in the Minnesota Center for Professional Development Registry~~ complete training on the topics in paragraph (c), clause (3).

~~(d) This subdivision only applies to legal nonlicensed family child care providers.~~

EFFECTIVE DATE. This section is effective September 25, 2017.

Sec. 29. Minnesota Statutes 2016, section 119B.125, subdivision 4, is amended to read:

Subd. 4. **Unsafe care.** A county may deny authorization as a child care provider to any applicant or ~~rescind~~ revoke the authorization of any provider when the county knows or has reason to believe that the provider is unsafe or that the circumstances of the chosen child care arrangement are unsafe. The county must include the conditions under which a provider or care arrangement will be determined to be unsafe in the county's child care fund plan under section 119B.08, subdivision 3.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 30. Minnesota Statutes 2016, section 119B.125, subdivision 6, is amended to read:

Subd. 6. **Record-keeping requirement.** (a) As a condition of payment, all providers receiving child care assistance payments must keep accurate and legible daily attendance records at the site where services are delivered for children receiving child care assistance and must make those records available immediately to the county or the commissioner upon request. The attendance records must be completed daily and include the date, the first and last name of each child in attendance, and the times when each child is dropped off and picked up. To the extent possible, the times that the child was dropped off to and picked up from the child care provider must be entered by the person dropping off or picking up the child. The daily attendance records must be retained at the site where services are delivered for six years after the date of service.

(b) A county or the commissioner may deny or revoke a provider's authorization ~~as a child care provider to any applicant, rescind authorization of any provider,~~ to receive child care assistance payments under section 119B.13, subdivision 6, paragraph (d), pursue a fraud disqualification under section 256.98, take an action against the provider under chapter 245E, or establish an attendance record overpayment ~~claim in the system~~ under paragraph (c) against a current or former provider, when the county or the commissioner knows or has reason to believe that the provider has not complied with the record-keeping requirement

in this subdivision. ~~A provider's failure to produce attendance records as requested on more than one occasion constitutes grounds for disqualification as a provider.~~

(c) To calculate an attendance record overpayment under this subdivision, the commissioner or county agency subtracts the maximum daily rate from the total amount paid to a provider for each day that a child's attendance record is missing, unavailable, incomplete, illegible, inaccurate, or otherwise inadequate.

(d) The commissioner shall develop criteria to direct a county when the county must establish an attendance overpayment under this subdivision.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 31. Minnesota Statutes 2016, section 119B.125, is amended by adding a subdivision to read:

Subd. 10. **Reporting required for child safety.** A legal nonlicensed child care provider must report to the county agency a death, serious injury, or instance of substantiated child abuse that occurred while a child was in the legal nonlicensed child care provider's care. A county agency shall report to the commissioner, in a manner prescribed by the commissioner, the number of deaths, serious injuries, and instances of substantiated child abuse that occurred in all legal nonlicensed child care providers in the county.

EFFECTIVE DATE. This section is effective September 25, 2017.

Sec. 32. Minnesota Statutes 2016, section 119B.125, is amended by adding a subdivision to read:

Subd. 11. **Emergency preparedness plan.** A legal nonlicensed child care provider must have a written emergency preparedness plan for an emergency. The commissioner shall develop a form for a provider to create a written emergency preparedness plan.

EFFECTIVE DATE. This section is effective September 25, 2017.

Sec. 33. Minnesota Statutes 2016, section 119B.125, is amended by adding a subdivision to read:

Subd. 12. **Compliance with health and safety requirements.** (a) The commissioner must establish health, safety, and fire standards specific to a legal nonlicensed unrelated provider. The commissioner must develop a tool for a county agency to conduct an annual inspection of a legal nonlicensed unrelated provider. The commissioner must develop a process for a legal nonlicensed unrelated provider to correct violations of the health, safety,

and fire standards. The commissioner must develop a process to revoke authorization of a legal nonlicensed unrelated provider if the provider fails to correct violations of the health, safety, and fire standards.

(b) A county agency must conduct at least one inspection annually of each legal nonlicensed unrelated provider. The county agency must be given access to the physical facility and grounds where care is provided and to children cared for by the legal nonlicensed unrelated provider. The county agency must be given access without prior notice and as often as the county agency considers necessary if the county agency is investigating alleged maltreatment, conducting an inspection, or investigating an alleged violation of applicable laws or rules. A provider's failure to give access to the county agency may result in termination of the legal nonlicensed unrelated provider's authorization to care for a child receiving child care assistance under this section.

EFFECTIVE DATE. This section is effective September 25, 2017.

Sec. 34. Minnesota Statutes 2016, section 119B.13, subdivision 1, is amended to read:

Subdivision 1. **Subsidy restrictions.** (a) ~~Beginning February 3, 2014, The~~ Beginning February 26, 2018, the maximum rate paid for child care assistance in any county or county price cluster under the child care fund shall be the greater of the 25th percentile of the ~~2011~~ 2016 child care provider rate survey or the maximum rate effective ~~November 28, 2011~~ February 3, 2014. The commissioner may: (1) assign a county with no reported provider prices to a similar price cluster; and (2) consider county level access when determining final price clusters.

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

(c) The department shall monitor the effect of this paragraph on provider rates. The county shall pay the provider's full charges for every child in care up to the maximum established. The commissioner shall determine the maximum rate for each type of care on an hourly, full-day, and weekly basis, including special needs and disability care.

(d) If a child uses one provider, the maximum payment ~~to a provider~~ for one day of care must not exceed the daily rate. The maximum payment ~~to a provider~~ for one week of care must not exceed the weekly rate.

~~(d)~~ (e) If a child uses two providers under section 119B.097, the maximum payment must not exceed:

(1) the daily rate for one day of care;

(2) the weekly rate for one week of care by a child's primary provider; and

(3) two daily rates during two weeks of care by a child's secondary provider.

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

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

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

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

EFFECTIVE DATE. Paragraph (a) is effective February 26, 2018. Paragraphs (d) to (i) are effective April 23, 2018.

Sec. 35. Minnesota Statutes 2016, section 119B.13, subdivision 6, is amended to read:

Subd. 6. **Provider payments.** (a) A provider must bill only for services documented according to section 119B.125, subdivision 6. The provider shall bill for services provided within ten days of the end of the service period. ~~If bills are submitted within ten days of the end of the service period,~~ Payments under the child care fund shall be made within ~~30~~ 21 days of receiving a complete bill from the provider. Counties or the state may establish policies that make payments on a more frequent basis.

(b) If a provider has received an authorization of care and been issued a billing form for an eligible family, the bill must be submitted within 60 days of the last date of service on the bill. A bill submitted more than 60 days after the last date of service must be paid if the county determines that the provider has shown good cause why the bill was not submitted within 60 days. Good cause must be defined in the county's child care fund plan under section 119B.08, subdivision 3, and the definition of good cause must include county error. Any bill submitted more than a year after the last date of service on the bill must not be paid.

(c) If a provider provided care for a time period without receiving an authorization of care and a billing form for an eligible family, payment of child care assistance may only be

made retroactively for a maximum of six months from the date the provider is issued an authorization of care and billing form.

(d) A county or the commissioner may refuse to issue a child care authorization to a licensed or legal nonlicensed provider, revoke an existing child care authorization to a licensed or legal nonlicensed provider, stop payment issued to a licensed or legal nonlicensed provider, or refuse to pay a bill submitted by a licensed or legal nonlicensed provider if:

(1) the provider admits to intentionally giving the county materially false information on the provider's billing forms;

(2) a county or the commissioner finds by a preponderance of the evidence that the provider intentionally gave the county materially false information on the provider's billing forms, or provided false attendance records to a county or the commissioner;

(3) the provider is in violation of child care assistance program rules, until the agency determines those violations have been corrected;

(4) the provider is operating after:

(i) an order of suspension of the provider's license issued by the commissioner; or

(ii) an order of revocation of the provider's license; ~~or~~

~~(iii) a final order of conditional license issued by the commissioner for as long as the conditional license is in effect;~~

(5) the provider submits ~~false~~ an inaccurate attendance ~~reports or refuses to provide documentation of the child's attendance upon request; or~~ record;

(6) the provider gives false child care price information~~.~~; or

(7) the provider fails to grant access to a county or the commissioner during regular business hours to examine all records necessary to determine the extent of services provided to a child care assistance recipient and the appropriateness of a claim for payment.

(e) If a county or the commissioner finds that a provider violated paragraph (d), clause (1) or (2), a county or the commissioner must deny or revoke the provider's authorization and either pursue a fraud disqualification under section 256.98, subdivision 8, paragraph (c) or refer the case to a law enforcement authority. A provider's rights related to an authorization denial or revocation under this paragraph are established in section 119B.161. If a provider's authorization is revoked or denied under this paragraph, the denial or revocation lasts until either:

(1) all criminal, civil, and administrative proceedings related to the provider's alleged misconduct conclude and any appeal rights are exhausted; or

(2) the commissioner decides, based on written evidence or argument submitted under section 119B.161, to authorize the provider.

(f) If a county or the commissioner denies or revokes a provider's authorization under paragraph (d), clause (4), the provider shall not be authorized until the order of suspension or order of revocation against the provider is lifted.

~~(e) For purposes of~~ (g) If a county or the commissioner finds that a provider violated paragraph (d), clauses (3), (5), ~~and~~ or (6), the county or the commissioner may ~~withhold~~ revoke or deny the provider's authorization ~~or payment for a period of time not to exceed three months beyond the time the condition has been corrected~~. If a provider's authorization is revoked or denied under this paragraph, the denial or revocation may last up to 90 days from the date a county or the commissioner denies or revokes the provider's authorization.

(h) If a county or the commissioner determines a provider violated paragraph (d), clause (7), a county or the commissioner must deny or revoke the provider's authorization until a county or the commissioner determines whether the records sought comply with this chapter and chapter 245E. The provider's rights related to an authorization denial or revocation under this paragraph are established in section 119B.161.

~~(f)~~ (i) A county's payment policies must be included in the county's child care plan under section 119B.08, subdivision 3. If payments are made by the state, in addition to being in compliance with this subdivision, the payments must be made in compliance with section 16A.124.

EFFECTIVE DATE. Paragraph (a) is effective September 25, 2017. Paragraphs (d) to (i) are effective April 23, 2018.

Sec. 36. Minnesota Statutes 2016, section 119B.16, subdivision 1, is amended to read:

Subdivision 1. **Fair hearing allowed for applicants and recipients.** (a) An applicant or recipient adversely affected by an action of a county agency ~~action~~ or the commissioner may request and receive a fair hearing in accordance with this subdivision and section 256.045.

(b) A county agency must offer an informal conference to an applicant or recipient who is entitled to a fair hearing under this section. A county agency shall advise an adversely affected applicant or recipient that a request for a conference is optional and does not delay or replace the right to a fair hearing.

(c) An applicant or recipient does not have a right to a fair hearing if a county agency or the commissioner takes action against a provider.

(d) If a provider's authorization is suspended, denied, or revoked, a county agency or the commissioner must mail notice to a child care assistance program recipient receiving care from the provider.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 37. Minnesota Statutes 2016, section 119B.16, subdivision 1a, is amended to read:

Subd. 1a. **Fair hearing allowed for providers.** (a) This subdivision applies to providers caring for children receiving child care assistance.

~~(b) A provider to whom a county agency has assigned responsibility for an overpayment may request a fair hearing in accordance with section 256.045 for the limited purpose of challenging the assignment of responsibility for the overpayment and the amount of the overpayment. The scope of the fair hearing does not include the issues of whether the provider wrongfully obtained public assistance in violation of section 256.98 or was properly disqualified under section 256.98, subdivision 8, paragraph (c), unless the fair hearing has been combined with an administrative disqualification hearing brought against the provider under section 256.046.~~

(b) A provider may request a fair hearing only as specified in this subdivision.

(c) A provider may request a fair hearing according to sections 256.045 and 256.046 if a county agency or the commissioner:

(1) denies or revokes a provider's authorization, unless the action entitles the provider to a consolidated contested case hearing under section 119B.16, subdivision 3, or an administrative review under section 119B.161;

(2) assigns responsibility for an overpayment to a provider under section 119B.11, subdivision 2a;

(3) establishes an overpayment for failure to comply with section 119B.125, subdivision 6;

(4) seeks monetary recovery or recoupment under section 245E.02, subdivision 4, paragraph (c), item (2);

(5) initiates an administrative fraud disqualification hearing; or

(6) issues a payment and the provider disagrees with the amount of the payment.

(d) A provider may request a fair hearing by submitting a written request to the Department of Human Services, Appeals Division. A provider's request must be received by the appeals division no later than 30 days after the date a county or the commissioner mails the notice. The provider's appeal request must contain the following:

(1) each disputed item, the reason for the dispute, and, if appropriate, an estimate of the dollar amount involved for each disputed item;

(2) the computation the provider believes to be correct, if appropriate;

(3) the statute or rule relied on for each disputed item; and

(4) the name, address, and telephone number of the person at the provider's place of business with whom contact may be made regarding the appeal.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 38. Minnesota Statutes 2016, section 119B.16, subdivision 1b, is amended to read:

Subd. 1b. **Joint fair hearings.** ~~When a provider requests a fair hearing under subdivision 1a, the family in whose case the overpayment was created must be made a party to the fair hearing. All other issues raised by the family must be resolved in the same proceeding. When a family requests a fair hearing and claims that the county should have assigned responsibility for an overpayment to a provider, the provider must be made a party to the fair hearing.~~ The human services judge assigned to a fair hearing may join a family or a provider as a party to the fair hearing whenever joinder of that party is necessary to fully and fairly resolve ~~overpayment~~ issues raised in the appeal.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 39. Minnesota Statutes 2016, section 119B.16, is amended by adding a subdivision to read:

Subd. 1c. **Notice to providers.** (a) Before taking an action appealable under subdivision 1a, paragraph (c), a county agency or the commissioner must mail written notice to the provider against whom the action is being taken.

(b) The notice shall state:

(1) the factual basis for the department's determination;

(2) the action the department intends to take;

(3) the dollar amount of the monetary recovery or recoupment, if known; and

(4) the right to appeal the department's proposed action.

(c) A county agency or the commissioner must mail the written notice at least 15 calendar days before the adverse action's effective date.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 40. Minnesota Statutes 2016, section 119B.16, is amended by adding a subdivision to read:

Subd. 3. **Consolidated contested case hearing.** If a county agency or the commissioner denies or revokes a provider's authorization based on a licensing action, the provider may only appeal the denial or revocation in the same contested case proceeding that the provider appeals the licensing action.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 41. Minnesota Statutes 2016, section 119B.16, is amended by adding a subdivision to read:

Subd. 4. **Final department action.** Unless the commissioner receives a timely and proper request for an appeal, a county agency's or the commissioner's action shall be considered a final department action.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 42. **[119B.161] ADMINISTRATIVE REVIEW.**

Subdivision 1. **Temporary denial or revocation of authorization.** (a) A provider has the rights listed under this section if:

(1) the provider's authorization was denied or revoked under section 119B.13, subdivision 6, paragraph (d), clause (1), (2), or (7);

(2) the provider's authorization was temporarily suspended under paragraph (b); or

(3) a payment was suspended under chapter 245E.

(b) Unless the commissioner receives a timely and proper request for an appeal, a county's or the commissioner's action is a final department action.

(c) The commissioner may temporarily suspend a provider's authorization without prior notice and opportunity for hearing if the commissioner determines either that there is a credible allegation of fraud for which an investigation is pending under the child care assistance program, or that the suspension is necessary for public safety and the best interests

of the child care assistance program. An allegation is considered credible if the allegation has indications of reliability. The commissioner may determine that an allegation is credible, if the commissioner reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.

Subd. 2. **Notice.** (a) A county or the commissioner must mail a provider notice within five days of suspending, revoking, or denying a provider's authorization under subdivision 1.

(b) The notice must:

(1) state the provision under which a county or the commissioner is denying, revoking, or suspending a provider's authorization or suspending payment to the provider;

(2) set forth the general allegations leading to the revocation, denial, or suspension of a provider's authorization. The notice need not disclose any specific information concerning an ongoing investigation;

(3) state that the suspension, revocation, or denial of a provider's authorization is for a temporary period and explain the circumstances under which the action expires; and

(4) inform the provider of the right to submit written evidence and argument for consideration by the commissioner.

(c) Notwithstanding Minnesota Rules, part 3400.0185, if a county or the commissioner denies or revokes a provider's authorization under section 119B.13, subdivision 6, paragraph (d), clause (1), (2), or (7); suspends a payment to a provider under chapter 245E; or temporarily suspends a payment to a provider under section 119B.161, subdivision 1, a county or the commissioner must send notice of termination to an affected family. The termination sent to an affected family is effective on the date the notice is created.

Subd. 3. **Duration.** If a provider's authorization is denied or revoked under section 119B.13, subdivision 6, paragraph (d), clause (1), (2), or (7); authorization is temporarily suspended under section 119B.161; or payment is suspended under chapter 245E, the provider's denial, revocation, temporary suspension, or payment suspension remains in effect until:

(1) the commissioner or a law enforcement authority determines that there is insufficient evidence warranting the action and a county or the commissioner does not pursue an additional administrative remedy under chapter 245E or section 256.98; or

(2) all criminal, civil, and administrative proceedings related to the provider's alleged misconduct conclude and any appeal rights are exhausted.

Subd. 4. **Good cause exception.** A county or the commissioner may find that good cause exists not to deny, revoke, or suspend a provider's authorization, or not to continue a denial, revocation, or suspension of a provider's authorization if any of the following are applicable:

(1) a law enforcement authority specifically requested that a provider's authorization not be denied, revoked, or suspended because it may compromise an ongoing investigation;

(2) a county or the commissioner determines that the denial, revocation, or suspension should be removed based on the provider's written submission; or

(3) the commissioner determines that the denial, revocation, or suspension is not in the best interests of the program.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 43. Minnesota Statutes 2016, section 144.218, subdivision 5, is amended to read:

Subd. 5. **Replacement of vital records.** Upon ~~the~~ receipt of an order of a court of this state or a certificate of adjudication form, upon the request of a court of another state, or upon the filing of a recognition of parentage with the state registrar, a replacement birth record must be registered consistent with the findings of the court, the certificate of adjudication, or the recognition of parentage.

Sec. 44. Minnesota Statutes 2016, section 144.226, subdivision 1, is amended to read:

Subdivision 1. **Which services are for fee.** The fees for the following services shall be the following or an amount prescribed by rule of the commissioner:

(a) The fee for the administrative review and processing of a request for a certified vital record or a certification that the vital record cannot be found is $9. The fee is payable at the time of application and is nonrefundable.

(b) The fee for processing a request for the replacement of a birth record for all events, except when filing a recognition of parentage pursuant to section 257.73, subdivision 1, is $40. The fee is payable at the time of application and is nonrefundable. To the extent funds are available, the commissioner of human services shall pay the filing fee for the replacement of a birth record due to a paternity adjudication.

(c) The fee for administrative review and processing of a request for the filing of a delayed registration of birth, stillbirth, or death is $40. The fee is payable at the time of application and is nonrefundable.

(d) The fee for administrative review and processing of a request for the amendment of any vital record is $40. The fee is payable at the time of application and is nonrefundable.

(e) The fee for administrative review and processing of a request for the verification of information from vital records is $9 when the applicant furnishes the specific information to locate the vital record. When the applicant does not furnish specific information, the fee is $20 per hour for staff time expended. Specific information includes the correct date of the event and the correct name of the subject of the record. Fees charged shall approximate the costs incurred in searching and copying the vital records. The fee is payable at the time of application and is nonrefundable.

(f) The fee for administrative review and processing of a request for the issuance of a copy of any document on file pertaining to a vital record or statement that a related document cannot be found is $9. The fee is payable at the time of application and is nonrefundable.

Sec. 45. Minnesota Statutes 2016, section 245.814, is amended by adding a subdivision to read:

Subd. 5. **Foster care parent liability insurance.** The commissioner may use federal reimbursement money earned on an expenditure for foster care parent liability insurance premiums to offset the costs of the premiums.

Sec. 46. Minnesota Statutes 2016, section 245A.04, subdivision 1, is amended to read:

Subdivision 1. **Application for licensure.** (a) An individual, corporation, partnership, voluntary association, other organization or controlling individual that is subject to licensure under section 245A.03 must apply for a license. The application must be made on the forms and in the manner prescribed by the commissioner. The commissioner shall provide the applicant with instruction in completing the application and provide information about the rules and requirements of other state agencies that affect the applicant. An applicant seeking licensure in Minnesota with headquarters outside of Minnesota must have a program office located within the state.

The commissioner shall act on the application within 90 working days after a complete application and any required reports have been received from other state agencies or departments, counties, municipalities, or other political subdivisions. The commissioner shall not consider an application to be complete until the commissioner receives all of the information required under section 245C.05.

When the commissioner receives an application for initial licensure that is incomplete because the applicant failed to submit required documents or that is substantially deficient because the documents submitted do not meet licensing requirements, the commissioner shall provide the applicant written notice that the application is incomplete or substantially deficient. In the written notice to the applicant the commissioner shall identify documents that are missing or deficient and give the applicant 45 days to resubmit a second application that is substantially complete. An applicant's failure to submit a substantially complete application after receiving notice from the commissioner is a basis for license denial under section 245A.05.

(b) An application for licensure must identify all controlling individuals and must specify an agent who is responsible for dealing with the commissioner of human services on all matters provided for in this chapter and on whom service of all notices and orders must be made. The agent must be authorized to accept service on behalf of all of the controlling individuals of the program. Service on the agent is service on all of the controlling individuals of the program. It is not a defense to any action arising under this chapter that service was not made on each controlling individual of the program. The designation of one or more controlling individuals as agents under this paragraph does not affect the legal responsibility of any other controlling individual under this chapter.

(c) An applicant or license holder must have a policy that prohibits license holders, employees, subcontractors, and volunteers, when directly responsible for persons served by the program, from abusing prescription medication or being in any manner under the influence of a chemical that impairs the individual's ability to provide services or care. The license holder must train employees, subcontractors, and volunteers about the program's drug and alcohol policy.

(d) An applicant and license holder must have a program grievance procedure that permits persons served by the program and their authorized representatives to bring a grievance to the highest level of authority in the program.

(e) The applicant must be able to demonstrate competent knowledge of the applicable requirements of this chapter and chapter 245C, and the requirements of other licensing statutes and rules applicable to the program or services for which the applicant is seeking to be licensed. Effective January 1, 2013, the commissioner may require the applicant, except for child foster care, to demonstrate competence in the applicable licensing requirements by successfully completing a written examination. The commissioner may develop a prescribed written examination format.

(f) When an applicant is an individual, the individual must provide:

(1) the applicant's taxpayer identification numbers including the Social Security number, and federal employer identification number if the applicant has employees unless a variance is provided as permitted in paragraph (j);

(2) the complete business name, if any, and if doing business under a different name, the doing business as (DBA) name, as registered with the secretary of state; and

(3) ~~a~~ at the commissioner's request, the notarized signature of the applicant.

(g) When an applicant is a nonindividual, the applicant must provide the:

(1) applicant's taxpayer identification numbers including the Minnesota tax identification number and federal employer identification number;

(2) complete business name, and if doing business under a different name, the doing business as (DBA) name, as registered with the secretary of state;

(3) first, middle, and last name, and address for all individuals who will be controlling individuals, including all officers, owners, and managerial officials as defined in section 245A.02, subdivision 5a, and the date that the background study was initiated by the applicant for each controlling individual; and

(4) first, middle, and last name, mailing address, and notarized signature of the agent authorized by the applicant to accept service on behalf of the controlling individuals.

(h) At the time of application for licensure or renewal of a license, the applicant or license holder, except as provided in paragraph (i), must acknowledge on the form provided by the commissioner if the applicant or license holder elects to receive any public funding reimbursement from the commissioner for services provided under the license that:

(1) the applicant's or license holder's compliance with the provider enrollment agreement or registration requirements for receipt of public funding may be monitored by the commissioner as part of a licensing investigation or licensing inspection; and

(2) noncompliance with the provider enrollment agreement or registration requirements for receipt of public funding that is identified through a licensing investigation or licensing inspection, or noncompliance with a licensing requirement that is a basis of enrollment for reimbursement for a service, may result in:

(i) a correction order or a conditional license under section 245A.06, or sanctions under section 245A.07;

(ii) nonpayment of claims submitted by the license holder for public program reimbursement;

(iii) recovery of payments made for the service;

(iv) disenrollment in the public payment program; or

(v) other administrative, civil, or criminal penalties as provided by law.

(i) An applicant to provide child foster care who is an individual must attest on the form provided by the commissioner that any public funding received for providing child foster care services must be used for the benefit of the foster children receiving services.

(j) The commissioner of human services may grant a variance from the requirements in paragraph (f), clause (1), to an individual child foster care applicant who is unable to provide a Social Security number in the application for licensure.

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

Sec. 47. Minnesota Statutes 2016, section 245A.18, subdivision 2, is amended to read:

Subd. 2. **Child passenger restraint systems; training requirement.** (a) Programs licensed by the Department of Human Services under Minnesota Rules, chapter 2960, that serve a child or children under nine years of age must document training that fulfills the requirements in this subdivision.

(b) For child foster care programs, within 30 days of an emergency placement of a relative child, and prior to licensure of a foster care home, the relative provider and applicants, caregivers, and staff persons who will be responsible for transporting children younger than nine years of age in a motor vehicle that have not completed the training required in paragraph (c) within 30 days of emergency placement or prior to licensure must view a video, approved by the Department of Public Safety, on child passenger safety. For all other programs licensed under Minnesota Rules, chapter 2960, all staff persons who will be responsible for transporting children younger than nine years of age in a motor vehicle that have not completed the training required in paragraph (c) must view a video, approved by the Department of Public Safety, on child passenger safety before transporting children.

~~(b) Before a license holder, staff person, or caregiver transports a child or~~ (c) For child foster care programs, within the first three months of licensure, license holders, caregivers, and staff persons who transport foster children ~~under age nine~~ younger than nine years of age in a motor vehicle~~, the person transporting the child~~ must satisfactorily complete training on the proper use and installation of child restraint systems in motor vehicles. Training

completed under this section may be used to meet initial or ongoing training under Minnesota Rules, part 2960.3070, subparts 1 and 2. For all other programs licensed under Minnesota Rules, chapter 2960, within three months of hire, all staff persons who transport children younger than nine years of age in a motor vehicle must satisfactorily complete training on the proper use and installation of child care restraint systems in motor vehicles.

~~For all providers licensed prior to July 1, 2006, the training required in this subdivision must be obtained by December 31, 2007.~~

~~(c)~~ (d) At a minimum, training required under ~~this section must be at least one hour in length, completed at orientation or initial training, and repeated at least once every five years. At a minimum, the training~~ paragraph (c) must address the proper use of child restraint systems based on the child's size, weight, and age, and the proper installation of a car seat or booster seat in the motor vehicle used ~~by the license holder~~ to transport the child or children.

~~(d)~~ (e) The training ~~under paragraph (c) must~~ is required to be provided by individuals who are certified and approved by the Department of Public Safety, Office of Traffic Safety. License holders may obtain a list of certified and approved trainers through the Department of Public Safety Web site or by contacting the agency. The training must be repeated at least once every five years.

~~(e) Child care providers that only transport school age children as defined in section 245A.02, subdivision 16, in school buses as defined in section 169.011, subdivision 71, paragraphs (c) to (f), are exempt from this subdivision.~~

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

Sec. 48. Minnesota Statutes 2016, section 245E.01, is amended by adding a subdivision to read:

Subd. 6a. **Credible allegation of fraud.** "Credible allegation of fraud" has the meaning given in section 256B.064, subdivision 2, paragraph (b), clause (2).

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

Sec. 49. Minnesota Statutes 2016, section 245E.02, subdivision 1, is amended to read:

Subdivision 1. **Investigating provider or recipient financial misconduct.** The department shall investigate alleged or suspected financial misconduct by providers and errors related to payments issued by the child care assistance program under this chapter. Recipients, employees, agents and consultants, and staff may be investigated when the

evidence shows that their conduct is related to the financial misconduct of a provider, license holder, or controlling individual. When the alleged or suspected financial misconduct relates to acting as a recruiter offering conditional employment on behalf of a provider that has received funds from the child care assistance program, the department may investigate the provider, center owner, director, manager, license holder, or other controlling individual or agent, who is alleged to have acted as a recruiter offering conditional employment.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 50. Minnesota Statutes 2016, section 245E.02, subdivision 3, is amended to read:

Subd. 3. **Determination of investigation.** After completing its investigation, the department shall ~~issue one of the following determinations~~ determine that:

(1) no violation of child care assistance requirements occurred;

(2) there is insufficient evidence to show that a violation of child care assistance requirements occurred;

(3) a preponderance of evidence shows a violation of child care assistance program law, rule, or policy; or

(4) there exists a credible allegation of fraud involving the child care assistance program.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 51. Minnesota Statutes 2016, section 245E.02, subdivision 4, is amended to read:

Subd. 4. **~~Actions~~ Referrals or administrative ~~sanctions~~ actions.** (a) After completing the determination under subdivision 3, the department may take one or more of the actions or sanctions specified in this subdivision.

(b) The department may take any of the following actions:

(1) refer the investigation to law enforcement or a county attorney for possible criminal prosecution;

(2) refer relevant information to the department's licensing division, the background studies division, the child care assistance program, the Department of Education, the federal child and adult care food program, or appropriate child or adult protection agency;

(3) enter into a settlement agreement with a provider, license holder, owner, agent, controlling individual, or recipient; or

(4) refer the matter for review by a prosecutorial agency with appropriate jurisdiction for possible civil action under the Minnesota False Claims Act, chapter 15C.

(c) In addition to section 256.98, the department may impose sanctions by:

(1) pursuing administrative disqualification through hearings or waivers;

(2) establishing and seeking monetary recovery or recoupment;

(3) issuing an order of corrective action that states the practices that are violations of child care assistance program policies, laws, or regulations, and that they must be corrected; ~~or~~

(4) suspending~~, denying, or terminating~~ payments to a provider~~.~~; or

(5) taking an action under section 119B.13, subdivision 6, paragraph (d).

(d) ~~Upon a finding by~~ If the commissioner determines that any child care provider, center owner, director, manager, license holder, or other controlling individual of a child care center has employed, used, or acted as a recruiter offering conditional employment for a child care center that has received child care assistance program funding, the commissioner shall:

(1) immediately suspend all program payments to all child care centers in which the person employing, using, or acting as a recruiter offering conditional employment is an owner, director, manager, license holder, or other controlling individual. The commissioner shall suspend program payments under this clause even if services have already been provided; and

(2) immediately and permanently revoke the licenses of all child care centers of which the person employing, using, or acting as a recruiter offering conditional employment is an owner, director, manager, license holder, or other controlling individual.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 52. Minnesota Statutes 2016, section 245E.03, subdivision 2, is amended to read:

Subd. 2. **Failure to provide access.** ~~Failure to provide access may result in denial or termination of authorizations for or payments to a recipient, provider, license holder, or controlling individual in the child care assistance program.~~ If a provider fails to grant the department immediate access to records, the department may immediately suspend payments under section 119B.161, or the department may deny or revoke the provider's authorization. A provider, license holder, controlling individual, employee, or staff member must grant the department access during any hours that the program is open to examine the provider's

program or the records listed in section 245E.05. A provider shall make records immediately available at the provider's place of business at the time the department requests access, unless the provider and the department both agree otherwise.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 53. Minnesota Statutes 2016, section 245E.03, subdivision 4, is amended to read:

Subd. 4. **Continued or repeated failure to provide access.** If the provider continues to fail to provide access at the expiration of the 15-day notice period, child care assistance program payments to the provider must be ~~denied~~ suspended beginning the 16th day following notice of the initial failure or refusal to provide access. ~~The department may rescind the denial based upon good cause if the provider submits in writing a good cause basis for having failed or refused to provide access. The writing must be postmarked no later than the 15th day following the provider's notice of initial failure to provide access.~~ A provider's, license holder's, controlling individual's, employee's, staff member's, or recipient's duty to provide access in this section continues after the provider's authorization is denied, revoked, or suspended. Additionally, the provider, license holder, or controlling individual must immediately provide complete, ongoing access to the department. Repeated failures to provide access must, after the initial failure or for any subsequent failure, result in termination from participation in the child care assistance program.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 54. Minnesota Statutes 2016, section 245E.04, is amended to read:

245E.04 HONEST AND TRUTHFUL STATEMENTS.

It shall be unlawful for a provider, license holder, controlling individual, or recipient to:

(1) falsify, conceal, or cover up by any ~~trick, scheme, or device a material fact~~ means;

(2) make any materially false, fictitious, or fraudulent statement or representation; or

(3) make or use any false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry related to any child care assistance program services that the provider, license holder, or controlling individual supplies or in relation to any child care assistance payments received by a provider, license holder, or controlling individual or to any fraud investigator or law enforcement officer conducting a financial misconduct investigation.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 55. Minnesota Statutes 2016, section 245E.05, subdivision 1, is amended to read:

Subdivision 1. **Records required to be retained.** The following records must be maintained, controlled, and made immediately accessible to license holders, providers, and controlling individuals. The records must be organized and labeled to correspond to categories that make them easy to identify so that they can be made available immediately upon request to an investigator acting on behalf of the commissioner at the provider's place of business:

(1) payroll ledgers, canceled checks, bank deposit slips, and any other accounting records;

(2) daily attendance records required by and that comply with section 119B.125, subdivision 6;

(3) billing transmittal forms requesting payments from the child care assistance program and billing adjustments related to child care assistance program payments;

(4) records identifying all persons, corporations, partnerships, and entities with an ownership or controlling interest in the provider's child care business;

(5) employee or contractor records identifying those persons currently employed by the provider's child care business or who have been employed by the business at any time within the previous five years. The records must include each employee's name, hourly and annual salary, qualifications, position description, job title, and dates of employment. In addition, employee records that must be made available include the employee's time sheets, current home address of the employee or last known address of any former employee, and documentation of background studies required under chapter 119B or 245C;

(6) records related to transportation of children in care, including but not limited to:

(i) the dates and times that transportation is provided to children for transportation to and from the provider's business location for any purpose. For transportation related to field trips or locations away from the provider's business location, the names and addresses of those field trips and locations must also be provided;

(ii) the name, business address, phone number, and Web site address, if any, of the transportation service utilized; and

(iii) all billing or transportation records related to the transportation.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 56. Minnesota Statutes 2016, section 245E.06, subdivision 1, is amended to read:

Subdivision 1. **Factors regarding imposition of administrative ~~sanctions~~ actions.** (a) The department shall consider the following factors in determining the administrative ~~sanctions~~ actions to be imposed:

(1) nature and extent of financial misconduct;

(2) history of financial misconduct;

(3) actions taken or recommended by other state agencies, other divisions of the department, and court and administrative decisions;

(4) prior ~~imposition of sanctions~~ actions;

(5) size and type of provider;

(6) information obtained through an investigation from any source;

(7) convictions or pending criminal charges; and

(8) any other information relevant to the acts or omissions related to the financial misconduct.

(b) Any single factor under paragraph (a) may be determinative of the department's decision of whether and what ~~sanctions are imposed~~ actions to take.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 57. Minnesota Statutes 2016, section 245E.06, subdivision 2, is amended to read:

Subd. 2. **Written notice of department ~~sanction~~ action; ~~sanction~~ action effective date; ~~informal meeting~~.** ~~(a) The department shall give notice in writing to a person of an administrative sanction that is to be imposed. The notice shall be sent by mail as defined in section 245E.01, subdivision 11.~~

~~(b) The notice shall state:~~

~~(1) the factual basis for the department's determination;~~

~~(2) the sanction the department intends to take;~~

~~(3) the dollar amount of the monetary recovery or recoupment, if any;~~

~~(4) how the dollar amount was computed;~~

~~(5) the right to dispute the department's determination and to provide evidence;~~

~~(6) the right to appeal the department's proposed sanction; and~~

~~(7) the option to meet informally with department staff, and to bring additional documentation or information, to resolve the issues.~~

~~(c) In cases of determinations resulting in denial or termination of payments, in addition to the requirements of paragraph (b), the notice must state:~~

~~(1) the length of the denial or termination;~~

~~(2) the requirements and procedures for reinstatement; and~~

~~(3) the provider's right to submit documents and written arguments against the denial or termination of payments for review by the department before the effective date of denial or termination.~~

~~(d) The submission of documents and written argument for review by the department under paragraph (b), clause (5) or (7), or paragraph (c), clause (3), does not stay the deadline for filing an appeal.~~

(a) When taking an action against a provider, the department must give notice to:

(1) the provider as specified in section 119B.16 or 119B.161; and

(2) a family as specified under Minnesota Rules, part 3400.0185, or section 119B.161.

~~(c)~~ (b) Notwithstanding section 245E.03, subdivision 4, and except for a payment suspension or action under section 119B.161, subdivision 1, the effective date of the proposed ~~sanction~~ action under this chapter shall be 30 days after the license holder's, provider's, controlling individual's, or recipient's receipt of the notice, unless timely appealed. If a timely appeal is made, the proposed ~~sanction~~ action shall be delayed pending the final outcome of the appeal. Implementation of a proposed ~~sanction~~ action following the resolution of a timely appeal may be postponed if, in the opinion of the department, the delay of ~~sanction~~ action is necessary to protect the health or safety of children in care. ~~The department may consider the economic hardship of a person in implementing the proposed sanction, but economic hardship shall not be a determinative factor in implementing the proposed sanction.~~

~~(f) Requests for an informal meeting to attempt to resolve issues and requests for appeals must be sent or delivered to the department's Office of Inspector General, Financial Fraud and Abuse Division.~~

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 58. Minnesota Statutes 2016, section 245E.06, subdivision 3, is amended to read:

Subd. 3. **Appeal of department ~~sanction~~ action.** ~~(a) If the department does not pursue a criminal action against a provider, license holder, controlling individual, or recipient for financial misconduct, but the department imposes an administrative sanction under section 245E.02, subdivision 4, paragraph (c), any individual or entity against whom the sanction was imposed may appeal the department's administrative sanction under this section pursuant to section 119B.16 or 256.045 with the additional requirements in clauses (1) to (4). An appeal must specify:~~

~~(1) each disputed item, the reason for the dispute, and an estimate of the dollar amount involved for each disputed item, if appropriate;~~

~~(2) the computation that is believed to be correct, if appropriate;~~

~~(3) the authority in the statute or rule relied upon for each disputed item; and~~

~~(4) the name, address, and phone number of the person at the provider's place of business with whom contact may be made regarding the appeal.~~

~~(b) Notwithstanding section 245E.03, subdivision 4, an appeal is considered timely only if postmarked or received by the department's Appeals Division within 30 days after receiving a notice of department sanction.~~

~~(c) Before the appeal hearing, the department may deny or terminate authorizations or payment to the entity or individual if the department determines that the action is necessary to protect the public welfare or the interests of the child care assistance program.~~

A provider's rights related to an action taken under this chapter are established in sections 119B.16 and 119B.161.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 59. Minnesota Statutes 2016, section 245E.07, subdivision 1, is amended to read:

Subdivision 1. **Grounds for and methods of monetary recovery.** (a) The department may obtain monetary recovery from a provider who has been improperly paid by the child care assistance program, regardless of whether the error was on the part of the provider, the department, or the county and regardless of whether the error was intentional ~~or county error~~. The department does not need to establish a pattern ~~as a precondition of monetary recovery~~ of erroneous or false billing claims, duplicate billing claims, or billing claims based on false statements or financial misconduct.

(b) The department shall obtain monetary recovery from providers by the following means:

(1) permitting voluntary repayment of money, either in lump-sum payment or installment payments;

(2) using any legal collection process;

(3) deducting or withholding program payments; or

(4) utilizing the means set forth in chapter 16D.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 60. Minnesota Statutes 2016, section 256.98, subdivision 8, is amended to read:

Subd. 8. **Disqualification from program.** (a) Any person found to be guilty of wrongfully obtaining assistance by a federal or state court or by an administrative hearing determination, or waiver thereof, through a disqualification consent agreement, or as part of any approved diversion plan under section 401.065, or any court-ordered stay which carries with it any probationary or other conditions, in the Minnesota family investment program and any affiliated program to include the diversionary work program and the work participation cash benefit program, the food stamp or food support program, the general assistance program, the group residential housing program, or the Minnesota supplemental aid program shall be disqualified from that program. In addition, any person disqualified from the Minnesota family investment program shall also be disqualified from the food stamp or food support program. The needs of that individual shall not be taken into consideration in determining the grant level for that assistance unit:

(1) for one year after the first offense;

(2) for two years after the second offense; and

(3) permanently after the third or subsequent offense.

The period of program disqualification shall begin on the date stipulated on the advance notice of disqualification without possibility of postponement for administrative stay or administrative hearing and shall continue through completion unless and until the findings upon which the sanctions were imposed are reversed by a court of competent jurisdiction. The period for which sanctions are imposed is not subject to review. The sanctions provided under this subdivision are in addition to, and not in substitution for, any other sanctions that may be provided for by law for the offense involved. A disqualification established through hearing or waiver shall result in the disqualification period beginning immediately unless

the person has become otherwise ineligible for assistance. If the person is ineligible for assistance, the disqualification period begins when the person again meets the eligibility criteria of the program from which they were disqualified and makes application for that program.

(b) A family receiving assistance through child care assistance programs under chapter 119B with a family member who is found to be guilty of wrongfully obtaining child care assistance by a federal court, state court, or an administrative hearing determination or waiver, through a disqualification consent agreement, as part of an approved diversion plan under section 401.065, or a court-ordered stay with probationary or other conditions, is disqualified from child care assistance programs. The disqualifications must be for periods of one year and two years for the first and second offenses, respectively. Subsequent violations must result in permanent disqualification. During the disqualification period, disqualification from any child care program must extend to all child care programs and must be immediately applied.

(c) A provider caring for children receiving assistance through child care assistance programs under chapter 119B is disqualified from receiving payment for child care services from the child care assistance program under chapter 119B when the provider is found to have wrongfully obtained child care assistance by a federal court, state court, or an administrative hearing determination or waiver under section 256.046, through a disqualification consent agreement, as part of an approved diversion plan under section 401.065, or a court-ordered stay with probationary or other conditions. The disqualification must be for a period of ~~one year~~ two years for the first offense ~~and two years for the second offense~~. Any subsequent violation must result in permanent disqualification. The disqualification period must be imposed immediately after a determination is made under this paragraph. During the disqualification period, the provider is disqualified from receiving payment from any child care program under chapter 119B.

(d) Any person found to be guilty of wrongfully obtaining MinnesotaCare for adults without children and upon federal approval, all categories of medical assistance and remaining categories of MinnesotaCare, except for children through age 18, by a federal or state court or by an administrative hearing determination, or waiver thereof, through a disqualification consent agreement, or as part of any approved diversion plan under section 401.065, or any court-ordered stay which carries with it any probationary or other conditions, is disqualified from that program. The period of disqualification is one year after the first offense, two years after the second offense, and permanently after the third or subsequent offense. The period of program disqualification shall begin on the date stipulated on the

advance notice of disqualification without possibility of postponement for administrative stay or administrative hearing and shall continue through completion unless and until the findings upon which the sanctions were imposed are reversed by a court of competent jurisdiction. The period for which sanctions are imposed is not subject to review. The sanctions provided under this subdivision are in addition to, and not in substitution for, any other sanctions that may be provided for by law for the offense involved.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 61. Minnesota Statutes 2016, section 256N.26, subdivision 5, is amended to read:

Subd. 5. **Alternate rates for preschool entry and certain transitioned children.** A child who ~~entered~~ enters the Northstar kinship assistance or adoption assistance components of Northstar Care for Children while under the age of six shall receive ~~50 percent of the amount the child would otherwise be entitled to under subdivisions 3 and 4~~ the full amount under subdivisions 3 and 4. The commissioner may ~~also~~ use the 50 percent rate for a child who was transitioned into those components through declaration of the commissioner under section 256N.28, subdivision 7.

EFFECTIVE DATE. This section is effective February 21, 2018.

Sec. 62. Minnesota Statutes 2016, section 256N.27, subdivision 2, is amended to read:

Subd. 2. **State share.** The commissioner shall pay the state share of the maintenance payments as determined under subdivision 4, and an identical share of the pre-Northstar Care foster care program under section 260C.4411, subdivision 1, the relative custody assistance program under section 257.85, and the pre-Northstar Care for Children adoption assistance program under chapter 259A. The state share shall include the cost of eliminating the alternate rate for preschool entry under section 256N.26, subdivision 5.

EFFECTIVE DATE. This section is effective February 21, 2018.

Sec. 63. Minnesota Statutes 2016, section 256N.27, subdivision 4, is amended to read:

Subd. 4. **Nonfederal share.** (a) The commissioner shall establish a percentage share of the maintenance payments, reduced by federal reimbursements under title IV-E of the Social Security Act, to be paid by the state and to be paid by the financially responsible agency.

(b) These state and local shares must initially be calculated based on the ratio of the average appropriate expenditures made by the state and all financially responsible agencies during calendar years 2011, 2012, 2013, and 2014. For purposes of this calculation,

appropriate expenditures for the financially responsible agencies must include basic and difficulty of care payments for foster care reduced by federal reimbursements, but not including any initial clothing allowance, administrative payments to child care agencies specified in section 317A.907, child care, or other support or ancillary expenditures. For purposes of this calculation, appropriate expenditures for the state shall include adoption assistance and relative custody assistance, reduced by federal reimbursements.

(c) For each of the periods January 1, 2015, to June 30, 2016, and fiscal years 2017, 2018, and 2019, the commissioner shall adjust this initial percentage of state and local shares to reflect the relative expenditure trends during calendar years 2011, 2012, 2013, and 2014, taking into account appropriations for Northstar Care for Children, the cost of eliminating the alternate rates for preschool entry under section 256N.26, subdivision 5, and the turnover rates of the components. In making these adjustments, the commissioner's goal shall be to make these state and local expenditures other than the appropriations for Northstar Care for Children to be the same as they would have been had Northstar Care for Children not been implemented, or if that is not possible, proportionally higher or lower, as appropriate. Except for adjustments so that the costs of the phase-in, the cost of eliminating the alternate rates for preschool entry under section 256N.26, subdivision 5, are borne by the state, the state and local share percentages for fiscal year 2019 must be used for all subsequent years.

EFFECTIVE DATE. This section is effective February 21, 2018.

Sec. 64. Minnesota Statutes 2016, section 256P.05, subdivision 1, is amended to read:

Subdivision 1. **Exempted programs.** ~~Participants~~ A participant who ~~qualify~~ qualifies for ~~child care assistance programs under chapter 119B,~~ Minnesota supplemental aid under chapter 256D~~,~~ and group residential housing under chapter 256I on the basis of eligibility for Supplemental Security Income are exempt from this section. A participant who qualifies for a child care assistance program under chapter 119B is subject to subdivision 2 of this section.

EFFECTIVE DATE. This section is effective July 30, 2018.

Sec. 65. Minnesota Statutes 2016, section 256P.07, subdivision 3, is amended to read:

Subd. 3. **Changes that must be reported.** An assistance unit must report the changes or anticipated changes specified in clauses (1) to (12) within ten days of the date they occur, at the time of recertification of eligibility under section 256P.04, subdivisions 8 and 9, or within eight calendar days of a reporting period, whichever occurs first. An assistance unit must report other changes at the time of recertification of eligibility under section 256P.04,

subdivisions 8 and 9, or at the end of a reporting period, as applicable. When an agency could have reduced or terminated assistance for one or more payment months if a delay in reporting a change specified under clauses (1) to (12) had not occurred, the agency must determine whether a timely notice could have been issued on the day that the change occurred. When a timely notice could have been issued, each month's overpayment subsequent to that notice must be considered a client error overpayment under section 119B.11, subdivision 2a, or 256P.08. Changes in circumstances that must be reported within ten days must also be reported for the reporting period in which those changes occurred. Within ten days, an assistance unit must report:

(1) a change in earned income of $100 per month or greater with the exception of a program under chapter 119B;

(2) a change in unearned income of $50 per month or greater with the exception of a program under chapter 119B;

(3) a change in employment status and hours with the exception of a program under a chapter 119B;

(4) a change in address or residence;

(5) a change in household composition with the exception of programs under chapter 256I;

(6) a receipt of a lump-sum payment with the exception of a program under chapter 119B;

(7) an increase in assets if over $9,000 with the exception of programs under chapter 119B;

(8) a change in citizenship or immigration status;

(9) a change in family status with the exception of programs under chapter 256I;

(10) a change in disability status of a unit member, with the exception of programs under chapter 119B;

(11) a new rent subsidy or a change in rent subsidy with the exception of a program under chapter 119B; and

(12) a sale, purchase, or transfer of real property with the exception of a program under chapter 119B.

EFFECTIVE DATE. This section is effective December 18, 2017.

Sec. 66. Minnesota Statutes 2016, section 256P.07, subdivision 6, is amended to read:

Subd. 6. **Child care assistance programs-specific reporting.** (a) In addition to subdivision 3, an assistance unit under chapter 119B, within ten days of the change, must report:

(1) a change in a parentally responsible individual's ~~visitation schedule or~~ custody ~~arrangement~~ schedule for any child receiving child care assistance program benefits; ~~and~~

(2) a ~~change in~~ permanent end in a parentally responsible individual's authorized activity ~~status.~~; and

(3) if the unit's family's annual included income exceeds 85 percent of the state median income, adjusted for family size.

(b) An assistance unit subject to chapter 119B.095, subdivision 1, paragraph (b), must report a change in the unit's authorized activity status.

(c) An assistance unit must notify the county when the unit wants to reduce the number of authorized hours for children in the unit.

EFFECTIVE DATE. This section is effective December 18, 2017.

Sec. 67. Minnesota Statutes 2016, section 257.73, subdivision 1, is amended to read:

Subdivision 1. **Replacement birth record.** Upon an adjudication of paternity in a IV-D matter, the court shall provide a certificate of adjudication form for children who were born in Minnesota to the Office of Vital Records at the Department of Health.

Upon compliance with the provisions of section 257.55, subdivision 1, paragraph (e), or a recognition of parentage pursuant to section 257.75, or upon receipt of a certificate of adjudication form or an order of a court of this state or upon request of a court of another state, the state registrar of vital records shall prepare a replacement record of birth consistent with the acknowledgment, the certificate of adjudication form, or the findings of the court and shall substitute the replacement certificate for the original record of birth as required under section 144.218.

Sec. 68. Minnesota Statutes 2016, section 257.73, is amended by adding a subdivision to read:

Subd. 1a. **Certificate of adjudication forms.** The commissioner of health, in consultation with the commissioner of human services, shall prepare a certificate of adjudication form that includes all information necessary for the registrar of vital records to prepare a

replacement birth record that is consistent with the order or findings of the court, and identifies whether paternity was adjudicated as part of an IV-D case.

Sec. 69. Minnesota Statutes 2016, section 518.68, subdivision 2, is amended to read:

Subd. 2. **Contents.** The required notices must be substantially as follows:

IMPORTANT NOTICE

1. PAYMENTS TO PUBLIC AGENCY

According to Minnesota Statutes, section 518A.50, payments ordered for maintenance and support must be paid to the public agency responsible for child support enforcement as long as the person entitled to receive the payments is receiving or has applied for public assistance or has applied for support and maintenance collection services. MAIL PAYMENTS TO:

2. DEPRIVING ANOTHER OF CUSTODIAL OR PARENTAL RIGHTS -- A FELONY

A person may be charged with a felony who conceals a minor child or takes, obtains, retains, or fails to return a minor child from or to the child's parent (or person with custodial or visitation rights), according to Minnesota Statutes, section 609.26. A copy of that section is available from any district court clerk.

3. NONSUPPORT OF A SPOUSE OR CHILD -- CRIMINAL PENALTIES

A person who fails to pay court-ordered child support or maintenance may be charged with a crime, which may include misdemeanor, gross misdemeanor, or felony charges, according to Minnesota Statutes, section 609.375. A copy of that section is available from any district court clerk.

4. RULES OF SUPPORT, MAINTENANCE, PARENTING TIME

(a) Payment of support or spousal maintenance is to be as ordered, and the giving of gifts or making purchases of food, clothing, and the like will not fulfill the obligation.

(b) Payment of support must be made as it becomes due, and failure to secure or denial of parenting time is NOT an excuse for nonpayment, but the aggrieved party must seek relief through a proper motion filed with the court.

(c) Nonpayment of support is not grounds to deny parenting time. The party entitled to receive support may apply for support and collection services, file a contempt motion, or obtain a judgment as provided in Minnesota Statutes, section 548.091.

(d) The payment of support or spousal maintenance takes priority over payment of debts and other obligations.

(e) A party who accepts additional obligations of support does so with the full knowledge of the party's prior obligation under this proceeding.

(f) Child support or maintenance is based on annual income, and it is the responsibility of a person with seasonal employment to budget income so that payments are made throughout the year as ordered.

(g) Reasonable parenting time guidelines are contained in Appendix B, which is available from the court administrator.

(h) The nonpayment of support may be enforced through the denial of student grants; interception of state and federal tax refunds; suspension of driver's, recreational, and occupational licenses; referral to the department of revenue or private collection agencies; seizure of assets, including bank accounts and other assets held by financial institutions; reporting to credit bureaus; interest charging, income withholding, and contempt proceedings; and other enforcement methods allowed by law.

(i) The public authority may suspend or resume collection of the amount allocated for child care expenses if the conditions of section 518A.40, subdivision 4, are met.

(j) Child care support automatically terminates when the youngest child reaches 13 years of age unless child care assistance under chapter 119B continues on behalf of the child. If child care support is calculated separately for each child, child care support for the child shall automatically terminate when the child turns 13 years of age. If a child continues to receive child care assistance under chapter 119B after 13 years of age, child care assistance terminates on the first of the month following the termination of child care support payments on behalf of the child. The court may order a different age or event that terminates child care support.

~~(j)~~ (k) The public authority may remove or resume a medical support offset if the conditions of section 518A.41, subdivision 16, are met.

~~(k)~~ (l) The public authority may suspend or resume interest charging on child support judgments if the conditions of section 548.091, subdivision 1a, are met.

5. MODIFYING CHILD SUPPORT

If either the obligor or obligee is laid off from employment or receives a pay reduction, child support may be modified, increased, or decreased. Any modification will only take effect when it is ordered by the court, and will only relate back to the time that a motion

is filed. Either the obligor or obligee may file a motion to modify child support, and may request the public agency for help. UNTIL A MOTION IS FILED, THE CHILD SUPPORT OBLIGATION WILL CONTINUE AT THE CURRENT LEVEL. THE COURT IS NOT PERMITTED TO REDUCE SUPPORT RETROACTIVELY.

6. PARENTAL RIGHTS FROM MINNESOTA STATUTES, SECTION 518.17, SUBDIVISION 3

Unless otherwise provided by the Court:

(a) Each party has the right of access to, and to receive copies of, school, medical, dental, religious training, and other important records and information about the minor children. Each party has the right of access to information regarding health or dental insurance available to the minor children. Presentation of a copy of this order to the custodian of a record or other information about the minor children constitutes sufficient authorization for the release of the record or information to the requesting party.

(b) Each party shall keep the other informed as to the name and address of the school of attendance of the minor children. Each party has the right to be informed by school officials about the children's welfare, educational progress and status, and to attend school and parent teacher conferences. The school is not required to hold a separate conference for each party.

(c) In case of an accident or serious illness of a minor child, each party shall notify the other party of the accident or illness, and the name of the health care provider and the place of treatment.

(d) Each party has the right of reasonable access and telephone contact with the minor children.

7. WAGE AND INCOME DEDUCTION OF SUPPORT AND MAINTENANCE

Child support and/or spousal maintenance may be withheld from income, with or without notice to the person obligated to pay, when the conditions of Minnesota Statutes, section 518A.53 have been met. A copy of those sections is available from any district court clerk.

8. CHANGE OF ADDRESS OR RESIDENCE

Unless otherwise ordered, each party shall notify the other party, the court, and the public authority responsible for collection, if applicable, of the following information within ten days of any change: the residential and mailing address, telephone number, driver's

license number, Social Security number, and name, address, and telephone number of the employer.

9. COST OF LIVING INCREASE OF SUPPORT AND MAINTENANCE

Basic support and/or spousal maintenance may be adjusted every two years based upon a change in the cost of living (using Department of Labor Consumer Price Index ....., unless otherwise specified in this order) when the conditions of Minnesota Statutes, section 518A.75, are met. Cost of living increases are compounded. A copy of Minnesota Statutes, section 518A.75, and forms necessary to request or contest a cost of living increase are available from any district court clerk.

10. JUDGMENTS FOR UNPAID SUPPORT

If a person fails to make a child support payment, the payment owed becomes a judgment against the person responsible to make the payment by operation of law on or after the date the payment is due, and the person entitled to receive the payment or the public agency may obtain entry and docketing of the judgment WITHOUT NOTICE to the person responsible to make the payment under Minnesota Statutes, section 548.091. Interest begins to accrue on a payment or installment of child support whenever the unpaid amount due is greater than the current support due, according to Minnesota Statutes, section 548.091, subdivision 1a.

11. JUDGMENTS FOR UNPAID MAINTENANCE

A judgment for unpaid spousal maintenance may be entered when the conditions of Minnesota Statutes, section 548.091, are met. A copy of that section is available from any district court clerk.

12. ATTORNEY FEES AND COLLECTION COSTS FOR ENFORCEMENT OF CHILD SUPPORT

A judgment for attorney fees and other collection costs incurred in enforcing a child support order will be entered against the person responsible to pay support when the conditions of section 518A.735, are met. A copy of sections 518.14 and 518A.735 and forms necessary to request or contest these attorney fees and collection costs are available from any district court clerk.

13. PARENTING TIME EXPEDITOR PROCESS

On request of either party or on its own motion, the court may appoint a parenting time expeditor to resolve parenting time disputes under Minnesota Statutes, section 518.1751.

A copy of that section and a description of the expeditor process is available from any district court clerk.

14. PARENTING TIME REMEDIES AND PENALTIES

Remedies and penalties for the wrongful denial of parenting time are available under Minnesota Statutes, section 518.175, subdivision 6. These include compensatory parenting time; civil penalties; bond requirements; contempt; and reversal of custody. A copy of that subdivision and forms for requesting relief are available from any district court clerk.

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

Sec. 70. Minnesota Statutes 2016, section 518A.40, subdivision 4, is amended to read:

Subd. 4. **Change in child care.** (a) When a court order provides for child care expenses, and child care support is not assigned under section 256.741, the public authority, if the public authority provides child support enforcement services, may suspend collecting the amount allocated for child care expenses when either party informs the public authority that no child care costs are being incurred and:

(1) the public authority verifies the accuracy of the information with the obligee; or

(2) the obligee fails to respond within 30 days of the date of a written request from the public authority for information regarding child care costs. A written or oral response from the obligee that child care costs are being incurred is sufficient for the public authority to continue collecting child care expenses.

The suspension is effective as of the first day of the month following the date that the public authority either verified the information with the obligee or the obligee failed to respond. The public authority will resume collecting child care expenses when either party provides information that child care costs are incurred, or when a child care support assignment takes effect under section 256.741, subdivision 4. The resumption is effective as of the first day of the month after the date that the public authority received the information.

(b) If the parties provide conflicting information to the public authority regarding whether child care expenses are being incurred, the public authority will continue or resume collecting child care expenses. Either party, by motion to the court, may challenge the suspension, continuation, or resumption of the collection of child care expenses under this subdivision. If the public authority suspends collection activities for the amount allocated for child care expenses, all other provisions of the court order remain in effect.

(c) In cases where there is a substantial increase or decrease in child care expenses, the parties may modify the order under section 518A.39.

(d) Unless otherwise ordered by the court, if the obligor has arrearages for basic, medical, or child care support at the time a child care support obligation is suspended under this subdivision, the public authority shall continue to collect the child care support obligation until the arrearages are paid in full. After a child care support obligation has terminated, the 20 percent arrears payback under section 518A.53, subdivision 10, shall be calculated without including the amount of the child care support obligation.

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

Sec. 71. Minnesota Statutes 2016, section 518A.40, is amended by adding a subdivision to read:

Subd. 5. **Automatic termination of child care support.** (a) Unless child care assistance under chapter 119B continues to be paid on behalf of a child 13 years of age or older, or a court orders otherwise, if a child care support obligation is ordered in a specific amount per child, the child care support obligation for each child terminates automatically and without any action by the obligor to reduce, modify, or terminate the order upon the first of the month following the month in which that child reaches 13 years of age. If child care assistance is paid on behalf of a child, the obligation to pay child care support on behalf of that child terminates on the first of the month following the month in which the child care assistance terminates.

(b) Unless child care assistance under chapter 119B continues to be paid on behalf of a child 13 years of age or older, a child care support obligation for two or more children that is not a child care support obligation in a specific amount per child continues in the full amount until the first of the month following the month in which the youngest child reaches 13 years of age or until further order of the court. If child care assistance is paid on behalf of a child, the obligation to pay child care support on behalf of that child terminates on the first of the month following the month in which the child care assistance terminates.

(c) Either party, or the public authority if child care assistance under chapter 119B is provided on behalf of the supported child, by motion to the court, may challenge the termination of child care support.

(d) The obligor may request a modification of the obligor's child care support order when a child reaches 13 years of age if there is still a minor child under the child care support

order. The child care support obligation shall be determined based on the income of the parties and the costs of work-related child care at the time the modification is sought.

(e) Unless otherwise ordered by the court, if the obligor has arrearages for basic, medical, or child care support at the time child care support is terminated under this subdivision, the public authority shall continue to collect the child care support obligation until the arrearages are paid in full. After a child care support obligation has terminated, the 20 percent arrears payback under section 518A.23, subdivision 10, shall be calculated without including the amount of the child care support obligation.

(f) If the public authority provides child support services at the time child care support is set to terminate under this subdivision, the public authority shall send the parties 90 days' notice of the child care support obligation termination. The notice shall state that the child care support obligation must continue to be collected in full until any existing arrears have been paid in full, and that collection of the child care support obligation is in addition to the 20 percent paid under section 518A.53.

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

Sec. 72. Minnesota Statutes 2016, section 626.556, subdivision 3c, is amended to read:

Subd. 3c. **Local welfare agency, Department of Human Services or Department of Health responsible for assessing or investigating reports of maltreatment or death.** (a) Except as provided in paragraph (b), the county local welfare agency is the agency responsible for assessing or investigating allegations of maltreatment in child foster care, and family child care that do not involve the death of a child, legally unlicensed child care, juvenile correctional facilities licensed under section 241.021 located in the local welfare agency's county, and reports involving children served by an unlicensed personal care provider organization under section 256B.0659. Copies of findings related to personal care provider organizations under section 256B.0659 must be forwarded to the Department of Human Services provider enrollment.

(b) The Department of Human Services is the agency responsible for assessing or investigating allegations of maltreatment in:

(1) facilities licensed under chapters 245A and 245D, except ~~for child foster care and~~ in family child care ~~.~~ and child foster care homes that are monitored by county agencies according to section 245A.16, subdivision 1;

(2) child foster care homes that are monitored by private agencies and homes are licensed by the commissioner to perform licensing functions and activities according to section 245A.16, subdivision 1; and

(3) child foster care and family child care homes that are monitored by county agencies according to section 245A.16, subdivision 1, upon agreement by the county and the Department of Human Services for a specific case, or when the commissioner identifies cause.

(c) The Department of Human Services is responsible for investigating the death of a child in a child foster care program or family child care program.

~~(c)~~ (d) The Department of Health is the agency responsible for assessing or investigating allegations of child maltreatment in facilities licensed under sections 144.50 to 144.58 ~~and 144A.43 to 144A.482~~.

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

Sec. 73. Minnesota Statutes 2016, section 626.556, subdivision 10b, is amended to read:

Subd. 10b. **Duties of commissioner; neglect ~~or~~, abuse, or death in a facility.** (a) This section applies to the commissioners of human services, health, and education. The commissioner of the agency responsible for assessing or investigating the report shall immediately assess or investigate if the report alleges that:

(1) a child who is in the care of a facility as defined in subdivision 2 is neglected, physically abused, sexually abused, or is the victim of maltreatment in a facility by an individual in that facility, or has been so neglected or abused, or been the victim of maltreatment in a facility by an individual in that facility within the three years preceding the report; or

(2) a child was neglected, physically abused, sexually abused, or is the victim of maltreatment in a facility by an individual in a facility defined in subdivision 2, while in the care of that facility within the three years preceding the report.

The commissioner of the agency responsible for assessing or investigating the report shall arrange for the transmittal to the commissioner of reports received by local agencies and may delegate to a local welfare agency the duty to investigate reports. In conducting an investigation under this section, the commissioner has the powers and duties specified for local welfare agencies under this section. The commissioner of the agency responsible for assessing or investigating the report or local welfare agency may interview any children

who are or have been in the care of a facility under investigation and their parents, guardians, or legal custodians.

(b) Prior to any interview, the commissioner of the agency responsible for assessing or investigating the report or local welfare agency shall notify the parent, guardian, or legal custodian of a child who will be interviewed in the manner provided for in subdivision 10d, paragraph (a). If reasonable efforts to reach the parent, guardian, or legal custodian of a child in an out-of-home placement have failed, the child may be interviewed if there is reason to believe the interview is necessary to protect the child or other children in the facility. The commissioner of the agency responsible for assessing or investigating the report or local agency must provide the information required in this subdivision to the parent, guardian, or legal custodian of a child interviewed without parental notification as soon as possible after the interview. When the investigation is completed, any parent, guardian, or legal custodian notified under this subdivision shall receive the written memorandum provided for in subdivision 10d, paragraph (c).

(c) In conducting investigations under this subdivision the commissioner or local welfare agency shall obtain access to information consistent with subdivision 10, paragraphs (h), (i), and (j). In conducting assessments or investigations under this subdivision, the commissioner of education shall obtain access to reports and investigative data that are relevant to a report of maltreatment and are in the possession of a school facility as defined in subdivision 2, paragraph (c), notwithstanding the classification of the data as educational or personnel data under chapter 13. This includes, but is not limited to, school investigative reports, information concerning the conduct of school personnel alleged to have committed maltreatment of students, information about witnesses, and any protective or corrective action taken by the school facility regarding the school personnel alleged to have committed maltreatment.

(d) The commissioner may request assistance from the local social services agency.

(e) The commissioner of human services shall investigate every incident involving the death of a child during placement in a child foster care home licensed under chapter 245A and Minnesota Rules, chapter 2960. The investigation, notifications, and data classifications are governed by this section, even if abuse or neglect is not alleged in the report.

(f) The commissioner of human services shall investigate every incident involving the death of a child in a family child care program licensed under chapter 245A and Minnesota Rules, chapter 9502. The investigation, notifications, and data classifications are governed by this section, even if abuse or neglect is not alleged in the report.

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

Sec. 74. Minnesota Statutes 2016, section 626.559, subdivision 1, is amended to read:

Subdivision 1. **Job classification; continuing education.** The commissioner of human services, for employees subject to the Minnesota Merit System, and directors of county personnel systems, for counties not subject to the Minnesota Merit System, shall establish a job classification consisting exclusively of persons with the specialized knowledge, skills, and experience required to satisfactorily perform child protection duties pursuant to section 626.556, subdivisions 10, 10a, and 10b.

All child protection workers or social services staff having responsibility for child protective duties under section 626.556 shall receive ~~15~~ 20 hours of continuing education or in-service training each year relevant to providing child protective services. At least ten of the hours shall include advanced training in topics to be decided and developed by the commissioner of human services. The local social service agency shall maintain a record of training completed by each employee having responsibility for performing child protective duties.

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

Sec. 75. **REPEALER.**

(a) Minnesota Statutes 2016, section 119B.07, is repealed effective December 18, 2017.

(b) Minnesota Statutes 2016, section 119B.125, subdivision 5, is repealed effective the day following final enactment.

(c) Minnesota Statutes 2016, sections 119B.16, subdivision 2; 245E.03, subdivision 3; and 245E.06, subdivisions 4 and 5, and Minnesota Rules, part 3400.0185, subpart 5, are repealed effective April 23, 2018.

ARTICLE 8

CHEMICAL AND MENTAL HEALTH SERVICES

Section 1. Minnesota Statutes 2016, section 245.4661, subdivision 9, is amended to read:

Subd. 9. **Services and programs.** (a) The following ~~three~~ distinct grant programs are funded under this section:

(1) mental health crisis services;

(2) housing with supports for adults with serious mental illness; ~~and~~

(3) projects for assistance in transitioning from homelessness (PATH program)~~.~~; and

(4) community-based mental health infrastructure development grants.

(b) In addition, the following are eligible for grant funds:

(1) community education and prevention;

(2) client outreach;

(3) early identification and intervention;

(4) adult outpatient diagnostic assessment and psychological testing;

(5) peer support services;

(6) community support program services (CSP);

(7) adult residential crisis stabilization;

(8) supported employment;

(9) assertive community treatment (ACT);

(10) housing subsidies;

(11) basic living, social skills, and community intervention;

(12) emergency response services;

(13) adult outpatient psychotherapy;

(14) adult outpatient medication management;

(15) adult mobile crisis services;

(16) adult day treatment;

(17) partial hospitalization;

(18) adult residential treatment;

(19) adult mental health targeted case management;

(20) intensive community rehabilitative services (ICRS); and

(21) transportation.

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

Sec. 2. Minnesota Statutes 2016, section 245.4889, subdivision 1, is amended to read:

Subdivision 1. **Establishment and authority.** (a) The commissioner is authorized to make grants from available appropriations to assist:

(1) counties;

(2) Indian tribes;

(3) children's collaboratives under section 124D.23 or 245.493; or

(4) mental health service providers.

(b) The following services are eligible for grants under this section:

(1) services to children with emotional disturbances as defined in section 245.4871, subdivision 15, and their families;

(2) transition services under section 245.4875, subdivision 8, for young adults under age 21 and their families;

(3) respite care services for children with severe emotional disturbances who are at risk of out-of-home placement;

(4) children's mental health crisis services;

(5) mental health services for people from cultural and ethnic minorities;

(6) children's mental health screening and follow-up diagnostic assessment and treatment;

(7) services to promote and develop the capacity of providers to use evidence-based practices in providing children's mental health services;

(8) school-linked mental health services;

(9) building evidence-based mental health intervention capacity for children birth to age five;

(10) suicide prevention and counseling services that use text messaging statewide;

(11) mental health first aid training;

(12) training for parents, collaborative partners, and mental health providers on the impact of adverse childhood experiences and trauma and development of an interactive Web site to share information and strategies to promote resilience and prevent trauma;

(13) transition age services to develop or expand mental health treatment and supports for adolescents and young adults 26 years of age or younger;

(14) early childhood mental health consultation;

(15) evidence-based interventions for youth at risk of developing or experiencing a first episode of psychosis, and a public awareness campaign on the signs and symptoms of psychosis; ~~and~~

(16) psychiatric consultation for primary care practitioners~~.~~; and

(17) start-up funding to establish new childrens' mental health programs to support providers to meet all program requirements and begin operations.

(c) Services under paragraph (b) must be designed to help each child to function and remain with the child's family in the community and delivered consistent with the child's treatment plan. Transition services to eligible young adults under paragraph (b) must be designed to foster independent living in the community.

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

Sec. 3. Minnesota Statutes 2016, section 245A.03, subdivision 2, is amended to read:

Subd. 2. **Exclusion from licensure.** (a) This chapter does not apply to:

(1) residential or nonresidential programs that are provided to a person by an individual who is related unless the residential program is a child foster care placement made by a local social services agency or a licensed child-placing agency, except as provided in subdivision 2a;

(2) nonresidential programs that are provided by an unrelated individual to persons from a single related family;

(3) residential or nonresidential programs that are provided to adults who do not ~~abuse chemicals or who do not have a chemical dependency~~ misuse substances or have a substance use disorder, a mental illness, a developmental disability, a functional impairment, or a physical disability;

(4) sheltered workshops or work activity programs that are certified by the commissioner of employment and economic development;

(5) programs operated by a public school for children 33 months or older;

(6) nonresidential programs primarily for children that provide care or supervision for periods of less than three hours a day while the child's parent or legal guardian is in the same building as the nonresidential program or present within another building that is directly contiguous to the building in which the nonresidential program is located;

(7) nursing homes or hospitals licensed by the commissioner of health except as specified under section 245A.02;

(8) board and lodge facilities licensed by the commissioner of health that do not provide children's residential services under Minnesota Rules, chapter 2960, mental health or chemical dependency treatment;

(9) homes providing programs for persons placed by a county or a licensed agency for legal adoption, unless the adoption is not completed within two years;

(10) programs licensed by the commissioner of corrections;

(11) recreation programs for children or adults that are operated or approved by a park and recreation board whose primary purpose is to provide social and recreational activities;

(12) programs operated by a school as defined in section 120A.22, subdivision 4; YMCA as defined in section 315.44; YWCA as defined in section 315.44; or JCC as defined in section 315.51, whose primary purpose is to provide child care or services to school-age children;

(13) Head Start nonresidential programs which operate for less than 45 days in each calendar year;

(14) noncertified boarding care homes unless they provide services for five or more persons whose primary diagnosis is mental illness or a developmental disability;

(15) programs for children such as scouting, boys clubs, girls clubs, and sports and art programs, and nonresidential programs for children provided for a cumulative total of less than 30 days in any 12-month period;

(16) residential programs for persons with mental illness, that are located in hospitals;

(17) the religious instruction of school-age children; Sabbath or Sunday schools; or the congregate care of children by a church, congregation, or religious society during the period used by the church, congregation, or religious society for its regular worship;

(18) camps licensed by the commissioner of health under Minnesota Rules, chapter 4630;

(19) mental health outpatient services for adults with mental illness or children with emotional disturbance;

(20) residential programs serving school-age children whose sole purpose is cultural or educational exchange, until the commissioner adopts appropriate rules;

(21) community support services programs as defined in section 245.462, subdivision 6, and family community support services as defined in section 245.4871, subdivision 17;

(22) the placement of a child by a birth parent or legal guardian in a preadoptive home for purposes of adoption as authorized by section 259.47;

(23) settings registered under chapter 144D which provide home care services licensed by the commissioner of health to fewer than seven adults;

(24) ~~chemical dependency or~~ substance ~~abuse~~ use disorder treatment activities of licensed professionals in private practice as defined in ~~Minnesota Rules, part 9530.6405, subpart 15, when the treatment activities are not paid for by the consolidated chemical dependency treatment fund~~ section 245G.01, subdivision 17;

(25) consumer-directed community support service funded under the Medicaid waiver for persons with developmental disabilities when the individual who provided the service is:

(i) the same individual who is the direct payee of these specific waiver funds or paid by a fiscal agent, fiscal intermediary, or employer of record; and

(ii) not otherwise under the control of a residential or nonresidential program that is required to be licensed under this chapter when providing the service;

(26) a program serving only children who are age 33 months or older, that is operated by a nonpublic school, for no more than four hours per day per child, with no more than 20 children at any one time, and that is accredited by:

(i) an accrediting agency that is formally recognized by the commissioner of education as a nonpublic school accrediting organization; or

(ii) an accrediting agency that requires background studies and that receives and investigates complaints about the services provided.

A program that asserts its exemption from licensure under item (ii) shall, upon request from the commissioner, provide the commissioner with documentation from the accrediting agency that verifies: that the accreditation is current; that the accrediting agency investigates complaints about services; and that the accrediting agency's standards require background studies on all people providing direct contact services; or

(27) a program operated by a nonprofit organization incorporated in Minnesota or another state that serves youth in kindergarten through grade 12; provides structured, supervised youth development activities; and has learning opportunities take place before or after

school, on weekends, or during the summer or other seasonal breaks in the school calendar. A program exempt under this clause is not eligible for child care assistance under chapter 119B. A program exempt under this clause must:

(i) have a director or supervisor on site who is responsible for overseeing written policies relating to the management and control of the daily activities of the program, ensuring the health and safety of program participants, and supervising staff and volunteers;

(ii) have obtained written consent from a parent or legal guardian for each youth participating in activities at the site; and

(iii) have provided written notice to a parent or legal guardian for each youth at the site that the program is not licensed or supervised by the state of Minnesota and is not eligible to receive child care assistance payments.

(b) For purposes of paragraph (a), clause (6), a building is directly contiguous to a building in which a nonresidential program is located if it shares a common wall with the building in which the nonresidential program is located or is attached to that building by skyway, tunnel, atrium, or common roof.

(c) Except for the home and community-based services identified in section 245D.03, subdivision 1, nothing in this chapter shall be construed to require licensure for any services provided and funded according to an approved federal waiver plan where licensure is specifically identified as not being a condition for the services and funding.

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

Sec. 4. Minnesota Statutes 2016, section 245A.03, subdivision 7, is amended to read:

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

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

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

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

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

(5) new foster care licenses or community residential setting licenses determined to be needed by the commissioner for the transition of people from personal care assistance to the home and community-based services.

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

(c) When an adult resident served by the program moves out of a foster home that is not the primary residence of the license holder according to section 256B.49, subdivision 15, paragraph (f), or the adult community residential setting, the county shall immediately inform the Department of Human Services Licensing Division. The department shall decrease the statewide licensed capacity for adult foster care settings where the physical location is not the primary residence of the license holder, or for adult community residential settings, if the voluntary changes described in paragraph (e) are not sufficient to meet the savings required by reductions in licensed bed capacity under Laws 2011, First Special Session chapter 9, article 7, sections 1 and 40, paragraph (f), and maintain statewide long-term care residential services capacity within budgetary limits. Implementation of the statewide licensed capacity reduction shall begin on July 1, 2013. The commissioner shall delicense up to 128 beds by June 30, 2014, using the needs determination process. Prior to any

involuntary reduction of licensed capacity, the commissioner shall consult with lead agencies and license holders to determine which adult foster care settings, where the physical location is not the primary residence of the license holder, or community residential settings, are licensed for up to five beds, but have operated at less than full capacity for 12 or more months as of March 1, 2014. The settings that meet these criteria must be the first to be considered for an involuntary decrease in statewide licensed capacity, up to a maximum of 35 beds. If more than 35 beds are identified that meet these criteria, the commissioner shall prioritize the selection of those beds to be closed based on the length of time the beds have been vacant. The longer a bed has been vacant, the higher priority it must be given for closure. Under this paragraph, the commissioner has the authority to reduce unused licensed capacity of a current foster care program, or the community residential settings, to accomplish the consolidation or closure of settings. Under this paragraph, the commissioner has the authority to manage statewide capacity, including adjusting the capacity available to each county and adjusting statewide available capacity, to meet the statewide needs identified through the process in paragraph (e). A decreased licensed capacity according to this paragraph is not subject to appeal under this chapter.

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

(e) A resource need determination process, managed at the state level, using the available reports required by section 144A.351, and other data and information shall be used to determine where the reduced capacity required under paragraph (c) will be implemented. The commissioner shall consult with the stakeholders described in section 144A.351, and employ a variety of methods to improve the state's capacity to meet long-term care service needs within budgetary limits, including seeking proposals from service providers or lead agencies to change service type, capacity, or location to improve services, increase the independence of residents, and better meet needs identified by the long-term care services reports and statewide data and information. By February 1, 2013, and August 1, 2014, and each following year, the commissioner shall provide information and data on the overall capacity of licensed long-term care services, actions taken under this subdivision to manage statewide long-term care services and supports resources, and any recommendations for change to the legislative committees with jurisdiction over health and human services budget.

(f) At the time of application and reapplication for licensure, the applicant and the license holder that are subject to the moratorium or an exclusion established in paragraph (a) are

required to inform the commissioner whether the physical location where the foster care will be provided is or will be the primary residence of the license holder for the entire period of licensure. If the primary residence of the applicant or license holder changes, the applicant or license holder must notify the commissioner immediately. The commissioner shall print on the foster care license certificate whether or not the physical location is the primary residence of the license holder.

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

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

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

Sec. 5. Minnesota Statutes 2016, section 245A.191, is amended to read:

245A.191 PROVIDER ELIGIBILITY FOR PAYMENTS FROM THE CHEMICAL DEPENDENCY CONSOLIDATED TREATMENT FUND.

(a) When a ~~chemical dependency~~ substance use disorder treatment provider licensed under chapter 245G or Minnesota Rules, parts 2960.0430 to 2960.0490 ~~or 9530.6405 to 9530.6505~~, agrees to meet the applicable requirements under section 254B.05, subdivision 5, ~~paragraphs (b), clauses (1) to (4) and (6), (c), and (e),~~ to be eligible for enhanced funding from the chemical dependency consolidated treatment fund, the applicable requirements under section 254B.05 are also licensing requirements that may be monitored for compliance through licensing investigations and licensing inspections.

(b) Noncompliance with the requirements identified under paragraph (a) may result in:

(1) a correction order or a conditional license under section 245A.06, or sanctions under section 245A.07;

(2) nonpayment of claims submitted by the license holder for public program reimbursement;

(3) recovery of payments made for the service;

(4) disenrollment in the public payment program; or

(5) other administrative, civil, or criminal penalties as provided by law.

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

Sec. 6. **[245G.01] DEFINITIONS.**

Subdivision 1. **Scope.** The terms used in this chapter have the meanings given them.

Subd. 2. **Administration of medication.** "Administration of medication" means providing a medication to a client, and includes the following tasks, performed in the following order:

(1) checking the client's medication record;

(2) preparing the medication for administration;

(3) administering the medication to the client;

(4) documenting the administration of the medication, or the reason for not administering a medication as prescribed; and

(5) reporting information to a licensed practitioner or a nurse regarding a problem with the administration of medication or the client's refusal to take the medication, if applicable.

Subd. 3. **Adolescent.** "Adolescent" means an individual under 18 years of age.

Subd. 4. **Alcohol and drug counselor.** "Alcohol and drug counselor" has the meaning given in section 148F.01, subdivision 5.

Subd. 5. **Applicant.** "Applicant" means an individual, corporation, partnership, voluntary association, controlling individual, or other organization that applied for a license under this chapter.

Subd. 6. **Capacity management system.** "Capacity management system" means a database maintained by the department to compile and make information available to the public about the waiting list status and current admission capability of each opioid treatment program.

Subd. 7. **Central registry.** "Central registry" means a database maintained by the department to collect identifying information from two or more programs about an individual applying for maintenance treatment or detoxification treatment for opioid addiction to prevent an individual's concurrent enrollment in more than one program.

Subd. 8. **Client.** "Client" means an individual accepted by a license holder for assessment or treatment of a substance use disorder. An individual remains a client until the license holder no longer provides or intends to provide the individual with treatment service.

Subd. 9. **Commissioner.** "Commissioner" means the commissioner of human services.

Subd. 10. **Co-occurring disorders.** "Co-occurring disorders" means a diagnosis of both a substance use disorder and a mental health disorder.

Subd. 11. **Department.** "Department" means the Department of Human Services.

Subd. 12. **Direct contact.** "Direct contact" has the meaning given for "direct contact" in section 245C.02, subdivision 11.

Subd. 13. **Face-to-face.** "Face-to-face" means two-way, real-time, interactive and visual communication between a client and a treatment service provider and includes services delivered via telemedicine.

Subd. 14. **License.** "License" means a certificate issued by the commissioner authorizing the license holder to provide a specific program for a specified period of time according to the terms of the license and the rules of the commissioner.

Subd. 15. **License holder.** "License holder" means an individual, corporation, partnership, voluntary organization, or other organization that is legally responsible for the operation of the program, was granted a license by the commissioner under this chapter, and is a controlling individual.

Subd. 16. **Licensed practitioner.** "Licensed practitioner" means an individual who is authorized to prescribe medication as defined in section 151.01, subdivision 23.

Subd. 17. **Licensed professional in private practice.** "Licensed professional in private practice" means an individual who:

(1) is licensed under chapter 148F, or is exempt from licensure under that chapter but is otherwise licensed to provide alcohol and drug counseling services;

(2) practices solely within the permissible scope of the individual's license as defined in the law authorizing licensure; and

(3) does not affiliate with other licensed or unlicensed professionals to provide alcohol and drug counseling services. Affiliation does not include conferring with another professional or making a client referral.

Subd. 18. **Nurse.** "Nurse" means an individual licensed and currently registered to practice professional or practical nursing as defined in section 148.171, subdivisions 14 and 15.

Subd. 19. **Opioid treatment program.** "Opioid treatment program" or "OTP" means a program or practitioner engaged in opioid treatment of an individual that provides dispensing of an opioid agonist treatment medication, along with a comprehensive range of medical and rehabilitative services, when clinically necessary, to an individual to alleviate the adverse medical, psychological, or physical effects of an opioid addiction. OTP includes detoxification treatment, short-term detoxification treatment, long-term detoxification treatment, maintenance treatment, comprehensive maintenance treatment, and interim maintenance treatment.

Subd. 20. **Paraprofessional.** "Paraprofessional" means an employee, agent, or independent contractor of the license holder who performs tasks to support treatment service. A paraprofessional may be referred to by a variety of titles including but not limited to technician, case aide, or counselor assistant. If currently a client of the license holder, the client cannot be a paraprofessional for the license holder.

Subd. 21. **Student intern.** "Student intern" means an individual who is authorized by a licensing board to provide services under supervision of a licensed professional.

Subd. 22. **Substance.** "Substance" means alcohol, solvents, controlled substances as defined in section 152.01, subdivision 4, and other mood-altering substances.

Subd. 23. **Substance use disorder.** "Substance use disorder" has the meaning given in the current Diagnostic and Statistical Manual of Mental Disorders.

Subd. 24. **Substance use disorder treatment.** "Substance use disorder treatment" means treatment of a substance use disorder, including the process of assessment of a client's needs, development of planned methods, including interventions or services to address a client's needs, provision of services, facilitation of services provided by other service providers, and ongoing reassessment by a qualified professional when indicated. The goal of substance use disorder treatment is to assist or support the client's efforts to recover from a substance use disorder.

Subd. 25. **Target population.** "Target population" means individuals with a substance use disorder and the specified characteristics that a license holder proposes to serve.

Subd. 26. **Telemedicine.** "Telemedicine" means the delivery of a substance use disorder treatment service while the client is at an originating site and the licensed health care provider is at a distant site as specified in section 254B.05, subdivision 5, paragraph (f).

Subd. 27. **Treatment director.** "Treatment director" means an individual who meets the qualifications specified in section 245G.11, subdivisions 1 and 3, and is designated by the license holder to be responsible for all aspects of the delivery of treatment service.

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

Sec. 7. **[245G.02] APPLICABILITY.**

Subdivision 1. **Applicability.** Except as provided in subdivisions 2 and 3, no person, corporation, partnership, voluntary association, controlling individual, or other organization may provide a substance use disorder treatment service to an individual with a substance use disorder unless licensed by the commissioner.

Subd. 2. **Exemption from license requirement.** This chapter does not apply to a county or recovery community organization that is a vendor under section 254B.05 or to an organization whose primary functions are information, referral, diagnosis, case management, and assessment for the purposes of client placement, education, support group services, or self-help programs. This chapter does not apply to the activities of a licensed professional in private practice.

Subd. 3. **Excluded hospitals.** This chapter does not apply to substance use disorder treatment provided by a hospital licensed under chapter 62J, or under sections 144.50 to 144.56, unless the hospital accepts funds for substance use disorder treatment from the consolidated chemical dependency treatment fund under chapter 254B, medical assistance under chapter 256B, or MinnesotaCare or health care cost containment under chapter 256L, or general assistance medical care formerly codified in chapter 256D.

Subd. 4. **Applicability of Minnesota Rules, chapter 2960.** A residential adolescent substance use disorder treatment program serving an individual younger than 16 years of age must be licensed according to Minnesota Rules, chapter 2960.

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

Sec. 8. **[245G.03] LICENSING REQUIREMENTS.**

Subdivision 1. **License requirements.** (a) An applicant for a license to provide substance use disorder treatment must comply with the general requirements in chapters 245A and 245C, sections 626.556 and 626.557, and Minnesota Rules, chapter 9544.

(b) The commissioner may grant variances to the requirements in this chapter that do not affect the client's health or safety if the conditions in section 245A.04, subdivision 9, are met.

Subd. 2. **Application.** Before the commissioner issues a license, an applicant must submit, on forms provided by the commissioner, any documents the commissioner requires to demonstrate the following:

(1) compliance with this chapter;

(2) compliance with applicable building, fire and safety codes, health rules, zoning ordinances, and other applicable rules and regulations or documentation that a waiver was granted. An applicant's receipt of a waiver does not constitute modification of any requirement in this chapter;

(3) completion of an assessment of need for a new or expanded program according to Minnesota Rules, part 9530.6800, subpart 1. If an application proposes a program that would be subject to the federal Institution for Mental Diseases (IMD) exclusion, the applicant must demonstrate the need for the proposed bed capacity and that the program would be more cost-effective for the state than a non-IMD model; and

(4) insurance coverage, including bonding, sufficient to cover all client funds, property, and interests.

Subd. 3. **Change in license terms.** (a) The commissioner must determine whether a new license is needed when a change in clauses (1) to (4) occurs. A license holder must notify the commissioner before a change in one of the following occurs:

(1) the Department of Health's licensure of the program;

(2) whether the license holder provides services specified in sections 245G.18 to 245G.22;

(3) location; or

(4) capacity if the license holder meets the requirements of section 245G.21.

(b) A license holder must notify the commissioner and must apply for a new license if there is a change in program ownership.

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

Sec. 9. **[245G.04] INITIAL SERVICES PLAN.**

(a) The license holder must complete an initial services plan on the day of service initiation. The plan must address the client's immediate health and safety concerns, identify

the needs to be addressed in the first treatment session, and make treatment suggestions for the client during the time between intake and completion of the individual treatment plan.

(b) The initial services plan must include a determination of whether a client is a vulnerable adult as defined in section 626.5572, subdivision 21. An adult client of a residential program is a vulnerable adult. An individual abuse prevention plan, according to sections 245A.65, subdivision 2, paragraph (b), and 626.557, subdivision 14, paragraph (b), is required for a client who meets the definition of vulnerable adult.

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

Sec. 10. **[245G.05] COMPREHENSIVE ASSESSMENT AND ASSESSMENT SUMMARY.**

Subdivision 1. **Comprehensive assessment.** (a) A comprehensive assessment of the client's substance use disorder must be administered face-to-face by an alcohol and drug counselor within three calendar days after service initiation for a residential program or during the initial session for all other programs. If the comprehensive assessment is not completed during the initial session, the client-centered reason for the delay must be documented in the client's file and the planned completion date. If the client received a comprehensive assessment that authorized the treatment service, an alcohol and drug counselor must review the assessment to determine compliance with this subdivision, including applicable timelines. If available, the alcohol and drug counselor may use current information provided by a referring agency or other source as a supplement. Information gathered more than 45 days before the date of admission is not considered current. If the comprehensive assessment cannot be completed in the time specified, the treatment plan must indicate a person-centered reason for the delay, and how and when the comprehensive assessment will be completed. The comprehensive assessment must include sufficient information to complete the assessment summary according to subdivision 2 and the individual treatment plan according to section 245G.06. The comprehensive assessment must include information about the client's needs that relate to substance use and personal strengths that support recovery, including:

(1) age, sex, cultural background, sexual orientation, living situation, economic status, and level of education;

(2) circumstances of service initiation;

(3) previous attempts at treatment for substance misuse or substance use disorder, compulsive gambling, or mental illness;

(4) substance use history including amounts and types of substances used, frequency and duration of use, periods of abstinence, and circumstances of relapse, if any. For each substance used within the previous 30 days, the information must include the date and time of the most recent use and previous withdrawal symptoms;

(5) specific problem behaviors exhibited by the client when under the influence of substances;

(6) family status, family history, including history or presence of physical or sexual abuse, level of family support, and substance misuse or substance use disorder of a family member or significant other;

(7) physical concerns or diagnoses, the severity of the concerns, and whether the concerns are being addressed by a health care professional;

(8) mental health history and psychiatric status, including symptoms, disability, current treatment supports, and psychotropic medication needed to maintain stability; the assessment must utilize screening tools approved by the commissioner pursuant to section 245.4863 to identify whether the client screens positive for co-occurring disorders;

(9) arrests and legal interventions related to substance use;

(10) ability to function appropriately in work and educational settings;

(11) ability to understand written treatment materials, including rules and the client's rights;

(12) risk-taking behavior, including behavior that puts the client at risk of exposure to blood-borne or sexually transmitted diseases;

(13) social network in relation to expected support for recovery and leisure time activities that are associated with substance use;

(14) whether the client is pregnant and, if so, the health of the unborn child and the client's current involvement in prenatal care;

(15) whether the client recognizes problems related to substance use and is willing to follow treatment recommendations; and

(16) collateral information. If the assessor gathered sufficient information from the referral source or the client to apply the criteria in parts 9530.6620 and 9530.6622, a collateral contact is not required.

(b) If the client is identified as having opioid use disorder or seeking treatment for opioid use disorder, the program must provide educational information to the client concerning:

(1) risks for opioid use disorder and dependence;

(2) treatment options, including the use of a medication for opioid use disorder;

(3) the risk of and recognizing opioid overdose; and

(4) the use, availability, and administration of naloxone to respond to opioid overdose.

(c) The commissioner shall develop educational materials that are supported by research and updated periodically. The license holder must use the educational materials that are approved by the commissioner to comply with this requirement.

(d) If the comprehensive assessment is completed to authorize treatment service for the client, at the earliest opportunity during the assessment interview the assessor shall determine if:

(1) the client is in severe withdrawal and likely to be a danger to self or others;

(2) the client has severe medical problems that require immediate attention; or

(3) the client has severe emotional or behavioral symptoms that place the client or others at risk of harm.

If one or more of the conditions in clauses (1) to (3) are present, the assessor must end the assessment interview and follow the procedures in the program's medical services plan under section 245G.08, subdivision 2, to help the client obtain the appropriate services. The assessment interview may resume when the condition is resolved.

Subd. 2. **Assessment summary.** (a) An alcohol and drug counselor must complete an assessment summary within three calendar days after service initiation for a residential program and within three sessions for all other programs. If the comprehensive assessment is used to authorize the treatment service, the alcohol and drug counselor must prepare an assessment summary on the same date the comprehensive assessment is completed. If the comprehensive assessment and assessment summary are to authorize treatment services, the assessor must determine appropriate services for the client using the dimensions in Minnesota Rules, part 9530.6622, and document the recommendations.

(b) An assessment summary must include:

(1) a risk description according to section 245G.05 for each dimension listed in paragraph (c);

(2) a narrative summary supporting the risk descriptions; and

(3) a determination of whether the client has a substance use disorder.

(c) An assessment summary must contain information relevant to treatment service planning and recorded in the dimensions in clauses (1) to (6). The license holder must consider:

(1) Dimension 1, acute intoxication/withdrawal potential; the client's ability to cope with withdrawal symptoms and current state of intoxication;

(2) Dimension 2, biomedical conditions and complications; the degree to which any physical disorder of the client would interfere with treatment for substance use, and the client's ability to tolerate any related discomfort. The license holder must determine the impact of continued chemical use on the unborn child, if the client is pregnant;

(3) Dimension 3, emotional, behavioral, and cognitive conditions and complications; the degree to which any condition or complication is likely to interfere with treatment for substance use or with functioning in significant life areas and the likelihood of harm to self or others;

(4) Dimension 4, readiness for change; the support necessary to keep the client involved in treatment service;

(5) Dimension 5, relapse, continued use, and continued problem potential; the degree to which the client recognizes relapse issues and has the skills to prevent relapse of either substance use or mental health problems; and

(6) Dimension 6, recovery environment; whether the areas of the client's life are supportive of or antagonistic to treatment participation and recovery.

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

Sec. 11. **[245G.06] INDIVIDUAL TREATMENT PLAN.**

Subdivision 1. **General.** Each client must have an individual treatment plan developed by an alcohol and drug counselor within seven days of service initiation for a residential program and within three sessions for all other programs. The client must have active, direct involvement in selecting the anticipated outcomes of the treatment process and developing the treatment plan. The individual treatment plan must be signed by the client and the alcohol and drug counselor and document the client's involvement in the development of the plan. The plan may be a continuation of the initial services plan required in section 245G.04. Treatment planning must include ongoing assessment of client needs. An individual treatment plan must be updated based on new information gathered about the client's condition and on whether methods identified have the intended effect. A change to the plan must be signed by the client and the alcohol and drug counselor. The plan must provide for the involvement

of the client's family and people selected by the client as important to the success of treatment at the earliest opportunity, consistent with the client's treatment needs and written consent.

Subd. 2. **Plan contents.** An individual treatment plan must be recorded in the six dimensions listed in section 245G.05, subdivision 2, paragraph (c), must address each issue identified in the assessment summary, prioritized according to the client's needs and focus, and must include:

(1) specific methods to address each identified need, including amount, frequency, and anticipated duration of treatment service. The methods must be appropriate to the client's language, reading skills, cultural background, and strengths;

(2) resources to refer the client to when the client's needs are to be addressed concurrently by another provider; and

(3) goals the client must reach to complete treatment and terminate services.

Subd. 3. **Daily documentation; residential programs.** For a client receiving residential services licensed under section 245G.21, notes must be entered in a client's file every calendar day. The note must include observations about the client's behavior, incidents involving the client, absences from the program, and treatment services received that day. The note may be entered by nontreatment staff unless the note is a clinical observation or record.

Subd. 4. **Documentation of treatment services; treatment plan review.** (a) A review of all treatment services must be documented weekly and include a review of:

(1) care coordination activities;

(2) medical and other appointments the client attended;

(3) issues related to medications that are not documented in the medication administration record; and

(4) issues related to attendance for treatment services, including the reason for any client absence from a treatment service.

(b) A note must be entered immediately following any significant event. A significant event is an event that impacts the client's relationship with other clients, staff, the client's family, or the client's treatment plan.

(c) A treatment plan review must be entered in a client's file weekly or after each treatment service, whichever is less frequent, by the staff member providing the service. The review must indicate the span of time covered by the review and each of the six dimensions listed in section 245G.05, subdivision 2, paragraph (c). The review must:

(1) indicate the date, type, and amount of each treatment service provided and the client's response to each service;

(2) address each goal in the treatment plan and whether the methods to address the goals are effective;

(3) include monitoring of any physical and mental health problems;

(4) document the participation of others;

(5) document staff recommendations for changes in the methods identified in the treatment plan and whether the client agrees with the change; and

(6) include a review and evaluation of the individual abuse prevention plan according to section 245A.65.

(d) Each entry in a client's record must be accurate, legible, signed, and dated. A late entry must be clearly labeled "late entry." A correction to an entry must be made in a way in which the original entry can still be read.

Subd. 5. **Service discharge summary.** (a) An alcohol and drug counselor must write a service discharge summary for each client. For a planned discharge, the service discharge summary must be completed within 24 hours before the client's discharge and provided to the client at discharge. For an unplanned discharge, the service discharge summary must be completed and provided to the client at discharge or within five days following the client's discharge, or document why providing the discharge summary was not possible.

(b) The service discharge summary must be recorded in the six dimensions listed in section 245G.05, subdivision 2, paragraph (c), and include the following information:

(1) the client's issues, strengths, and needs while participating in treatment, including services provided;

(2) the client's progress toward achieving each goal identified in the individual treatment plan;

(3) a risk description according to section 245G.05; and

(4) the reasons for and circumstances of service termination. If a program discharges a client at staff request, the reason for discharge and the procedure followed for the decision to discharge must be documented and comply with the program's policies on staff-initiated client discharge. If a client is discharged at staff request, the program must give the client crisis and other referrals appropriate for the client's needs and offer assistance to the client to access the services.

(c) For a client who successfully completes treatment, the summary must also include:

(1) the client's living arrangements at service termination;

(2) continuing care recommendations, including transitions between more or less intense services, or more frequent to less frequent services, and referrals made with specific attention to continuity of care for mental health, as needed;

(3) service termination diagnosis; and

(4) the client's prognosis.

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

Sec. 12. **[245G.07] TREATMENT SERVICE.**

Subdivision 1. **Treatment service.** (a) A license holder must offer the following treatment services, unless clinically inappropriate and the justifying clinical rationale is documented:

(1) individual and group counseling to help the client identify and address needs related to substance use and develop strategies to avoid harmful substance use after discharge and to help the client obtain the services necessary to establish a lifestyle free of the harmful effects of substance use disorder;

(2) client education strategies to avoid inappropriate substance use and health problems related to substance use and the necessary lifestyle changes to regain and maintain health. Client education must include information on tuberculosis education on a form approved by the commissioner, the human immunodeficiency virus according to Minnesota Statutes, section 245A.19, other sexually transmitted diseases, drug and alcohol use during pregnancy, and hepatitis;

(3) a service to help the client integrate gains made during treatment into daily living and to reduce the client's reliance on a staff member for support;

(4) a service to address issues related to co-occurring disorders, including client education on symptoms of mental illness, the possibility of comorbidity, and the need for continued medication compliance while recovering from substance use disorder. A group must address co-occurring disorders, as needed. When treatment for mental health problems is indicated, the treatment must be integrated into the client's individual treatment plan;

(5) on July 1, 2018, or upon federal approval, whichever is later, peer recovery support services provided one-to-one by an individual in recovery. Peer support services include education, advocacy, mentoring through self-disclosure of personal recovery experiences, attending recovery and other support groups with a client, accompanying the client to

appointments that support recovery, assistance accessing resources to obtain housing, employment, education, and advocacy services, and nonclinical recovery support to assist the transition from treatment into the recovery community; and

(6) on July 1, 2018, or upon federal approval, whichever is later, care coordination provided by an individual who meets the staff qualifications in section 245G.11, subdivision 7. Care coordination services include:

(i) assistance in coordination with significant others to help in the treatment planning process whenever possible;

(ii) assistance in coordination with and follow up for medical services as identified in the treatment plan;

(iii) facilitation of referrals to substance use disorder services as indicated by a client's medical provider, comprehensive assessment, or treatment plan;

(iv) facilitation of referrals to mental health services as identified by a client's comprehensive assessment or treatment plan;

(v) assistance with referrals to economic assistance, social services, housing resources, and prenatal care according to the client's needs;

(vi) life skills advocacy and support accessing treatment follow-up, disease management, and education services, including referral and linkages to long-term services and supports as needed; and

(vii) documentation of the provision of care coordination services in the client's file.

(b) A treatment service provided to a client must be provided according to the individual treatment plan and must consider cultural differences and special needs of a client.

Subd. 2. **Additional treatment service.** A license holder may provide or arrange the following additional treatment service as a part of the client's individual treatment plan:

(1) relationship counseling provided by a qualified professional to help the client identify the impact of the client's substance use disorder on others and to help the client and persons in the client's support structure identify and change behaviors that contribute to the client's substance use disorder;

(2) therapeutic recreation to allow the client to participate in recreational activities without the use of mood-altering chemicals and to plan and select leisure activities that do not involve the inappropriate use of chemicals;

(3) stress management and physical well-being to help the client reach and maintain an appropriate level of health, physical fitness, and well-being;

(4) living skills development to help the client learn basic skills necessary for independent living;

(5) employment or educational services to help the client become financially independent;

(6) socialization skills development to help the client live and interact with others in a positive and productive manner; and

(7) room, board, and supervision at the treatment site to provide the client with a safe and appropriate environment to gain and practice new skills.

Subd. 3. **Counselors.** A treatment service, including therapeutic recreation, must be provided by an alcohol and drug counselor according to section 245G.11, unless the individual providing the service is specifically qualified according to the accepted credential required to provide the service. Therapeutic recreation does not include planned leisure activities.

Subd. 4. **Location of service provision.** The license holder may provide services at any of the license holder's licensed locations or at another suitable location including a school, government building, medical or behavioral health facility, or social service organization. If services are provided off site from the licensed site, the reason for the provision of services remotely must be documented.

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

Sec. 13. **[245G.08] MEDICAL SERVICES.**

Subdivision 1. **Health care services.** An applicant or license holder must maintain a complete description of the health care services, nursing services, dietary services, and emergency physician services offered by the applicant or license holder.

Subd. 2. **Procedures.** The applicant or license holder must have written procedures for obtaining a medical intervention for a client, that are approved in writing by a physician who is licensed under chapter 147, unless:

(1) the license holder does not provide a service under section 245G.21; and

(2) a medical intervention is referred to 911, the emergency telephone number, or the client's physician.

Subd. 3. **Standing order protocol.** A license holder that maintains a supply of naloxone available for emergency treatment of opioid overdose must have a written standing order protocol by a physician who is licensed under chapter 147, that permits the license holder to maintain a supply of naloxone on site, and must require staff to undergo specific training in administration of naloxone.

Subd. 4. **Consultation services.** The license holder must have access to and document the availability of a licensed mental health professional to provide diagnostic assessment and treatment planning assistance.

Subd. 5. **Administration of medication and assistance with self-medication.** (a) A license holder must meet the requirements in this subdivision if a service provided includes the administration of medication.

(b) A staff member, other than a licensed practitioner or nurse, who is delegated by a licensed practitioner or a registered nurse the task of administration of medication or assisting with self-medication, must:

(1) successfully complete a medication administration training program for unlicensed personnel through an accredited Minnesota postsecondary educational institution. A staff member's completion of the course must be documented in writing and placed in the staff member's personnel file;

(2) be trained according to a formalized training program that is taught by a registered nurse and offered by the license holder. The training must include the process for administration of naloxone, if naloxone is kept on site. A staff member's completion of the training must be documented in writing and placed in the staff member's personnel records; or

(3) demonstrate to a registered nurse competency to perform the delegated activity. A registered nurse must be employed or contracted to develop the policies and procedures for administration of medication or assisting with self-administration of medication, or both.

(c) A registered nurse must provide supervision as defined in section 148.171, subdivision 23. The registered nurse's supervision must include, at a minimum, monthly on-site supervision or more often if warranted by a client's health needs. The policies and procedures must include:

(1) a provision that a delegation of administration of medication is limited to the administration of a medication that is administered orally, topically, or as a suppository, an eye drop, an ear drop, or an inhalant;

(2) a provision that each client's file must include documentation indicating whether staff must conduct the administration of medication or the client must self-administer medication, or both;

(3) a provision that a client may carry emergency medication such as nitroglycerin as instructed by the client's physician;

(4) a provision for the client to self-administer medication when a client is scheduled to be away from the facility;

(5) a provision that if a client self-administers medication when the client is present in the facility, the client must self-administer medication under the observation of a trained staff member;

(6) a provision that when a license holder serves a client who is a parent with a child, the parent may only administer medication to the child under a staff member's supervision;

(7) requirements for recording the client's use of medication, including staff signatures with date and time;

(8) guidelines for when to inform a nurse of problems with self-administration of medication, including a client's failure to administer, refusal of a medication, adverse reaction, or error; and

(9) procedures for acceptance, documentation, and implementation of a prescription, whether written, verbal, telephonic, or electronic.

Subd. 6. **Control of drugs.** A license holder must have and implement written policies and procedures developed by a registered nurse that contain:

(1) a requirement that each drug must be stored in a locked compartment. A Schedule II drug, as defined by section 152.02, subdivision 3, must be stored in a separately locked compartment, permanently affixed to the physical plant or medication cart;

(2) a system which accounts for all scheduled drugs each shift;

(3) a procedure for recording the client's use of medication, including the signature of the staff member who completed the administration of the medication with the time and date;

(4) a procedure to destroy a discontinued, outdated, or deteriorated medication;

(5) a statement that only authorized personnel are permitted access to the keys to a locked compartment;

(6) a statement that no legend drug supply for one client shall be given to another client; and

(7) a procedure for monitoring the available supply of naloxone on site, replenishing the naloxone supply when needed, and destroying naloxone according to clause (4).

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

Sec. 14. **[245G.09] CLIENT RECORDS.**

Subdivision 1. **Client records required.** (a) A license holder must maintain a file of current and accurate client records on the premises where the treatment service is provided or coordinated. For services provided off site, client records must be available at the program and adhere to the same clinical and administrative policies and procedures as services provided on site. A program using an electronic health record must maintain virtual access to client records on the premises where the treatment service is delivered. The content and format of client records must be uniform and entries in each record must be signed and dated by the staff member making the entry. Client records must be protected against loss, tampering, or unauthorized disclosure according to section 254A.09, chapter 13, and Code of Federal Regulations, title 42, chapter 1, part 2, subpart B, sections 2.1 to 2.67, and title 45, parts 160 to 164.

(b) The program must have a policy and procedure that identifies how the program will track and record client attendance at treatment activities, including the date, duration, and nature of each treatment service provided to the client.

Subd. 2. **Record retention.** The client records of a discharged client must be retained by a license holder for seven years. A license holder that ceases to provide treatment service must retain client records for seven years from the date of facility closure and must notify the commissioner of the location of the client records and the name of the individual responsible for maintaining the client's records.

Subd. 3. **Contents.** Client records must contain the following:

(1) documentation that the client was given information on client rights and responsibilities, grievance procedures, tuberculosis, and HIV, and that the client was provided an orientation to the program abuse prevention plan required under section 245A.65, subdivision 2, paragraph (a), clause (4);

(2) an initial services plan completed according to section 245G.04;

(3) a comprehensive assessment completed according to section 245G.05;

(4) an assessment summary completed according to section 245G.05, subdivision 2;

(5) an individual abuse prevention plan according to sections 245A.65, subdivision 2, and 626.557, subdivision 14, when applicable;

(6) an individual treatment plan according to section 245G.06, subdivisions 1 and 2;

(7) daily documentation, according to section 245G.06, subdivision 3;

(8) documentation of treatment services and treatment plan review according to section 245G.06, subdivision 4; and

(9) a summary at the time of service termination according to section 245G.06, subdivision 5.

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

Sec. 15. **[245G.10] STAFF REQUIREMENTS.**

Subdivision 1. **Treatment director.** A license holder must have a treatment director.

Subd. 2. **Alcohol and drug counselor supervisor.** A license holder must employ an alcohol and drug counselor supervisor who meets the requirements of section 245G.11, subdivision 4. An individual may be simultaneously employed as a treatment director, alcohol and drug counselor supervisor, and an alcohol and drug counselor if the individual meets the qualifications for each position. If an alcohol and drug counselor is simultaneously employed as an alcohol and drug counselor supervisor or treatment director, that individual must be considered a 0.5 full-time equivalent alcohol and drug counselor for staff requirements under subdivision 4.

Subd. 3. **Responsible staff member.** A treatment director must designate a staff member who, when present in the facility, is responsible for the delivery of treatment service. A license holder must have a designated staff member during all hours of operation. A license holder providing room and board and treatment at the same site must have a responsible staff member on duty 24 hours a day. The designated staff member must know and understand the implications of this chapter and sections 245A.65, 626.556, 626.557, and 626.5572.

Subd. 4. **Staff requirement.** It is the responsibility of the license holder to determine an acceptable group size based on each client's needs except that treatment services provided in a group shall not exceed 16 clients. A counselor in an opioid treatment program must not supervise more than 50 clients. The license holder must maintain a record that documents compliance with this subdivision.

Subd. 5. **Medical emergency.** When a client is present, a license holder must have at least one staff member on the premises who has a current American Red Cross standard first aid certificate or an equivalent certificate and at least one staff member on the premises who has a current American Red Cross community, American Heart Association, or equivalent CPR certificate. A single staff member with both certifications satisfies this requirement.

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

Sec. 16. **[245G.11] STAFF QUALIFICATIONS.**

Subdivision 1. **General qualifications.** (a) All staff members who have direct contact must be 18 years of age or older. At the time of employment, each staff member must meet the qualifications in this subdivision. For purposes of this subdivision, "problematic substance use" means a behavior or incident listed by the license holder in the personnel policies and procedures according to section 245G.13, subdivision 1, clause (5).

(b) A treatment director, supervisor, nurse, counselor, student intern, or other professional must be free of problematic substance use for at least the two years immediately preceding employment and must sign a statement attesting to that fact.

(c) A paraprofessional, recovery peer, or any other staff member with direct contact must be free of problematic substance use for at least one year immediately preceding employment and must sign a statement attesting to that fact.

Subd. 2. **Employment; prohibition on problematic substance use.** A staff member with direct contact must be free from problematic substance use as a condition of employment, but is not required to sign additional statements. A staff member with direct contact who is not free from problematic substance use must be removed from any responsibilities that include direct contact for the time period specified in subdivision 1. The time period begins to run on the date of the last incident of problematic substance use as described in the facility's policies and procedures according to section 245G.13, subdivision 1, clause (5).

Subd. 3. **Treatment directors.** A treatment director must:

(1) have at least one year of work experience in direct service to an individual with substance use disorder or one year of work experience in the management or administration of direct service to an individual with substance use disorder;

(2) have a baccalaureate degree or three years of work experience in administration or personnel supervision in human services; and

(3) know and understand the implications of this chapter, chapter 245A, and sections 626.556, 626.557, and 626.5572. Demonstration of the treatment director's knowledge must be documented in the personnel record.

Subd. 4. **Alcohol and drug counselor supervisors.** An alcohol and drug counselor supervisor must:

(1) meet the qualification requirements in subdivision 5;

(2) have three or more years of experience providing individual and group counseling to individuals with substance use disorder; and

(3) know and understand the implications of this chapter and sections 245A.65, 626.556, 626.557, and 626.5572.

Subd. 5. **Alcohol and drug counselor qualifications.** (a) An alcohol and drug counselor must either be: (1) licensed under chapter 148F; or (2) exempt from licensure under chapter 148F and be a mental health professional as defined in section 245.462, subdivision 18.

(b) An alcohol and drug counselor must document competence in screening for and working with clients with mental health disorders through education, training, and experience, according to section 245G.13, subdivision 2, clause (5). For the purposes of enforcing this section, the commissioner has the authority to monitor a service provider's compliance with the relevant standards of a service provider's profession and may issue licensing actions according to sections 245A.05, 245A.06, and 245A.07 based on the commissioner's determination of noncompliance.

(c) A mental health professional identified in section 245.462, subdivision 18, must meet one of the following criteria:

(1) completion of 270 hours of alcohol and drug counselor training that covers each of the core functions listed in section 148F.01, subdivision 10, and successful completion of 880 hours of supervised experience as an alcohol and drug counselor, either as a student or as a staff member; or

(2) current certification as an alcohol and drug counselor or alcohol and drug counselor reciprocal, through the evaluation process established by the International Certification and Reciprocity Consortium Alcohol and Other Drug Abuse, Inc.

(d) An individual who is currently certified as an alcohol and drug counselor by the Upper Midwest Indian Council on Addictive Disorders meets the qualifications of an alcohol and drug counselor when providing services to Native American people.

Subd. 6. **Paraprofessionals.** A paraprofessional must have knowledge of client rights, according to section 148F.165, and staff member responsibilities. A paraprofessional may not admit, transfer, or discharge a client but may be responsible for the delivery of treatment service according to section 245G.10, subdivision 3.

Subd. 7. **Care coordination provider qualifications.** (a) Care coordination must be provided by qualified staff. An individual is qualified to provide care coordination if the individual:

(1) is skilled in the process of identifying and assessing a wide range of client needs;

(2) is knowledgeable about local community resources and how to use those resources for the benefit of the client;

(3) has successfully completed 30 hours of classroom instruction on care coordination for an individual with substance use disorder;

(4) has either:

(i) a bachelor's degree in one of the behavioral sciences or related fields; or

(ii) current certification as an alcohol and drug counselor, level I, by the Upper Midwest Indian Council on Addictive Disorders; and

(5) has at least 2,000 hours of supervised experience working with individuals with substance use disorder.

(b) A care coordinator must receive at least one hour of supervision regarding individual service delivery from an alcohol and drug counselor weekly.

Subd. 8. **Recovery peer qualifications.** A recovery peer must:

(1) be at least 21 years of age and have a high school diploma or its equivalent;

(2) have a minimum of one year in recovery from substance use disorder;

(3) hold a current credential from a certification body approved by the commissioner that demonstrates skills and training in the domains of ethics and boundaries, advocacy, mentoring and education, and recovery and wellness support; and

(4) receive ongoing supervision in areas specific to the domains of the recovery peer's role by an alcohol and drug counselor or an individual with a certification approved by the commissioner.

Subd. 9. **Volunteers.** A volunteer may provide treatment service when the volunteer is supervised and can be seen or heard by a staff member meeting the criteria in subdivision

4 or 5, but may not practice alcohol and drug counseling unless qualified under subdivision 5.

Subd. 10. **Student interns.** A qualified staff member must supervise and be responsible for a treatment service performed by a student intern and must review and sign each assessment, progress note, and individual treatment plan prepared by a student intern. A student intern must receive the orientation and training required in section 245G.13, subdivisions 1, clause (7), and 2. No more than 50 percent of the treatment staff may be students or licensing candidates with time documented to be directly related to the provision of treatment services for which the staff are authorized.

Subd. 11. **Individuals with temporary permit.** (a) An individual with a temporary permit from the Board of Behavioral Health and Therapy may provide chemical dependency treatment service according to this subdivision.

(b) An individual with a temporary permit must be supervised by a licensed alcohol and drug counselor assigned by the license holder. The supervising licensed alcohol and drug counselor must document the amount and type of supervision provided at least on a weekly basis. The supervision must relate to the clinical practice.

(c) An individual with a temporary permit must be supervised by a clinical supervisor approved by the Board of Behavioral Health and Therapy. The supervision must be documented and meet the requirements of section 148F.04, subdivision 4.

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

Sec. 17. **[245G.12] PROVIDER POLICIES AND PROCEDURES.**

A license holder must develop a written policies and procedures manual, indexed according to section 245A.04, subdivision 14, paragraph (c), that provides staff members immediate access to all policies and procedures and provides a client and other authorized parties access to all policies and procedures. The manual must contain the following materials:

(1) assessment and treatment planning policies, including screening for mental health concerns and treatment objectives related to the client's identified mental health concerns in the client's treatment plan;

(2) policies and procedures regarding HIV according to section 245A.19;

(3) the license holder's methods and resources to provide information on tuberculosis and tuberculosis screening to each client and to report a known tuberculosis infection according to section 144.4804;

(4) personnel policies according to section 245G.13;

(5) policies and procedures that protect a client's rights according to section 245G.15;

(6) a medical services plan according to section 245G.08;

(7) emergency procedures according to section 245G.16;

(8) policies and procedures for maintaining client records according to section 245G.09;

(9) procedures for reporting the maltreatment of minors according to section 626.556, and vulnerable adults according to sections 245A.65, 626.557, and 626.5572;

(10) a description of treatment services, including the amount and type of services provided;

(11) the methods used to achieve desired client outcomes;

(12) the hours of operation; and

(13) the target population served.

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

Sec. 18. **[245G.13] PROVIDER PERSONNEL POLICIES.**

Subdivision 1. **Personnel policy requirements.** A license holder must have written personnel policies that are available to each staff member. The personnel policies must:

(1) ensure that staff member retention, promotion, job assignment, or pay are not affected by a good faith communication between a staff member and the department, the Department of Health, the ombudsman for mental health and developmental disabilities, law enforcement, or a local agency for the investigation of a complaint regarding a client's rights, health, or safety;

(2) contain a job description for each staff member position specifying responsibilities, degree of authority to execute job responsibilities, and qualification requirements;

(3) provide for a job performance evaluation based on standards of job performance conducted on a regular and continuing basis, including a written annual review;

(4) describe behavior that constitutes grounds for disciplinary action, suspension, or dismissal, including policies that address staff member problematic substance use and the

requirements of section 245G.11, subdivision 1, policies prohibiting personal involvement with a client in violation of chapter 604, and policies prohibiting client abuse described in sections 245A.65, 626.556, 626.557, and 626.5572;

(5) identify how the program will identify whether behaviors or incidents are problematic substance use, including a description of how the facility must address:

(i) receiving treatment for substance use within the period specified for the position in the staff qualification requirements, including medication-assisted treatment;

(ii) substance use that negatively impacts the staff member's job performance;

(iii) chemical use that affects the credibility of treatment services with a client, referral source, or other member of the community;

(iv) symptoms of intoxication or withdrawal on the job; and

(v) the circumstances under which an individual who participates in monitoring by the health professional services program for a substance use or mental health disorder is able to provide services to the program's clients;

(6) include a chart or description of the organizational structure indicating lines of authority and responsibilities;

(7) include orientation within 24 working hours of starting for each new staff member based on a written plan that, at a minimum, must provide training related to the staff member's specific job responsibilities, policies and procedures, client confidentiality, HIV minimum standards, and client needs; and

(8) include policies outlining the license holder's response to a staff member with a behavior problem that interferes with the provision of treatment service.

Subd. 2. **Staff development.** (a) A license holder must ensure that each staff member has the training described in this subdivision.

(b) Each staff member must be trained every two years in:

(1) client confidentiality rules and regulations and client ethical boundaries; and

(2) emergency procedures and client rights as specified in sections 144.651, 148F.165, and 253B.03.

(c) Annually each staff member with direct contact must be trained on mandatory reporting as specified in sections 245A.65, 626.556, 626.5561, 626.557, and 626.5572,

including specific training covering the license holder's policies for obtaining a release of client information.

(d) Upon employment and annually thereafter, each staff member with direct contact must receive training on HIV minimum standards according to section 245A.19.

(e) A treatment director, supervisor, nurse, or counselor must have a minimum of 12 hours of training in co-occurring disorders that includes competencies related to philosophy, trauma-informed care, screening, assessment, diagnosis and person-centered treatment planning, documentation, programming, medication, collaboration, mental health consultation, and discharge planning. A new staff member who has not obtained the training must complete the training within six months of employment. A staff member may request, and the license holder may grant, credit for relevant training obtained before employment, which must be documented in the staff member's personnel file.

Subd. 3. **Personnel files.** The license holder must maintain a separate personnel file for each staff member. At a minimum, the personnel file must conform to the requirements of this chapter. A personnel file must contain the following:

(1) a completed application for employment signed by the staff member and containing the staff member's qualifications for employment;

(2) documentation related to the staff member's background study data, according to chapter 245C;

(3) for a staff member who provides psychotherapy services, employer names and addresses for the past five years for which the staff member provided psychotherapy services, and documentation of an inquiry required by sections 604.20 to 604.205 made to the staff member's former employer regarding substantiated sexual contact with a client;

(4) documentation that the staff member completed orientation and training;

(5) documentation that the staff member meets the requirements in section 245G.11;

(6) documentation demonstrating the staff member's compliance with section 245G.08, subdivision 3, for a staff member who conducts administration of medication; and

(7) documentation demonstrating the staff member's compliance with section 245G.18, subdivision 2, for a staff member that treats an adolescent client.

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

Sec. 19. **[245G.14] SERVICE INITIATION AND TERMINATION POLICIES.**

Subdivision 1. **Service initiation policy.** A license holder must have a written service initiation policy containing service initiation preferences that comply with this section and Code of Federal Regulations, title 45, part 96.131, and specific service initiation criteria. The license holder must not initiate services for an individual who does not meet the service initiation criteria. The service initiation criteria must be either posted in the area of the facility where services for a client are initiated, or given to each interested person upon request. Titles of each staff member authorized to initiate services for a client must be listed in the services initiation and termination policies.

Subd. 2. **License holder responsibilities.** (a) The license holder must have and comply with a written protocol for (1) assisting a client in need of care not provided by the license holder, and (2) a client who poses a substantial likelihood of harm to the client or others, if the behavior is beyond the behavior management capabilities of the staff members.

(b) A service termination and denial of service initiation that poses an immediate threat to the health of any individual or requires immediate medical intervention must be referred to a medical facility capable of admitting the client.

(c) A service termination policy and a denial of service initiation that involves the commission of a crime against a license holder's staff member or on a license holder's premises, as provided under Code of Federal Regulations, title 42, section 2.12(c)(5), and title 45, parts 160 to 164, must be reported to a law enforcement agency with jurisdiction.

Subd. 3. **Service termination policies.** A license holder must have a written policy specifying the conditions when a client must be terminated from service. The service termination policy must include:

(1) procedures for a client whose services were terminated under subdivision 2;

(2) a description of client behavior that constitutes reason for a staff-requested service termination and a process for providing this information to a client;

(3) a requirement that before discharging a client from a residential setting, for not reaching treatment plan goals, the license holder must confer with other interested persons to review the issues involved in the decision. The documentation requirements for a staff-requested service termination must describe why the decision to discharge is warranted, the reasons for the discharge, and the alternatives considered or attempted before discharging the client;

(4) procedures consistent with section 253B.16, subdivision 2, that staff members must follow when a client admitted under chapter 253B is to have services terminated;

(5) procedures a staff member must follow when a client leaves against staff or medical advice and when the client may be dangerous to the client or others, including a policy that requires a staff member to assist the client with assessing needs of care or other resources;

(6) procedures for communicating staff-approved service termination criteria to a client, including the expectations in the client's individual treatment plan according to section 245G.06; and

(7) titles of each staff member authorized to terminate a client's service must be listed in the service initiation and service termination policies.

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

Sec. 20. **[245G.15] CLIENT RIGHTS PROTECTION.**

Subdivision 1. **Explanation.** A client has the rights identified in sections 144.651, 148F.165, 253B.03, and 254B.02, subdivision 2, as applicable. The license holder must give each client at service initiation a written statement of the client's rights and responsibilities. A staff member must review the statement with a client at that time.

Subd. 2. **Grievance procedure.** At service initiation, the license holder must explain the grievance procedure to the client or the client's representative. The grievance procedure must be posted in a place visible to clients, and made available upon a client's or former client's request. The grievance procedure must require that:

(1) a staff member helps the client develop and process a grievance;

(2) current telephone numbers and addresses of the Department of Human Services, Licensing Division; the Office of Ombudsman for Mental Health and Developmental Disabilities; the Department of Health Office of Health Facilities Complaints; and the Board of Behavioral Health and Therapy, when applicable, be made available to a client; and

(3) a license holder responds to the client's grievance within three days of a staff member's receipt of the grievance, and the client may bring the grievance to the highest level of authority in the program if not resolved by another staff member.

Subd. 3. **Photographs of client.** (a) A photograph, video, or motion picture of a client taken in the provision of treatment service is considered client records. A photograph for identification and a recording by video or audio technology to enhance either therapy or staff member supervision may be required of a client, but may only be available for use as

communications within a program. A client must be informed when the client's actions are being recorded by camera or other technology, and the client must have the right to refuse any recording or photography, except as authorized by this subdivision.

(b) A license holder must have a written policy regarding the use of any personal electronic device that can record, transmit, or make images of another client. A license holder must inform each client of this policy and the client's right to refuse being photographed or recorded.

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

Sec. 21. **[245G.16] BEHAVIORAL EMERGENCY PROCEDURES.**

(a) A license holder or applicant must have written behavioral emergency procedures that staff must follow when responding to a client who exhibits behavior that is threatening to the safety of the client or others. Programs must incorporate person-centered planning and trauma-informed care in the program's behavioral emergency procedure policies. The procedures must include:

(1) a plan designed to prevent a client from hurting themselves or others;

(2) contact information for emergency resources that staff must consult when a client's behavior cannot be controlled by the behavioral emergency procedures;

(3) types of procedures that may be used;

(4) circumstances under which behavioral emergency procedures may be used; and

(5) staff members authorized to implement behavioral emergency procedures.

(b) Behavioral emergency procedures must not be used to enforce facility rules or for the convenience of staff. Behavioral emergency procedures must not be part of any client's treatment plan, or used at any time for any reason except in response to specific current behavior that threatens the safety of the client or others. Behavioral emergency procedures may not include the use of seclusion or restraint.

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

Sec. 22. **[245G.17] EVALUATION.**

A license holder must participate in the drug and alcohol abuse normative evaluation system by submitting information about each client to the commissioner in a manner prescribed by the commissioner. A license holder must submit additional information

requested by the commissioner that is necessary to meet statutory or federal funding requirements.

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

Sec. 23. **[245G.18] LICENSE HOLDERS SERVING ADOLESCENTS.**

Subdivision 1. **License.** A residential treatment program that serves an adolescent younger than 16 years of age must be licensed as a residential program for a child in out-of-home placement by the department unless the license holder is exempt under section 245A.03, subdivision 2.

Subd. 2. **Alcohol and drug counselor qualifications.** In addition to the requirements specified in section 245G.11, subdivisions 1 and 5, an alcohol and drug counselor providing treatment service to an adolescent must have:

(1) an additional 30 hours of classroom instruction or one three-credit semester college course in adolescent development. This training need only be completed one time; and

(2) at least 150 hours of supervised experience as an adolescent counselor, either as a student or as a staff member.

Subd. 3. **Staff ratios.** At least 25 percent of a counselor's scheduled work hours must be allocated to indirect services, including documentation of client services, coordination of services with others, treatment team meetings, and other duties. A counseling group consisting entirely of adolescents must not exceed 16 adolescents. It is the responsibility of the license holder to determine an acceptable group size based on the needs of the clients.

Subd. 4. **Academic program requirements.** A client who is required to attend school must be enrolled and attending an educational program that was approved by the Department of Education.

Subd. 5. **Program requirements.** In addition to the requirements specified in the client's treatment plan under section 245G.06, programs serving an adolescent must include:

(1) coordination with the school system to address the client's academic needs;

(2) when appropriate, a plan that addresses the client's leisure activities without chemical use; and

(3) a plan that addresses family involvement in the adolescent's treatment.

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

Sec. 24. **[245G.19] LICENSE HOLDERS SERVING CLIENTS WITH CHILDREN.**

Subdivision 1. **Health license requirements.** In addition to the requirements of sections 245G.01 to 245G.17, a license holder that offers supervision of a child of a client is subject to the requirements of this section. A license holder providing room and board for a client and the client's child must have an appropriate facility license from the Department of Health.

Subd. 2. **Supervision of a child.** "Supervision of a child" means a caregiver is within sight or hearing of an infant, toddler, or preschooler at all times so that the caregiver can intervene to protect the child's health and safety. For a school-age child it means a caregiver is available to help and care for the child to protect the child's health and safety.

Subd. 3. **Policy and schedule required.** A license holder must meet the following requirements:

(1) have a policy and schedule delineating the times and circumstances when the license holder is responsible for supervision of a child in the program and when the child's parents are responsible for supervision of a child. The policy must explain how the program will communicate its policy about supervision of a child responsibility to the parent; and

(2) have written procedures addressing the actions a staff member must take if a child is neglected or abused, including while the child is under the supervision of the child's parent.

Subd. 4. **Additional licensing requirements.** During the times the license holder is responsible for the supervision of a child, the license holder must meet the following standards:

(1) child and adult ratios in Minnesota Rules, part 9502.0367;

(2) day care training in section 245A.50;

(3) behavior guidance in Minnesota Rules, part 9502.0395;

(4) activities and equipment in Minnesota Rules, part 9502.0415;

(5) physical environment in Minnesota Rules, part 9502.0425; and

(6) water, food, and nutrition in Minnesota Rules, part 9502.0445, unless the license holder has a license from the Department of Health.

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

Sec. 25. **[245G.20] LICENSE HOLDERS SERVING PERSONS WITH CO-OCCURRING DISORDERS.**

A license holder specializing in the treatment of a person with co-occurring disorders must:

(1) demonstrate that staff levels are appropriate for treating a client with a co-occurring disorder, and that there are adequate staff members with mental health training;

(2) have continuing access to a medical provider with appropriate expertise in prescribing psychotropic medication;

(3) have a mental health professional available for staff member supervision and consultation;

(4) determine group size, structure, and content considering the special needs of a client with a co-occurring disorder;

(5) have documentation of active interventions to stabilize mental health symptoms present in the individual treatment plans and progress notes;

(6) have continuing documentation of collaboration with continuing care mental health providers, and involvement of the providers in treatment planning meetings;

(7) have available program materials adapted to a client with a mental health problem;

(8) have policies that provide flexibility for a client who may lapse in treatment or may have difficulty adhering to established treatment rules as a result of a mental illness, with the goal of helping a client successfully complete treatment; and

(9) have individual psychotherapy and case management available during treatment service.

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

Sec. 26. **[245G.21] REQUIREMENTS FOR LICENSED RESIDENTIAL TREATMENT.**

Subdivision 1. **Applicability.** A license holder who provides supervised room and board at the licensed program site as a treatment component is defined as a residential program according to section 245A.02, subdivision 14, and is subject to this section.

Subd. 2. **Visitors.** A client must be allowed to receive visitors at times prescribed by the license holder. The license holder must set and post a notice of visiting rules and hours, including both day and evening times. A client's right to receive visitors other than a personal

physician, religious adviser, county case manager, parole or probation officer, or attorney may be subject to visiting hours established by the license holder for all clients. The treatment director or designee may impose limitations as necessary for the welfare of a client provided the limitation and the reasons for the limitation are documented in the client's file. A client must be allowed to receive visits at all reasonable times from the client's personal physician, religious adviser, county case manager, parole or probation officer, and attorney.

Subd. 3. **Client property management.** A license holder who provides room and board and treatment services to a client in the same facility, and any license holder that accepts client property must meet the requirements for handling client funds and property in section 245A.04, subdivision 13. License holders:

(1) may establish policies regarding the use of personal property to ensure that treatment activities and the rights of other clients are not infringed upon;

(2) may take temporary custody of a client's property for violation of a facility policy;

(3) must retain the client's property for a minimum of seven days after the client's service termination if the client does not reclaim property upon service termination, or for a minimum of 30 days if the client does not reclaim property upon service termination and has received room and board services from the license holder; and

(4) must return all property held in trust to the client at service termination regardless of the client's service termination status, except that:

(i) a drug, drug paraphernalia, or drug container that is subject to forfeiture under section 609.5316, must be given to the custody of a local law enforcement agency. If giving the property to the custody of a local law enforcement agency violates Code of Federal Regulations, title 42, sections 2.1 to 2.67, or title 45, parts 160 to 164, a drug, drug paraphernalia, or drug container must be destroyed by a staff member designated by the program director; and

(ii) a weapon, explosive, and other property that can cause serious harm to the client or others must be given to the custody of a local law enforcement agency, and the client must be notified of the transfer and of the client's right to reclaim any lawful property transferred; and

(iii) a medication that was determined by a physician to be harmful after examining the client must be destroyed, except when the client's personal physician approves the medication for continued use.

Subd. 4. **Health facility license.** A license holder who provides room and board and treatment services in the same facility must have the appropriate license from the Department of Health.

Subd. 5. **Facility abuse prevention plan.** A license holder must establish and enforce an ongoing facility abuse prevention plan consistent with sections 245A.65 and 626.557, subdivision 14.

Subd. 6. **Individual abuse prevention plan.** A license holder must prepare an individual abuse prevention plan for each client as specified under sections 245A.65, subdivision 2, and 626.557, subdivision 14.

Subd. 7. **Health services.** A license holder must have written procedures for assessing and monitoring a client's health, including a standardized data collection tool for collecting health-related information about each client. The policies and procedures must be approved and signed by a registered nurse.

Subd. 8. **Administration of medication.** A license holder must meet the administration of medications requirements of section 245G.08, subdivision 5, if services include medication administration.

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

Sec. 27. **[245G.22] OPIOID TREATMENT PROGRAMS.**

Subdivision 1. **Additional requirements.** (a) An opioid treatment program licensed under this chapter must also comply with the requirements of this section and Code of Federal Regulations, title 42, part 8. When federal guidance or interpretations are issued on federal standards or requirements also required under this section, the federal guidance or interpretations shall apply.

(b) Where a standard in this section differs from a standard in an otherwise applicable administrative rule or statute, the standard of this section applies.

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

(b) "Diversion" means the use of a medication for the treatment of opioid addiction being diverted from intended use of the medication.

(c) "Guest dose" means administration of a medication used for the treatment of opioid addiction to a person who is not a client of the program that is administering or dispensing the medication.

(d) "Medical director" means a physician licensed to practice medicine in the jurisdiction that the opioid treatment program is located who assumes responsibility for administering all medical services performed by the program, either by performing the services directly or by delegating specific responsibility to authorized program physicians and health care professionals functioning under the medical director's direct supervision.

(e) "Medication used for the treatment of opioid use disorder" means a medication approved by the Food and Drug Administration for the treatment of opioid use disorder.

(f) "Minnesota health care programs" has the meaning given in section 256B.0636.

(g) "Opioid treatment program" has the meaning given in Code of Federal Regulations, title 42, section 8.12, and includes programs licensed under this chapter.

(h) "Placing authority" has the meaning given in Minnesota Rules, part 9530.6605, subpart 21a.

(i) "Unsupervised use" means the use of a medication for the treatment of opioid use disorder dispensed for use by a client outside of the program setting.

Subd. 3. **Medication orders.** Before the program may administer or dispense a medication used for the treatment of opioid use disorder:

(1) a client-specific order must be received from an appropriately credentialed physician who is enrolled as a Minnesota health care programs provider and meets all applicable provider standards;

(2) the signed order must be documented in the client's record; and

(3) if the physician that issued the order is not able to sign the order when issued, the unsigned order must be entered in the client record at the time it was received, and the physician must review the documentation and sign the order in the client's record within 72 hours of the medication being ordered. The license holder must report to the commissioner any medication error that endangers a client's health, as determined by the medical director.

Subd. 4. **High dose requirements.** A client being administered or dispensed a dose beyond that set forth in subdivision 6, paragraph (a), clause (1), that exceeds 150 milligrams of methadone or 24 milligrams of buprenorphine daily, and for each subsequent increase, must meet face-to-face with a prescribing physician. The meeting must occur before the administration or dispensing of the increased medication dose.

Subd. 5. **Drug testing.** Each client enrolled in the program must receive a minimum of eight random drug abuse tests per 12 months of treatment. Drug abuse tests must be

reasonably disbursed over the 12-month period. A license holder may elect to conduct more drug abuse tests.

Subd. 6. **Criteria for unsupervised use.** (a) To limit the potential for diversion of medication used for the treatment of opioid use disorder to the illicit market, medication dispensed to a client for unsupervised use shall be subject to the following requirements:

(1) any client in an opioid treatment program may receive a single unsupervised use dose for a day that the clinic is closed for business, including Sundays and state and federal holidays; and

(2) other treatment program decisions on dispensing medications used for the treatment of opioid use disorder to a client for unsupervised use shall be determined by the medical director.

(b) In determining whether a client may be permitted unsupervised use of medications, a physician with authority to prescribe must consider the criteria in this paragraph. The criteria in this paragraph must also be considered when determining whether dispensing medication for a client's unsupervised use is appropriate to increase or to extend the amount of time between visits to the program. The criteria are:

(1) absence of recent abuse of drugs including but not limited to opioids, nonnarcotics, and alcohol;

(2) regularity of program attendance;

(3) absence of serious behavioral problems at the program;

(4) absence of known recent criminal activity such as drug dealing;

(5) stability of the client's home environment and social relationships;

(6) length of time in comprehensive maintenance treatment;

(7) reasonable assurance that unsupervised use medication will be safely stored within the client's home; and

(8) whether the rehabilitative benefit the client derived from decreasing the frequency of program attendance outweighs the potential risks of diversion or unsupervised use.

(c) The determination, including the basis of the determination must be documented in the client's medical record.

Subd. 7. **Restrictions for unsupervised use of methadone hydrochloride.** (a) If a physician with authority to prescribe determines that a client meets the criteria in subdivision

6 and may be dispensed a medication used for the treatment of opioid addiction, the restrictions in this subdivision must be followed when the medication to be dispensed is methadone hydrochloride.

(b) During the first 90 days of treatment, the unsupervised use medication supply must be limited to a maximum of a single dose each week and the client shall ingest all other doses under direct supervision.

(c) In the second 90 days of treatment, the unsupervised use medication supply must be limited to two doses per week.

(d) In the third 90 days of treatment, the unsupervised use medication supply must not exceed three doses per week.

(e) In the remaining months of the first year, a client may be given a maximum six-day unsupervised use medication supply.

(f) After one year of continuous treatment, a client may be given a maximum two-week unsupervised use medication supply.

(g) After two years of continuous treatment, a client may be given a maximum one-month unsupervised use medication supply, but must make monthly visits to the program.

Subd. 8. **Restriction exceptions.** When a license holder has reason to accelerate the number of unsupervised use doses of methadone hydrochloride, the license holder must comply with the requirements of Code of Federal Regulations, title 42, section 8.12, the criteria for unsupervised use and must use the exception process provided by the federal Center for Substance Abuse Treatment Division of Pharmacologic Therapies. For the purposes of enforcement of this subdivision, the commissioner has the authority to monitor a program for compliance with federal regulations and may issue licensing actions according to sections 245A.05, 245A.06, and 245A.07 based on the commissioner's determination of noncompliance.

Subd. 9. **Guest dose.** To receive a guest dose, the client must be enrolled in an opioid treatment program elsewhere in the state or country and be receiving the medication on a temporary basis because the client is not able to receive the medication at the program in which the client is enrolled. Such arrangements shall not exceed 30 consecutive days in any one program and must not be for the convenience or benefit of either program. A guest dose may also occur when the client's primary clinic is not open and the client is not receiving unsupervised use doses.

Subd. 10. **Capacity management and waiting list system compliance.** An opioid treatment program must notify the department within seven days of the program reaching both 90 and 100 percent of the program's capacity to care for clients. Each week, the program must report its capacity, currently enrolled dosing clients, and any waiting list. A program reporting 90 percent of capacity must also notify the department when the program's census increases or decreases from the 90 percent level.

Subd. 11. **Waiting list.** An opioid treatment program must have a waiting list system. If the person seeking admission cannot be admitted within 14 days of the date of application, each person seeking admission must be placed on the waiting list, unless the person seeking admission is assessed by the program and found ineligible for admission according to this chapter and Code of Federal Regulations, title 42, part 1, subchapter A, section 8.12(e), and title 45, parts 160 to 164. The waiting list must assign a unique client identifier for each person seeking treatment while awaiting admission. A person seeking admission on a waiting list who receives no services under section 245G.07, subdivision 1, must not be considered a "client" as defined in section 245G.01, subdivision 9.

Subd. 12. **Client referral.** An opioid treatment program must consult the capacity management system to ensure that a person on a waiting list is admitted at the earliest time to a program providing appropriate treatment within a reasonable geographic area. If the client was referred through a public payment system and if the program is not able to serve the client within 14 days of the date of application for admission, the program must contact and inform the referring agency of any available treatment capacity listed in the state capacity management system.

Subd. 13. **Outreach.** An opioid treatment program must carry out activities to encourage an individual in need of treatment to undergo treatment. The program's outreach model must:

(1) select, train, and supervise outreach workers;

(2) contact, communicate, and follow up with individuals with high-risk substance misuse, individuals with high-risk substance misuse associates, and neighborhood residents within the constraints of federal and state confidentiality requirements;

(3) promote awareness among individuals who engage in substance misuse by injection about the relationship between injecting substances and communicable diseases such as HIV; and

(4) recommend steps to prevent HIV transmission.

Subd. 14. **Central registry.** (a) A license holder must comply with requirements to submit information and necessary consents to the state central registry for each client admitted, as specified by the commissioner. The license holder must submit data concerning medication used for the treatment of opioid use disorder. The data must be submitted in a method determined by the commissioner and the original information must be kept in the client's record. The information must be submitted for each client at admission and discharge. The program must document the date the information was submitted. The client's failure to provide the information shall prohibit participation in an opioid treatment program. The information submitted must include the client's:

(1) full name and all aliases;

(2) date of admission;

(3) date of birth;

(4) Social Security number or Alien Registration Number, if any;

(5) current or previous enrollment status in another opioid treatment program;

(6) government-issued photo identification card number; and

(7) driver's license number, if any.

(b) The requirements in paragraph (a) are effective upon the commissioner's implementation of changes to the drug and alcohol abuse normative evaluation system or development of an electronic system by which to submit the data.

Subd. 15. **Nonmedication treatment services; documentation.** (a) The program must offer at least 50 consecutive minutes of individual or group therapy treatment services as defined in section 245G.07, subdivision 1, paragraph (a), clause (1), per week, for the first ten weeks following admission, and at least 50 consecutive minutes per month thereafter. As clinically appropriate, the program may offer these services cumulatively and not consecutively in increments of no less than 15 minutes over the required time period, and for a total of 60 minutes of treatment services over the time period, and must document the reason for providing services cumulatively in the client's record. The program may offer additional levels of service when deemed clinically necessary.

(b) Notwithstanding the requirements of comprehensive assessments in section 245G.05, the assessment must be completed within 21 days of service initiation.

(c) Notwithstanding the requirements of individual treatment plans set forth in section 245G.06:

(1) treatment plan contents for a maintenance client are not required to include goals the client must reach to complete treatment and have services terminated;

(2) treatment plans for a client in a taper or detox status must include goals the client must reach to complete treatment and have services terminated;

(3) for the initial ten weeks after admission for all new admissions, readmissions, and transfers, progress notes must be entered in a client's file at least weekly and be recorded in each of the six dimensions upon the development of the treatment plan and thereafter. Subsequently, the counselor must document progress in the six dimensions at least once monthly or, when clinical need warrants, more frequently; and

(4) upon the development of the treatment plan and thereafter, treatment plan reviews must occur weekly, or after each treatment service, whichever is less frequent, for the first ten weeks after the treatment plan is developed. Following the first ten weeks of treatment plan reviews, reviews may occur monthly, unless the client's needs warrant more frequent revisions or documentation.

Subd. 16. **Prescription monitoring program.** (a) The program must develop and maintain a policy and procedure that requires the ongoing monitoring of the data from the prescription monitoring program (PMP) for each client. The policy and procedure must include how the program meets the requirements in paragraph (b).

(b) If a medication used for the treatment of substance use disorder is administered or dispensed to a client, the license holder shall be subject to the following requirements:

(1) upon admission to a methadone clinic outpatient treatment program, a client must be notified in writing that the commissioner of human services and the medical director must monitor the PMP to review the prescribed controlled drugs a client received;

(2) the medical director or the medical director's delegate must review the data from the PMP described in section 152.126 before the client is ordered any controlled substance, as defined under section 152.126, subdivision 1, paragraph (c), including medications used for the treatment of opioid addiction, and the medical director's or the medical director's delegate's subsequent reviews of the PMP data must occur at least every 90 days;

(3) a copy of the PMP data reviewed must be maintained in the client's file;

(4) when the PMP data contains a recent history of multiple prescribers or multiple prescriptions for controlled substances, the physician's review of the data and subsequent actions must be documented in the client's file within 72 hours and must contain the medical director's determination of whether or not the prescriptions place the client at risk of harm

and the actions to be taken in response to the PMP findings. The provider must conduct subsequent reviews of the PMP on a monthly basis; and

(5) if at any time the medical director believes the use of the controlled substances places the client at risk of harm, the program must seek the client's consent to discuss the client's opioid treatment with other prescribers and must seek the client's consent for the other prescriber to disclose to the opioid treatment program's medical director the client's condition that formed the basis of the other prescriptions. If the information is not obtained within seven days, the medical director must document whether or not changes to the client's medication dose or number of unsupervised use doses are necessary until the information is obtained.

(c) The commissioner shall collaborate with the Minnesota Board of Pharmacy to develop and implement an electronic system for the commissioner to routinely access the PMP data to determine whether any client enrolled in an opioid addiction treatment program licensed according to this section was prescribed or dispensed a controlled substance in addition to that administered or dispensed by the opioid addiction treatment program. When the commissioner determines there have been multiple prescribers or multiple prescriptions of controlled substances for a client, the commissioner shall:

(1) inform the medical director of the opioid treatment program only that the commissioner determined the existence of multiple prescribers or multiple prescriptions of controlled substances; and

(2) direct the medical director of the opioid treatment program to access the data directly, review the effect of the multiple prescribers or multiple prescriptions, and document the review.

(d) If determined necessary, the commissioner shall seek a federal waiver of, or exception to, any applicable provision of Code of Federal Regulations, title 42, section 2.34(c), before implementing this subdivision.

Subd. 17. **Policies and procedures.** (a) A license holder must develop and maintain the policies and procedures required in this subdivision.

(b) For a program that is not open every day of the year, the license holder must maintain a policy and procedure that permits a client to receive a single unsupervised use of medication used for the treatment of opioid use disorder for days that the program is closed for business, including, but not limited to, Sundays and state and federal holidays as required under subdivision 6, paragraph (a), clause (1).

(c) The license holder must maintain a policy and procedure that includes specific measures to reduce the possibility of diversion. The policy and procedure must:

(1) specifically identify and define the responsibilities of the medical and administrative staff for performing diversion control measures; and

(2) include a process for contacting no less than five percent of clients who have unsupervised use of medication, excluding clients approved solely under subdivision 6, paragraph (a), clause (1), to require clients to physically return to the program each month. The system must require clients to return to the program within a stipulated time frame and turn in all unused medication containers related to opioid use disorder treatment. The license holder must document all related contacts on a central log and the outcome of the contact for each client in the client's record.

(d) Medication used for the treatment of opioid use disorder must be ordered, administered, and dispensed according to applicable state and federal regulations and the standards set by applicable accreditation entities. If a medication order requires assessment by the person administering or dispensing the medication to determine the amount to be administered or dispensed, the assessment must be completed by an individual whose professional scope of practice permits an assessment. For the purposes of enforcement of this paragraph, the commissioner has the authority to monitor the person administering or dispensing the medication for compliance with state and federal regulations and the relevant standards of the license holder's accreditation agency and may issue licensing actions according to sections 245A.05, 245A.06, and 245A.07, based on the commissioner's determination of noncompliance.

Subd. 18. **Quality improvement plan.** The license holder must develop and maintain a quality improvement plan that:

(1) includes evaluation of the services provided to clients to identify issues that may improve service delivery and client outcomes;

(2) includes goals for the program to accomplish based on the evaluation;

(3) is reviewed annually by the management of the program to determine whether the goals were met and, if not, whether additional action is required;

(4) is updated at least annually to include new or continued goals based on an updated evaluation of services; and

(5) identifies two specific goal areas, in addition to others identified by the program, including:

(i) a goal concerning oversight and monitoring of the premises around and near the exterior of the program to reduce the possibility of medication used for the treatment of opioid use disorder being inappropriately used by a client, including but not limited to the sale or transfer of the medication to others; and

(ii) a goal concerning community outreach, including but not limited to communications with local law enforcement and county human services agencies, to increase coordination of services and identification of areas of concern to be addressed in the plan.

Subd. 19. **Placing authorities.** A program must provide certain notification and client-specific updates to placing authorities for a client who is enrolled in Minnesota health care programs. At the request of the placing authority, the program must provide client-specific updates, including but not limited to informing the placing authority of positive drug screenings and changes in medications used for the treatment of opioid use disorder ordered for the client.

Subd. 20. **Duty to report suspected drug diversion.** (a) To the fullest extent permitted under Code of Federal Regulations, title 42, sections 2.1 to 2.67, a program shall report to law enforcement any credible evidence that the program or its personnel knows, or reasonably should know, that is directly related to a diversion crime on the premises of the program, or a threat to commit a diversion crime.

(b) "Diversion crime," for the purposes of this section, means diverting, attempting to divert, or conspiring to divert Schedule I, II, III, or IV drugs, as defined in section 152.02, on the program's premises.

(c) The program must document the program's compliance with the requirement in paragraph (a) in either a client's record or an incident report. A program's failure to comply with paragraph (a) may result in sanctions as provided in sections 245A.06 and 245A.07.

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

Sec. 28. Minnesota Statutes 2016, section 254A.01, is amended to read:

254A.01 PUBLIC POLICY.

It is hereby declared to be the public policy of this state that scientific evidence shows that addiction to alcohol or other drugs is a chronic brain disorder with potential for recurrence, and as with many other chronic conditions, people with substance use disorders can be effectively treated and can enter recovery. The interests of society are best served by reducing the stigma of substance use disorder and providing persons who are dependent upon alcohol or other drugs with a comprehensive range of rehabilitative and social services

that span intensity levels and are not restricted to a particular point in time. Further, it is declared that treatment under these services shall be voluntary when possible: treatment shall not be denied on the basis of prior treatment; treatment shall be based on an individual treatment plan for each person undergoing treatment; treatment shall include a continuum of services available for a person leaving a program of treatment; treatment shall include all family members at the earliest possible phase of the treatment process.

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

Sec. 29. Minnesota Statutes 2016, section 254A.02, subdivision 2, is amended to read:

Subd. 2. **Approved treatment program.** "Approved treatment program" means care and treatment services provided by any individual, organization or association to ~~drug dependent~~ persons with a substance use disorder, which meets the standards established by the commissioner of human services.

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

Sec. 30. Minnesota Statutes 2016, section 254A.02, subdivision 3, is amended to read:

Subd. 3. **Comprehensive program.** "Comprehensive program" means the range of services which are to be made available for the purpose of prevention, care and treatment of ~~alcohol and drug abuse~~ substance misuse and substance use disorder.

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

Sec. 31. Minnesota Statutes 2016, section 254A.02, subdivision 5, is amended to read:

Subd. 5. **Drug dependent person.** "Drug dependent person" means any ~~inebriate person or any~~ person incapable of self-management or management of personal affairs or unable to function physically or mentally in an effective manner because of the abuse of a drug, including alcohol.

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

Sec. 32. Minnesota Statutes 2016, section 254A.02, subdivision 6, is amended to read:

Subd. 6. **Facility.** "Facility" means any treatment facility administered under an approved treatment program ~~established under Laws 1973, chapter 572~~.

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

Sec. 33. Minnesota Statutes 2016, section 254A.02, is amended by adding a subdivision to read:

Subd. 6a. **Substance misuse.** "Substance misuse" means the use of any psychoactive or mood-altering substance, without compelling medical reason, in a manner that results in mental, emotional, or physical impairment and causes socially dysfunctional or socially disordering behavior and that results in psychological dependence or physiological addiction as a function of continued use. Substance misuse has the same meaning as "drug abuse" or "abuse of drugs."

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

Sec. 34. Minnesota Statutes 2016, section 254A.02, subdivision 8, is amended to read:

Subd. 8. **Other drugs.** "Other drugs" means any psychoactive ~~chemical~~ substance other than alcohol.

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

Sec. 35. Minnesota Statutes 2016, section 254A.02, subdivision 10, is amended to read:

Subd. 10. **State authority.** "State authority" is a division established within the Department of Human Services for the purpose of relating the authority of state government in the area of ~~alcohol and drug abuse~~ substance misuse and substance use disorder to the ~~alcohol and drug abuse~~ substance misuse and substance use disorder-related activities within the state.

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

Sec. 36. Minnesota Statutes 2016, section 254A.02, is amended by adding a subdivision to read:

Subd. 10a. **Substance use disorder.** "Substance use disorder" has the meaning given in the current Diagnostic and Statistical Manual of Mental Disorders.

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

Sec. 37. Minnesota Statutes 2016, section 254A.03, is amended to read:

254A.03 STATE AUTHORITY ON ALCOHOL AND DRUG ABUSE.

Subdivision 1. **Alcohol and Other Drug Abuse Section.** There is hereby created an Alcohol and Other Drug Abuse Section in the Department of Human Services. This section

shall be headed by a director. The commissioner may place the director's position in the unclassified service if the position meets the criteria established in section 43A.08, subdivision 1a. The section shall:

(1) conduct and foster basic research relating to the cause, prevention and methods of diagnosis, treatment and rehabilitation of ~~alcoholic and other drug dependent~~ persons with substance misuse and substance use disorder;

(2) coordinate and review all activities and programs of all the various state departments as they relate to ~~alcohol and other drug dependency and abuse~~ problems associated with substance misuse and substance use disorder;

(3) develop, demonstrate, and disseminate new methods and techniques for ~~the~~ prevention, early intervention, treatment and ~~rehabilitation of alcohol and other drug abuse and dependency problems~~ recovery support for substance misuse and substance use disorder;

(4) gather facts and information about ~~alcoholism and other drug dependency and abuse~~ substance misuse and substance use disorder, and about the efficiency and effectiveness of prevention, treatment, and ~~rehabilitation~~ recovery support services from all comprehensive programs, including programs approved or licensed by the commissioner of human services or the commissioner of health or accredited by the Joint Commission on Accreditation of Hospitals. The state authority is authorized to require information from comprehensive programs which is reasonable and necessary to fulfill these duties. When required information has been previously furnished to a state or local governmental agency, the state authority shall collect the information from the governmental agency. The state authority shall disseminate facts and summary information about ~~alcohol and other drug abuse dependency~~ problems associated with substance misuse and substance use disorder to public and private agencies, local governments, local and regional planning agencies, and the courts for guidance to and assistance in prevention, treatment and ~~rehabilitation~~ recovery support;

(5) inform and educate the general public on ~~alcohol and other drug dependency and abuse problems~~ substance misuse and substance use disorder;

(6) serve as the state authority concerning ~~alcohol and other drug dependency and abuse~~ substance misuse and substance use disorder by monitoring the conduct of diagnosis and referral services, research and comprehensive programs. The state authority shall submit a biennial report to the governor and the legislature containing a description of public services delivery and recommendations concerning increase of coordination and quality of services, and decrease of service duplication and cost;

(7) establish a state plan which shall set forth goals and priorities for a comprehensive ~~alcohol and other drug dependency and abuse program~~ continuum of care for substance misuse and substance use disorder for Minnesota. All state agencies operating ~~alcohol and other drug abuse or dependency~~ substance misuse or substance use disorder programs or administering state or federal funds for such programs shall annually set their program goals and priorities in accordance with the state plan. Each state agency shall annually submit its plans and budgets to the state authority for review. The state authority shall certify whether proposed services comply with the comprehensive state plan and advise each state agency of review findings;

(8) make contracts with and grants to public and private agencies and organizations, both profit and nonprofit, and individuals, using federal funds, and state funds as authorized to pay for costs of state administration, including evaluation, statewide programs and services, research and demonstration projects, and American Indian programs;

(9) receive and administer ~~monies~~ money available for ~~alcohol and drug abuse~~ substance misuse and substance use disorder programs under the alcohol, drug abuse, and mental health services block grant, United States Code, title 42, sections 300X to 300X-9;

(10) solicit and accept any gift of money or property for purposes of Laws 1973, chapter 572, and any grant of money, services, or property from the federal government, the state, any political subdivision thereof, or any private source;

(11) with respect to ~~alcohol and other drug abuse~~ substance misuse and substance use disorder programs serving the American Indian community, establish guidelines for the employment of personnel with considerable practical experience in ~~alcohol and other drug abuse problems~~ substance misuse and substance use disorder, and understanding of social and cultural problems related to ~~alcohol and other drug abuse~~ substance misuse and substance use disorder, in the American Indian community.

Subd. 2. **American Indian programs.** There is hereby created a section of American Indian programs, within the Alcohol and Drug Abuse Section of the Department of Human Services, to be headed by a special assistant for American Indian programs on ~~alcoholism and drug abuse~~ substance misuse and substance use disorder and two assistants to that position. The section shall be staffed with all personnel necessary to fully administer programming for ~~alcohol and drug abuse~~ substance misuse and substance use disorder services for American Indians in the state. The special assistant position shall be filled by a person with considerable practical experience in and understanding of ~~alcohol and other drug abuse problems~~ substance misuse and substance use disorder in the American Indian

community, who shall be responsible to the director of the Alcohol and Drug Abuse Section created in subdivision 1 and shall be in the unclassified service. The special assistant shall meet and consult with the American Indian Advisory Council as described in section 254A.035 and serve as a liaison to the Minnesota Indian Affairs Council and tribes to report on the status of ~~alcohol and other drug abuse~~ substance misuse and substance use disorder among American Indians in the state of Minnesota. The special assistant with the approval of the director shall:

(1) administer funds appropriated for American Indian groups, organizations and reservations within the state for American Indian ~~alcoholism and drug abuse~~ substance misuse and substance use disorder programs;

(2) establish policies and procedures for such American Indian programs with the assistance of the American Indian Advisory Board; and

(3) hire and supervise staff to assist in the administration of the American Indian program section within the Alcohol and Drug Abuse Section of the Department of Human Services.

Subd. 3. **Rules for ~~chemical dependency~~ substance use disorder care.** (a) The commissioner of human services shall establish by rule criteria to be used in determining the appropriate level of chemical dependency care for each recipient of public assistance seeking treatment for ~~alcohol or other drug dependency and abuse problems.~~ substance misuse or substance use disorder. On July 1, 2018, or upon federal approval, whichever is later, of comprehensive assessment as a Medicaid benefit and notwithstanding the criteria in Minnesota Rules, parts 9530 6600 to 9530.6655, an eligible vendor of comprehensive assessments under section 254B.05 may determine and approve the appropriate level of substance use disorder treatment for a recipient of public assistance. The process for determining an individual's financial eligibility for the consolidated chemical dependency treatment fund or determining an individual's enrollment in or eligibility for a publicly subsidized health plan is not affected by the individual's choice to access a comprehensive assessment for placement.

(b) The commissioner shall develop and implement a utilization review process for publicly funded treatment placements to monitor and review the clinical appropriateness and timeliness of all publicly funded placements in treatment.

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

Sec. 38. Minnesota Statutes 2016, section 254A.035, subdivision 1, is amended to read:

Subdivision 1. **Establishment.** There is created an American Indian Advisory Council to assist the state authority on ~~alcohol and drug abuse~~ substance misuse and substance use disorder in proposal review and formulating policies and procedures relating to ~~chemical dependency and the abuse of alcohol and other drugs~~ substance misuse and substance use disorder by American Indians.

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

Sec. 39. Minnesota Statutes 2016, section 254A.04, is amended to read:

254A.04 CITIZENS ADVISORY COUNCIL.

There is hereby created an Alcohol and Other Drug Abuse Advisory Council to advise the Department of Human Services concerning the problems of ~~alcohol and other drug dependency and abuse~~ substance misuse and substance use disorder, composed of ten members. Five members shall be individuals whose interests or training are in the field of ~~alcohol dependency~~ alcohol-specific substance use disorder and ~~abuse~~ alcohol misuse; and five members whose interests or training are in the field of ~~dependency~~ substance use disorder and ~~abuse of drugs~~ misuse of substances other than alcohol. The terms, compensation and removal of members shall be as provided in section 15.059. The council expires June 30, 2018. The commissioner of human services shall appoint members whose terms end in even-numbered years. The commissioner of health shall appoint members whose terms end in odd-numbered years.

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

Sec. 40. Minnesota Statutes 2016, section 254A.08, is amended to read:

254A.08 DETOXIFICATION CENTERS.

Subdivision 1. **Detoxification services.** Every county board shall provide detoxification services for ~~drug dependent persons~~ any person incapable of self-management or management of personal affairs or unable to function physically or mentally in an effective manner because of the use of a drug, including alcohol. The board may utilize existing treatment programs and other agencies to meet this responsibility.

Subd. 2. **Program requirements.** For the purpose of this section, a detoxification program means a social rehabilitation program licensed by the Department of Human Services under Minnesota Rules, parts 9530.6510 to 9530.6590, and established for the purpose of facilitating access into care and treatment by detoxifying and evaluating the

person and providing entrance into a comprehensive program. Evaluation of the person shall include verification by a professional, after preliminary examination, that the person is intoxicated or has symptoms of ~~chemical dependency~~ substance misuse or substance use disorder and appears to be in imminent danger of harming self or others. A detoxification program shall have available the services of a licensed physician for medical emergencies and routine medical surveillance. A detoxification program licensed by the Department of Human Services to serve both adults and minors at the same site must provide for separate sleeping areas for adults and minors.

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

Sec. 41. Minnesota Statutes 2016, section 254A.09, is amended to read:

254A.09 CONFIDENTIALITY OF RECORDS.

The Department of Human Services shall assure confidentiality to individuals who are the subject of research by the state authority or are recipients of ~~alcohol or drug abuse~~ substance misuse or substance use disorder information, assessment, or treatment from a licensed or approved program. The commissioner shall withhold from all persons not connected with the conduct of the research the names or other identifying characteristics of a subject of research unless the individual gives written permission that information relative to treatment and recovery may be released. Persons authorized to protect the privacy of subjects of research may not be compelled in any federal, state or local, civil, criminal, administrative or other proceeding to identify or disclose other confidential information about the individuals. Identifying information and other confidential information related to ~~alcohol or drug abuse~~ substance misuse or substance use disorder information, assessment, treatment, or aftercare services may be ordered to be released by the court for the purpose of civil or criminal investigations or proceedings if, after review of the records considered for disclosure, the court determines that the information is relevant to the purpose for which disclosure is requested. The court shall order disclosure of only that information which is determined relevant. In determining whether to compel disclosure, the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the treatment relationship in the program affected and in other programs similarly situated, and the actual or potential harm to the ability of programs to attract and retain patients if disclosure occurs. This section does not exempt any person from the reporting obligations under section 626.556, nor limit the use of information reported in any proceeding arising out of the abuse or neglect of a child. Identifying information and other confidential information related to ~~alcohol or drug abuse information~~ substance misuse or substance use disorder, assessment,

treatment, or aftercare services may be ordered to be released by the court for the purpose of civil or criminal investigations or proceedings. No information may be released pursuant to this section that would not be released pursuant to section 595.02, subdivision 2.

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

Sec. 42. Minnesota Statutes 2016, section 254A.19, subdivision 3, is amended to read:

Subd. 3. **Financial conflicts of interest.** (a) Except as provided in paragraph (b) or (c), an assessor conducting a chemical use assessment under Minnesota Rules, parts 9530.6600 to 9530.6655, may not have any direct or shared financial interest or referral relationship resulting in shared financial gain with a treatment provider.

(b) A county may contract with an assessor having a conflict described in paragraph (a) if the county documents that:

(1) the assessor is employed by a culturally specific service provider or a service provider with a program designed to treat individuals of a specific age, sex, or sexual preference;

(2) the county does not employ a sufficient number of qualified assessors and the only qualified assessors available in the county have a direct or shared financial interest or a referral relationship resulting in shared financial gain with a treatment provider; or

(3) the county social service agency has an existing relationship with an assessor or service provider and elects to enter into a contract with that assessor to provide both assessment and treatment under circumstances specified in the county's contract, provided the county retains responsibility for making placement decisions.

(c) The county may contract with a hospital to conduct chemical assessments if the requirements in subdivision 1a are met.

An assessor under this paragraph may not place clients in treatment. The assessor shall gather required information and provide it to the county along with any required documentation. The county shall make all placement decisions for clients assessed by assessors under this paragraph.

(d) An eligible vendor under section 254B.05 conducting a comprehensive assessment for an individual seeking treatment shall approve the nature, intensity level, and duration of treatment service if a need for services is indicated, but the individual assessed can access any enrolled provider that is licensed to provide the level of service authorized, including the provider or program that completed the assessment. If an individual is enrolled in a

prepaid health plan, the individual must comply with any provider network requirements or limitations.

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

Sec. 43. Minnesota Statutes 2016, section 254B.01, subdivision 3, is amended to read:

Subd. 3. **~~Chemical dependency~~ Substance use disorder treatment services.** "~~Chemical dependency~~ Substance use disorder treatment services" means a planned program of care for the treatment of ~~chemical dependency~~ substance misuse or ~~chemical abuse~~ substance use disorder to minimize or prevent further ~~chemical abuse~~ substance misuse by the person. Diagnostic, evaluation, prevention, referral, detoxification, and aftercare services that are not part of a program of care licensable as a residential or nonresidential ~~chemical dependency~~ substance use disorder treatment program are not ~~chemical dependency~~ substance use disorder services for purposes of this section. For pregnant and postpartum women, ~~chemical dependency~~ substance use disorder services include halfway house services, aftercare services, psychological services, and case management.

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

Sec. 44. Minnesota Statutes 2016, section 254B.01, is amended by adding a subdivision to read:

Subd. 8. **Recovery community organization.** "Recovery community organization" means a community-based organization that promotes a recovery-orientation as an underlying concept of healthy communities. A key role of a recovery community organization is the training of recovery peers, who provide mentorship and ongoing support to persons dealing with a substance use disorder, connecting them with the resources that can support that person's recovery.

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

Sec. 45. Minnesota Statutes 2016, section 254B.03, subdivision 2, is amended to read:

Subd. 2. **Chemical dependency fund payment.** (a) Payment from the chemical dependency fund is limited to payments for services other than detoxification licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, that, if located outside of federally recognized tribal lands, would be required to be licensed by the commissioner as a chemical dependency treatment or rehabilitation program under sections 245A.01 to 245A.16, and services other than detoxification provided in another state that would be required to be licensed as a chemical dependency program if the program were in the state. Out of state

vendors must also provide the commissioner with assurances that the program complies substantially with state licensing requirements and possesses all licenses and certifications required by the host state to provide chemical dependency treatment. ~~Except for chemical dependency transitional rehabilitation programs,~~ Vendors receiving payments from the chemical dependency fund must not require co-payment from a recipient of benefits for services provided under this subdivision. This includes but is not limited to cash or SNAP benefits. Retention of SNAP benefits is a right of a client receiving services through the consolidated chemical dependency treatment fund or through state contracted managed care entities. Payment from the chemical dependency fund shall be made for necessary room and board costs provided by vendors certified according to section 254B.05, or in a community hospital licensed by the commissioner of health according to sections 144.50 to 144.56 to a client who is:

(1) determined to meet the criteria for placement in a residential chemical dependency treatment program according to rules adopted under section 254A.03, subdivision 3; and

(2) concurrently receiving a chemical dependency treatment service in a program licensed by the commissioner and reimbursed by the chemical dependency fund.

(b) A county may, from its own resources, provide chemical dependency services for which state payments are not made. A county may elect to use the same invoice procedures and obtain the same state payment services as are used for chemical dependency services for which state payments are made under this section if county payments are made to the state in advance of state payments to vendors. When a county uses the state system for payment, the commissioner shall make monthly billings to the county using the most recent available information to determine the anticipated services for which payments will be made in the coming month. Adjustment of any overestimate or underestimate based on actual expenditures shall be made by the state agency by adjusting the estimate for any succeeding month.

(c) The commissioner shall coordinate chemical dependency services and determine whether there is a need for any proposed expansion of chemical dependency treatment services. The commissioner shall deny vendor certification to any provider that has not received prior approval from the commissioner for the creation of new programs or the expansion of existing program capacity. The commissioner shall consider the provider's capacity to obtain clients from outside the state based on plans, agreements, and previous utilization history, when determining the need for new treatment services.

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

Sec. 46. Minnesota Statutes 2016, section 254B.04, subdivision 1, is amended to read:

Subdivision 1. **Eligibility.** ~~(a)~~ Persons eligible for benefits under Code of Federal Regulations, title 25, part 20, and persons eligible for medical assistance benefits under sections 256B.055, 256B.056, and 256B.057, subdivisions 1, 5, and 6, or who meet the income standards of section 256B.056, subdivision 4, are entitled to chemical dependency fund services. State money appropriated for this paragraph must be placed in a separate account established for this purpose.

Persons with dependent children who are determined to be in need of chemical dependency treatment pursuant to an assessment under section 626.556, subdivision 10, or a case plan under section 260C.201, subdivision 6, or 260C.212, shall be assisted by the local agency to access needed treatment services. Treatment services must be appropriate for the individual or family, which may include long-term care treatment or treatment in a facility that allows the dependent children to stay in the treatment facility. The county shall pay for out-of-home placement costs, if applicable.

~~(b) A person not entitled to services under paragraph (a), but with family income that is less than 215 percent of the federal poverty guidelines for the applicable family size, shall be eligible to receive chemical dependency fund services within the limit of funds appropriated for this group for the fiscal year. If notified by the state agency of limited funds, a county must give preferential treatment to persons with dependent children who are in need of chemical dependency treatment pursuant to an assessment under section 626.556, subdivision 10, or a case plan under section 260C.201, subdivision 6, or 260C.212. A county may spend money from its own sources to serve persons under this paragraph. State money appropriated for this paragraph must be placed in a separate account established for this purpose.~~

~~(c) Persons whose income is between 215 percent and 412 percent of the federal poverty guidelines for the applicable family size shall be eligible for chemical dependency services on a sliding fee basis, within the limit of funds appropriated for this group for the fiscal year. Persons eligible under this paragraph must contribute to the cost of services according to the sliding fee scale established under subdivision 3. A county may spend money from its own sources to provide services to persons under this paragraph. State money appropriated for this paragraph must be placed in a separate account established for this purpose.~~

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

Sec. 47. Minnesota Statutes 2016, section 254B.04, subdivision 2b, is amended to read:

Subd. 2b. **Eligibility for placement in opioid treatment programs.** ~~(a) Notwithstanding provisions of Minnesota Rules, part 9530.6622, subpart 5, related to a placement authority's requirement to authorize services or service coordination in a program that complies with Minnesota Rules, part 9530.6500, or Code of Federal Regulations, title 42, part 8, and after taking into account an individual's preference for placement in an opioid treatment program, a placement authority may, but is not required to, authorize services or service coordination or otherwise place an individual in an opioid treatment program. Prior to making a determination of placement for an individual, the placing authority must consult with the current treatment provider, if any.~~

~~(b)~~ Prior to placement of an individual who is determined by the assessor to require treatment for opioid addiction, the assessor must provide educational information concerning treatment options for opioid addiction, including the use of a medication for the use of opioid addiction. The commissioner shall develop educational materials supported by research and updated periodically that must be used by assessors to comply with this requirement.

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

Sec. 48. Minnesota Statutes 2016, section 254B.05, subdivision 1, is amended to read:

Subdivision 1. **Licensure required.** (a) Programs licensed by the commissioner are eligible vendors. Hospitals may apply for and receive licenses to be eligible vendors, notwithstanding the provisions of section 245A.03. American Indian programs that provide ~~chemical dependency primary~~ substance use disorder treatment, extended care, transitional residence, or outpatient treatment services, and are licensed by tribal government are eligible vendors.

(b) On July 1, 2018, or upon federal approval, whichever is later, a licensed professional in private practice who meets the requirements of section 245G.11, subdivisions 1 and 4, is an eligible vendor of a comprehensive assessment and assessment summary provided according to section 245G.05, and treatment services provided according to sections 245G.06 and 245G.07, subdivision 1, paragraphs (a), clauses (1) to (5), and (b); and subdivision 2.

(c) On July 1, 2018, or upon federal approval, whichever is later, a county is an eligible vendor for a comprehensive assessment and assessment summary when provided by an individual who meets the staffing credentials of section 245G.11, subdivisions 1 and 4, and completed according to the requirements of section 245G.05. A county is an eligible vendor

of care coordination services when provided by an individual who meets the staffing credentials of section 245G.11, subdivisions 1 and 7, and provided according to the requirements of section 245G.07, subdivision 1, clause (7).

(d) On July 1, 2018, or upon federal approval, whichever is later, a recovery community organization that meets certification requirements identified by the commissioner is an eligible vendor of peer support services.

(e) Detoxification programs licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, are not eligible vendors. Programs that are not licensed as a ~~chemical dependency~~ residential or nonresidential substance use disorder treatment or withdrawal management program by the commissioner or by tribal government or do not meet the requirements of subdivisions 1a and 1b are not eligible vendors.

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

Sec. 49. Minnesota Statutes 2016, section 254B.05, subdivision 1a, is amended to read:

Subd. 1a. **Room and board provider requirements.** (a) Effective January 1, 2000, vendors of room and board are eligible for chemical dependency fund payment if the vendor:

(1) has rules prohibiting residents bringing chemicals into the facility or using chemicals while residing in the facility and provide consequences for infractions of those rules;

(2) is determined to meet applicable health and safety requirements;

(3) is not a jail or prison;

(4) is not concurrently receiving funds under chapter 256I for the recipient;

(5) admits individuals who are 18 years of age or older;

(6) is registered as a board and lodging or lodging establishment according to section 157.17;

(7) has awake staff on site 24 hours per day;

(8) has staff who are at least 18 years of age and meet the requirements of ~~Minnesota Rules, part 9530.6450, subpart 1, item A~~ section 245G.11, subdivision 1, paragraph (a);

(9) has emergency behavioral procedures that meet the requirements of ~~Minnesota Rules, part 9530.6475~~ section 245G.16;

(10) meets the requirements of ~~Minnesota Rules, part 9530.6435, subparts 3 and 4, items A and B~~ section 245G.08, subdivision 5, if administering medications to clients;

(11) meets the abuse prevention requirements of section 245A.65, including a policy on fraternization and the mandatory reporting requirements of section 626.557;

(12) documents coordination with the treatment provider to ensure compliance with section 254B.03, subdivision 2;

(13) protects client funds and ensures freedom from exploitation by meeting the provisions of section 245A.04, subdivision 13;

(14) has a grievance procedure that meets the requirements of ~~Minnesota Rules, part 9530.6470, subpart 2~~ section 245G.15, subdivision 2; and

(15) has sleeping and bathroom facilities for men and women separated by a door that is locked, has an alarm, or is supervised by awake staff.

(b) Programs licensed according to Minnesota Rules, chapter 2960, are exempt from paragraph (a), clauses (5) to (15).

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

Sec. 50. Minnesota Statutes 2016, section 254B.05, subdivision 5, is amended to read:

Subd. 5. **Rate requirements.** (a) The commissioner shall establish rates for ~~chemical dependency~~ substance use disorder services and service enhancements funded under this chapter.

(b) Eligible ~~chemical dependency~~ substance use disorder treatment services include:

(1) outpatient treatment services that are licensed according to ~~Minnesota Rules, parts 9530.6405 to 9530.6480~~ sections 245G.01 to 245G.17, or applicable tribal license;

(2) on July 1, 2018, or upon federal approval, whichever is later, comprehensive assessments provided according to sections 245.4863, paragraph (a), and 245G.05, and Minnesota Rules, part 9530.6422;

(3) on July 1, 2018, or upon federal approval, whichever is later, care coordination services provided according to section 245G.07, subdivision 1, paragraph (a), clause (6);

(4) on July 1, 2018, or upon federal approval, whichever is later, peer recovery support services provided according to section 245G.07, subdivision 1, paragraph (a), clause (5);

(5) on July 1, 2018, or upon federal approval, whichever is later, withdrawal management services provided according to chapter 245F;

~~(2)~~ (6) medication-assisted therapy services that are licensed according to ~~Minnesota Rules, parts 9530.6405 to 9530.6480 and 9530.6500~~ section 245G.07, subdivision 1, or applicable tribal license;

~~(3)~~ (7) medication-assisted therapy plus enhanced treatment services that meet the requirements of clause ~~(2)~~ (6) and provide nine hours of clinical services each week;

~~(4)~~ (8) high, medium, and low intensity residential treatment services that are licensed according to ~~Minnesota Rules, parts 9530.6405 to 9530.6480 and 9530.6505,~~ sections 245G.01 to 245G.17 and 245G.22 or applicable tribal license which provide, respectively, 30, 15, and five hours of clinical services each week;

~~(5)~~ (9) hospital-based treatment services that are licensed according to ~~Minnesota Rules, parts 9530.6405 to 9530.6480,~~ sections 245G.01 to 245G.17 or applicable tribal license and licensed as a hospital under sections 144.50 to 144.56;

~~(6)~~ (10) adolescent treatment programs that are licensed as outpatient treatment programs according to ~~Minnesota Rules, parts 9530.6405 to 9530.6485,~~ sections 245G.01 to 245G.18 or as residential treatment programs according to Minnesota Rules, parts 2960.0010 to 2960.0220, and 2960.0430 to 2960.0490, or applicable tribal license;

~~(7)~~ (11) high-intensity residential treatment services that are licensed according to ~~Minnesota Rules, parts 9530.6405 to 9530.6480 and 9530.6505,~~ sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license, which provide 30 hours of clinical services each week provided by a state-operated vendor or to clients who have been civilly committed to the commissioner, present the most complex and difficult care needs, and are a potential threat to the community; and

~~(8)~~ (12) room and board facilities that meet the requirements of subdivision 1a.

(c) The commissioner shall establish higher rates for programs that meet the requirements of paragraph (b) and one of the following additional requirements:

(1) programs that serve parents with their children if the program:

(i) provides on-site child care during the hours of treatment activity that:

(A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter 9503; or

(B) meets the licensure exclusion criteria of section 245A.03, subdivision 2, paragraph (a), clause (6), and meets the requirements under ~~Minnesota Rules, part 9530.6490, subpart 4~~ section 245G.19, subdivision 4; or

(ii) arranges for off-site child care during hours of treatment activity at a facility that is licensed under chapter 245A as:

(A) a child care center under Minnesota Rules, chapter 9503; or

(B) a family child care home under Minnesota Rules, chapter 9502;

(2) culturally specific programs as defined in section 254B.01, subdivision 4a, or programs or subprograms serving special populations, if the program or subprogram meets the following requirements:

(i) is designed to address the unique needs of individuals who share a common language, racial, ethnic, or social background;

(ii) is governed with significant input from individuals of that specific background; and

(iii) employs individuals to provide individual or group therapy, at least 50 percent of whom are of that specific background, except when the common social background of the individuals served is a traumatic brain injury or cognitive disability and the program employs treatment staff who have the necessary professional training, as approved by the commissioner, to serve clients with the specific disabilities that the program is designed to serve;

(3) programs that offer medical services delivered by appropriately credentialed health care staff in an amount equal to two hours per client per week if the medical needs of the client and the nature and provision of any medical services provided are documented in the client file; and

(4) programs that offer services to individuals with co-occurring mental health and chemical dependency problems if:

(i) the program meets the co-occurring requirements in ~~Minnesota Rules, part 9530.6495~~ section 245G.20;

(ii) 25 percent of the counseling staff are licensed mental health professionals, as defined in section 245.462, subdivision 18, clauses (1) to (6), or are students or licensing candidates under the supervision of a licensed alcohol and drug counselor supervisor and licensed mental health professional, except that no more than 50 percent of the mental health staff may be students or licensing candidates with time documented to be directly related to provisions of co-occurring services;

(iii) clients scoring positive on a standardized mental health screen receive a mental health diagnostic assessment within ten days of admission;

(iv) the program has standards for multidisciplinary case review that include a monthly review for each client that, at a minimum, includes a licensed mental health professional and licensed alcohol and drug counselor, and their involvement in the review is documented;

(v) family education is offered that addresses mental health and substance abuse disorders and the interaction between the two; and

(vi) co-occurring counseling staff shall receive eight hours of co-occurring disorder training annually.

(d) In order to be eligible for a higher rate under paragraph (c), clause (1), a program that provides arrangements for off-site child care must maintain current documentation at the chemical dependency facility of the child care provider's current licensure to provide child care services. Programs that provide child care according to paragraph (c), clause (1), must be deemed in compliance with the licensing requirements in ~~Minnesota Rules, part 9530.6490~~ section 245G.19.

(e) Adolescent residential programs that meet the requirements of Minnesota Rules, parts 2960.0430 to 2960.0490 and 2960.0580 to 2960.0690, are exempt from the requirements in paragraph (c), clause (4), items (i) to (iv).

(f) Subject to federal approval, chemical dependency services that are otherwise covered as direct face-to-face services may be provided via two-way interactive video. The use of two-way interactive video must be medically appropriate to the condition and needs of the person being served. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to direct face-to-face services. The interactive video equipment and connection must comply with Medicare standards in effect at the time the service is provided.

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

Sec. 51. Minnesota Statutes 2016, section 254B.051, is amended to read:

254B.051 SUBSTANCE ~~ABUSE~~ USE DISORDER TREATMENT EFFECTIVENESS.

In addition to the substance ~~abuse~~ use disorder treatment program performance outcome measures that the commissioner of human services collects annually from treatment providers, the commissioner shall request additional data from programs that receive appropriations from the consolidated chemical dependency treatment fund. This data shall include number of client readmissions six months after release from inpatient treatment, and the cost of

treatment per person for each program receiving consolidated chemical dependency treatment funds. The commissioner may post this data on the department Web site.

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

Sec. 52. Minnesota Statutes 2016, section 254B.07, is amended to read:

254B.07 THIRD-PARTY LIABILITY.

The state agency provision and payment of, or liability for, ~~chemical dependency~~ substance use disorder medical care is the same as in section 256B.042.

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

Sec. 53. Minnesota Statutes 2016, section 254B.08, is amended to read:

254B.08 FEDERAL WAIVERS.

The commissioner shall apply for any federal waivers necessary to secure, to the extent allowed by law, federal financial participation for the provision of services to persons who need ~~chemical dependency~~ substance use disorder services. The commissioner may seek amendments to the waivers or apply for additional waivers to contain costs. The commissioner shall ensure that payment for the cost of providing ~~chemical dependency~~ substance use disorder services under the federal waiver plan does not exceed the cost of ~~chemical dependency~~ substance use disorder services that would have been provided without the waivered services.

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

Sec. 54. Minnesota Statutes 2016, section 254B.09, is amended to read:

254B.09 INDIAN RESERVATION ALLOCATION OF CHEMICAL DEPENDENCY FUND.

Subdivision 1. **Vendor payments.** The commissioner shall pay eligible vendors for ~~chemical dependency~~ substance use disorder services to American Indians on the same basis as other payments, except that no local match is required when an invoice is submitted by the governing authority of a federally recognized American Indian tribal body or a county if the tribal governing body has not entered into an agreement under subdivision 2 on behalf of a current resident of the reservation under this section.

Subd. 2. **American Indian agreements.** The commissioner may enter into agreements with federally recognized tribal units to pay for ~~chemical dependency~~ substance use disorder

treatment services provided under Laws 1986, chapter 394, sections 8 to 20. The agreements must clarify how the governing body of the tribal unit fulfills local agency responsibilities regarding:

(1) the form and manner of invoicing; and

(2) provide that only invoices for eligible vendors according to section 254B.05 will be included in invoices sent to the commissioner for payment, to the extent that money allocated under subdivisions 4 and 5 is used.

Subd. 6. **American Indian tribal placements.** After entering into an agreement under subdivision 2, the governing authority of each reservation may submit invoices to the state for the cost of providing ~~chemical dependency~~ substance use disorder services to residents of the reservation according to the placement rules governing county placements, except that local match requirements are waived. The governing body may designate an agency to act on its behalf to provide placement services and manage invoices by written notice to the commissioner and evidence of agreement by the agency designated.

Subd. 8. **Payments to improve services to American Indians.** The commissioner may set rates for ~~chemical dependency~~ substance use disorder services to American Indians according to the American Indian Health Improvement Act, Public Law 94-437, for eligible vendors. These rates shall supersede rates set in county purchase of service agreements when payments are made on behalf of clients eligible according to Public Law 94-437.

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

Sec. 55. Minnesota Statutes 2016, section 254B.12, subdivision 2, is amended to read:

Subd. 2. **Payment methodology for highly specialized vendors.** Notwithstanding subdivision 1, the commissioner shall seek federal authority to develop separate payment methodologies for ~~chemical dependency~~ substance use disorder treatment services provided under the consolidated chemical dependency treatment fund: (1) by a state-operated vendor; or (2) for persons who have been civilly committed to the commissioner, present the most complex and difficult care needs, and are a potential threat to the community. A payment methodology under this subdivision is effective for services provided on or after October 1, 2015, or on or after the receipt of federal approval, whichever is later.

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

Sec. 56. Minnesota Statutes 2016, section 254B.13, subdivision 2a, is amended to read:

Subd. 2a. **Eligibility for navigator pilot program.** (a) To be considered for participation in a navigator pilot program, an individual must:

(1) be a resident of a county with an approved navigator program;

(2) be eligible for consolidated chemical dependency treatment fund services;

(3) be a voluntary participant in the navigator program;

(4) satisfy one of the following items:

(i) have at least one severity rating of three or above in dimension four, five, or six in a comprehensive assessment under ~~Minnesota Rules, part 9530.6422~~ section 245G.05, paragraph (c), clauses (4) to (6); or

(ii) have at least one severity rating of two or above in dimension four, five, or six in a comprehensive assessment under ~~Minnesota Rules, part 9530.6422,~~ section 245G.05, paragraph (c), clauses (4) to (6), and be currently participating in a Rule 31 treatment program under ~~Minnesota Rules, parts 9530.6405 to 9530.6505,~~ chapter 245G or be within 60 days following discharge after participation in a Rule 31 treatment program; and

(5) have had at least two treatment episodes in the past two years, not limited to episodes reimbursed by the consolidated chemical dependency treatment funds. An admission to an emergency room, a detoxification program, or a hospital may be substituted for one treatment episode if it resulted from the individual's substance use disorder.

(b) New eligibility criteria may be added as mutually agreed upon by the commissioner and participating navigator programs.

EFFECTIVE DATE. This section is effective July 1, 2017.

Sec. 57. Minnesota Statutes 2016, section 256B.0945, subdivision 2, is amended to read:

Subd. 2. **Covered services.** All services must be included in a child's individualized treatment or multiagency plan of care as defined in chapter 245.

For facilities that are not institutions for mental diseases according to federal statute and regulation, medical assistance covers mental health-related services that are required to be provided by a residential facility under section 245.4882 and administrative rules promulgated thereunder, except for room and board. For residential facilities determined by the federal Centers for Medicare and Medicaid Services to be an institution for mental diseases, medical

assistance covers medically necessary mental health services provided by the facility according to section 256B.055, subdivision 13, except for room and board.

EFFECTIVE DATE. This section is effective for services provided on July 1, 2017, through June 30, 2020, and expires effective July 1, 2020.

Sec. 58. Minnesota Statutes 2016, section 256B.0945, subdivision 4, is amended to read:

Subd. 4. **Payment rates.** (a) Notwithstanding sections 256B.19 and 256B.041, payments to counties for residential services provided under this section by a residential facility shall:

(1) for services provided by a residential facility that is not an institution for mental diseases, only be made of federal earnings for services provided ~~under this section,~~ and the nonfederal share of costs for services provided under this section shall be paid by the county from sources other than federal funds or funds used to match other federal funds. Payment to counties for services provided according to this section shall be a proportion of the per day contract rate that relates to rehabilitative mental health services and shall not include payment for costs or services that are billed to the IV-E program as room and board~~.~~; and

(2) for services provided by a residential facility that is determined to be an institution for mental diseases, be equivalent to the federal share of the payment that would have been made if the residential facility were not an institution for mental diseases. The portion of the payment representing what would be the nonfederal share shall be paid by the county. Payment to counties for services provided according to this section shall be a proportion of the per-day contract rate that relates to rehabilitative mental health services and shall not include payment for costs or services that are billed to the IV-E program as room and board.

(b) Per diem rates paid to providers under this section by prepaid plans shall be the proportion of the per-day contract rate that relates to rehabilitative mental health services and shall not include payment for group foster care costs or services that are billed to the county of financial responsibility. Services provided in facilities located in bordering states are eligible for reimbursement on a fee-for-service basis only as described in paragraph (a) and are not covered under prepaid health plans.

(c) Payment for mental health rehabilitative services provided under this section by or under contract with an American Indian tribe or tribal organization or by agencies operated by or under contract with an American Indian tribe or tribal organization must be made according to section 256B.0625, subdivision 34, or other relevant federally approved rate-setting methodology.

(d) The commissioner shall set aside a portion not to exceed five percent of the federal funds earned for county expenditures under this section to cover the state costs of administering this section. Any unexpended funds from the set-aside shall be distributed to the counties in proportion to their earnings under this section.

EFFECTIVE DATE. This section is effective for services provided on July 1, 2017, through June 30, 2020, and expires effective July 1, 2020.

Sec. 59. **RESIDENTIAL TREATMENT AND PAYMENT RATE REFORM.**

The commissioner shall contract with an outside expert to identify recommendations for the development of a substance use disorder residential treatment program model and payment structure that is not subject to the federal institutions for mental diseases exclusion and that is financially sustainable for providers, while incentivizing best practices and improved treatment outcomes. The analysis and report must include recommendations and a timeline for supporting providers to transition to the new models of care delivery. No later than December 15, 2018, a report with recommendations must be delivered to members of the legislative committees in the house of representatives and senate with jurisdiction over health and human services policy and finance.

EFFECTIVE DATE. This section is effective July 1, 2017.

Sec. 60. **CHILDREN'S MENTAL HEALTH REPORT AND RECOMMENDATIONS.**

The commissioner of human services shall conduct a comprehensive analysis of Minnesota's continuum of intensive mental health services and shall develop recommendations for a sustainable and community-driven continuum of care for children with serious mental health needs, including children currently being served in residential treatment. The commissioner's analysis shall include, but not be limited to:

(1) data related to access, utilization, efficacy, and outcomes for Minnesota's current system of residential mental health treatment for a child with a severe emotional disturbance;

(2) potential expansion of the state's psychiatric residential treatment facility (PRTF) capacity, including increasing the number of PRTF beds and conversion of existing children's mental health residential treatment programs into PRTFs;

(3) the capacity need for PRTF and other group settings within the state if adequate community-based alternatives are accessible, equitable, and effective statewide;

(4) recommendations for expanding alternative community-based service models to meet the needs of a child with a serious mental health disorder who would otherwise require

residential treatment and potential service models that could be utilized, including data related to access, utilization, efficacy, and outcomes;

(5) models of care used in other states; and

(6) analysis and specific recommendations for the design and implementation of new service models, including analysis to inform rate setting as necessary.

The analysis shall be supported and informed by extensive stakeholder engagement. Stakeholders include individuals who receive services, family members of individuals who receive services, providers, counties, health plans, advocates and others. Stakeholder engagement shall include interviews with key stakeholders, intentional outreach to individuals who receive services and the individual's family members, and regional listening sessions.

The commissioner shall provide a report with specific recommendations and timelines for implementation to the legislative committees with jurisdiction over children's mental health policy and finance by November 15, 2018.

EFFECTIVE DATE. This section is effective July 1, 2017.

Sec. 61. **REVISOR'S INSTRUCTION.**

In Minnesota Statutes and Minnesota Rules, the revisor of statutes, in consultation with the with the Department of Human Services, shall make necessary cross-reference changes that are needed as a result of the enactment of sections 5 to 26 and 56. The revisor shall make any necessary technical and grammatical changes to preserve the meaning of the text.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 62. **REPEALER.**

(a) Minnesota Statutes 2016, sections 245A.1915; 245A.192; and 254A.02, subdivision 4, are repealed.

(b) Minnesota Rules, parts 9530.6405, subparts 1, 1a, 2, 3, 4, 5, 6, 7, 7a, 8, 9, 10, 11, 12, 13, 14, 14a, 15, 15a, 16, 17, 17a, 17b, 17c, 18, 20, and 21; 9530.6410; 9530.6415; 9530.6420; 9530.6422; 9530.6425; 9530.6430; 9530.6435; 9530.6440; 9530.6445; 9530.6450; 9530.6455; 9530.6460; 9530.6465; 9530.6470; 9530.6475; 9530.6480; 9530.6485; 9530.6490; 9530.6495; 9530.6500; and 9530.6505, are repealed.

EFFECTIVE DATE. This section is effective July 1, 2017.

ARTICLE 9

OPERATIONS

Section 1. Minnesota Statutes 2016, section 245A.04, subdivision 4, is amended to read:

Subd. 4. **Inspections; waiver.** (a) Before issuing an initial license, the commissioner shall conduct an inspection of the program. The inspection must include but is not limited to:

(1) an inspection of the physical plant;

(2) an inspection of records and documents;

(3) an evaluation of the program by consumers of the program; ~~and~~

(4) observation of the program in operation~~.~~; and

(5) an inspection for the health, safety, and fire standards in licensing requirements for a child care license holder.

For the purposes of this subdivision, "consumer" means a person who receives the services of a licensed program, the person's legal guardian, or the parent or individual having legal custody of a child who receives the services of a licensed program.

(b) The evaluation required in paragraph (a), clause (3) or the observation in paragraph (a), clause (4) is not required prior to issuing an initial license under subdivision 7. If the commissioner issues an initial license under subdivision 7, these requirements must be completed within one year after the issuance of an initial license.

(c) The commissioner or the county shall inspect at least annually a child care provider licensed under this chapter and Minnesota Rules, chapter 9502 or 9503, for compliance with applicable licensing standards.

(d) No later than November 19, 2017, the commissioner shall make publicly available on the department's Web site the results of inspection reports of all child care providers licensed under this chapter and under Minnesota Rules, chapter 9502 or 9503, and the number of deaths, serious injuries, and instances of substantiated child maltreatment that occurred in licensed child care settings each year.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 2. Minnesota Statutes 2016, section 245A.07, subdivision 3, is amended to read:

Subd. 3. **License suspension, revocation, or fine.** (a) The commissioner may suspend or revoke a license, or impose a fine if:

(1) a license holder fails to comply fully with applicable laws or rules;

(2) a license holder, a controlling individual, or an individual living in the household where the licensed services are provided or is otherwise subject to a background study has a disqualification which has not been set aside under section 245C.22;

(3) a license holder knowingly withholds relevant information from or gives false or misleading information to the commissioner in connection with an application for a license, in connection with the background study status of an individual, during an investigation, or regarding compliance with applicable laws or rules; or

(4) after July 1, 2012, and upon request by the commissioner, a license holder fails to submit the information required of an applicant under section 245A.04, subdivision 1, paragraph (f) or (g).

A license holder who has had a license suspended, revoked, or has been ordered to pay a fine must be given notice of the action by certified mail or personal service. If mailed, the notice must be mailed to the address shown on the application or the last known address of the license holder. The notice must state the reasons the license was suspended, revoked, or a fine was ordered.

(b) If the license was suspended or revoked, the notice must inform the license holder of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The license holder may appeal an order suspending or revoking a license. The appeal of an order suspending or revoking a license must be made in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within ten calendar days after the license holder receives notice that the license has been suspended or revoked. If a request is made by personal service, it must be received by the commissioner within ten calendar days after the license holder received the order. Except as provided in subdivision 2a, paragraph (c), if a license holder submits a timely appeal of an order suspending or revoking a license, the license holder may continue to operate the program as provided in section 245A.04, subdivision 7, paragraphs (g) and (h), until the commissioner issues a final order on the suspension or revocation.

(c)(1) If the license holder was ordered to pay a fine, the notice must inform the license holder of the responsibility for payment of fines and the right to a contested case hearing

under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The appeal of an order to pay a fine must be made in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within ten calendar days after the license holder receives notice that the fine has been ordered. If a request is made by personal service, it must be received by the commissioner within ten calendar days after the license holder received the order.

(2) The license holder shall pay the fines assessed on or before the payment date specified. If the license holder fails to fully comply with the order, the commissioner may issue a second fine or suspend the license until the license holder complies. If the license holder receives state funds, the state, county, or municipal agencies or departments responsible for administering the funds shall withhold payments and recover any payments made while the license is suspended for failure to pay a fine. A timely appeal shall stay payment of the fine until the commissioner issues a final order.

(3) A license holder shall promptly notify the commissioner of human services, in writing, when a violation specified in the order to forfeit a fine is corrected. If upon reinspection the commissioner determines that a violation has not been corrected as indicated by the order to forfeit a fine, the commissioner may issue a second fine. The commissioner shall notify the license holder by certified mail or personal service that a second fine has been assessed. The license holder may appeal the second fine as provided under this subdivision.

(4) Fines shall be assessed as follows:

(i) the license holder shall forfeit $1,000 for each determination of maltreatment of a child under section 626.556 or the maltreatment of a vulnerable adult under section 626.557 for which the license holder is determined responsible for the maltreatment under section 626.556, subdivision 10e, paragraph (i), or 626.557, subdivision 9c, paragraph (c);

(ii) if the commissioner determines that a license holder is responsible for more than one determination of maltreatment at the same site within a 12-month period, the license holder shall forfeit $2,000 for each additional determination of maltreatment for which the license holder is responsible;

(iii) if the commissioner determines that a determination of maltreatment for which the license holder is responsible is the result of systemic failure and the underlying facts that constitute maltreatment meet the definition of "serious maltreatment" in section 245C.02, subdivision 18, the license holder shall forfeit $5,000;

(iv) for a program that operates out of the license holder's home and a program licensed under Minnesota Rules, parts 9502.0300 to 9502.0455, the fine assessed against the license holder shall not exceed $1,000 for each determination of maltreatment;

(v) the license holder shall forfeit $200 for each occurrence of a violation of law or rule governing matters of health, safety, or supervision, including but not limited to the provision of adequate staff-to-child or adult ratios, and failure to comply with background study requirements under chapter 245C; and

(vi) the license holder shall forfeit $100 for each occurrence of a violation of law or rule other than those subject to a $200, $1,000, $2,000, or ~~$200~~ $5,000 fine ~~above~~ in items (i) to (v).

For purposes of this section, "occurrence" means each violation identified in the commissioner's fine order. Fines assessed against a license holder that holds a license to provide home and community-based services, as identified in section 245D.03, subdivision 1, and a community residential setting or day services facility license under chapter 245D where the services are provided, may be assessed against both licenses for the same occurrence, but the combined amount of the fines shall not exceed the amount specified in this clause for that occurrence.

(5) When a fine has been assessed, the license holder may not avoid payment by closing, selling, or otherwise transferring the licensed program to a third party. In such an event, the license holder will be personally liable for payment. In the case of a corporation, each controlling individual is personally and jointly liable for payment.

(d) Except for background study violations involving the failure to comply with an order to immediately remove an individual or an order to provide continuous, direct supervision, the commissioner shall not issue a fine under paragraph (c) relating to a background study violation to a license holder who self-corrects a background study violation before the commissioner discovers the violation. A license holder who has previously exercised the provisions of this paragraph to avoid a fine for a background study violation may not avoid a fine for a subsequent background study violation unless at least 365 days have passed since the license holder self-corrected the earlier background study violation.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 3. Minnesota Statutes 2016, section 245A.09, subdivision 7, is amended to read:

Subd. 7. **Regulatory methods.** (a) Where appropriate and feasible the commissioner shall identify and implement alternative methods of regulation and enforcement to the extent authorized in this subdivision. These methods shall include:

(1) expansion of the types and categories of licenses that may be granted;

(2) when the standards of another state or federal governmental agency or an independent accreditation body have been shown to require the same standards, methods, or alternative methods to achieve substantially the same intended outcomes as the licensing standards, the commissioner shall consider compliance with the governmental or accreditation standards to be equivalent to partial compliance with the licensing standards; and

(3) use of an abbreviated inspection that employs key standards that have been shown to predict full compliance with the rules.

(b) If the commissioner accepts accreditation as documentation of compliance with a licensing standard under paragraph (a), the commissioner shall continue to investigate complaints related to noncompliance with all licensing standards. The commissioner may take a licensing action for noncompliance under this chapter and shall recognize all existing appeal rights regarding any licensing actions taken under this chapter.

(c) The commissioner shall work with the commissioners of health, public safety, administration, and education in consolidating duplicative licensing and certification rules and standards if the commissioner determines that consolidation is administratively feasible, would significantly reduce the cost of licensing, and would not reduce the protection given to persons receiving services in licensed programs. Where administratively feasible and appropriate, the commissioner shall work with the commissioners of health, public safety, administration, and education in conducting joint agency inspections of programs.

(d) The commissioner shall work with the commissioners of health, public safety, administration, and education in establishing a single point of application for applicants who are required to obtain concurrent licensure from more than one of the commissioners listed in this clause.

(e) Unless otherwise specified in statute, the commissioner may conduct routine inspections biennially.

(f) For a licensed child care center, the commissioner shall conduct one unannounced licensing inspection at least annually.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 4. Minnesota Statutes 2016, section 245A.10, subdivision 2, is amended to read:

Subd. 2. **County fees for background studies and licensing inspections.** (a) Before the implementation of NETStudy 2.0, for purposes of family and group family child care licensing under this chapter, a county agency may charge a fee to an applicant or license holder to recover the actual cost of background studies, but in any case not to exceed $100 annually. A county agency may also charge a license fee to an applicant or license holder not to exceed $50 for a one-year license or $100 for a two-year license.

(b) Before the implementation of NETStudy 2.0, a county agency may charge a fee to a legal nonlicensed child care provider or applicant for authorization to recover the actual cost of background studies completed under section 119B.125, but in any case not to exceed $100 annually.

(c) Counties may elect to reduce or waive the fees in paragraph (a) or (b):

(1) in cases of financial hardship;

(2) if the county has a shortage of providers in the county's area;

(3) for new providers; or

(4) for providers who have attained at least 16 hours of training before seeking initial licensure.

(d) Counties may allow providers to pay the applicant fees in paragraph (a) or (b) on an installment basis for up to one year. If the provider is receiving child care assistance payments from the state, the provider may have the fees under paragraph (a) or (b) deducted from the child care assistance payments for up to one year and the state shall reimburse the county for the county fees collected in this manner.

(e) For purposes of adult foster care and child foster care licensing, and licensing the physical plant of a community residential setting, under this chapter, a county agency may charge a fee to a corporate applicant or corporate license holder to recover the actual cost of licensing inspections, not to exceed $500 annually.

(f) Counties may elect to reduce or waive the fees in paragraph (e) under the following circumstances:

(1) in cases of financial hardship;

(2) if the county has a shortage of providers in the county's area; or

(3) for new providers.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 5. Minnesota Statutes 2016, section 245A.10, subdivision 4, is amended to read:

Subd. 4. **License or certification fee for certain programs.** (a) Child care centers shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	Child Care Center License Fee
1 to 24 persons	$200
25 to 49 persons	$300
50 to 74 persons	$400
75 to 99 persons	$500
100 to 124 persons	$600
125 to 149 persons	$700
150 to 174 persons	$800
175 to 199 persons	$900
200 to 224 persons	$1,000
225 or more persons	$1,100

(b)(1) A program licensed to provide one or more of the home and community-based services and supports identified under chapter 245D to persons with disabilities or age 65 and older, shall pay an annual nonrefundable license fee ~~based on~~ that is the greater of either $400 or 0.34 percent of revenues derived from the provision of services that would require licensure under this chapter ~~245D~~ and that are specified under section 245D.03, subdivision 1, during the calendar year immediately preceding the year in which the license fee is paid~~, according to the following schedule:~~.

~~License Holder Annual Revenue~~	~~License Fee~~
~~less than or equal to $10,000~~	~~$200~~
~~greater than $10,000 but less than or equal to $25,000~~	~~$300~~
~~greater than $25,000 but less than or equal to $50,000~~	~~$400~~
~~greater than $50,000 but less than or equal to $100,000~~	~~$500~~
~~greater than $100,000 but less than or equal to $150,000~~	~~$600~~
~~greater than $150,000 but less than or equal to $200,000~~	~~$800~~
~~greater than $200,000 but less than or equal to $250,000~~	~~$1,000~~

~~greater than $250,000 but less than or equal to $300,000~~	~~$1,200~~
~~greater than $300,000 but less than or equal to $350,000~~	~~$1,400~~
~~greater than $350,000 but less than or equal to $400,000~~	~~$1,600~~
~~greater than $400,000 but less than or equal to $450,000~~	~~$1,800~~
~~greater than $450,000 but less than or equal to $500,000~~	~~$2,000~~
~~greater than $500,000 but less than or equal to $600,000~~	~~$2,250~~
~~greater than $600,000 but less than or equal to $700,000~~	~~$2,500~~
~~greater than $700,000 but less than or equal to $800,000~~	~~$2,750~~
~~greater than $800,000 but less than or equal to $900,000~~	~~$3,000~~
~~greater than $900,000 but less than or equal to $1,000,000~~	~~$3,250~~
~~greater than $1,000,000 but less than or equal to $1,250,000~~	~~$3,500~~
~~greater than $1,250,000 but less than or equal to $1,500,000~~	~~$3,750~~
~~greater than $1,500,000 but less than or equal to $1,750,000~~	~~$4,000~~
~~greater than $1,750,000 but less than or equal to $2,000,000~~	~~$4,250~~
~~greater than $2,000,000 but less than or equal to $2,500,000~~	~~$4,500~~
~~greater than $2,500,000 but less than or equal to $3,000,000~~	~~$4,750~~
~~greater than $3,000,000 but less than or equal to $3,500,000~~	~~$5,000~~
~~greater than $3,500,000 but less than or equal to $4,000,000~~	~~$5,500~~
~~greater than $4,000,000 but less than or equal to $4,500,000~~	~~$6,000~~
~~greater than $4,500,000 but less than or equal to $5,000,000~~	~~$6,500~~
~~greater than $5,000,000 but less than or equal to $7,500,000~~	~~$7,000~~
~~greater than $7,500,000 but less than or equal to $10,000,000~~	~~$8,500~~
~~greater than $10,000,000 but less than or equal to $12,500,000~~	~~$10,000~~

~~greater than $12,500,000 but less than or equal to $15,000,000~~	~~$14,000~~
~~greater than $15,000,000~~	~~$18,000~~

(2) If requested, the license holder shall provide the commissioner information to verify the license holder's annual revenues or other information as needed, including copies of documents submitted to the Department of Revenue.

~~(3) At each annual renewal, a license holder may elect to pay the highest renewal fee, and not provide annual revenue information to the commissioner.~~

~~(4)~~ (3) A license holder that knowingly provides the commissioner incorrect revenue amounts for the purpose of paying a lower license fee shall be subject to a civil penalty in the amount of double the fee the provider should have paid.

~~(5) Notwithstanding clause (1), a license holder providing services under one or more licenses under chapter 245B that are in effect on May 15, 2013, shall pay an annual license fee for calendar years 2014, 2015, and 2016, equal to the total license fees paid by the license holder for all licenses held under chapter 245B for calendar year 2013. For calendar year 2017 and thereafter, the license holder shall pay an annual license fee according to clause (1).~~

(4) The commissioner shall calculate the licensing fee for a provider of home and community-based services and supports under this paragraph and invoice the license holder annually. If the license holder challenges the fee amount invoiced, the commissioner shall provide the license holder with a report identifying the medical assistance claims paid by the commissioner to the license holder that formed the basis for the licensing fee calculation.

(c) A chemical dependency treatment program licensed under Minnesota Rules, parts 9530.6405 to 9530.6505, to provide chemical dependency treatment shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$600
25 to 49 persons	$800
50 to 74 persons	$1,000
75 to 99 persons	$1,200
100 or more persons	$1,400

(d) A chemical dependency program licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, to provide detoxification services shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$760
25 to 49 persons	$960
50 or more persons	$1,160

(e) Except for child foster care, a residential facility licensed under Minnesota Rules, chapter 2960, to serve children shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$1,000
25 to 49 persons	$1,100
50 to 74 persons	$1,200
75 to 99 persons	$1,300
100 or more persons	$1,400

(f) A residential facility licensed under Minnesota Rules, parts 9520.0500 to 9520.0670, to serve persons with mental illness shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$2,525
25 or more persons	$2,725

(g) A residential facility licensed under Minnesota Rules, parts 9570.2000 to 9570.3400, to serve persons with physical disabilities shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$450
25 to 49 persons	$650
50 to 74 persons	$850
75 to 99 persons	$1,050
100 or more persons	$1,250

(h) A program licensed to provide independent living assistance for youth under section 245A.22 shall pay an annual nonrefundable license fee of $1,500.

(i) A private agency licensed to provide foster care and adoption services under Minnesota Rules, parts 9545.0755 to 9545.0845, shall pay an annual nonrefundable license fee of $875.

(j) A program licensed as an adult day care center licensed under Minnesota Rules, parts 9555.9600 to 9555.9730, shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$500
25 to 49 persons	$700
50 to 74 persons	$900
75 to 99 persons	$1,100
100 or more persons	$1,300

(k) A program licensed to provide treatment services to persons with sexual psychopathic personalities or sexually dangerous persons under Minnesota Rules, parts 9515.3000 to 9515.3110, shall pay an annual nonrefundable license fee of $20,000.

(l) A mental health center or mental health clinic requesting certification for purposes of insurance and subscriber contract reimbursement under Minnesota Rules, parts 9520.0750 to 9520.0870, shall pay a certification fee of $1,550 per year. If the mental health center or mental health clinic provides services at a primary location with satellite facilities, the satellite facilities shall be certified with the primary location without an additional charge.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 6. Minnesota Statutes 2016, section 245A.14, is amended by adding a subdivision to read:

Subd. 15. **Parental access in child care programs.** An enrolled child's parent or legal guardian must be allowed access to the parent's or legal guardian's child any time while the child is in care.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 7. Minnesota Statutes 2016, section 245A.151, is amended to read:

245A.151 FIRE MARSHAL INSPECTION.

When licensure under this chapter requires an inspection by a fire marshal to determine compliance with the State Fire Code under section 299F.011, a local fire code inspector ~~approved~~ trained by the state fire marshal may conduct the inspection. If a community does not have a local fire code inspector or if the local fire code inspector does not perform the inspection, the state fire marshal must conduct the inspection. A local fire code inspector or the state fire marshal may recover the cost of these inspections through a fee of no more

than $50 per inspection charged to the applicant or license holder. The fees collected by the state fire marshal under this section are appropriated to the commissioner of public safety for the purpose of conducting the inspections.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 8. Minnesota Statutes 2016, section 245A.16, subdivision 1, is amended to read:

Subdivision 1. **Delegation of authority to agencies.** (a) County agencies and private agencies that have been designated or licensed by the commissioner to perform licensing functions and activities under section 245A.04 and background studies for family child care under chapter 245C; to recommend denial of applicants under section 245A.05; to issue correction orders, to issue variances, and recommend a conditional license under section 245A.06; or to recommend suspending or revoking a license or issuing a fine under section 245A.07, shall comply with rules and directives of the commissioner governing those functions and with this section. The following variances are excluded from the delegation of variance authority and may be issued only by the commissioner:

(1) dual licensure of family child care and child foster care, dual licensure of child and adult foster care, and adult foster care and family child care;

(2) adult foster care maximum capacity;

(3) adult foster care minimum age requirement;

(4) child foster care maximum age requirement;

(5) variances regarding disqualified individuals except that, before the implementation of NETStudy 2.0, county agencies may issue variances under section 245C.30 regarding disqualified individuals when the county is responsible for conducting a consolidated reconsideration according to sections 245C.25 and 245C.27, subdivision 2, clauses (a) and (b), of a county maltreatment determination and a disqualification based on serious or recurring maltreatment;

(6) the required presence of a caregiver in the adult foster care residence during normal sleeping hours; and

(7) variances to requirements relating to chemical use problems of a license holder or a household member of a license holder.

Except as provided in section 245A.14, subdivision 4, paragraph (e), a county agency must not grant a license holder a variance to exceed the maximum allowable family child care license capacity of 14 children.

(b) Before the implementation of NETStudy 2.0, county agencies must report information about disqualification reconsiderations under sections 245C.25 and 245C.27, subdivision 2, paragraphs (a) and (b), and variances granted under paragraph (a), clause (5), to the commissioner at least monthly in a format prescribed by the commissioner.

(c) For family ~~day~~ child care programs, the commissioner ~~may authorize~~ shall require a county agency to conduct one unannounced licensing ~~reviews every two years after a licensee has had at least one annual~~ review at least annually.

(d) For family adult day services programs, the commissioner may authorize licensing reviews every two years after a licensee has had at least one annual review.

(e) A license issued under this section may be issued for up to two years.

(f) During implementation of chapter 245D, the commissioner shall consider:

(1) the role of counties in quality assurance;

(2) the duties of county licensing staff; and

(3) the possible use of joint powers agreements, according to section 471.59, with counties through which some licensing duties under chapter 245D may be delegated by the commissioner to the counties.

Any consideration related to this paragraph must meet all of the requirements of the corrective action plan ordered by the federal Centers for Medicare and Medicaid Services.

(g) Licensing authority specific to section 245D.06, subdivisions 5, 6, 7, and 8, or successor provisions; and section 245D.061 or successor provisions, for family child foster care programs providing out-of-home respite, as identified in section 245D.03, subdivision 1, paragraph (b), clause (1), is excluded from the delegation of authority to county and private agencies.

(h) A county agency shall report to the commissioner, in a manner prescribed by the commissioner, the following information for a licensed family child care program:

(1) the results of each licensing review completed, including the date of the review, any licensing correction order issued; and

(2) any death, serious injury, or determination of substantiated maltreatment.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 9. Minnesota Statutes 2016, section 245A.16, is amended by adding a subdivision to read:

Subd. 7. **Family child care licensing oversight.** (a) Only county staff trained by the commissioner on the family child care licensing standards in this chapter and Minnesota Rules, chapter 9502, shall perform family child care licensing functions under subdivision 1. Training must occur within 90 days of a staff person's employment.

(b) The commissioner shall consult with county agencies to develop a formula to allocate county family child care licensing grant funding.

(c) If a county fails to perform the family child care licensing functions of this section, the commissioner may reduce or delay the county's licensing grant payment until compliance is achieved.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 10. Minnesota Statutes 2016, section 245A.40, subdivision 1, is amended to read:

Subdivision 1. **Orientation.** The child care center license holder must ensure that every staff person and volunteer is given orientation training and successfully completes the training before starting assigned duties. The orientation training in this subdivision applies to volunteers who will have direct contact with or access to children and who are not under the direct supervision of a staff person. Completion of the orientation must be documented in the individual's personnel record. The orientation training must include information about:

(1) the center's philosophy, child care program, and procedures for maintaining health and safety according to section 245A.41 and Minnesota Rules, part 9503.0140, and handling emergencies and accidents according to Minnesota Rules, part 9503.0110;

(2) specific job responsibilities;

(3) the behavior guidance standards in Minnesota Rules, part 9503.0055; and

(4) the reporting responsibilities in section 626.556, and Minnesota Rules, part 9503.0130.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 11. Minnesota Statutes 2016, section 245A.40, subdivision 2, is amended to read:

Subd. 2. **Child ~~growth and~~ development and learning training.** (a) For purposes of child care centers, the director and all staff hired after July 1, 2006, shall complete and document at least two hours of child ~~growth and~~ development and learning training within the first year of employment. For purposes of this subdivision, "child ~~growth and~~ development

and learning training" means training in understanding how children ~~acquire language and~~ develop physically, cognitively, emotionally, and socially and learn as part of the children's family, culture, and community. Training completed under this subdivision may be used to meet ~~the orientation training requirements under subdivision 1 and~~ the in-service training requirements under subdivision 7.

(b) Notwithstanding paragraph (a), individuals are exempt from this requirement if they:

(1) have taken a three-credit college course on early childhood development within the past five years;

(2) have received a baccalaureate or master's degree in early childhood education or school-age child care within the past five years;

(3) are licensed in Minnesota as a prekindergarten teacher, an early childhood educator, a kindergarten to sixth grade teacher with a prekindergarten specialty, an early childhood special education teacher, or an elementary teacher with a kindergarten endorsement; or

(4) have received a baccalaureate degree with a Montessori certificate within the past five years.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 12. Minnesota Statutes 2016, section 245A.40, subdivision 3, is amended to read:

Subd. 3. **First aid.** (a) All teachers and assistant teachers in a child care center governed by Minnesota Rules, parts 9503.0005 to 9503.0170, and at least one staff person during field trips and when transporting children in care, must satisfactorily complete first aid training within 90 days of the start of work, unless the training has been completed within the previous ~~three~~ two years.

(b) Notwithstanding paragraph (a), which allows 90 days to complete training, at least one staff person who has satisfactorily completed first aid training must be present at all times in the center, during field trips, and when transporting children in care.

(c) The first aid training must be repeated at least every ~~three~~ two years, documented in the person's personnel record and indicated on the center's staffing chart, and provided by an individual approved as a first aid instructor. This training may be less than eight hours.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 13. Minnesota Statutes 2016, section 245A.40, subdivision 4, is amended to read:

Subd. 4. **Cardiopulmonary resuscitation.** (a) All teachers and assistant teachers in a child care center governed by Minnesota Rules, parts 9503.0005 to 9503.0170, and at least one staff person during field trips and when transporting children in care, must satisfactorily complete training in cardiopulmonary resuscitation (CPR) that includes CPR techniques for infants and children and in the treatment of obstructed airways. The CPR training must be completed within 90 days of the start of work, unless the training has been completed within the previous ~~three~~ two years. The CPR training must have been provided by an individual approved to provide CPR instruction, must be repeated at least once every ~~three~~ two years, and must be documented in the staff person's records.

(b) Notwithstanding paragraph (a), which allows 90 days to complete training, at least one staff person who has satisfactorily completed cardiopulmonary resuscitation training must be present at all times in the center, during field trips, and when transporting children in care.

(c) CPR training may be provided for less than four hours.

(d) Persons providing CPR training must use CPR training that has been developed:

(1) by the American Heart Association or the American Red Cross and incorporates psychomotor skills to support the instruction; or

(2) using nationally recognized, evidence-based guidelines for CPR and incorporates psychomotor skills to support the instruction.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 14. Minnesota Statutes 2016, section 245A.40, subdivision 7, is amended to read:

Subd. 7. **In-service.** (a) A license holder must ensure that ~~an annual in-service training plan is developed and carried out and that it meets the requirements in clauses (1) to (7). The in-service training plan must:~~ the center director and all staff who have direct contact with a child complete annual in-service training. In-service training requirements must be met by a staff person's participation in the following training areas:

~~(1) be consistent with the center's child care program plan;~~

~~(2) meet the training needs of individual staff persons as specified in each staff person's annual evaluation report;~~

~~(3) provide training, at least one-fourth of which is by a resource not affiliated with the license holder;~~

~~(4) include Minnesota Rules, parts 9503.0005 to 9503.0170, relevant to the staff person's position and must occur within two weeks of initial employment;~~

~~(5) provide that at least one-half of the annual in-service training completed by a staff person each year pertains to the age of children for which the person is providing care;~~

~~(6) provide that no more than four hours of each annual in-service training requirement relate to administration, finances, and records training for a teacher, assistant teacher, or aide; and~~

~~(7) provide that the remainder of the in-service training requirement be met by participation in training in child growth and development; learning environment and curriculum; assessment and planning for individual needs; interactions with children; families and communities; health, safety, and nutrition; and program planning and evaluation.~~

(1) child development and learning;

(2) developmentally appropriate learning experiences;

(3) relationships with families;

(4) assessment, evaluation, and individualization;

(5) historical and contemporary development of early childhood education;

(6) professionalism; and

(7) health, safety, and nutrition.

(b) For purposes of this subdivision, the following terms have the meanings given them.

(1) "Child ~~growth and~~ development and learning training" has the meaning given it in subdivision 2, paragraph (a).

~~(2) "Learning environment and curriculum" means training in establishing an environment that provides learning experiences to meet each child's needs, capabilities, and interests, including early childhood education methods or theory, recreation, sports, promoting creativity in the arts, arts and crafts methods or theory, and early childhood special education methods or theory.~~

~~(3) "Assessment and planning for individual needs" means training in observing and assessing what children know and can do in order to provide curriculum and instruction that addresses their developmental and learning needs, including children with special needs.~~

~~(4) "Interactions with children" means training in establishing supportive relationships with children and guiding them as individuals and as part of a group, including child study techniques and behavior guidance.~~

~~(5) "Families and communities" means training in working collaboratively with families, agencies, and organizations to meet children's needs and to encourage the community's involvement, including family studies and parent involvement.~~

~~(6) "Health, safety, and nutrition" means training in establishing and maintaining an environment that ensures children's health, safety, and nourishment, including first aid, cardiopulmonary resuscitation, child nutrition, and child abuse and neglect prevention.~~

~~(7) "Program planning and evaluation" means training in establishing, implementing, evaluating, and enhancing program operations.~~

(2) "Developmentally appropriate learning experiences" means creating positive learning experiences, promoting cognitive development, promoting social and emotional development, promoting physical development, and promoting creative development.

(3) "Relationships with families" means training on building a positive, respectful relationship with the child's family.

(4) "Assessment, evaluation, and individualization" means training in observing, recording, and assessing development; assessing and using information to plan; and assessing and using information to enhance and maintain program quality.

(5) "Historical and contemporary development of early childhood education" means training in past and current practices in early childhood education and how current events and issues affect children, families, and programs.

(6) "Professionalism" means training in knowledge, skills, and abilities that promote ongoing professional development.

(7) "Health, safety, and nutrition" means training in establishing health practices, ensuring safety, and providing healthy nutrition.

(c) The director and all program staff persons must annually complete a number of hours of in-service training equal to at least two percent of the hours for which the director or program staff person is annually paid, unless one of the following is applicable.

(1) A teacher at a child care center must complete one percent of working hours of in-service training annually if the teacher:

(i) possesses a baccalaureate or master's degree in early childhood education or school-age care;

(ii) is licensed in Minnesota as a prekindergarten teacher, an early childhood educator, a kindergarten to sixth grade teacher with a prekindergarten specialty, an early childhood special education teacher, or an elementary teacher with a kindergarten endorsement; or

(iii) possesses a baccalaureate degree with a Montessori certificate.

(2) A teacher or assistant teacher at a child care center must complete one and one-half percent of working hours of in-service training annually if the individual is:

(i) a registered nurse or licensed practical nurse with experience working with infants;

(ii) possesses a Montessori certificate, a technical college certificate in early childhood development, or a child development associate certificate; or

(iii) possesses an associate of arts degree in early childhood education, a baccalaureate degree in child development, or a technical college diploma in early childhood development.

(d) The number of required training hours may be prorated for individuals not employed full time or for an entire year.

(e) The annual in-service training must be completed within the calendar year for which it was required. In-service training completed by staff persons is transferable upon a staff person's change in employment to another child care program.

(f) The license holder must ensure that, when a staff person completes in-service training, the training is documented in the staff person's personnel record. The documentation must include the date training was completed, the goal of the training and topics covered, trainer's name and organizational affiliation, trainer's signed statement that training was successfully completed, and the director's approval of the training.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 15. Minnesota Statutes 2016, section 245A.40, is amended by adding a subdivision to read:

Subd. 9. **Ongoing health and safety training.** A staff person's orientation training on maintaining health and safety and handling emergencies and accidents, as required in subdivision 1, must be repeated at least once each calendar year by each staff person. The completion of the annual training must be documented in the staff person's personnel record.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 16. **[245A.41] CHILD CARE CENTER HEALTH AND SAFETY REQUIREMENTS.**

Subdivision 1. **Allergy prevention and response.** (a) Before admitting a child for care, the license holder must obtain documentation of any known allergy from the child's parent or legal guardian or the child's source of medical care. If a child has a known allergy, the license holder must maintain current information about the allergy in the child's record and develop an individual child care program plan as specified in Minnesota Rules, part 9503.0065, subpart 3. The individual child care program plan must include but not be limited to a description of the allergy, specific triggers, avoidance techniques, symptoms of an allergic reaction, and procedures for responding to an allergic reaction, including medication, dosages, and a doctor's contact information.

(b) The license holder must ensure that each staff person who is responsible for carrying out the individual child care program plan review and follow the plan. Documentation of a staff person's review must be kept on site.

(c) At least annually or following any changes made to allergy-related information in the child's record, the license holder must update the child's individual child care program plan and inform each staff person who is responsible for carrying out the individual child care program plan of the change. The license holder must keep on site documentation that a staff person was informed of a change.

(d) A child's allergy information must be available at all times including on site, when on field trips, or during transportation. A child's food allergy information must be readily available to a staff person in the area where food is prepared and served to the child.

(e) The license holder must contact the child's parent or legal guardian as soon as possible in any instance of exposure or allergic reaction that requires medication or medical intervention. The license holder must call emergency medical services when epinephrine is administered to a child in the license holder's care.

Subd. 2. **Handling and disposal of bodily fluids.** The licensed child care center must comply with the following procedures for safely handling and disposing of bodily fluids:

(1) surfaces that come in contact with potentially infectious bodily fluids, including blood and vomit, must be cleaned and disinfected according to Minnesota Rules, part 9503.0005, subpart 11;

(2) blood-contaminated material must be disposed of in a plastic bag with a secure tie;

(3) sharp items used for a child with special care needs must be disposed of in a "sharps container." The sharps container must be stored out of reach of a child;

(4) the license holder must have the following bodily fluid disposal supplies in the center: disposable gloves, disposal bags, and eye protection; and

(5) the license holder must ensure that each staff person is trained on universal precautions to reduce the risk of spreading infectious disease. A staff person's completion of the training must be documented in the staff person's personnel record.

Subd. 3. **Emergency preparedness.** (a) No later than September 30, 2017, a licensed child care center must have a written emergency plan for emergencies that require evacuation, sheltering, or other protection of a child, such as fire, natural disaster, intruder, or other threatening situation that may pose a health or safety hazard to a child. The plan must be written on a form developed by the commissioner and must include:

(1) procedures for an evacuation, relocation, shelter-in-place, or lockdown;

(2) a designated relocation site and evacuation route;

(3) procedures for notifying a child's parent or legal guardian of the evacuation, relocation, shelter-in-place, or lockdown, including procedures for reunification with families;

(4) accommodations for a child with a disability or a chronic medical condition;

(5) procedures for storing a child's medically necessary medicine that facilitates easy removal during an evacuation or relocation;

(6) procedures for continuing operations in the period during and after a crisis; and

(7) procedures for communicating with local emergency management officials, law enforcement officials, or other appropriate state or local authorities.

(b) The license holder must train staff persons on the emergency plan at orientation, when changes are made to the plan, and at least once each calendar year. Training must be documented in each staff person's personnel file.

(c) The license holder must conduct drills according to the requirements in Minnesota Rules, part 9503.0110, subpart 3. The date and time of the drills must be documented.

(d) The license holder must review and update the emergency plan annually. Documentation of the annual emergency plan review shall be maintained in the program's administrative records.

(e) The license holder must include the emergency plan in the program's policies and procedures as specified under section 245A.04, subdivision 14. The license holder must provide a physical or electronic copy of the emergency plan to the child's parent or legal guardian upon enrollment.

(f) The relocation site and evacuation route must be posted in a visible place as part of the written procedures for emergencies and accidents in Minnesota Rules, part 9503.0140, subpart 21.

Sec. 17. Minnesota Statutes 2016, section 245A.50, subdivision 2, is amended to read:

Subd. 2. **Child ~~growth and~~ development and learning and behavior guidance training.** (a) For purposes of family and group family child care, the license holder and each adult caregiver who provides care in the licensed setting for more than 30 days in any 12-month period shall complete and document at least four hours of child growth and ~~development~~ learning and behavior guidance training prior to initial licensure, and before caring for children. For purposes of this subdivision, "child ~~growth and~~ development and learning training" means training in understanding how children ~~acquire language and~~ develop physically, cognitively, emotionally, and socially and learn as part of the children's family, culture, and community. "Behavior guidance training" means training in the understanding of the functions of child behavior and strategies for managing challenging situations. At least two hours of child ~~growth and~~ development and learning or behavior guidance training must be repeated annually. Training curriculum shall be developed or approved by the commissioner of human services ~~by January 1, 2014~~.

(b) Notwithstanding paragraph (a), individuals are exempt from this requirement if they:

(1) have taken a three-credit course on early childhood development within the past five years;

(2) have received a baccalaureate or master's degree in early childhood education or school-age child care within the past five years;

(3) are licensed in Minnesota as a prekindergarten teacher, an early childhood educator, a kindergarten to grade 6 teacher with a prekindergarten specialty, an early childhood special education teacher, or an elementary teacher with a kindergarten endorsement; or

(4) have received a baccalaureate degree with a Montessori certificate within the past five years.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 18. Minnesota Statutes 2016, section 245A.50, subdivision 7, is amended to read:

Subd. 7. **Training requirements for family and group family child care.** For purposes of family and group family child care, the license holder and each primary caregiver must complete 16 hours of ongoing training each year. For purposes of this subdivision, a primary caregiver is an adult caregiver who provides services in the licensed setting for more than 30 days in any 12-month period. Repeat of topical training requirements in subdivisions 2 to 8 shall count toward the annual 16-hour training requirement. Additional ongoing training subjects to meet the annual 16-hour training requirement must be selected from the following areas:

(1) child ~~growth and~~ development and learning training under subdivision 2, paragraph (a);

~~(2) learning environment and curriculum, including training in establishing an environment and providing activities that provide learning experiences to meet each child's needs, capabilities, and interests;~~

~~(3) assessment and planning for individual needs, including training in observing and assessing what children know and can do in order to provide curriculum and instruction that addresses their developmental and learning needs, including children with special needs and bilingual children or children for whom English is not their primary language;~~

~~(4) interactions with children, including training in establishing supportive relationships with children, guiding them as individuals and as part of a group;~~

~~(5) families and communities, including training in working collaboratively with families and agencies or organizations to meet children's needs and to encourage the community's involvement;~~

~~(6) health, safety, and nutrition, including training in establishing and maintaining an environment that ensures children's health, safety, and nourishment, including child abuse, maltreatment, prevention, and reporting; home and fire safety; child injury prevention; communicable disease prevention and control; first aid; and CPR;~~

~~(7) program planning and evaluation, including training in establishing, implementing, evaluating, and enhancing program operations; and~~

~~(8) behavior guidance, including training in the understanding of the functions of child behavior and strategies for managing behavior.~~

(2) developmentally appropriate learning experiences, including training in creating positive learning experiences, promoting cognitive development, promoting social and

emotional development, promoting physical development, promoting creative development; and behavior guidance;

(3) relationships with families, including training in building a positive, respectful relationship with the child's family;

(4) assessment, evaluation, and individualization, including training in observing, recording, and assessing development; assessing and using information to plan; and assessing and using information to enhance and maintain program quality;

(5) historical and contemporary development of early childhood education, including training in past and current practices in early childhood education and how current events and issues affect children, families, and programs;

(6) professionalism, including training in knowledge, skills, and abilities that promote ongoing professional development; and

(7) health, safety, and nutrition, including training in establishing healthy practices; ensuring safety; and providing healthy nutrition.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 19. Minnesota Statutes 2016, section 245A.50, subdivision 9, is amended to read:

Subd. 9. **Supervising for safety; training requirement.** ~~Effective July 1, 2014~~ (a) Before initial licensure and before caring for a child, all family child care license holders and each adult caregiver who provides care in the licensed family child care home for more than 30 days in any 12-month period shall complete and document ~~at least six hours of approved training on supervising for safety prior to initial licensure, and before caring for children. At least two hours of training on supervising for safety must be repeated annually. For purposes of this subdivision, "supervising for safety" includes supervision basics, supervision outdoors, equipment and materials, illness, injuries, and disaster preparedness. The commissioner shall develop the supervising for safety curriculum by January 1, 2014.~~ the completion of the six-hour Supervising for Safety for Family Child Care course developed by the commissioner.

(b) The family child care license holder and each adult caregiver who provides care in the licensed family child care home for more than 30 days in any 12-month period shall complete and document:

(1) the annual completion of a two-hour active supervision course developed by the commissioner; and

(2) the completion at least once every five years of the two-hour courses Health and Safety I and Health and Safety II. A license holder's or adult caregiver's completion of each of these trainings meets the annual active supervision training requirement in clause (1).

Sec. 20. **[245A.51] FAMILY CHILD CARE HEALTH AND SAFETY REQUIREMENTS.**

Subdivision 1. **Allergy prevention and response.** (a) Before admitting a child for care, the license holder must obtain information about any known allergy from the child's parent or legal guardian. The license holder must maintain current allergy information in each child's record. The allergy information must include a description of the allergy, specific triggers, avoidance techniques, symptoms of an allergic reaction, and procedures for responding to an allergic reaction, including medication, dosages, and a doctor's contact information.

(b) The child's allergy information must be documented on a form approved by the commissioner, readily available to all caregivers, and reviewed annually by the license holder and each caregiver.

Subd. 2. **Handling and disposal of bodily fluids.** The licensed family child care provider must comply with the following procedures for safely handling and disposing of bodily fluids:

(1) surfaces that come in contact with potentially infectious bodily fluids, including blood and vomit, must be cleaned and disinfected as described in section 245A.148;

(2) blood-contaminated material must be disposed of in a plastic bag with a secure tie;

(3) sharp items used for a child with special care needs must be disposed of in a "sharps container." The sharps container must be stored out of reach of a child; and

(4) the license holder must have the following bodily fluid disposal supplies available: disposable gloves, disposal bags, and eye protection.

Subd. 3. **Emergency preparedness plan.** (a) No later than September 30, 2017, a licensed family child care provider must have a written emergency preparedness plan for emergencies that require evacuation, sheltering, or other protection of children, such as fire, natural disaster, intruder, or other threatening situation that may pose a health or safety hazard to children. The plan must be written on a form developed by the commissioner and updated at least annually. The plan must include:

(1) procedures for an evacuation, relocation, shelter-in-place, or lockdown;

(2) a designated relocation site and evacuation route;

(3) procedures for notifying a child's parent or legal guardian of the evacuation, shelter-in-place, or lockdown, including procedures for reunification with families;

(4) accommodations for a child with a disability or a chronic medical condition;

(5) procedures for storing a child's medically necessary medicine that facilitate easy removal during an evacuation or relocation;

(6) procedures for continuing operations in the period during and after a crisis; and

(7) procedures for communicating with local emergency management officials, law enforcement officials, or other appropriate state or local authorities.

(b) The license holder must train caregivers before the caregiver provides care and at least annually on the emergency preparedness plan and document completion of this training.

(c) The license holder must conduct drills according to the requirements in Minnesota Rules, part 9502.0435, subpart 8. The date and time of the drills must be documented.

(d) The license holder must have the emergency preparedness plan available for review and posted in a prominent location. The license holder must provide a physical or electronic copy of the plan to the child's parent or legal guardian upon enrollment.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 21. Minnesota Statutes 2016, section 245C.02, is amended by adding a subdivision to read:

Subd. 6a. **Child care staff person.** "Child care staff person" means an individual other than an individual who is related to all children for whom child care services are provided and:

(1) who is employed by a child care provider for compensation;

(2) whose activities involve the care or supervision of a child for a child care provider or unsupervised access to a child who is cared for or supervised by a child care provider; or

(3) an individual 13 years of age or older residing in a licensed family child care home or legal nonlicensed child care program.

EFFECTIVE DATE. This section is effective October 1, 2017.

Sec. 22. Minnesota Statutes 2016, section 245C.03, subdivision 1, is amended to read:

Subdivision 1. **Licensed programs.** (a) The commissioner shall conduct a background study on:

(1) the person or persons applying for a license;

(2) an individual age 13 and over living in the household where the licensed program will be provided who is not receiving licensed services from the program;

(3) current or prospective employees or contractors of the applicant who will have direct contact with persons served by the facility, agency, or program;

(4) volunteers or student volunteers who will have direct contact with persons served by the program to provide program services if the contact is not under the continuous, direct supervision by an individual listed in clause (1) or (3);

(5) an individual age ten to 12 living in the household where the licensed services will be provided when the commissioner has reasonable cause;

(6) an individual who, without providing direct contact services at a licensed program, may have unsupervised access to children or vulnerable adults receiving services from a program, when the commissioner has reasonable cause; ~~and~~

(7) all ~~managerial officials~~ controlling individuals as defined ~~under~~ in section 245A.02, subdivision 5a~~.~~; and

(8) child care staff persons as defined in section 245C.02, subdivision 6a.

(b) Paragraph (a), clauses (5) and (6), apply to legal nonlicensed child care and certified license-exempt child care programs.

~~(b)~~ (c) For family child foster care settings, a short-term substitute caregiver providing direct contact services for a child for less than 72 hours of continuous care is not required to receive a background study under this chapter.

EFFECTIVE DATE. This section is effective when the Department of Human Services implements NETStudy 2.0 or October 1, 2017, whichever is later. The commissioner of human services shall notify the revisor of statutes when the department implements NETStudy 2.0.

Sec. 23. Minnesota Statutes 2016, section 245C.03, is amended by adding a subdivision to read:

Subd. 6a. **Legal nonlicensed and certified child care programs.** The commissioner shall conduct background studies on an individual required under sections 119B.125 and 245G.10 to complete a background study under this chapter.

EFFECTIVE DATE. This section is effective October 1, 2017.

Sec. 24. Minnesota Statutes 2016, section 245C.04, subdivision 1, is amended to read:

Subdivision 1. **Licensed programs; other child care programs.** (a) The commissioner shall conduct a background study of an individual required to be studied under section 245C.03, subdivision 1, at least upon application for initial license for all license types.

(b) The commissioner shall conduct a background study of an individual required to be studied under section 245C.03, subdivision 1, including a child care staff person as defined in section 245C.02, subdivision 6a, in a family child care program, licensed child care center, certified license-exempt child care center, or legal nonlicensed child care provider, on a schedule determined by the commissioner. The background study must include submission of fingerprints for a national criminal history record check and a review of the information under section 245C.08. A background study for a child care program must be repeated within five years from the most recent study conducted under this paragraph.

(c) At reapplication ~~for a license~~ for a family child care~~.~~ license:

(1) for a background study affiliated with a licensed family child care center or legal nonlicensed child care provider, the individual shall provide information required under section 245C.05, subdivision 1, paragraphs (a), (b), and (d), to the county agency, and be fingerprinted and photographed under section 245C.05, subdivision 5;

(2) the county agency shall verify the information received under clause (1) and forward the information to the commissioner to complete the background study; and

(3) the background study conducted by the commissioner under this paragraph must include a review of the information required under section 245C.08.

~~(c)~~ (d) The commissioner is not required to conduct a study of an individual at the time of reapplication for a license if the individual's background study was completed by the commissioner of human services and the following conditions are met:

(1) a study of the individual was conducted either at the time of initial licensure or when the individual became affiliated with the license holder;

(2) the individual has been continuously affiliated with the license holder since the last study was conducted; and

(3) the last study of the individual was conducted on or after October 1, 1995.

~~(d)~~ (e) The commissioner of human services shall conduct a background study of an individual specified under section 245C.03, subdivision 1, paragraph (a), clauses (2) to (6), who is newly affiliated with a child foster care license holder. The county or private agency shall collect and forward to the commissioner the information required under section 245C.05, subdivisions 1 and 5. The background study conducted by the commissioner of human services under this paragraph must include a review of the information required under section 245C.08, subdivisions 1, 3, and 4.

~~(e)~~ (f) The commissioner shall conduct a background study of an individual specified under section 245C.03, subdivision 1, paragraph (a), clauses (2) to (6), who is newly affiliated with an adult foster care or family adult day services and with a family child care license holder or a legal nonlicensed child care provider authorized under chapter 119B: (1) the county shall collect and forward to the commissioner the information required under section 245C.05, subdivision 1, paragraphs (a) and (b), and subdivision 5, paragraphs (a) ~~and~~, (b), and (d), for background studies conducted by the commissioner for all family adult day services ~~and~~, for adult foster care when the adult foster care license holder resides in the adult foster care residence, and for family child care and legal nonlicensed child care authorized under chapter 119B; (2) the license holder shall collect and forward to the commissioner the information required under section 245C.05, subdivisions 1, paragraphs (a) and (b); and 5, paragraphs (a) and (b), for background studies conducted by the commissioner for adult foster care when the license holder does not reside in the adult foster care residence; and (3) the background study conducted by the commissioner under this paragraph must include a review of the information required under section 245C.08, subdivision 1, paragraph (a), and subdivisions 3 and 4.

~~(f)~~ (g) Applicants for licensure, license holders, and other entities as provided in this chapter must submit completed background study requests to the commissioner using the electronic system known as NETStudy before individuals specified in section 245C.03, subdivision 1, begin positions allowing direct contact in any licensed program.

~~(g)~~ (h) For an individual who is not on the entity's active roster, the entity must initiate a new background study through NETStudy when:

(1) an individual returns to a position requiring a background study following an absence of 120 or more consecutive days; or

(2) a program that discontinued providing licensed direct contact services for 120 or more consecutive days begins to provide direct contact licensed services again.

The license holder shall maintain a copy of the notification provided to the commissioner under this paragraph in the program's files. If the individual's disqualification was previously set aside for the license holder's program and the new background study results in no new information that indicates the individual may pose a risk of harm to persons receiving services from the license holder, the previous set-aside shall remain in effect.

~~(h)~~ (i) For purposes of this section, a physician licensed under chapter 147 is considered to be continuously affiliated upon the license holder's receipt from the commissioner of health or human services of the physician's background study results.

~~(i)~~ (j) For purposes of family child care, a substitute caregiver must receive repeat background studies at the time of each license renewal.

(k) A repeat background study at the time of license renewal is not required if the family child care substitute caregiver's background study was completed by the commissioner on or after October 1, 2017, and the substitute caregiver is on the license holder's active roster in NETStudy 2.0.

EFFECTIVE DATE. This section is effective October 1, 2017.

Sec. 25. Minnesota Statutes 2016, section 245C.04, subdivision 8, is amended to read:

Subd. 8. **Current or prospective contractors serving multiple family child care license holders.** (a) Before the implementation of NETStudy 2.0, current or prospective contractors who are required to have a background study under section 245C.03, subdivision 1, who provide services for multiple family child care license holders in a single county, and will have direct contact with children served in the family child care setting are required to have only one background study which is transferable to all family child care programs in that county if:

(1) the county agency maintains a record of the contractor's background study results which verify the contractor is approved to have direct contact with children receiving services;

(2) the license holder contacts the county agency and obtains notice that the current or prospective contractor is in compliance with background study requirements and approved to have direct contact; and

(3) the contractor's background study is repeated every two years.

(b) For a family child care license holder operating under NETStudy 2.0, the license holder's active roster shall be the system used to document when a background study subject is affiliated with the license holder.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 26. Minnesota Statutes 2016, section 245C.05, subdivision 2b, is amended to read:

Subd. 2b. **County agency to collect and forward information to commissioner.** (a) For background studies related to all family adult day services and to adult foster care when the adult foster care license holder resides in the adult foster care residence, the county agency must collect the information required under subdivision 1 and forward it to the commissioner.

(b) Upon implementation of NETStudy 2.0, for background studies related to family child care and legal nonlicensed child care authorized under chapter 119B, the county agency must collect the information required under subdivision 1 and provide the information to the commissioner.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 27. Minnesota Statutes 2016, section 245C.05, subdivision 4, is amended to read:

Subd. 4. **Electronic transmission.** (a) For background studies conducted by the Department of Human Services, the commissioner shall implement a secure system for the electronic transmission of:

(1) background study information to the commissioner;

(2) background study results to the license holder;

(3) background study results to county and private agencies for background studies conducted by the commissioner for child foster care; and

(4) background study results to county agencies for background studies conducted by the commissioner for adult foster care and family adult day services and, upon implementation of NETStudy 2.0, family child care and legal nonlicensed child care authorized under chapter 119B.

(b) Unless the commissioner has granted a hardship variance under paragraph (c), a license holder or an applicant must use the electronic transmission system known as NETStudy or NETStudy 2.0 to submit all requests for background studies to the commissioner as required by this chapter.

(c) A license holder or applicant whose program is located in an area in which high-speed Internet is inaccessible may request the commissioner to grant a variance to the electronic transmission requirement.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 28. Minnesota Statutes 2016, section 245C.05, subdivision 5, is amended to read:

Subd. 5. **Fingerprints and photograph.** (a) Before the implementation of NETStudy 2.0, except as provided in paragraph (c), for any background study completed under this chapter, when the commissioner has reasonable cause to believe that further pertinent information may exist on the subject of the background study, the subject shall provide the commissioner with a set of classifiable fingerprints obtained from an authorized agency.

(b) Before the implementation of NETStudy 2.0, for purposes of requiring fingerprints, the commissioner has reasonable cause when, but not limited to, the:

(1) information from the Bureau of Criminal Apprehension indicates that the subject is a multistate offender;

(2) information from the Bureau of Criminal Apprehension indicates that multistate offender status is undetermined; or

(3) commissioner has received a report from the subject or a third party indicating that the subject has a criminal history in a jurisdiction other than Minnesota.

(c) Notwithstanding paragraph (d), for background studies conducted by the commissioner for child foster care, adoptions, or a transfer of permanent legal and physical custody of a child, the subject of the background study, who is 18 years of age or older, shall provide the commissioner with a set of classifiable fingerprints obtained from an authorized agency for a national criminal history record check.

(d) For background studies initiated on or after the implementation of NETStudy 2.0, every subject of a background study must provide the commissioner with a set of the background study subject's classifiable fingerprints and photograph. The photograph and fingerprints must be recorded at the same time by the commissioner's authorized fingerprint collection vendor and sent to the commissioner through the commissioner's secure data system described in section 245C.32, subdivision 1a, paragraph (b). The fingerprints shall not be retained by the Department of Public Safety, Bureau of Criminal Apprehension, or the commissioner, but will be retained by the Federal Bureau of Investigation. The commissioner's authorized fingerprint collection vendor shall, for purposes of verifying the identity of the background study subject, be able to view the identifying information entered

into NETStudy 2.0 by the entity that initiated the background study, but shall not retain the subject's fingerprints, photograph, or information from NETStudy 2.0. The authorized fingerprint collection vendor shall retain no more than the name and date and time the subject's fingerprints were recorded and sent, only as necessary for auditing and billing activities.

(e) When specifically required by law, fingerprints collected under this section must be submitted for a national criminal history record check.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 29. Minnesota Statutes 2016, section 245C.05, subdivision 7, is amended to read:

Subd. 7. **Probation officer and corrections agent.** (a) A probation officer or corrections agent shall notify the commissioner of an individual's conviction if the individual:

(1) has been affiliated with a program or facility regulated by the Department of Human Services or Department of Health, a facility serving children or youth licensed by the Department of Corrections, or any type of home care agency or provider of personal care assistance services within the preceding year; and

(2) has been convicted of a crime constituting a disqualification under section 245C.14.

(b) For the purpose of this subdivision, "conviction" has the meaning given it in section 609.02, subdivision 5.

(c) The commissioner, in consultation with the commissioner of corrections, shall develop forms and information necessary to implement this subdivision and shall provide the forms and information to the commissioner of corrections for distribution to local probation officers and corrections agents.

(d) The commissioner shall inform individuals subject to a background study that criminal convictions for disqualifying crimes ~~will~~ shall be reported to the commissioner by the corrections system.

(e) A probation officer, corrections agent, or corrections agency is not civilly or criminally liable for disclosing or failing to disclose the information required by this subdivision.

(f) Upon receipt of disqualifying information, the commissioner shall provide the notice required under section 245C.17, as appropriate, to agencies on record as having initiated a background study or making a request for documentation of the background study status of the individual.

(g) This subdivision does not apply to family child care programs or legal nonlicensed child care programs for individuals whose background study was completed in NETStudy 2.0.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 30. Minnesota Statutes 2016, section 245C.08, subdivision 1, is amended to read:

Subdivision 1. **Background studies conducted by Department of Human Services.** (a) For a background study conducted by the Department of Human Services, the commissioner shall review:

(1) information related to names of substantiated perpetrators of maltreatment of vulnerable adults that has been received by the commissioner as required under section 626.557, subdivision 9c, paragraph (j);

(2) the commissioner's records relating to the maltreatment of minors in licensed programs, and from findings of maltreatment of minors as indicated through the social service information system;

(3) information from juvenile courts as required in subdivision 4 for individuals listed in section 245C.03, subdivision 1, paragraph (a), when there is reasonable cause;

(4) information from the Bureau of Criminal Apprehension, including information regarding a background study subject's registration in Minnesota as a predatory offender under section 243.166;

(5) except as provided in clause (6), information ~~from the national crime information system~~ received as a result of submission of fingerprints for a national criminal history record check, when the commissioner has reasonable cause as defined under section 245C.05, subdivision 5, or as required under section 144.057, subdivision 1, clause (2); ~~and~~

(6) for a background study related to a child foster care application for licensure, a transfer of permanent legal and physical custody of a child under sections 260C.503 to 260C.515, or adoptions, and for a background study required for family child care, certified license-exempt child care, child care centers, and legal nonlicensed child care authorized under chapter 119B, the commissioner shall also review:

(i) information from the child abuse and neglect registry for any state in which the background study subject has resided for the past five years; and

(ii) ~~information from national crime information databases,~~ when the background study subject is 18 years of age or older~~.~~, information received following submission of fingerprints for a national criminal history record check; and

(7) for a background study required for family child care, certified license-exempt child care centers, licensed child care centers, and legal nonlicensed child care authorized under chapter 119B. The background study shall also include a name and date-of-birth search of the National Sex Offender Public Web site.

(b) Notwithstanding expungement by a court, the commissioner may consider information obtained under paragraph (a), clauses (3) and (4), unless the commissioner received notice of the petition for expungement and the court order for expungement is directed specifically to the commissioner.

(c) The commissioner shall also review criminal case information received according to section 245C.04, subdivision 4a, from the Minnesota court information system that relates to individuals who have already been studied under this chapter and who remain affiliated with the agency that initiated the background study.

(d) When the commissioner has reasonable cause to believe that the identity of a background study subject is uncertain, the commissioner may require the subject to provide a set of classifiable fingerprints for purposes of completing a fingerprint-based record check with the Bureau of Criminal Apprehension. Fingerprints collected under this paragraph shall not be saved by the commissioner after they have been used to verify the identity of the background study subject against the particular criminal record in question.

(e) The commissioner may inform the entity that initiated a background study under NETStudy 2.0 of the status of processing of the subject's fingerprints.

EFFECTIVE DATE. This section is effective October 1, 2017.

Sec. 31. Minnesota Statutes 2016, section 245C.08, subdivision 2, is amended to read:

Subd. 2. **Background studies conducted by a county agency for family child care.** (a) Before the implementation of NETStudy 2.0, for a background study conducted by a county agency for family child care services, the commissioner shall review:

(1) information from the county agency's record of substantiated maltreatment of adults and the maltreatment of minors;

(2) information from juvenile courts as required in subdivision 4 for:

(i) individuals listed in section 245C.03, subdivision 1, paragraph (a), who are ages 13 through 23 living in the household where the licensed services will be provided; and

(ii) any other individual listed under section 245C.03, subdivision 1, when there is reasonable cause; and

(3) information from the Bureau of Criminal Apprehension.

(b) If the individual has resided in the county for less than five years, the study shall include the records specified under paragraph (a) for the previous county or counties of residence for the past five years.

(c) Notwithstanding expungement by a court, the county agency may consider information obtained under paragraph (a), clause (3), unless the commissioner received notice of the petition for expungement and the court order for expungement is directed specifically to the commissioner.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 32. Minnesota Statutes 2016, section 245C.08, subdivision 4, is amended to read:

Subd. 4. **Juvenile court records.** (a) For a background study conducted by the Department of Human Services, the commissioner shall review records from the juvenile courts for an individual studied under section 245C.03, subdivision 1, paragraph (a), when the commissioner has reasonable cause.

(b) For a background study conducted by a county agency for family child care before the implementation of NETStudy 2.0, the commissioner shall review records from the juvenile courts for individuals listed in section 245C.03, subdivision 1, who are ages 13 through 23 living in the household where the licensed services will be provided. The commissioner shall also review records from juvenile courts for any other individual listed under section 245C.03, subdivision 1, when the commissioner has reasonable cause.

(c) The juvenile courts shall help with the study by giving the commissioner existing juvenile court records relating to delinquency proceedings held on individuals described in section 245C.03, subdivision 1, paragraph (a), when requested pursuant to this subdivision.

(d) For purposes of this chapter, a finding that a delinquency petition is proven in juvenile court shall be considered a conviction in state district court.

(e) Juvenile courts shall provide orders of involuntary and voluntary termination of parental rights under section 260C.301 to the commissioner upon request for purposes of conducting a background study under this chapter.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 33. Minnesota Statutes 2016, section 245C.09, is amended by adding a subdivision to read:

Subd. 3. **False statement in connection with a background study.** An individual shall be disqualified for knowingly making a materially false statement in connection with a background study.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 34. Minnesota Statutes 2016, section 245C.10, subdivision 9, is amended to read:

Subd. 9. **Human services licensed programs.** The commissioner shall recover the cost of background studies required under section 245C.03, subdivision 1, for all programs that are licensed by the commissioner, except child foster care ~~and~~ for certified license-exempt child care centers, licensed child care centers, and legal nonlicensed care authorized under chapter 119B, and licensed family child care, through a fee of no more than $20 per study charged to the license holder. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 35. Minnesota Statutes 2016, section 245C.10, is amended by adding a subdivision to read:

Subd. 9a. **Child care programs.** The commissioner shall recover the cost of a background study required for family child care, certified license-exempt child care centers, licensed child care centers, and legal nonlicensed child care providers authorized under chapter 119B through a fee of no more than $30 per study charged to the license holder. The fees collected under this subdivision are appropriated to the commissioner to conduct background studies.

Sec. 36. Minnesota Statutes 2016, section 245C.11, subdivision 3, is amended to read:

Subd. 3. **Criminal history data.** County agencies shall have access to the criminal history data in the same manner as county licensing agencies under this chapter for purposes of background studies completed before the implementation of NETStudy 2.0 by county agencies on legal nonlicensed child care providers to determine eligibility for child care funds under chapter 119B.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 37. Minnesota Statutes 2016, section 245C.15, is amended to read:

245C.15 DISQUALIFYING CRIMES OR CONDUCT.

Subdivision 1. **Permanent disqualification.** (a) An individual is disqualified under section 245C.14 if: (1) regardless of how much time has passed since the discharge of the sentence imposed, if any, for the offense; and (2) unless otherwise specified, regardless of the level of the offense, the individual has committed any of the following offenses: sections 243.166 (violation of predatory offender registration law); 609.185 (murder in the first degree); 609.19 (murder in the second degree); 609.195 (murder in the third degree); 609.20 (manslaughter in the first degree); 609.205 (manslaughter in the second degree); a felony offense under 609.221 or 609.222 (assault in the first or second degree); a felony conviction under section 609.223 or 609.2231 (assault in the third or fourth degree); a felony offense under sections 609.2242 and 609.2243 (domestic assault), spousal abuse, child abuse or neglect, or a crime against children; 609.2247 (domestic assault by strangulation); any conviction under section 609.224 or 609.2242 (assault in the fifth degree or domestic assault) for an offense committed by an adult against a child; 609.228 (great bodily harm caused by distribution of drugs); 609.245 (aggravated robbery); 609.25 (kidnapping); 609.2661 (murder of an unborn child in the first degree); 609.2662 (murder of an unborn child in the second degree); 609.2663 (murder of an unborn child in the third degree); 609.282 (labor trafficking); 609.322 (solicitation, inducement, and promotion of prostitution); 609.324, subdivision 1 (other prohibited acts); 609.342 (criminal sexual conduct in the first degree); 609.343 (criminal sexual conduct in the second degree); 609.344 (criminal sexual conduct in the third degree); 609.345 (criminal sexual conduct in the fourth degree); 609.3451 (criminal sexual conduct in the fifth degree); 609.3453 (criminal sexual predatory conduct); 609.352 (solicitation of children to engage in sexual conduct); 609.365 (incest); a felony offense under 609.377 (malicious punishment of a child); a felony offense under 609.378 (neglect or endangerment of a child); 609.561 (arson in the first degree); a felony conviction under section 609.562 or 609.563 (arson in the second or third degree); 609.66, subdivision 1e (drive-by shooting); 609.746, subdivision 1, paragraph (e) (interference with privacy involving a minor); 609.749, subdivision 3, 4, or 5 (felony-level stalking); 609.855, subdivision 5 (shooting at or in a public transit vehicle or facility); 617.23, subdivision 2, clause (1), or subdivision 3, clause (1) (indecent exposure involving a minor); 617.246 (use of minors in sexual performance prohibited); or 617.247 (possession of pictorial representations of minors); a felony-level conviction for a crime against a child or involving child pornography. For a background study required for family child care, child care centers,

and legal nonlicensed child care authorized under chapter 119B, an individual is permanently disqualified for a conviction at any level for child abuse or child neglect.

(b) An individual's aiding and abetting, attempt, or conspiracy to commit any of the offenses listed in paragraph (a), as each of these offenses is defined in Minnesota Statutes, permanently disqualifies the individual under section 245C.14.

(c) An individual's offense in any other state or country, where the elements of the offense are substantially similar to any of the offenses listed in paragraph (a), permanently disqualifies the individual under section 245C.14.

(d) When a disqualification is based on a judicial determination other than a conviction, the disqualification period begins from the date of the court order. When a disqualification is based on an admission, the disqualification period begins from the date of an admission in court. When a disqualification is based on an Alford Plea, the disqualification period begins from the date the Alford Plea is entered in court. When a disqualification is based on a preponderance of evidence of a disqualifying act, the disqualification date begins from the date of the dismissal, the date of discharge of the sentence imposed for a conviction for a disqualifying crime of similar elements, or the date of the incident, whichever occurs last.

(e) If the individual studied commits one of the offenses listed in paragraph (a) that is specified as a felony-level only offense, but the sentence or level of offense is a gross misdemeanor or misdemeanor, the individual is disqualified, but the disqualification look-back period for the offense is the period applicable to gross misdemeanor or misdemeanor offenses.

(f) An individual shall be disqualified as long as the individual is registered, or required to be registered, on a state sex offender registry or repository or the National Sex Offender Registry.

Subd. 2. **15-year disqualification.** (a) An individual is disqualified under section 245C.14 if: (1) less than 15 years have passed since the discharge of the sentence imposed, if any, for the offense; and (2) the individual has committed a felony-level violation of any of the following offenses: sections 256.98 (wrongfully obtaining assistance); 268.182 (false representation; concealment of facts); 393.07, subdivision 10, paragraph (c) (federal Food Stamp Program fraud); 609.165 (felon ineligible to possess firearm); 609.2112, 609.2113, or 609.2114 (criminal vehicular homicide or injury); 609.215 (suicide); a preponderance of evidence of 609.223 or 609.2231 (assault in the third or fourth degree); repeat offenses under 609.224 (assault in the fifth degree); 609.229 (crimes committed for benefit of a gang); 609.2325 (criminal abuse of a vulnerable adult); 609.2335 (financial exploitation of

a vulnerable adult); 609.235 (use of drugs to injure or facilitate crime); 609.24 (simple robbery); 609.255 (false imprisonment); 609.2664 (manslaughter of an unborn child in the first degree); 609.2665 (manslaughter of an unborn child in the second degree); 609.267 (assault of an unborn child in the first degree); 609.2671 (assault of an unborn child in the second degree); 609.268 (injury or death of an unborn child in the commission of a crime); 609.27 (coercion); 609.275 (attempt to coerce); 609.466 (medical assistance fraud); 609.495 (aiding an offender); 609.498, subdivision 1 or 1b (aggravated first-degree or first-degree tampering with a witness); 609.52 (theft); 609.521 (possession of shoplifting gear); 609.525 (bringing stolen goods into Minnesota); 609.527 (identity theft); 609.53 (receiving stolen property); 609.535 (issuance of dishonored checks); a preponderance of evidence of 609.562 (arson in the second degree); a preponderance of evidence of 609.563 (arson in the third degree); 609.582 (burglary); 609.59 (possession of burglary tools); 609.611 (insurance fraud); 609.625 (aggravated forgery); 609.63 (forgery); 609.631 (check forgery; offering a forged check); 609.635 (obtaining signature by false pretense); 609.66 (dangerous weapons); 609.67 (machine guns and short-barreled shotguns); 609.687 (adulteration); 609.71 (riot); 609.713 (terroristic threats); 609.82 (fraud in obtaining credit); 609.821 (financial transaction card fraud); 617.23 (indecent exposure), not involving a minor; repeat offenses under 617.241 (obscene materials and performances; distribution and exhibition prohibited; penalty); 624.713 (certain persons not to possess firearms); chapter 152 (drugs; controlled substance); or Minnesota Statutes 2012, section 609.21; or a felony-level conviction involving alcohol or drug use.

(b) An individual is disqualified under section 245C.14 if less than 15 years has passed since the individual's aiding and abetting, attempt, or conspiracy to commit any of the offenses listed in paragraph (a), as each of these offenses is defined in Minnesota Statutes.

(c) An individual is disqualified under section 245C.14 if less than 15 years has passed since the termination of the individual's parental rights under section 260C.301, subdivision 1, paragraph (b), or subdivision 3.

(d) An individual is disqualified under section 245C.14 if less than 15 years has passed since the discharge of the sentence imposed for an offense in any other state or country, the elements of which are substantially similar to the elements of the offenses listed in paragraph (a).

(e) If the individual studied commits one of the offenses listed in paragraph (a), but the sentence or level of offense is a gross misdemeanor or misdemeanor, the individual is disqualified but the disqualification look-back period for the offense is the period applicable to the gross misdemeanor or misdemeanor disposition.

(f) When a disqualification is based on a judicial determination other than a conviction, the disqualification period begins from the date of the court order. When a disqualification is based on an admission, the disqualification period begins from the date of an admission in court. When a disqualification is based on an Alford Plea, the disqualification period begins from the date the Alford Plea is entered in court. When a disqualification is based on a preponderance of evidence of a disqualifying act, the disqualification date begins from the date of the dismissal, the date of discharge of the sentence imposed for a conviction for a disqualifying crime of similar elements, or the date of the incident, whichever occurs last.

Subd. 3. **Ten-year disqualification.** (a) An individual is disqualified under section 245C.14 if: (1) less than ten years have passed since the discharge of the sentence imposed, if any, for the offense; and (2) the individual has committed a gross misdemeanor-level violation of any of the following offenses: sections 256.98 (wrongfully obtaining assistance); 268.182 (false representation; concealment of facts); 393.07, subdivision 10, paragraph (c) (federal Food Stamp Program fraud); 609.2112, 609.2113, or 609.2114 (criminal vehicular homicide or injury); 609.221 or 609.222 (assault in the first or second degree); 609.223 or 609.2231 (assault in the third or fourth degree); 609.224 (assault in the fifth degree <u>not by an adult against a minor</u>); 609.224, subdivision 2, paragraph (c) (assault in the fifth degree by a caregiver against a vulnerable adult); 609.2242 and 609.2243 (domestic assault <u>not by an adult against a minor</u>); 609.23 (mistreatment of persons confined); 609.231 (mistreatment of residents or patients); 609.2325 (criminal abuse of a vulnerable adult); 609.233 (criminal neglect of a vulnerable adult); 609.2335 (financial exploitation of a vulnerable adult); 609.234 (failure to report maltreatment of a vulnerable adult); 609.265 (abduction); 609.275 (attempt to coerce); 609.324, subdivision 1a (other prohibited acts; minor engaged in prostitution); 609.33 (disorderly house); 609.377 (malicious punishment of a child); 609.378 (neglect or endangerment of a child); 609.466 (medical assistance fraud); 609.52 (theft); 609.525 (bringing stolen goods into Minnesota); 609.527 (identity theft); 609.53 (receiving stolen property); 609.535 (issuance of dishonored checks); 609.582 (burglary); 609.59 (possession of burglary tools); 609.611 (insurance fraud); 609.631 (check forgery; offering a forged check); 609.66 (dangerous weapons); 609.71 (riot); 609.72, subdivision 3 (disorderly conduct against a vulnerable adult); repeat <u>gross-misdemeanor level</u> offenses under 609.746 (interference with privacy); 609.749, subdivision 2 (stalking); 609.82 (fraud in obtaining credit); 609.821 (financial transaction card fraud); 617.23 (indecent exposure), not involving a minor; 617.241 (obscene materials and performances); 617.243 (indecent literature, distribution); 617.293 (harmful materials; dissemination and display to minors prohibited); or Minnesota Statutes 2012, section 609.21; or violation of an order for protection under section 518B.01, subdivision 14.

(b) An individual is disqualified under section 245C.14 if less than ten years has passed since the individual's aiding and abetting, attempt, or conspiracy to commit any of the offenses listed in paragraph (a), as each of these offenses is defined in Minnesota Statutes.

(c) An individual is disqualified under section 245C.14 if less than ten years has passed since the discharge of the sentence imposed for an offense in any other state or country, the elements of which are substantially similar to the elements of any of the offenses listed in paragraph (a).

(d) If the individual studied commits one of the offenses listed in paragraph (a), but the sentence or level of offense is a misdemeanor disposition, the individual is disqualified but the disqualification lookback period for the offense is the period applicable to misdemeanors.

(e) When a disqualification is based on a judicial determination other than a conviction, the disqualification period begins from the date of the court order. When a disqualification is based on an admission, the disqualification period begins from the date of an admission in court. When a disqualification is based on an Alford Plea, the disqualification period begins from the date the Alford Plea is entered in court. When a disqualification is based on a preponderance of evidence of a disqualifying act, the disqualification date begins from the date of the dismissal, the date of discharge of the sentence imposed for a conviction for a disqualifying crime of similar elements, or the date of the incident, whichever occurs last.

Subd. 4. **Seven-year disqualification.** (a) An individual is disqualified under section 245C.14 if: (1) less than seven years has passed since the discharge of the sentence imposed, if any, for the offense; and (2) the individual has committed a misdemeanor-level violation of any of the following offenses: sections 256.98 (wrongfully obtaining assistance); 268.182 (false representation; concealment of facts); 393.07, subdivision 10, paragraph (c) (federal Food Stamp Program fraud); 609.2112, 609.2113, or 609.2114 (criminal vehicular homicide or injury); 609.221 (assault in the first degree); 609.222 (assault in the second degree); 609.223 (assault in the third degree); 609.2231 (assault in the fourth degree); 609.224 (assault in the fifth degree <u>not by an adult against a minor</u>); 609.2242 (domestic assault <u>not by an adult against a minor</u>); 609.2335 (financial exploitation of a vulnerable adult); 609.234 (failure to report maltreatment of a vulnerable adult); 609.2672 (assault of an unborn child in the third degree); 609.27 (coercion); violation of an order for protection under 609.3232 (protective order authorized; procedures; penalties); 609.466 (medical assistance fraud); 609.52 (theft); 609.525 (bringing stolen goods into Minnesota); 609.527 (identity theft); 609.53 (receiving stolen property); 609.535 (issuance of dishonored checks); 609.611 (insurance fraud); 609.66 (dangerous weapons); 609.665 (spring guns); 609.746 (interference with privacy); 609.79 (obscene or harassing telephone calls); 609.795 (letter, telegram, or

package; opening; harassment); 609.82 (fraud in obtaining credit); 609.821 (financial transaction card fraud); 617.23 (indecent exposure), not involving a minor; 617.293 (harmful materials; dissemination and display to minors prohibited); or Minnesota Statutes 2012, section 609.21; or violation of an order for protection under section 518B.01 (Domestic Abuse Act).

(b) An individual is disqualified under section 245C.14 if less than seven years has passed since a determination or disposition of the individual's:

(1) failure to make required reports under section 626.556, subdivision 3, or 626.557, subdivision 3, for incidents in which: (i) the final disposition under section 626.556 or 626.557 was substantiated maltreatment, and (ii) the maltreatment was recurring or serious; or

(2) substantiated serious or recurring maltreatment of a minor under section 626.556, a vulnerable adult under section 626.557, or serious or recurring maltreatment in any other state, the elements of which are substantially similar to the elements of maltreatment under section 626.556 or 626.557 for which: (i) there is a preponderance of evidence that the maltreatment occurred, and (ii) the subject was responsible for the maltreatment.

(c) An individual is disqualified under section 245C.14 if less than seven years has passed since the individual's aiding and abetting, attempt, or conspiracy to commit any of the offenses listed in paragraphs (a) and (b), as each of these offenses is defined in Minnesota Statutes.

(d) An individual is disqualified under section 245C.14 if less than seven years has passed since the discharge of the sentence imposed for an offense in any other state or country, the elements of which are substantially similar to the elements of any of the offenses listed in paragraphs (a) and (b).

(e) When a disqualification is based on a judicial determination other than a conviction, the disqualification period begins from the date of the court order. When a disqualification is based on an admission, the disqualification period begins from the date of an admission in court. When a disqualification is based on an Alford Plea, the disqualification period begins from the date the Alford Plea is entered in court. When a disqualification is based on a preponderance of evidence of a disqualifying act, the disqualification date begins from the date of the dismissal, the date of discharge of the sentence imposed for a conviction for a disqualifying crime of similar elements, or the date of the incident, whichever occurs last.

(f) An individual is disqualified under section 245C.14 if less than seven years has passed since the individual was disqualified under section 256.98, subdivision 8.

Subd. 5. **Mental illness.** The commissioner may not disqualify an individual subject to a background study under this chapter because that individual has, or has had, a mental illness as defined in section 245.462, subdivision 20.

EFFECTIVE DATE. This section is effective October 1, 2017.

Sec. 38. Minnesota Statutes 2016, section 245C.16, subdivision 1, is amended to read:

Subdivision 1. **Determining immediate risk of harm.** (a) If the commissioner determines that the individual studied has a disqualifying characteristic, the commissioner shall review the information immediately available and make a determination as to the subject's immediate risk of harm to persons served by the program where the individual studied will have direct contact with, or access to, people receiving services.

(b) The commissioner shall consider all relevant information available, including the following factors in determining the immediate risk of harm:

(1) the recency of the disqualifying characteristic;

(2) the recency of discharge from probation for the crimes;

(3) the number of disqualifying characteristics;

(4) the intrusiveness or violence of the disqualifying characteristic;

(5) the vulnerability of the victim involved in the disqualifying characteristic;

(6) the similarity of the victim to the persons served by the program where the individual studied will have direct contact;

(7) whether the individual has a disqualification from a previous background study that has not been set aside; and

(8) if the individual has a disqualification which may not be set aside because it is a permanent bar under section 245C.24, subdivision 1, or the individual has a felony-level conviction for a drug-related offense in the last five years, the commissioner may order the immediate removal of the individual from any position allowing direct contact with, or access to, persons receiving services from the program.

(c) This section does not apply when the subject of a background study is regulated by a health-related licensing board as defined in chapter 214, and the subject is determined to be responsible for substantiated maltreatment under section 626.556 or 626.557.

(d) This section does not apply to a background study related to an initial application for a child foster care license.

(e) Except for paragraph (f), this section does not apply to a background study that is also subject to the requirements under section 256B.0659, subdivisions 11 and 13, for a personal care assistant or a qualified professional as defined in section 256B.0659, subdivision 1.

(f) If the commissioner has reason to believe, based on arrest information or an active maltreatment investigation, that an individual poses an imminent risk of harm to persons receiving services, the commissioner may order that the person be continuously supervised or immediately removed pending the conclusion of the maltreatment investigation or criminal proceedings.

EFFECTIVE DATE. This section is effective October 1, 2017.

Sec. 39. Minnesota Statutes 2016, section 245C.17, subdivision 6, is amended to read:

Subd. 6. **Notice to county agency.** For studies on individuals related to a license to provide adult foster care and family adult day services and, effective upon implementation of NETStudy 2.0, family child care and legal nonlicensed child care authorized under chapter 119B, the commissioner shall also provide a notice of the background study results to the county agency that initiated the background study.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 40. Minnesota Statutes 2016, section 245C.21, subdivision 1, is amended to read:

Subdivision 1. **Who may request reconsideration.** An individual who is the subject of a disqualification may request a reconsideration of the disqualification pursuant to this section. The individual must submit the request for reconsideration to the commissioner in writing.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 41. Minnesota Statutes 2016, section 245C.22, subdivision 5, is amended to read:

Subd. 5. **Scope of set-aside.** (a) If the commissioner sets aside a disqualification under this section, the disqualified individual remains disqualified, but may hold a license and have direct contact with or access to persons receiving services. Except as provided in paragraph (b), the commissioner's set-aside of a disqualification is limited solely to the licensed program, applicant, or agency specified in the set aside notice under section 245C.23. For personal care provider organizations, the commissioner's set-aside may further be limited to a specific individual who is receiving services. For new background studies required

under section 245C.04, subdivision 1, paragraph ~~(g)~~ (h), if an individual's disqualification was previously set aside for the license holder's program and the new background study results in no new information that indicates the individual may pose a risk of harm to persons receiving services from the license holder, the previous set-aside shall remain in effect.

(b) If the commissioner has previously set aside an individual's disqualification for one or more programs or agencies, and the individual is the subject of a subsequent background study for a different program or agency, the commissioner shall determine whether the disqualification is set aside for the program or agency that initiated the subsequent background study. A notice of a set-aside under paragraph (c) shall be issued within 15 working days if all of the following criteria are met:

(1) the subsequent background study was initiated in connection with a program licensed or regulated under the same provisions of law and rule for at least one program for which the individual's disqualification was previously set aside by the commissioner;

(2) the individual is not disqualified for an offense specified in section 245C.15, subdivision 1 or 2;

(3) the commissioner has received no new information to indicate that the individual may pose a risk of harm to any person served by the program; and

(4) the previous set-aside was not limited to a specific person receiving services.

(c) When a disqualification is set aside under paragraph (b), the notice of background study results issued under section 245C.17, in addition to the requirements under section 245C.17, shall state that the disqualification is set aside for the program or agency that initiated the subsequent background study. The notice must inform the individual that the individual may request reconsideration of the disqualification under section 245C.21 on the basis that the information used to disqualify the individual is incorrect.

EFFECTIVE DATE. This section is effective October 1, 2017.

Sec. 42. Minnesota Statutes 2016, section 245C.22, subdivision 7, is amended to read:

Subd. 7. **Classification of certain data.** (a) Notwithstanding section 13.46, except as provided in paragraph (f), upon setting aside a disqualification under this section, the identity of the disqualified individual who received the set-aside and the individual's disqualifying characteristics are public data if the set-aside was:

(1) for any disqualifying characteristic under section 245C.15, except a felony-level conviction for a drug-related offense within the past five years, when the set-aside relates

to a child care center or a family child care provider licensed under chapter 245A, certified license-exempt child care center, or legal nonlicensed family child care center; or

(2) for a disqualifying characteristic under section 245C.15, subdivision 2.

(b) Notwithstanding section 13.46, upon granting a variance to a license holder under section 245C.30, the identity of the disqualified individual who is the subject of the variance, the individual's disqualifying characteristics under section 245C.15, and the terms of the variance are public data, except as provided in paragraph (c), clause (6), when the variance:

(1) is issued to a child care center or a family child care provider licensed under chapter 245A; or

(2) relates to an individual with a disqualifying characteristic under section 245C.15, subdivision 2.

(c) The identity of a disqualified individual and the reason for disqualification remain private data when:

(1) a disqualification is not set aside and no variance is granted, except as provided under section 13.46, subdivision 4;

(2) the data are not public under paragraph (a) or (b);

(3) the disqualification is rescinded because the information relied upon to disqualify the individual is incorrect;

(4) the disqualification relates to a license to provide relative child foster care. As used in this clause, "relative" has the meaning given it under section 260C.007, subdivision 26b or 27; ~~or~~

(5) the disqualified individual is a household member of a licensed foster care provider and:

(i) the disqualified individual previously received foster care services from this licensed foster care provider;

(ii) the disqualified individual was subsequently adopted by this licensed foster care provider; and

(iii) the disqualifying act occurred before the adoption; or

(6) a variance is granted to a child care center or family child care license holder for an individual's disqualification that is based on a felony-level conviction for a drug-related offense that occurred within the past five years.

(d) Licensed family child care providers and child care centers must provide notices as required under section 245C.301.

(e) Notwithstanding paragraphs (a) and (b), the identity of household members who are the subject of a disqualification related set-aside or variance is not public data if:

(1) the household member resides in the residence where the family child care is provided;

(2) the subject of the set-aside or variance is under the age of 18 years; and

(3) the set-aside or variance only relates to a disqualification under section 245C.15, subdivision 4, for a misdemeanor-level theft crime as defined in section 609.52.

(f) When the commissioner has reason to know that a disqualified individual has received an order for expungement for the disqualifying record that does not limit the commissioner's access to the record, and the record was opened or exchanged with the commissioner for purposes of a background study under this chapter, the data that would otherwise become public under paragraph (a) or (b) remain private data.

EFFECTIVE DATE. This section is effective October 1, 2017.

Sec. 43. Minnesota Statutes 2016, section 245C.23, is amended to read:

245C.23 COMMISSIONER'S RECONSIDERATION NOTICE.

Subdivision 1. **Disqualification that is rescinded or set aside.** (a) If the commissioner rescinds or sets aside a disqualification, the commissioner shall notify the applicant, license holder, or other entity in writing or by electronic transmission of the decision.

(b) In the notice from the commissioner that a disqualification has been rescinded, the commissioner must inform the applicant, license holder, or other entity that the information relied upon to disqualify the individual was incorrect.

(c) Except as provided in ~~paragraph~~ paragraphs (d) and (e), in the notice from the commissioner that a disqualification has been set aside, the commissioner must inform the applicant, license holder, or other entity of the reason for the individual's disqualification and that information about which factors under section 245C.22, subdivision 4, were the basis of the decision to set aside the disqualification are available to the license holder upon request without the consent of the background study subject.

(d) When the commissioner has reason to know that a disqualified individual has received an order for expungement for the disqualifying record that does not limit the commissioner's access to the record, and the record was opened or exchanged with the commissioner for purposes of a background study under this chapter, the information provided under paragraph

(c) must only inform the applicant, license holder, or other entity that the disqualifying criminal record is sealed under a court order.

(e) The notification requirements in paragraph (c) do not apply when the set aside is granted to an individual related to a background study for a licensed child care center, certified license-exempt child care center, or family child care license holder, or for a legal nonlicensed child care provider authorized under chapter 119B, and the individual is disqualified for a felony-level conviction for a drug-related offense that occurred within the past five years. The notice that the individual's disqualification is set aside must inform the applicant, license holder, or legal nonlicensed child care provider that the disqualifying criminal record is not public.

Subd. 2. **Commissioner's notice of disqualification that is not set aside.** (a) The commissioner shall notify the license holder of the disqualification and order the license holder to immediately remove the individual from any position allowing direct contact with persons receiving services from the license holder if:

(1) the individual studied does not submit a timely request for reconsideration under section 245C.21;

(2) the individual submits a timely request for reconsideration, but the commissioner does not set aside the disqualification for that license holder under section 245C.22, unless the individual has a right to request a hearing under section 245C.27, 245C.28, or 256.045;

(3) an individual who has a right to request a hearing under sections 245C.27 and 256.045, or 245C.28 and chapter 14 for a disqualification that has not been set aside, does not request a hearing within the specified time; or

(4) an individual submitted a timely request for a hearing under sections 245C.27 and 256.045, or 245C.28 and chapter 14, but the commissioner does not set aside the disqualification under section 245A.08, subdivision 5, or 256.045.

(b) If the commissioner does not set aside the disqualification under section 245C.22, and the license holder was previously ordered under section 245C.17 to immediately remove the disqualified individual from direct contact with persons receiving services or to ensure that the individual is under continuous, direct supervision when providing direct contact services, the order remains in effect pending the outcome of a hearing under sections 245C.27 and 256.045, or 245C.28 and chapter 14.

(c) If the commissioner does not set aside the disqualification under section 245C.22, and the license holder was not previously ordered under section 245C.17 to immediately

remove the disqualified individual from direct contact with persons receiving services or to ensure that the individual is under continuous direct supervision when providing direct contact services, the commissioner shall order the individual to remain under continuous direct supervision pending the outcome of a hearing under sections 245C.27 and 256.045, or 245C.28 and chapter 14.

(d) For background studies related to child foster care, the commissioner shall also notify the county or private agency that initiated the study of the results of the reconsideration.

(e) For background studies related to family child care, legal nonlicensed child care, adult foster care, and family adult day services, the commissioner shall also notify the county that initiated the study of the results of the reconsideration.

EFFECTIVE DATE. This section is effective October 1, 2017.

Sec. 44. Minnesota Statutes 2016, section 245C.24, subdivision 3, is amended to read:

Subd. 3. **Ten-year bar to set aside disqualification.** (a) The commissioner may not set aside the disqualification of an individual in connection with a license to provide family child care for children, foster care for children in the provider's home, or foster care or day care services for adults in the provider's home if: (1) less than ten years has passed since the discharge of the sentence imposed, if any, for the offense; or (2) when disqualified based on a preponderance of evidence determination under section 245C.14, subdivision 1, paragraph (a), clause (2), or an admission under section 245C.14, subdivision 1, paragraph (a), clause (1), and less than ten years has passed since the individual committed the act or admitted to committing the act, whichever is later; and (3) the individual has committed a violation of any of the following offenses: sections 609.165 (felon ineligible to possess firearm); criminal vehicular homicide or criminal vehicular operation causing death under 609.2112, 609.2113, or 609.2114 (criminal vehicular homicide or injury); 609.215 (aiding suicide or aiding attempted suicide); preponderance of evidence of felony violations under 609.223 or 609.2231 (assault in the third or fourth degree); 609.229 (crimes committed for benefit of a gang); 609.713 (terroristic threats); 609.235 (use of drugs to injure or to facilitate crime); 609.24 (simple robbery); 609.255 (false imprisonment); 609.562 (arson in the second degree); 609.71 (riot); 609.498, subdivision 1 or 1b (aggravated first-degree or first-degree tampering with a witness); burglary in the first or second degree under 609.582 (burglary); 609.66 (dangerous weapon); 609.665 (spring guns); 609.67 (machine guns and short-barreled shotguns); 609.749, subdivision 2 (gross misdemeanor stalking); 152.021 or 152.022 (controlled substance crime in the first or second degree); 152.023, subdivision 1, clause (3) or (4) or subdivision 2, clause (4) (controlled substance crime in the third degree);

152.024, subdivision 1, clause (2), (3), or (4) (controlled substance crime in the fourth degree); 609.224, subdivision 2, paragraph (c) (fifth-degree assault by a caregiver against a vulnerable adult); 609.23 (mistreatment of persons confined); 609.231 (mistreatment of residents or patients); 609.2325 (criminal abuse of a vulnerable adult); 609.233 (criminal neglect of a vulnerable adult); 609.2335 (financial exploitation of a vulnerable adult); 609.234 (failure to report); 609.265 (abduction); 609.2664 to 609.2665 (manslaughter of an unborn child in the first or second degree); 609.267 to 609.2672 (assault of an unborn child in the first, second, or third degree); 609.268 (injury or death of an unborn child in the commission of a crime); repeat offenses under 617.23 (indecent exposure); 617.293 (disseminating or displaying harmful material to minors); a felony-level conviction involving alcohol or drug use, a gross misdemeanor offense under 609.324, subdivision 1 (other prohibited acts); a gross misdemeanor offense under 609.378 (neglect or endangerment of a child); a gross misdemeanor offense under 609.377 (malicious punishment of a child); 609.72, subdivision 3 (disorderly conduct against a vulnerable adult); or 624.713 (certain persons not to possess firearms); or Minnesota Statutes 2012, section 609.21.

(b) The commissioner may not set aside the disqualification of an individual if less than ten years have passed since the individual's aiding and abetting, attempt, or conspiracy to commit any of the offenses listed in paragraph (a) as each of these offenses is defined in Minnesota Statutes.

(c) The commissioner may not set aside the disqualification of an individual if less than ten years have passed since the discharge of the sentence imposed for an offense in any other state or country, the elements of which are substantially similar to the elements of any of the offenses listed in paragraph (a).

EFFECTIVE DATE. This section is effective October 1, 2017.

Sec. 45. Minnesota Statutes 2016, section 245C.25, is amended to read:

245C.25 CONSOLIDATED RECONSIDERATION OF MALTREATMENT DETERMINATION AND DISQUALIFICATION.

~~(a)~~ If an individual is disqualified on the basis of a determination of maltreatment under section 626.556 or 626.557, which was serious or recurring, and the individual requests reconsideration of the maltreatment determination under section 626.556, subdivision 10i, or 626.557, subdivision 9d, and also requests reconsideration of the disqualification under section 245C.21, the commissioner shall consolidate the reconsideration of the maltreatment determination and the disqualification into a single reconsideration.

~~(b) For maltreatment and disqualification determinations made by county agencies, the county agency shall conduct the consolidated reconsideration. If the county agency has disqualified an individual on multiple bases, one of which is a county maltreatment determination for which the individual has a right to request reconsideration, the county shall conduct the reconsideration of all disqualifications.~~

~~(c) If the county has previously conducted a consolidated reconsideration under paragraph (b) of a maltreatment determination and a disqualification based on serious or recurring maltreatment, and the county subsequently disqualifies the individual based on that determination, the county shall conduct the reconsideration of the subsequent disqualification. The scope of the subsequent disqualification shall be limited to whether the individual poses a risk of harm in accordance with section 245C.22, subdivision 4. If the commissioner subsequently disqualifies the individual in connection with a child foster care license based on the county's previous maltreatment determination, the commissioner shall conduct the reconsideration of the subsequent disqualification.~~

EFFECTIVE DATE. This section is effective October 1, 2017.

Sec. 46. Minnesota Statutes 2016, section 245C.30, subdivision 2, is amended to read:

Subd. 2. **Disclosure of reason for disqualification.** (a) The commissioner may not grant a variance for a disqualified individual unless the applicant or license holder requests the variance and the disqualified individual provides written consent for the commissioner to disclose to the applicant or license holder the reason for the disqualification.

(b) This subdivision does not apply to programs licensed to provide family child care for children, foster care for children in the provider's own home, or foster care or day care services for adults in the provider's own home. When the commissioner grants a variance for a disqualified individual in connection with a license to provide the services specified in this paragraph, the disqualified individual's consent is not required to disclose the reason for the disqualification to the license holder in the variance issued under subdivision 1, provided that the commissioner may not disclose the reason for the disqualification if the disqualification is based on a felony-level conviction for a drug-related offense within the past five years.

EFFECTIVE DATE. This section is effective October 1, 2017.

Sec. 47. **[245G.01] DEFINITIONS.**

Subdivision 1. **Scope.** The terms used in this chapter have the meanings given in this section.

Subd. 2. **Applicant.** "Applicant" means an individual or organization that is subject to certification under this chapter and that applied for but is not yet granted certification under this chapter.

Subd. 3. **Center operator or program operator.** "Center operator" or "program operator" means the person exercising supervision or control over the center's or program's operations, planning, and functioning. There may be more than one designated center operator or program operator.

Subd. 4. **Certification holder.** "Certification holder" means the individual or organization that is legally responsible for the operation of the center, and granted certification by the commissioner under this chapter.

Subd. 5. **Certified license-exempt child care center.** "Certified license-exempt child care center" means the commissioner's written authorization for a child care center excluded from licensure under section 245A.03, subdivision 2, paragraph (a), clause (5), (11) to (13), (15), (18), or (26), to register to receive child care assistance payments under chapter 119B.

Subd. 6. **Disinfecting.** "Disinfecting" means the use of a product capable of destroying or inactivating harmful germs, except bacterial spores, consistent with label directions on environmental surfaces including bathroom toilets and floors, diaper-changing surfaces, and surfaces exposed to blood or other bodily fluids.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 48. **[245G.02] WHO MUST BE CERTIFIED.**

A program that is exempt from licensure under section 245A.03, subdivision 2, paragraph (a), clause (5), (11) to (13), (15), (18), or (26), and is authorized to receive child care assistance payments under chapter 119B, must be a certified license-exempt child care center according to this section.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 49. **[245G.03] APPLICATION PROCEDURES.**

Subdivision 1. **Schedule.** The certification of license-exempt child care centers shall be implemented by September 30, 2017. Certification applications shall be received and processed on a phased-in schedule as determined by the commissioner.

Subd. 2. **Application submission.** The commissioner shall provide application instructions and information about the rules and requirements of other state agencies that affect the applicant. The certification application must be submitted in a manner prescribed by the commissioner. The commissioner shall act on the application within 90 working days of receiving a completed application.

Subd. 3. **Incomplete applications.** When the commissioner receives an application for initial certification that is incomplete because the applicant failed to submit required documents or is deficient because the documents submitted do not meet certification requirements, the commissioner shall provide the applicant written notice that the application is incomplete or deficient. In the notice, the commissioner shall identify documents that are missing or deficient and give the applicant 45 days to resubmit a second application that is complete. An applicant's failure to submit a complete application after receiving notice from the commissioner is basis for certification denial.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 50. **[245G.04] COMMISSIONER'S RIGHT OF ACCESS.**

(a) When the commissioner is exercising the powers conferred by this chapter, whenever the center is in operation and the information is relevant to the commissioner's inspection or investigation, the commissioner must be given access to:

(1) the physical facility and grounds where the program is provided;

(2) documentation and records, including electronically maintained records;

(3) children served by the center; and

(4) staff and personnel records of current and former staff.

(b) The commissioner must be given access without prior notice and as often as the commissioner considers necessary if the commissioner is investigating alleged maltreatment or a violation of a law or rule, or conducting an inspection. When conducting an inspection, the commissioner may request and shall receive assistance from other state, county, and municipal governmental agencies and departments. The applicant or certification holder

shall allow the commissioner, at the commissioner's expense, to photocopy, photograph, and make audio and video recordings during an inspection at the commissioner's expense.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 51. **[245G.05] MONITORING AND INSPECTIONS.**

(a) The commissioner must conduct an on-site inspection of a certified license-exempt child care center at least annually to determine compliance with the health, safety, and fire standards specific to a certified license-exempt child care center.

(b) No later than November 19, 2017, the commissioner shall make publicly available on the department's Web site the results of inspection reports for all certified centers including the number of deaths, serious injuries, and instances of substantiated child maltreatment that occurred in certified centers each year.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 52. **[245G.06] CORRECTION ORDER.**

Subdivision 1. **Correction order requirements.** If the applicant or certification holder failed to comply with a law or rule, the commissioner may issue a correction order. The correction order must state:

(1) the condition that constitutes a violation of the law or rule;

(2) the specific law or rule violated; and

(3) the time allowed to correct each violation.

Subd. 2. **Reconsideration request.** (a) If the applicant or certification holder believes that the commissioner's correction order is erroneous, the applicant or certification holder may ask the commissioner to reconsider the part of the correction order that is allegedly erroneous. A request for reconsideration must be made in writing, postmarked, and sent to the commissioner within 20 calendar days after the applicant or certification holder received the correction order, and must:

(1) specify the part of the correction order that is allegedly erroneous;

(2) explain why the specified part is erroneous; and

(3) include documentation to support the allegation of error.

(b) A request for reconsideration does not stay any provision or requirement of the correction order. The commissioner's disposition of a request for reconsideration is final and not subject to appeal.

Subd. 3. **Decertification following a correction order.** (a) If the commissioner finds that the applicant or certification holder failed to correct the violation specified in the correction order, the commissioner may decertify the license-exempt center pursuant to section 245G.07.

(b) Nothing in this section prohibits the commissioner from decertifying a center according to section 245G.07.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 53. **[245G.07] DECERTIFICATION.**

(a) The commissioner may decertify a center if a certification holder:

(1) failed to comply with an applicable law or rule; or

(2) knowingly withheld relevant information from or gave false or misleading information to the commissioner in connection with an application for certification, in connection with the background study status of an individual, during an investigation, or regarding compliance with applicable laws or rules.

(b) When considering decertification, the commissioner shall consider the nature, chronicity, or severity of the violation of law or rule.

(c) When a center is decertified, the center is ineligible to receive a child care assistance payment.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 54. **[245G.08] STAFFING REQUIREMENTS.**

Subdivision 1. **Staffing requirements.** During hours of operation, a certified center must have a director or designee on site who is responsible for overseeing implementation of written policies relating to the management and control of the daily activities of the program, ensuring the health and safety of program participants, and supervising staff and volunteers.

Subd. 2. **Director qualifications.** The director must be 18 years of age or older and have completed at least 16 hours of training in any of the following topic areas: child development and learning; developmentally appropriate learning experiences; relationships with families;

assessment, evaluation, and individualization; historical and contemporary development of early childhood education; professionalism; and health, safety, and nutrition.

Subd. 3. **Staff qualifications.** A staff person must be 16 years of age or older before providing direct, unsupervised care to a child.

Subd. 4. **Maximum group size.** (a) For a child six weeks old through 16 months old, the maximum group size shall be no more than eight children.

(b) For a child 16 months old through 33 months old, the maximum group size shall be no more than 14 children.

(c) For a child 33 months old through prekindergarten, a maximum group size shall be no more than 20 children.

(d) For a child in kindergarten through 13 years old, a maximum group size shall be no more than 30 children.

(e) The maximum group size applies at all times except during group activity coordination time not exceeding 15 minutes, during a meal, outdoor activity, field trip, nap and rest, and special activity including a film, guest speaker, indoor large muscle activity, or holiday program.

Subd. 5. **Ratios.** (a) The minimally acceptable staff-to-child ratios are:

six weeks old through 16 months old	1:4
16 months old through 33 months old	1:7
33 months old through prekindergarten	1:10
kindergarten through 13 years old	1:15

(b) Kindergarten includes a child of sufficient age to have attended the first day of kindergarten or who is eligible to enter kindergarten within the next four months.

(c) For mixed groups, the ratio for the age group of the youngest child applies.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 55. **[245G.10] BACKGROUND STUDIES.**

Subdivision 1. **Documentation.** (a) The applicant or certification holder must submit and maintain documentation of a completed background study for:

(1) each person applying for the certification;

(2) each person identified as a center operator or program operator as defined in section 245G.01, subdivision 5;

(3) each current or prospective staff person or contractor of the certified center who will have direct contact with a child served by the center;

(4) each volunteer who has direct contact with a child served by the center if the contact is not under the continuous, direct supervision by an individual listed in clause (1), (2), or (3); and

(5) each managerial staff of the certification holder with oversight and supervision of the certified center.

(b) To be accepted for certification, a background study on every individual in subdivision 1, clause (1), must be completed under chapter 245C and result in a not disqualified determination under section 245C.14 or a disqualification that was set aside under section 245C.22.

Subd. 2. **Direct contact.** (a) The subject of the background study may not provide direct contact services to a child served by a certified center unless the subject is under continuous direct supervision pending completion of the background study.

(b) The certified center must document in the staff person's personnel file the date the program initiates a background study and the date the subject of the study first had direct contact with a child served by the center.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 56. **[245G.11] REPORTING.**

(a) The certification holder must comply with the reporting requirements for abuse and neglect specified in section 626.556. A person mandated to report physical or sexual child abuse or neglect occurring within a certified center shall report the information to the commissioner.

(b) The certification holder must inform the commissioner within 24 hours of:

(1) the death of a child in the program; and

(2) any injury to a child in the program that required treatment by a physician.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 57. **[245G.12] FEES.**

The commissioner shall consult with stakeholders to develop an administrative fee to implement this chapter. By February 15, 2019, the commissioner shall provide

recommendations on the amount of an administrative fee to the legislative committees with jurisdiction over health and human services policy and finance.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 58. **[245G.13] HEALTH AND SAFETY REQUIREMENTS.**

Subdivision 1. **Exclusion of sick children and infectious disease outbreak control.** (a) A certified center must supervise and isolate a child from other children in the program when a child becomes sick and immediately notify the sick child's parent or legal guardian.

(b) A certified center must post or give notice to the parent or legal guardian of an exposed child the same day the program is notified of a child's contagious reportable disease specified in Minnesota Rules, part 4605.7040, or scabies, impetigo, ringworm, or chicken pox.

Subd. 2. **Immunizations.** By a child's date of attendance, the certified center must maintain or have access to a record detailing the child's current immunizations or applicable exemption.

Subd. 3. **Administration of medication.** (a) A certified center that chooses to administer medicine must meet the requirements in this subdivision.

(b) The certified center must obtain written permission from the child's parent or legal guardian before administering prescription medicine, diapering product, sunscreen lotion, and insect repellent.

(c) The certified center must administer nonprescription medicine, diapering product, sunscreen lotion, and insect repellent according to the manufacturer's instructions unless provided written instructions by a licensed health professional to use a product differently.

(d) The certified center must obtain and follow written instructions from the prescribing health professional before administering prescription medicine. Medicine with the child's first and last name and current prescription information on the label is considered written instructions.

(e) The certified center must ensure all medicine is:

(1) kept in the medicine's original container with a legible label stating the child's first and last name;

(2) given only to the child whose name is on the label;

(3) not given after an expiration date on the label; and

(4) returned to the child's parent or legal guardian or destroyed, if unused.

(f) The certified center must document in the child's record the administration of medication, including the child's first and last name; the name of the medication or prescription number; the date, time, and dosage; and the name and signature of the person who administered the medicine. This documentation must be available to the child's parent or legal guardian.

(g) The certified center must store medicines, insect repellents, and diapering products according to directions on the original container.

Subd. 4. **Preventing and responding to allergies.** (a) Before admitting a child for care, the certified center must obtain documentation of any known allergies from the child's parent or legal guardian. The certified center must maintain current allergy information in each child's record. The allergy information must include:

(1) a description of the allergy, specific triggers, avoidance techniques, and symptoms of an allergic reaction; and

(2) procedures for responding to an allergic reaction, including medication, dosages, and a doctor's contact information.

(b) The certified center must inform staff of each child's current allergy information. At least annually and when a change is made to allergy-related information in a child's record, the certified center must inform staff of any change. Documentation that staff were informed of the child's current allergy information must be kept on site.

(c) A child's allergy information must be available at all times including on site, when on field trips, or during transportation. Food allergy information must be readily available to staff in the area where food is prepared and served to the child.

Subd. 5. **Building and physical premises; free of hazards.** (a) The certified center must document compliance with the State Fire Code by providing documentation of a fire marshal inspection completed within the previous three years by a state fire marshal or a local fire code inspector trained by the state fire marshal.

(b) The certified center must designate a primary indoor and outdoor space used for child care on a facility site floor plan.

(c) The certified center must ensure the areas used by a child are clean and in good repair, with structurally sound and functional furniture and equipment that is appropriate to the age and size of a child who uses the area.

(d) The certified center must ensure hazardous items including but not limited to sharp objects, medicines, cleaning supplies, poisonous plants, and chemicals are out of reach of a child.

(e) The certified center must safely handle and dispose of bodily fluids and other potentially infectious fluids by using gloves, disinfecting surfaces that come in contact with potentially infectious bodily fluids, and disposing of bodily fluid in a securely sealed plastic bag.

Subd. 6. **Transporting children.** (a) If a certified center chooses to transport a child, the certified center must ensure that the driver of the vehicle holds a valid driver's license, appropriate to the vehicle driven.

(b) If a certified center chooses to transport a child, the center must comply with all seat belt and child passenger restraint system requirements under sections 169.685 and 169.686.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 59. **[245G.14] TRAINING REQUIREMENTS.**

Subdivision 1. **First aid and cardiopulmonary resuscitation.** At least one designated staff person who completed first aid training and cardiopulmonary resuscitation (CPR) training must be present at all times at the program, during field trips, and when transporting a child. The designated staff person must repeat first aid training and CPR training at least once every two years.

Subd. 2. **Sudden unexpected infant death.** A certified center that cares for an infant who is younger than one year of age must ensure that staff persons and volunteers receive training according to section 245A.1435 on reducing the risk of sudden unexpected infant death before assisting in the care of an infant.

Subd. 3. **Abusive head trauma.** A certified center that cares for a child through four years of age must ensure that staff persons and volunteers receive training on abusive head trauma from shaking infants and young children before assisting in the care of a child through four years of age.

Subd. 4. **Child development.** The certified center must ensure each staff person completes at least two hours of child development and learning training within 14 days of employment and annually thereafter. For purposes of this subdivision, "child development and learning training" means how a child develops physically, cognitively, emotionally, and socially and learns as part of the child's family, culture, and community.

Subd. 5. **Orientation.** The certified center must ensure each staff person is trained at orientation on health and safety requirements in sections 245G.11, 245G.13, 245G.14, and 245G.15. The certified center must provide staff with an orientation within 14 days of employment. Before the completion of orientation, a staff person must be supervised while providing direct care to a child.

Subd. 6. **In service.** (a) The certified center must ensure each staff person is trained at least annually on health and safety requirements in sections 245G.11, 245G.13, 245G.14, and 245G.15.

(b) Each staff person must annually complete at least six hours of training. Training required under paragraph (a) may be used toward the hourly training requirements of this subdivision.

Subd. 7. **Documentation.** A certified center must document the date of a completed training required by this section in the personnel record of each staff person.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 60. **[245G.15] EMERGENCY PREPAREDNESS.**

Subdivision 1. **Written emergency plan.** (a) A certified center must have a written emergency plan for emergencies that require evacuation, sheltering, or other protection of children, such as fire, natural disaster, intruder, or other threatening situation that may pose a health or safety hazard to children. The plan must be written on a form developed by the commissioner and reviewed and updated at least once each calendar year. The annual review of the emergency plan must be documented.

(b) The plan must include:

(1) procedures for an evacuation, relocation, shelter-in-place, or lockdown;

(2) a designated relocation site and evacuation route;

(3) procedures for notifying a child's parent or legal guardian of the relocation and reunification with families;

(4) accommodations for a child with a disability or a chronic medical condition;

(5) procedures for storing a child's medically necessary medicine that facilitates easy removal during an evacuation or relocation;

(6) procedures for continuing operations in the period during and after a crisis; and

(7) procedures for communicating with local emergency management officials, law enforcement officials, or other appropriate state or local authorities.

(c) The certification holder must have an emergency plan available for review upon request by the child's parent or legal guardian.

Subd. 2. **Staff person training.** The certification holder must train a staff person at orientation and at least once each calendar year on the emergency plan and document training in each personnel file. The certified center must conduct at least quarterly one evacuation drill and one shelter-in-place drill. The date and time of the drills must be documented.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 61. **[245G.16] PERSONNEL RECORD.**

The certification holder must maintain a personnel record for each staff person at the program that must contain:

(1) the staff person's name, home address, telephone number, and date of birth;

(2) documentation that the staff person completed training required by section 245G.14;

(3) documentation of the date the program initiated a background study for the staff person; and

(4) documentation of the date the staff person first had direct contact and access to a child while supervised, and the date the staff person first had direct contact and access to a child while unsupervised.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 62. **[245G.17] CERTIFICATION STANDARDS.**

The commissioner shall regularly consult with stakeholders for input related to implementing the standards in this chapter.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 63. **[245G.18] PARENTAL ACCESS.**

An enrolled child's parent or legal guardian must be allowed access to the parent's or legal guardian's child at any time while the child is in care.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 64. Minnesota Statutes 2016, section 256.98, subdivision 8, is amended to read:

Subd. 8. **Disqualification from program.** (a) Any person found to be guilty of wrongfully obtaining assistance by a federal or state court or by an administrative hearing determination, or waiver thereof, through a disqualification consent agreement, or as part of any approved diversion plan under section 401.065, or any court-ordered stay which carries with it any probationary or other conditions, in the Minnesota family investment program and any affiliated program to include the diversionary work program and the work participation cash benefit program, the food stamp or food support program, the general assistance program, the group residential housing program, or the Minnesota supplemental aid program shall be disqualified from that program. In addition, any person disqualified from the Minnesota family investment program shall also be disqualified from the food stamp or food support program. The needs of that individual shall not be taken into consideration in determining the grant level for that assistance unit:

(1) for one year after the first offense;

(2) for two years after the second offense; and

(3) permanently after the third or subsequent offense.

The period of program disqualification shall begin on the date stipulated on the advance notice of disqualification without possibility of postponement for administrative stay or administrative hearing and shall continue through completion unless and until the findings upon which the sanctions were imposed are reversed by a court of competent jurisdiction. The period for which sanctions are imposed is not subject to review. The sanctions provided under this subdivision are in addition to, and not in substitution for, any other sanctions that may be provided for by law for the offense involved. A disqualification established through hearing or waiver shall result in the disqualification period beginning immediately unless the person has become otherwise ineligible for assistance. If the person is ineligible for assistance, the disqualification period begins when the person again meets the eligibility criteria of the program from which they were disqualified and makes application for that program.

(b) A family receiving assistance through child care assistance programs under chapter 119B with a family member who is found to be guilty of wrongfully obtaining child care assistance by a federal court, state court, or an administrative hearing determination or waiver, through a disqualification consent agreement, as part of an approved diversion plan under section 401.065, or a court-ordered stay with probationary or other conditions, is disqualified from child care assistance programs. The disqualifications must be for periods

of one year and two years for the first and second offenses, respectively. Subsequent violations must result in permanent disqualification. During the disqualification period, disqualification from any child care program must extend to all child care programs and must be immediately applied.

(c) A provider caring for children receiving assistance through child care assistance programs under chapter 119B is disqualified from receiving payment for child care services from the child care assistance program under chapter 119B when the provider is found to have wrongfully obtained child care assistance by a federal court, state court, or an administrative hearing determination or waiver under section 256.046, through a disqualification consent agreement, as part of an approved diversion plan under section 401.065, or a court-ordered stay with probationary or other conditions. The disqualification must be for a period of ~~one year~~ two years for the first offense ~~and two years for the second offense~~. Any subsequent violation must result in permanent disqualification. The disqualification period must be imposed immediately after a determination is made under this paragraph. During the disqualification period, the provider is disqualified from receiving payment from any child care program under chapter 119B.

(d) Any person found to be guilty of wrongfully obtaining MinnesotaCare for adults without children and upon federal approval, all categories of medical assistance and remaining categories of MinnesotaCare, except for children through age 18, by a federal or state court or by an administrative hearing determination, or waiver thereof, through a disqualification consent agreement, or as part of any approved diversion plan under section 401.065, or any court-ordered stay which carries with it any probationary or other conditions, is disqualified from that program. The period of disqualification is one year after the first offense, two years after the second offense, and permanently after the third or subsequent offense. The period of program disqualification shall begin on the date stipulated on the advance notice of disqualification without possibility of postponement for administrative stay or administrative hearing and shall continue through completion unless and until the findings upon which the sanctions were imposed are reversed by a court of competent jurisdiction. The period for which sanctions are imposed is not subject to review. The sanctions provided under this subdivision are in addition to, and not in substitution for, any other sanctions that may be provided for by law for the offense involved.

EFFECTIVE DATE. This section is effective June 5, 2017.

Sec. 65. Minnesota Statutes 2016, section 626.556, subdivision 2, is amended to read:

Subd. 2. **Definitions.** As used in this section, the following terms have the meanings given them unless the specific content indicates otherwise:

(a) "Accidental" means a sudden, not reasonably foreseeable, and unexpected occurrence or event which:

(1) is not likely to occur and could not have been prevented by exercise of due care; and

(2) if occurring while a child is receiving services from a facility, happens when the facility and the employee or person providing services in the facility are in compliance with the laws and rules relevant to the occurrence or event.

(b) "Commissioner" means the commissioner of human services.

(c) "Facility" means:

(1) a licensed or unlicensed day care facility, certified license-exempt child care center, residential facility, agency, hospital, sanitarium, or other facility or institution required to be licensed under sections 144.50 to 144.58, 241.021, or 245A.01 to 245A.16, or chapter 245D or 245G;

(2) a school as defined in section 120A.05, subdivisions 9, 11, and 13; and chapter 124E; or

(3) a nonlicensed personal care provider organization as defined in section 256B.0625, subdivision 19a.

(d) "Family assessment" means a comprehensive assessment of child safety, risk of subsequent child maltreatment, and family strengths and needs that is applied to a child maltreatment report that does not allege sexual abuse or substantial child endangerment. Family assessment does not include a determination as to whether child maltreatment occurred but does determine the need for services to address the safety of family members and the risk of subsequent maltreatment.

(e) "Investigation" means fact gathering related to the current safety of a child and the risk of subsequent maltreatment that determines whether child maltreatment occurred and whether child protective services are needed. An investigation must be used when reports involve sexual abuse or substantial child endangerment, and for reports of maltreatment in facilities required to be licensed or certified under chapter 245A ~~or~~, 245D, or 245G; under sections 144.50 to 144.58 and 241.021; in a school as defined in section 120A.05,

subdivisions 9, 11, and 13, and chapter 124E; or in a nonlicensed personal care provider association as defined in section 256B.0625, subdivision 19a.

(f) "Mental injury" means an injury to the psychological capacity or emotional stability of a child as evidenced by an observable or substantial impairment in the child's ability to function within a normal range of performance and behavior with due regard to the child's culture.

(g) "Neglect" means the commission or omission of any of the acts specified under clauses (1) to (9), other than by accidental means:

(1) failure by a person responsible for a child's care to supply a child with necessary food, clothing, shelter, health, medical, or other care required for the child's physical or mental health when reasonably able to do so;

(2) failure to protect a child from conditions or actions that seriously endanger the child's physical or mental health when reasonably able to do so, including a growth delay, which may be referred to as a failure to thrive, that has been diagnosed by a physician and is due to parental neglect;

(3) failure to provide for necessary supervision or child care arrangements appropriate for a child after considering factors as the child's age, mental ability, physical condition, length of absence, or environment, when the child is unable to care for the child's own basic needs or safety, or the basic needs or safety of another child in their care;

(4) failure to ensure that the child is educated as defined in sections 120A.22 and 260C.163, subdivision 11, which does not include a parent's refusal to provide the parent's child with sympathomimetic medications, consistent with section 125A.091, subdivision 5;

(5) nothing in this section shall be construed to mean that a child is neglected solely because the child's parent, guardian, or other person responsible for the child's care in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the child in lieu of medical care; except that a parent, guardian, or caretaker, or a person mandated to report pursuant to subdivision 3, has a duty to report if a lack of medical care may cause serious danger to the child's health. This section does not impose upon persons, not otherwise legally responsible for providing a child with necessary food, clothing, shelter, education, or medical care, a duty to provide that care;

(6) prenatal exposure to a controlled substance, as defined in section 253B.02, subdivision 2, used by the mother for a nonmedical purpose, as evidenced by withdrawal symptoms in

the child at birth, results of a toxicology test performed on the mother at delivery or the child at birth, medical effects or developmental delays during the child's first year of life that medically indicate prenatal exposure to a controlled substance, or the presence of a fetal alcohol spectrum disorder;

(7) "medical neglect" as defined in section 260C.007, subdivision 6, clause (5);

(8) chronic and severe use of alcohol or a controlled substance by a parent or person responsible for the care of the child that adversely affects the child's basic needs and safety; or

(9) emotional harm from a pattern of behavior which contributes to impaired emotional functioning of the child which may be demonstrated by a substantial and observable effect in the child's behavior, emotional response, or cognition that is not within the normal range for the child's age and stage of development, with due regard to the child's culture.

(h) "Nonmaltreatment mistake" means:

(1) at the time of the incident, the individual was performing duties identified in the center's child care program plan required under Minnesota Rules, part 9503.0045;

(2) the individual has not been determined responsible for a similar incident that resulted in a finding of maltreatment for at least seven years;

(3) the individual has not been determined to have committed a similar nonmaltreatment mistake under this paragraph for at least four years;

(4) any injury to a child resulting from the incident, if treated, is treated only with remedies that are available over the counter, whether ordered by a medical professional or not; and

(5) except for the period when the incident occurred, the facility and the individual providing services were both in compliance with all licensing requirements relevant to the incident.

This definition only applies to child care centers licensed under Minnesota Rules, chapter 9503. If clauses (1) to (5) apply, rather than making a determination of substantiated maltreatment by the individual, the commissioner of human services shall determine that a nonmaltreatment mistake was made by the individual.

(i) "Operator" means an operator or agency as defined in section 245A.02.

(j) "Person responsible for the child's care" means (1) an individual functioning within the family unit and having responsibilities for the care of the child such as a parent, guardian,

or other person having similar care responsibilities, or (2) an individual functioning outside the family unit and having responsibilities for the care of the child such as a teacher, school administrator, other school employees or agents, or other lawful custodian of a child having either full-time or short-term care responsibilities including, but not limited to, day care, babysitting whether paid or unpaid, counseling, teaching, and coaching.

(k) "Physical abuse" means any physical injury, mental injury, or threatened injury, inflicted by a person responsible for the child's care on a child other than by accidental means, or any physical or mental injury that cannot reasonably be explained by the child's history of injuries, or any aversive or deprivation procedures, or regulated interventions, that have not been authorized under section 125A.0942 or 245.825.

Abuse does not include reasonable and moderate physical discipline of a child administered by a parent or legal guardian which does not result in an injury. Abuse does not include the use of reasonable force by a teacher, principal, or school employee as allowed by section 121A.582. Actions which are not reasonable and moderate include, but are not limited to, any of the following:

(1) throwing, kicking, burning, biting, or cutting a child;

(2) striking a child with a closed fist;

(3) shaking a child under age three;

(4) striking or other actions which result in any nonaccidental injury to a child under 18 months of age;

(5) unreasonable interference with a child's breathing;

(6) threatening a child with a weapon, as defined in section 609.02, subdivision 6;

(7) striking a child under age one on the face or head;

(8) striking a child who is at least age one but under age four on the face or head, which results in an injury;

(9) purposely giving a child poison, alcohol, or dangerous, harmful, or controlled substances which were not prescribed for the child by a practitioner, in order to control or punish the child; or other substances that substantially affect the child's behavior, motor coordination, or judgment or that results in sickness or internal injury, or subjects the child to medical procedures that would be unnecessary if the child were not exposed to the substances;

(10) unreasonable physical confinement or restraint not permitted under section 609.379, including but not limited to tying, caging, or chaining; or

(11) in a school facility or school zone, an act by a person responsible for the child's care that is a violation under section 121A.58.

(l) "Practice of social services," for the purposes of subdivision 3, includes but is not limited to employee assistance counseling and the provision of guardian ad litem and parenting time expeditor services.

(m) "Report" means any communication received by the local welfare agency, police department, county sheriff, or agency responsible for child protection pursuant to this section that describes neglect or physical or sexual abuse of a child and contains sufficient content to identify the child and any person believed to be responsible for the neglect or abuse, if known.

(n) "Sexual abuse" means the subjection of a child by a person responsible for the child's care, by a person who has a significant relationship to the child, as defined in section 609.341, or by a person in a position of authority, as defined in section 609.341, subdivision 10, to any act which constitutes a violation of section 609.342 (criminal sexual conduct in the first degree), 609.343 (criminal sexual conduct in the second degree), 609.344 (criminal sexual conduct in the third degree), 609.345 (criminal sexual conduct in the fourth degree), or 609.3451 (criminal sexual conduct in the fifth degree). Sexual abuse also includes any act which involves a minor which constitutes a violation of prostitution offenses under sections 609.321 to 609.324 or 617.246. Effective May 29, 2017, sexual abuse includes all reports of known or suspected child sex trafficking involving a child who is identified as a victim of sex trafficking. Sexual abuse includes child sex trafficking as defined in section 609.321, subdivisions 7a and 7b. Sexual abuse includes threatened sexual abuse which includes the status of a parent or household member who has committed a violation which requires registration as an offender under section 243.166, subdivision 1b, paragraph (a) or (b), or required registration under section 243.166, subdivision 1b, paragraph (a) or (b).

(o) "Substantial child endangerment" means a person responsible for a child's care, by act or omission, commits or attempts to commit an act against a child under their care that constitutes any of the following:

(1) egregious harm as defined in section 260C.007, subdivision 14;

(2) abandonment under section 260C.301, subdivision 2;

(3) neglect as defined in paragraph (g), clause (2), that substantially endangers the child's physical or mental health, including a growth delay, which may be referred to as failure to thrive, that has been diagnosed by a physician and is due to parental neglect;

(4) murder in the first, second, or third degree under section 609.185, 609.19, or 609.195;

(5) manslaughter in the first or second degree under section 609.20 or 609.205;

(6) assault in the first, second, or third degree under section 609.221, 609.222, or 609.223;

(7) solicitation, inducement, and promotion of prostitution under section 609.322;

(8) criminal sexual conduct under sections 609.342 to 609.3451;

(9) solicitation of children to engage in sexual conduct under section 609.352;

(10) malicious punishment or neglect or endangerment of a child under section 609.377 or 609.378;

(11) use of a minor in sexual performance under section 617.246; or

(12) parental behavior, status, or condition which mandates that the county attorney file a termination of parental rights petition under section 260C.503, subdivision 2.

(p) "Threatened injury" means a statement, overt act, condition, or status that represents a substantial risk of physical or sexual abuse or mental injury. Threatened injury includes, but is not limited to, exposing a child to a person responsible for the child's care, as defined in paragraph (j), clause (1), who has:

(1) subjected a child to, or failed to protect a child from, an overt act or condition that constitutes egregious harm, as defined in section 260C.007, subdivision 14, or a similar law of another jurisdiction;

(2) been found to be palpably unfit under section 260C.301, subdivision 1, paragraph (b), clause (4), or a similar law of another jurisdiction;

(3) committed an act that has resulted in an involuntary termination of parental rights under section 260C.301, or a similar law of another jurisdiction; or

(4) committed an act that has resulted in the involuntary transfer of permanent legal and physical custody of a child to a relative under Minnesota Statutes 2010, section 260C.201, subdivision 11, paragraph (d), clause (1), section 260C.515, subdivision 4, or a similar law of another jurisdiction.

A child is the subject of a report of threatened injury when the responsible social services agency receives birth match data under paragraph (q) from the Department of Human Services.

(q) Upon receiving data under section 144.225, subdivision 2b, contained in a birth record or recognition of parentage identifying a child who is subject to threatened injury under paragraph (p), the Department of Human Services shall send the data to the responsible social services agency. The data is known as "birth match" data. Unless the responsible social services agency has already begun an investigation or assessment of the report due to the birth of the child or execution of the recognition of parentage and the parent's previous history with child protection, the agency shall accept the birth match data as a report under this section. The agency may use either a family assessment or investigation to determine whether the child is safe. All of the provisions of this section apply. If the child is determined to be safe, the agency shall consult with the county attorney to determine the appropriateness of filing a petition alleging the child is in need of protection or services under section 260C.007, subdivision 6, clause (16), in order to deliver needed services. If the child is determined not to be safe, the agency and the county attorney shall take appropriate action as required under section 260C.503, subdivision 2.

(r) Persons who conduct assessments or investigations under this section shall take into account accepted child-rearing practices of the culture in which a child participates and accepted teacher discipline practices, which are not injurious to the child's health, welfare, and safety.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 66. Minnesota Statutes 2016, section 626.556, subdivision 3, is amended to read:

Subd. 3. **Persons mandated to report; persons voluntarily reporting.** (a) A person who knows or has reason to believe a child is being neglected or physically or sexually abused, as defined in subdivision 2, or has been neglected or physically or sexually abused within the preceding three years, shall immediately report the information to the local welfare agency, agency responsible for assessing or investigating the report, police department, county sheriff, tribal social services agency, or tribal police department if the person is:

(1) a professional or professional's delegate who is engaged in the practice of the healing arts, social services, hospital administration, psychological or psychiatric treatment, child care, education, correctional supervision, probation and correctional services, or law enforcement; or

(2) employed as a member of the clergy and received the information while engaged in ministerial duties, provided that a member of the clergy is not required by this subdivision to report information that is otherwise privileged under section 595.02, subdivision 1, paragraph (c).

(b) Any person may voluntarily report to the local welfare agency, agency responsible for assessing or investigating the report, police department, county sheriff, tribal social services agency, or tribal police department if the person knows, has reason to believe, or suspects a child is being or has been neglected or subjected to physical or sexual abuse.

(c) A person mandated to report physical or sexual child abuse or neglect occurring within a licensed facility shall report the information to the agency responsible for licensing or certifying the facility under sections 144.50 to 144.58; 241.021; 245A.01 to 245A.16; or chapter 245D or 245G; or a nonlicensed personal care provider organization as defined in section 256B.0625, subdivision 19. A health or corrections agency receiving a report may request the local welfare agency to provide assistance pursuant to subdivisions 10, 10a, and 10b. A board or other entity whose licensees perform work within a school facility, upon receiving a complaint of alleged maltreatment, shall provide information about the circumstances of the alleged maltreatment to the commissioner of education. Section 13.03, subdivision 4, applies to data received by the commissioner of education from a licensing entity.

(d) Notification requirements under subdivision 10 apply to all reports received under this section.

(e) For purposes of this section, "immediately" means as soon as possible but in no event longer than 24 hours.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 67. Minnesota Statutes 2016, section 626.556, subdivision 3c, is amended to read:

Subd. 3c. **Local welfare agency, Department of Human Services or Department of Health responsible for assessing or investigating reports of maltreatment.** (a) The ~~county~~ local welfare agency is the agency responsible for assessing or investigating allegations of maltreatment in child foster care, family child care, legally ~~unlicensed~~ nonlicensed child care, ~~juvenile correctional facilities licensed under section 241.021 located in the local welfare agency's county,~~ and reports involving children served by an unlicensed personal care provider organization under section 256B.0659. Copies of findings related to personal

care provider organizations under section 256B.0659 must be forwarded to the Department of Human Services provider enrollment.

(b) The Department of Human Services is the agency responsible for assessing or investigating allegations of maltreatment in juvenile correctional facilities listed under section 241.021 located in the local welfare agency's county and in facilities licensed or certified under chapters 245A ~~and~~, 245D, and 245G, except for child foster care and family child care.

(c) The Department of Health is the agency responsible for assessing or investigating allegations of child maltreatment in facilities licensed under sections 144.50 to 144.58 and 144A.43 to 144A.482.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 68. Minnesota Statutes 2016, section 626.556, subdivision 4, is amended to read:

Subd. 4. **Immunity from liability.** (a) The following persons are immune from any civil or criminal liability that otherwise might result from their actions, if they are acting in good faith:

(1) any person making a voluntary or mandated report under subdivision 3 or under section 626.5561 or assisting in an assessment under this section or under section 626.5561;

(2) any person with responsibility for performing duties under this section or supervisor employed by a local welfare agency, the commissioner of an agency responsible for operating or supervising a licensed or unlicensed day care facility, residential facility, agency, hospital, sanitarium, or other facility or institution required to be licensed or certified under sections 144.50 to 144.58; 241.021; 245A.01 to 245A.16; or chapter 245B~~,~~ or 245G; or a school as defined in section 120A.05, subdivisions 9, 11, and 13; and chapter 124E; or a nonlicensed personal care provider organization as defined in section 256B.0625, subdivision 19a, complying with subdivision 10d; and

(3) any public or private school, facility as defined in subdivision 2, or the employee of any public or private school or facility who permits access by a local welfare agency, the Department of Education, or a local law enforcement agency and assists in an investigation or assessment pursuant to subdivision 10 or under section 626.5561.

(b) A person who is a supervisor or person with responsibility for performing duties under this section employed by a local welfare agency, the commissioner of human services, or the commissioner of education complying with subdivisions 10 and 11 or section 626.5561 or any related rule or provision of law is immune from any civil or criminal liability that

might otherwise result from the person's actions, if the person is (1) acting in good faith and exercising due care, or (2) acting in good faith and following the information collection procedures established under subdivision 10, paragraphs (h), (i), and (j).

(c) This subdivision does not provide immunity to any person for failure to make a required report or for committing neglect, physical abuse, or sexual abuse of a child.

(d) If a person who makes a voluntary or mandatory report under subdivision 3 prevails in a civil action from which the person has been granted immunity under this subdivision, the court may award the person attorney fees and costs.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 69. Minnesota Statutes 2016, section 626.556, subdivision 10d, is amended to read:

Subd. 10d. **Notification of neglect or abuse in facility.** (a) When a report is received that alleges neglect, physical abuse, sexual abuse, or maltreatment of a child while in the care of a licensed or unlicensed day care facility, residential facility, agency, hospital, sanitarium, or other facility or institution required to be licensed or certified according to sections 144.50 to 144.58; 241.021; or 245A.01 to 245A.16; or chapter 245D or 245G, or a school as defined in section 120A.05, subdivisions 9, 11, and 13; and chapter 124E; or a nonlicensed personal care provider organization as defined in section 256B.0625, subdivision 19a, the commissioner of the agency responsible for assessing or investigating the report or local welfare agency investigating the report shall provide the following information to the parent, guardian, or legal custodian of a child alleged to have been neglected, physically abused, sexually abused, or the victim of maltreatment of a child in the facility: the name of the facility; the fact that a report alleging neglect, physical abuse, sexual abuse, or maltreatment of a child in the facility has been received; the nature of the alleged neglect, physical abuse, sexual abuse, or maltreatment of a child in the facility; that the agency is conducting an assessment or investigation; any protective or corrective measures being taken pending the outcome of the investigation; and that a written memorandum will be provided when the investigation is completed.

(b) The commissioner of the agency responsible for assessing or investigating the report or local welfare agency may also provide the information in paragraph (a) to the parent, guardian, or legal custodian of any other child in the facility if the investigative agency knows or has reason to believe the alleged neglect, physical abuse, sexual abuse, or maltreatment of a child in the facility has occurred. In determining whether to exercise this authority, the commissioner of the agency responsible for assessing or investigating the report or local welfare agency shall consider the seriousness of the alleged neglect, physical

abuse, sexual abuse, or maltreatment of a child in the facility; the number of children allegedly neglected, physically abused, sexually abused, or victims of maltreatment of a child in the facility; the number of alleged perpetrators; and the length of the investigation. The facility shall be notified whenever this discretion is exercised.

(c) When the commissioner of the agency responsible for assessing or investigating the report or local welfare agency has completed its investigation, every parent, guardian, or legal custodian previously notified of the investigation by the commissioner or local welfare agency shall be provided with the following information in a written memorandum: the name of the facility investigated; the nature of the alleged neglect, physical abuse, sexual abuse, or maltreatment of a child in the facility; the investigator's name; a summary of the investigation findings; a statement whether maltreatment was found; and the protective or corrective measures that are being or will be taken. The memorandum shall be written in a manner that protects the identity of the reporter and the child and shall not contain the name, or to the extent possible, reveal the identity of the alleged perpetrator or of those interviewed during the investigation. If maltreatment is determined to exist, the commissioner or local welfare agency shall also provide the written memorandum to the parent, guardian, or legal custodian of each child in the facility who had contact with the individual responsible for the maltreatment. When the facility is the responsible party for maltreatment, the commissioner or local welfare agency shall also provide the written memorandum to the parent, guardian, or legal custodian of each child who received services in the population of the facility where the maltreatment occurred. This notification must be provided to the parent, guardian, or legal custodian of each child receiving services from the time the maltreatment occurred until either the individual responsible for maltreatment is no longer in contact with a child or children in the facility or the conclusion of the investigation. In the case of maltreatment within a school facility, as defined in section 120A.05, subdivisions 9, 11, and 13, and chapter 124E, the commissioner of education need not provide notification to parents, guardians, or legal custodians of each child in the facility, but shall, within ten days after the investigation is completed, provide written notification to the parent, guardian, or legal custodian of any student alleged to have been maltreated. The commissioner of education may notify the parent, guardian, or legal custodian of any student involved as a witness to alleged maltreatment.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 70. Minnesota Statutes 2016, section 626.556, subdivision 10e, is amended to read:

Subd. 10e. **Determinations.** (a) The local welfare agency shall conclude the family assessment or the investigation within 45 days of the receipt of a report. The conclusion of the assessment or investigation may be extended to permit the completion of a criminal investigation or the receipt of expert information requested within 45 days of the receipt of the report.

(b) After conducting a family assessment, the local welfare agency shall determine whether services are needed to address the safety of the child and other family members and the risk of subsequent maltreatment.

(c) After conducting an investigation, the local welfare agency shall make two determinations: first, whether maltreatment has occurred; and second, whether child protective services are needed. No determination of maltreatment shall be made when the alleged perpetrator is a child under the age of ten.

(d) If the commissioner of education conducts an assessment or investigation, the commissioner shall determine whether maltreatment occurred and what corrective or protective action was taken by the school facility. If a determination is made that maltreatment has occurred, the commissioner shall report to the employer, the school board, and any appropriate licensing entity the determination that maltreatment occurred and what corrective or protective action was taken by the school facility. In all other cases, the commissioner shall inform the school board or employer that a report was received, the subject of the report, the date of the initial report, the category of maltreatment alleged as defined in paragraph (f), the fact that maltreatment was not determined, and a summary of the specific reasons for the determination.

(e) When maltreatment is determined in an investigation involving a facility, the investigating agency shall also determine whether the facility or individual was responsible, or whether both the facility and the individual were responsible for the maltreatment using the mitigating factors in paragraph (i). Determinations under this subdivision must be made based on a preponderance of the evidence and are private data on individuals or nonpublic data as maintained by the commissioner of education.

(f) For the purposes of this subdivision, "maltreatment" means any of the following acts or omissions:

(1) physical abuse as defined in subdivision 2, paragraph (k);

(2) neglect as defined in subdivision 2, paragraph (g);

(3) sexual abuse as defined in subdivision 2, paragraph (n);

(4) mental injury as defined in subdivision 2, paragraph (f); or

(5) maltreatment of a child in a facility as defined in subdivision 2, paragraph (c).

(g) For the purposes of this subdivision, a determination that child protective services are needed means that the local welfare agency has documented conditions during the assessment or investigation sufficient to cause a child protection worker, as defined in section 626.559, subdivision 1, to conclude that a child is at significant risk of maltreatment if protective intervention is not provided and that the individuals responsible for the child's care have not taken or are not likely to take actions to protect the child from maltreatment or risk of maltreatment.

(h) This subdivision does not mean that maltreatment has occurred solely because the child's parent, guardian, or other person responsible for the child's care in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the child, in lieu of medical care. However, if lack of medical care may result in serious danger to the child's health, the local welfare agency may ensure that necessary medical services are provided to the child.

(i) When determining whether the facility or individual is the responsible party, or whether both the facility and the individual are responsible for determined maltreatment in a facility, the investigating agency shall consider at least the following mitigating factors:

(1) whether the actions of the facility or the individual caregivers were according to, and followed the terms of, an erroneous physician order, prescription, individual care plan, or directive; however, this is not a mitigating factor when the facility or caregiver was responsible for the issuance of the erroneous order, prescription, individual care plan, or directive or knew or should have known of the errors and took no reasonable measures to correct the defect before administering care;

(2) comparative responsibility between the facility, other caregivers, and requirements placed upon an employee, including the facility's compliance with related regulatory standards and the adequacy of facility policies and procedures, facility training, an individual's participation in the training, the caregiver's supervision, and facility staffing levels and the scope of the individual employee's authority and discretion; and

(3) whether the facility or individual followed professional standards in exercising professional judgment.

The evaluation of the facility's responsibility under clause (2) must not be based on the completeness of the risk assessment or risk reduction plan required under section 245A.66, but must be based on the facility's compliance with the regulatory standards for policies and procedures, training, and supervision as cited in Minnesota Statutes and Minnesota Rules.

(j) Notwithstanding paragraph (i), when maltreatment is determined to have been committed by an individual who is also the facility license or certification holder, both the individual and the facility must be determined responsible for the maltreatment, and both the background study disqualification standards under section 245C.15, subdivision 4, and the licensing or certification actions under ~~sections~~ section 245A.06 ~~or~~, 245A.07, 245G.06, or 245G.07 apply.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 71. Minnesota Statutes 2016, section 626.556, subdivision 10f, is amended to read:

Subd. 10f. **Notice of determinations.** Within ten working days of the conclusion of a family assessment, the local welfare agency shall notify the parent or guardian of the child of the need for services to address child safety concerns or significant risk of subsequent child maltreatment. The local welfare agency and the family may also jointly agree that family support and family preservation services are needed. Within ten working days of the conclusion of an investigation, the local welfare agency or agency responsible for investigating the report shall notify the parent or guardian of the child, the person determined to be maltreating the child, and, if applicable, the director of the facility, of the determination and a summary of the specific reasons for the determination. When the investigation involves a child foster care setting that is monitored by a private licensing agency under section 245A.16, the local welfare agency responsible for investigating the report shall notify the private licensing agency of the determination and shall provide a summary of the specific reasons for the determination. The notice to the private licensing agency must include identifying private data, but not the identity of the reporter of maltreatment. The notice must also include a certification that the information collection procedures under subdivision 10, paragraphs (h), (i), and (j), were followed and a notice of the right of a data subject to obtain access to other private data on the subject collected, created, or maintained under this section. In addition, the notice shall include the length of time that the records will be kept under subdivision 11c. The investigating agency shall notify the parent or guardian of the child who is the subject of the report, and any person or facility determined to have maltreated a child, of their appeal or review rights under this section. The notice must also state that a

finding of maltreatment may result in denial of a license or certification application or background study disqualification under chapter 245C related to employment or services that are licensed or certified by the Department of Human Services under chapter 245A or 245G, the Department of Health under chapter 144 or 144A, the Department of Corrections under section 241.021, and from providing services related to an unlicensed personal care provider organization under chapter 256B.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 72. Minnesota Statutes 2016, section 626.556, subdivision 10i, is amended to read:

Subd. 10i. **Administrative reconsideration; review panel.** (a) Administrative reconsideration is not applicable in family assessments since no determination concerning maltreatment is made. For investigations, except as provided under paragraph (e), an individual or facility that the commissioner of human services, a local social service agency, or the commissioner of education determines has maltreated a child, an interested person acting on behalf of the child, regardless of the determination, who contests the investigating agency's final determination regarding maltreatment, may request the investigating agency to reconsider its final determination regarding maltreatment. The request for reconsideration must be submitted in writing to the investigating agency within 15 calendar days after receipt of notice of the final determination regarding maltreatment or, if the request is made by an interested person who is not entitled to notice, within 15 days after receipt of the notice by the parent or guardian of the child. If mailed, the request for reconsideration must be postmarked and sent to the investigating agency within 15 calendar days of the individual's or facility's receipt of the final determination. If the request for reconsideration is made by personal service, it must be received by the investigating agency within 15 calendar days after the individual's or facility's receipt of the final determination. Effective January 1, 2002, an individual who was determined to have maltreated a child under this section and who was disqualified on the basis of serious or recurring maltreatment under sections 245C.14 and 245C.15, may request reconsideration of the maltreatment determination and the disqualification. The request for reconsideration of the maltreatment determination and the disqualification must be submitted within 30 calendar days of the individual's receipt of the notice of disqualification under sections 245C.16 and 245C.17. If mailed, the request for reconsideration of the maltreatment determination and the disqualification must be postmarked and sent to the investigating agency within 30 calendar days of the individual's receipt of the maltreatment determination and notice of disqualification. If the request for reconsideration is made by personal service, it must be received by the investigating agency within 30 calendar days after the individual's receipt of the notice of disqualification.

(b) Except as provided under paragraphs (e) and (f), if the investigating agency denies the request or fails to act upon the request within 15 working days after receiving the request for reconsideration, the person or facility entitled to a fair hearing under section 256.045 may submit to the commissioner of human services or the commissioner of education a written request for a hearing under that section. Section 256.045 also governs hearings requested to contest a final determination of the commissioner of education. The investigating agency shall notify persons who request reconsideration of their rights under this paragraph. The hearings specified under this section are the only administrative appeal of a decision issued under paragraph (a). Determinations under this section are not subject to accuracy and completeness challenges under section 13.04.

(c) If, as a result of a reconsideration or review, the investigating agency changes the final determination of maltreatment, that agency shall notify the parties specified in subdivisions 10b, 10d, and 10f.

(d) Except as provided under paragraph (f), if an individual or facility contests the investigating agency's final determination regarding maltreatment by requesting a fair hearing under section 256.045, the commissioner of human services shall assure that the hearing is conducted and a decision is reached within 90 days of receipt of the request for a hearing. The time for action on the decision may be extended for as many days as the hearing is postponed or the record is held open for the benefit of either party.

(e) If an individual was disqualified under sections 245C.14 and 245C.15, on the basis of a determination of maltreatment, which was serious or recurring, and the individual has requested reconsideration of the maltreatment determination under paragraph (a) and requested reconsideration of the disqualification under sections 245C.21 to 245C.27, reconsideration of the maltreatment determination and reconsideration of the disqualification shall be consolidated into a single reconsideration. If reconsideration of the maltreatment determination is denied and the individual remains disqualified following a reconsideration decision, the individual may request a fair hearing under section 256.045. If an individual requests a fair hearing on the maltreatment determination and the disqualification, the scope of the fair hearing shall include both the maltreatment determination and the disqualification.

(f) If a maltreatment determination or a disqualification based on serious or recurring maltreatment is the basis for a denial of a license under section 245A.05 or a licensing sanction under section 245A.07, the license holder has the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. As provided for under section 245A.08, subdivision 2a, the scope of the contested case hearing shall include the maltreatment determination, disqualification, and licensing sanction or denial of a license.

In such cases, a fair hearing regarding the maltreatment determination and disqualification shall not be conducted under section 256.045. Except for family child care and child foster care, reconsideration of a maltreatment determination as provided under this subdivision, and reconsideration of a disqualification as provided under section 245C.22, shall also not be conducted when:

(1) a denial of a license under section 245A.05 or a licensing sanction under section 245A.07, is based on a determination that the license holder is responsible for maltreatment or the disqualification of a license holder based on serious or recurring maltreatment;

(2) the denial of a license or licensing sanction is issued at the same time as the maltreatment determination or disqualification; and

(3) the license holder appeals the maltreatment determination or disqualification, and denial of a license or licensing sanction.

Notwithstanding clauses (1) to (3), if the license holder appeals the maltreatment determination or disqualification, but does not appeal the denial of a license or a licensing sanction, reconsideration of the maltreatment determination shall be conducted under sections 626.556, subdivision 10i, and 626.557, subdivision 9d, and reconsideration of the disqualification shall be conducted under section 245C.22. In such cases, a fair hearing shall also be conducted as provided under sections 245C.27, 626.556, subdivision 10i, and 626.557, subdivision 9d.

If the disqualified subject is an individual other than the license holder and upon whom a background study must be conducted under chapter 245C, the hearings of all parties may be consolidated into a single contested case hearing upon consent of all parties and the administrative law judge.

(g) For purposes of this subdivision, "interested person acting on behalf of the child" means a parent or legal guardian; stepparent; grandparent; guardian ad litem; adult stepbrother, stepsister, or sibling; or adult aunt or uncle; unless the person has been determined to be the perpetrator of the maltreatment.

(h) If a maltreatment determination is the basis for a correction order under section 245G.06 or decertification under section 245G.07, the certification holder has the right to request reconsideration under sections 245G.06 and 245G.07. If the certification holder appeals the maltreatment determination or disqualification, but does not appeal the correction order or decertification, reconsideration of the maltreatment determination shall be conducted under section 626.556, subdivision 10i, and reconsideration of the disqualification shall be conducted under section 245C.22.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 73. Laws 2012, chapter 247, article 6, section 2, subdivision 2, is amended to read:

Subd. 2. **Central Office Operations**

(a) **Operations**	118,000	356,000
Base Level Adjustment. The general fund base is increased by $91,000 in fiscal year 2014 and $44,000 in fiscal year 2015.		
(b) **Health Care**	24,000	346,000
This is a onetime appropriation.		
Managed Care Audit Activities. In fiscal year 2014, ~~and in each even-numbered year thereafter,~~ the commissioner shall transfer from the health care access fund $1,740,000 to the legislative auditor for managed care audit services under Minnesota Statutes, section 256B.69, subdivision 9d. This is a biennial appropriation. The health care access fund base is increased by $1,842,000 in fiscal year 2014. ~~Notwithstanding any contrary provision in this article, this paragraph does not expire.~~		
(c) **Continuing Care**	19,000	375,000
Base Level Adjustment. The general fund base is decreased by $159,000 in fiscal years 2014 and 2015.		

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 74. **REPEALER.**

(a) Minnesota Statutes 2016, sections 245C.11, subdivision 4; 245C.16, subdivision 3; and 245C.17, subdivision 4, are repealed.

(b) Minnesota Rules, part 9503.0145, subpart 6, is repealed.

EFFECTIVE DATE. This section is effective the day following final enactment.

ARTICLE 10

DEPARTMENT OF HEALTH

Section 1. Minnesota Statutes 2016, section 103I.005, subdivision 2, is amended to read:

Subd. 2. **Boring.** "Boring" means a hole or excavation that is not used to extract water and includes exploratory borings, ~~environmental bore holes,~~ bored geothermal heat exchangers, and elevator ~~shafts~~ borings.

Sec. 2. Minnesota Statutes 2016, section 103I.005, subdivision 2a, is amended to read:

Subd. 2a. **Certified representative.** "Certified representative" means a person certified by the commissioner to represent a well contractor, limited well/boring contractor, ~~monitoring~~ environmental well contractor, or elevator boring contractor.

Sec. 3. Minnesota Statutes 2016, section 103I.005, is amended by adding a subdivision to read:

Subd. 8a. **Environmental well.** "Environmental well" means an excavation 15 or more feet in depth that is drilled, cored, bored, washed, driven, dug, jetted, or otherwise constructed to:

(1) conduct physical, chemical, or biological testing of groundwater, and includes a groundwater quality monitoring or sampling well;

(2) lower a groundwater level to control or remove contamination in groundwater, and includes a remedial well and excludes horizontal trenches; or

(3) monitor or measure physical, chemical, radiological, or biological parameters of the earth and earth fluids, or for vapor recovery or venting systems. An environmental well includes an excavation used to:

(i) measure groundwater levels, including a piezometer;

(ii) determine groundwater flow direction or velocity;

(iii) measure earth properties such as hydraulic conductivity, bearing capacity, or resistance;

(iv) obtain samples of geologic materials for testing or classification; or

(v) remove or remediate pollution or contamination from groundwater or soil through the use of a vent, vapor recovery system, or sparge point.

Sec. 4. Minnesota Statutes 2016, section 103I.005, is amended by adding a subdivision to read:

Subd. 8b. **Environmental well contractor.** "Environmental well contractor" means a person with an environmental well contractor's license issued by the commissioner.

Sec. 5. Minnesota Statutes 2016, section 103I.005, subdivision 12, is amended to read:

Subd. 12. **Limited well/boring contractor.** "Limited well/boring contractor" means a person with a limited well/boring contractor's license issued by the commissioner. Limited well/boring contractor's licenses are issued for:

(1) constructing, repairing, and sealing bored geothermal heat exchangers;

(2) installing, repairing, and modifying pitless units and pitless adaptors, well casings above the pitless unit or pitless adaptor, well screens, ~~or~~ well diameters~~; constructing, repairing, and sealing drive point wells or dug wells~~, and well pumps and pumping equipment;

(3) constructing, repairing, and sealing dewatering wells; and

(4) sealing wells~~; and installing well pumps or pumping equipment~~ and borings.

Sec. 6. Minnesota Statutes 2016, section 103I.005, is amended by adding a subdivision to read:

Subd. 17a. **Temporary environmental well.** "Temporary environmental well" means an environmental well as defined in section 103I.005, subdivision 8a, that is sealed within 72 hours of the time construction on the well begins.

Sec. 7. Minnesota Statutes 2016, section 103I.005, subdivision 20a, is amended to read:

Subd. 20a. **Water supply well.** "Water supply well" means a well that is not a dewatering well or ~~monitoring~~ environmental well and includes wells used:

(1) for potable water supply;

(2) for irrigation;

(3) for agricultural, commercial, or industrial water supply;

(4) for heating or cooling; and

(5) ~~as a remedial well; and~~

~~(6)~~ for testing water yield for irrigation, commercial or industrial uses, residential supply, or public water supply.

Sec. 8. Minnesota Statutes 2016, section 103I.005, subdivision 21, is amended to read:

Subd. 21. **Well.** "Well" means an excavation that is drilled, cored, bored, washed, driven, dug, jetted, or otherwise constructed if the excavation is intended for the location, diversion, artificial recharge, monitoring, testing, remediation, or acquisition of groundwater. Well includes ~~monitoring~~ environmental wells, drive point wells, and dewatering wells. "Well" does not include:

(1) an excavation by backhoe, or otherwise for temporary dewatering of groundwater for nonpotable use during construction, if the depth of the excavation is 25 feet or less;

(2) an excavation made to obtain or prospect for oil, natural gas, minerals, or products of mining or quarrying;

(3) an excavation to insert media to repressure oil or natural gas bearing formations or to store petroleum, natural gas, or other products;

(4) an excavation for nonpotable use for wildfire suppression activities; or

(5) borings.

Sec. 9. Minnesota Statutes 2016, section 103I.101, subdivision 2, is amended to read:

Subd. 2. **Duties.** The commissioner shall:

(1) regulate the drilling, construction, modification, repair, and sealing of wells and borings;

(2) examine and license:

(i) well contractors;

(ii) persons constructing, repairing, and sealing bored geothermal heat exchangers;

(iii) persons modifying or repairing well casings above the pitless unit or adaptor, well screens, ~~or~~ well diameters~~; persons constructing, repairing, and sealing drive point wells or dug wells~~, and installing well pumps or pumping equipment;

(iv) persons constructing, repairing, and sealing dewatering wells;

(v) persons sealing wells~~; persons installing well pumps or pumping equipment~~ or borings; and

(vi) persons excavating or drilling holes for the installation of elevator borings ~~or hydraulic cylinders~~;

(3) ~~register~~ examine and ~~examine monitoring~~ license environmental well contractors;

(4) license explorers engaged in exploratory boring and examine individuals who supervise or oversee exploratory boring;

(5) after consultation with the commissioner of natural resources and the Pollution Control Agency, establish standards for the design, location, construction, repair, and sealing of wells and borings within the state; and

(6) issue permits for wells, groundwater thermal devices, bored geothermal heat exchangers, and elevator borings.

Sec. 10. Minnesota Statutes 2016, section 103I.101, subdivision 5, is amended to read:

Subd. 5. **Commissioner to adopt rules.** The commissioner shall adopt rules including:

(1) issuance of licenses for:

(i) qualified well contractors~~, persons modifying or repairing well casings, well screens, or well diameters~~;

(ii) ~~persons constructing, repairing, and sealing drive point wells or dug wells;~~

~~(iii)~~ persons constructing, repairing, and sealing dewatering wells;

~~(iv)~~ (iii) persons sealing wells or borings;

~~(v)~~ (iv) persons installing, modifying, or repairing well casings, well screens, well diameters, and well pumps or pumping equipment;

~~(vi)~~ (v) persons constructing, repairing, and sealing bored geothermal heat exchangers; ~~and~~

~~(vii)~~ (vi) persons constructing, repairing, and sealing elevator borings; and

(vii) persons constructing, repairing, and sealing environmental wells;

(2) ~~issuance of registration for monitoring well contractors;~~

~~(3)~~ establishment of conditions for examination and review of applications for license and ~~registration~~ certification;

~~(4)~~ (3) establishment of conditions for revocation and suspension of license and ~~registration~~ certification;

~~(5)~~ (4) establishment of minimum standards for design, location, construction, repair, and sealing of wells and borings to implement the purpose and intent of this chapter;

~~(6)~~ (5) establishment of a system for reporting on wells and borings drilled and sealed;

~~(7)~~ (6) establishment of standards for the construction, maintenance, sealing, and water quality monitoring of wells in areas of known or suspected contamination;

~~(8)~~ (7) establishment of wellhead protection measures for wells serving public water supplies;

~~(9)~~ (8) establishment of procedures to coordinate collection of well and boring data with other state and local governmental agencies;

~~(10)~~ (9) establishment of criteria and procedures for submission of well and boring logs, formation samples or well or boring cuttings, water samples, or other special information required for and water resource mapping; and

~~(11)~~ (10) establishment of minimum standards for design, location, construction, maintenance, repair, sealing, safety, and resource conservation related to borings, including exploratory borings as defined in section 103I.005, subdivision 9.

Sec. 11. Minnesota Statutes 2016, section 103I.101, subdivision 6, is amended to read:

Subd. 6. **Fees for variances.** The commissioner shall charge a nonrefundable application fee of ~~$235~~ $275 to cover the administrative cost of processing a request for a variance or modification of rules adopted by the commissioner under this chapter.

Sec. 12. Minnesota Statutes 2016, section 103I.105, is amended to read:

103I.105 ADVISORY COUNCIL ON WELLS AND BORINGS.

(a) The Advisory Council on Wells and Borings is established as an advisory council to the commissioner. The advisory council shall consist of 18 voting members. Of the 18 voting members:

(1) one member must be from the Department of Health, appointed by the commissioner of health;

(2) one member must be from the Department of Natural Resources, appointed by the commissioner of natural resources;

(3) one member must be a member of the Minnesota Geological Survey of the University of Minnesota, appointed by the director;

(4) one member must be a responsible individual for a licensed explorer;

(5) one member must be a certified representative of a licensed elevator boring contractor;

(6) two members must be members of the public who are not connected with the boring or well drilling industry;

(7) one member must be from the Pollution Control Agency, appointed by the commissioner of the Pollution Control Agency;

(8) one member must be from the Department of Transportation, appointed by the commissioner of transportation;

(9) one member must be from the Board of Water and Soil Resources appointed by its chair;

(10) one member must be a certified representative of ~~a monitoring~~ an environmental well contractor;

(11) six members must be residents of this state appointed by the commissioner, who are certified representatives of licensed well contractors, with not more than two from the seven-county metropolitan area and at least four from other areas of the state who represent different geographical regions; and

(12) one member must be a certified representative of a licensed bored geothermal heat exchanger contractor.

(b) An appointee of the well drilling industry may not serve more than two consecutive terms.

(c) The appointees to the advisory council from the well drilling industry must:

(1) have been residents of this state for at least three years before appointment; and

(2) have at least five years' experience in the well drilling business.

(d) The terms of the appointed members and the compensation and removal of all members are governed by section 15.059.

Sec. 13. Minnesota Statutes 2016, section 103I.111, subdivision 6, is amended to read:

Subd. 6. **Unsealed wells and borings are public health nuisances.** A well or boring that is required to be sealed under section 103I.301 but is not sealed is a public health nuisance. A county may abate the unsealed well or boring with the same authority of a community health board to abate a public health nuisance under section 145A.04, subdivision 8.

Sec. 14. Minnesota Statutes 2016, section 103I.111, subdivision 8, is amended to read:

Subd. 8. **Municipal regulation of drilling.** A municipality may regulate all drilling, except well, elevator ~~shaft~~ boring, and exploratory drilling that is subject to the provisions of this chapter, above, in, through, and adjacent to subsurface areas designated for mined underground space development and existing mined underground space. The regulations may prohibit, restrict, control, and require permits for the drilling.

Sec. 15. Minnesota Statutes 2016, section 103I.205, subdivision 1, is amended to read:

Subdivision 1. **Notification required.** (a) Except as provided in ~~paragraphs~~ paragraph (d) ~~and (e)~~, a person may not construct a water-supply, dewatering, or environmental well until a notification of the proposed well on a form prescribed by the commissioner is filed with the commissioner with the filing fee in section 103I.208, and, when applicable, the person has met the requirements of paragraph ~~(f)~~ (e). If after filing the well notification an attempt to construct a well is unsuccessful, a new notification is not required unless the information relating to the successful well has substantially changed. A notification is not required prior to construction of a temporary environmental well.

(b) The property owner, the property owner's agent, or the ~~well~~ licensed contractor where a well is to be located must file the well notification with the commissioner.

(c) The well notification under this subdivision preempts local permits and notifications, and counties or home rule charter or statutory cities may not require a permit or notification for wells unless the commissioner has delegated the permitting or notification authority under section 103I.111.

(d) A person who is an individual that constructs a drive point water-supply well on property owned or leased by the individual for farming or agricultural purposes or as the individual's place of abode must notify the commissioner of the installation and location of the well. The person must complete the notification form prescribed by the commissioner and mail it to the commissioner by ten days after the well is completed. A fee may not be charged for the notification. A person who sells drive point wells at retail must provide buyers with notification forms and informational materials including requirements regarding wells, their location, construction, and disclosure. The commissioner must provide the notification forms and informational materials to the sellers.

~~(e) A person may not construct a monitoring well until a permit is issued by the commissioner for the construction. If after obtaining a permit an attempt to construct a well~~

~~is unsuccessful, a new permit is not required as long as the initial permit is modified to indicate the location of the successful well.~~

~~(f)~~ (e) When the operation of a well will require an appropriation permit from the commissioner of natural resources, a person may not begin construction of the well until the person submits the following information to the commissioner of natural resources:

(1) the location of the well;

(2) the formation or aquifer that will serve as the water source;

(3) the maximum daily, seasonal, and annual pumpage rates and volumes that will be requested in the appropriation permit; and

(4) other information requested by the commissioner of natural resources that is necessary to conduct the preliminary assessment required under section 103G.287, subdivision 1, paragraph (c).

The person may begin construction after receiving preliminary approval from the commissioner of natural resources.

Sec. 16. Minnesota Statutes 2016, section 103I.205, subdivision 2, is amended to read:

Subd. 2. **Emergency permit and notification exemptions.** The commissioner may adopt rules that modify the procedures for filing a well notification or well or boring permit if conditions occur that:

(1) endanger the public health and welfare or cause a need to protect the groundwater; or

(2) require the ~~monitoring~~ environmental well contractor, limited well/boring contractor, or well contractor to begin constructing a well or boring before obtaining a permit or notification.

Sec. 17. Minnesota Statutes 2016, section 103I.205, subdivision 3, is amended to read:

Subd. 3. **Maintenance permit.** (a) Except as provided under paragraph (b), a well that is not in use must be sealed or have a maintenance permit.

(b) If ~~a monitoring~~ an environmental well or a dewatering well is not sealed by 14 months after completion of construction, the owner of the property on which the well is located must obtain and annually renew a maintenance permit from the commissioner.

Sec. 18. Minnesota Statutes 2016, section 103I.205, subdivision 4, is amended to read:

Subd. 4. **License required.** (a) Except as provided in paragraph (b), (c), (d), or (e), section 103I.401, subdivision 2, or 103I.601, subdivision 2, a person may not drill, construct, repair, or seal a well or boring unless the person has a well contractor's license in possession.

(b) A person may construct, repair, and seal ~~a monitoring~~ an environmental well if the person:

(1) is a professional engineer licensed under sections 326.02 to 326.15 in the branches of civil or geological engineering;

(2) is a hydrologist or hydrogeologist certified by the American Institute of Hydrology;

(3) is a professional geoscientist licensed under sections 326.02 to 326.15;

(4) is a geologist certified by the American Institute of Professional Geologists; or

(5) meets the qualifications established by the commissioner in rule.

A person must ~~register with~~ be licensed by the commissioner as ~~a monitoring~~ an environmental well contractor on forms provided by the commissioner.

(c) A person may do the following work with a limited well/boring contractor's license in possession. A separate license is required for each of the ~~six~~ four activities:

(1) installing ~~or~~, repairing, and modifying well screens ~~or~~, pitless units ~~or~~ and pitless adaptors, well pumps and pumping equipment, and well casings from the pitless adaptor or pitless unit to the upper termination of the well casing;

(2) ~~constructing, repairing, and sealing drive point wells or dug wells;~~

~~(3) installing well pumps or pumping equipment;~~

~~(4)~~ sealing wells and borings;

~~(5)~~ (3) constructing, repairing, ~~or~~ and sealing dewatering wells; or

~~(6)~~ (4) constructing, repairing, ~~or~~ and sealing bored geothermal heat exchangers.

(d) A person may construct, repair, and seal an elevator boring with an elevator boring contractor's license.

(e) Notwithstanding other provisions of this chapter requiring a license ~~or registration~~, a license ~~or registration~~ is not required for a person who complies with the other provisions of this chapter if the person is:

(1) an individual who constructs a water-supply well on land that is owned or leased by the individual and is used by the individual for farming or agricultural purposes or as the individual's place of abode;

(2) an individual who performs labor or services for a contractor licensed ~~or registered~~ under the provisions of this chapter in connection with the construction, sealing, or repair of a well or boring at the direction and under the personal supervision of a contractor licensed ~~or registered~~ under the provisions of this chapter; or

(3) a licensed plumber who is repairing submersible pumps or water pipes associated with well water systems if: (i) the repair location is within an area where there is no licensed ~~or registered~~ well contractor within 50 miles, and (ii) the licensed plumber complies with all relevant sections of the plumbing code.

Sec. 19. Minnesota Statutes 2016, section 103I.205, subdivision 5, is amended to read:

Subd. 5. **At-grade ~~monitoring~~ environmental wells.** At-grade ~~monitoring~~ environmental wells are authorized without variance and may be installed for the purpose of evaluating groundwater conditions or for use as a leak detection device. An at-grade ~~monitoring~~ environmental well must be installed in accordance with the rules of the commissioner. The at-grade ~~monitoring~~ environmental wells must be installed with an impermeable double locking cap approved by the commissioner and must be labeled environmental or monitoring wells.

Sec. 20. Minnesota Statutes 2016, section 103I.205, subdivision 6, is amended to read:

Subd. 6. **Distance requirements for sources of contamination buildings, gas pipes, liquid propane tanks, and electric lines.** (a) A person may not place, construct, or install an actual or potential source of contamination, building, gas pipe, liquid propane tank, or electric line any closer to a well or boring than the isolation distances prescribed by the commissioner by rule unless a variance has been prescribed by rule.

(b) The commissioner shall establish by rule reduced isolation distances for facilities which have safeguards in accordance with sections 18B.01, subdivision 26, and 18C.005, subdivision 29.

Sec. 21. Minnesota Statutes 2016, section 103I.208, subdivision 1, is amended to read:

Subdivision 1. **Well notification fee.** The well notification fee to be paid by a property owner is:

(1) for construction of a ~~new~~ water supply well, ~~$235~~ $275, which includes the state core function fee;

(2) for a well sealing, ~~$65~~ $75 for each well, which includes the state core function fee, except that a single fee of $75 is required for ~~monitoring~~ all temporary environmental wells ~~constructed on~~ recorded on the sealing notification for a single property, having depths within a 25 foot range, and sealed within ~~48~~ 72 hours of start of construction~~, a single fee of $65~~; ~~and~~

(3) for construction of a dewatering well, ~~$235~~ $275, which includes the state core function fee, for each dewatering well except a dewatering project comprising five or more dewatering wells shall be assessed a single fee of ~~$1,175~~ $1,375 for the dewatering wells recorded on the notification~~.~~; and

(4) for construction of an environmental well, $275, which includes the state core function fee, except that a single fee of $275 is required for all environmental wells recorded on the notification that are located on a single property, and except that no fee is required for construction of a temporary environmental well.

Sec. 22. Minnesota Statutes 2016, section 103I.208, subdivision 2, is amended to read:

Subd. 2. **Permit fee.** The permit fee to be paid by a property owner is:

(1) for a water supply well that is not in use under a maintenance permit, $175 annually;

(2) ~~for construction of a monitoring well, $235, which includes the state core function fee;~~

~~(3)~~ for ~~a monitoring~~ an environmental well that is unsealed under a maintenance permit, $175 annually except no fee is required for an environmental well owned by a federal agency, state agency, or local unit of government that is unsealed under a maintenance permit. "Local unit of government" means a statutory or home rule charter city, town, county, or soil and water conservation district, watershed district, an organization formed for the joint exercise of powers under section 471.59, a community health board, or other special purpose district or authority with local jurisdiction in water and related land resources management;

~~(4) for a monitoring well owned by a federal agency, state agency, or local unit of government that is unsealed under a maintenance permit, $50 annually. "Local unit of government" means a statutory or home rule charter city, town, county, or soil and water conservation district, watershed district, an organization formed for the joint exercise of~~

~~powers under section 471.59, a community health board, or other special purpose district or authority with local jurisdiction in water and related land resources management;~~

~~(5)~~ (3) for ~~monitoring~~ environmental wells ~~used as a leak detection device at a single motor fuel retail outlet, a single petroleum bulk storage site excluding tank farms, or a single agricultural chemical facility site, the construction permit fee is $235, which includes the state core function fee, per site regardless of the number of wells constructed on the site, and the annual fee for~~ that are unsealed under a maintenance permit ~~for unsealed monitoring wells is,~~ $175 annually per site regardless of the number of ~~monitoring~~ environmental wells located on site;

~~(6)~~ (4) for a groundwater thermal exchange device, in addition to the notification fee for water supply wells, ~~$235~~ $275, which includes the state core function fee;

~~(7)~~ (5) for a bored geothermal heat exchanger with less than ten tons of heating/cooling capacity, ~~$235~~ $275;

~~(8)~~ (6) for a bored geothermal heat exchanger with ten to 50 tons of heating/cooling capacity, ~~$475~~ $515;

~~(9)~~ (7) for a bored geothermal heat exchanger with greater than 50 tons of heating/cooling capacity, ~~$700~~ $740;

~~(10)~~ (8) for a dewatering well that is unsealed under a maintenance permit, $175 annually for each dewatering well, except a dewatering project comprising more than five dewatering wells shall be issued a single permit for $875 annually for dewatering wells recorded on the permit; and

~~(11)~~ (9) for an elevator boring, ~~$235~~ $275 for each boring.

Sec. 23. Minnesota Statutes 2016, section 103I.235, is amended by adding a subdivision to read:

Subd. 3. **Temporary environmental well and unsuccessful well exemption.** This section does not apply to temporary environmental wells or unsuccessful wells that have been sealed by a licensed contractor in compliance with this chapter.

Sec. 24. Minnesota Statutes 2016, section 103I.301, subdivision 1, is amended to read:

Subdivision 1. **Wells and borings.** (a) A property owner must have a well or boring sealed if:

(1) the well or boring is contaminated or may contribute to the spread of contamination;

(2) the well or boring was attempted to be sealed but was not sealed according to the provisions of this chapter; or

(3) the well or boring is located, constructed, or maintained in a manner that its continued use or existence endangers groundwater quality or is a safety or health hazard.

(b) A well or boring that is not in use must be sealed unless the property owner has a maintenance permit for the well.

(c) The property owner must have a well or boring sealed by a ~~registered or~~ licensed person authorized to seal the well or boring, consistent with provisions of this chapter.

Sec. 25. Minnesota Statutes 2016, section 103I.301, subdivision 2, is amended to read:

Subd. 2. ~~**Monitoring**~~ **Environmental wells.** The owner of the property where ~~a monitoring~~ an environmental well is located must have the ~~monitoring~~ environmental well sealed when the well is no longer in use. The owner must have a well contractor, limited well/boring sealing contractor, or ~~a monitoring~~ an environmental well contractor seal the ~~monitoring~~ environmental well.

Sec. 26. Minnesota Statutes 2016, section 103I.315, subdivision 1, is amended to read:

Subdivision 1. **Order to seal well or boring.** The commissioner may order a property owner to seal a well or boring if:

(1) the commissioner determines that without being sealed the well or boring is an imminent threat to public health or public safety;

(2) the well or boring is required to be sealed under section 103I.301; or

(3) a well is ~~a monitoring~~ an environmental well or dewatering well and by 14 months after construction of the well, the owner has not obtained a maintenance permit, or after a maintenance permit has been issued the owner has not renewed a maintenance permit.

Sec. 27. Minnesota Statutes 2016, section 103I.501, is amended to read:

103I.501 LICENSING AND REGULATION OF WELLS AND BORINGS.

(a) The commissioner shall regulate and license:

(1) drilling, constructing, and repair of wells;

(2) sealing of wells;

(3) installing of well pumps and pumping equipment;

(4) excavating, drilling, repairing, and sealing of elevator borings;

(5) construction, repair, and sealing of environmental ~~bore holes~~ wells; and

(6) construction, repair, and sealing of bored geothermal heat exchangers.

(b) The commissioner shall examine and license well contractors, limited well/boring contractors, ~~and~~ elevator boring contractors, and ~~examine and register monitoring~~ environmental well contractors.

(c) The commissioner shall license explorers engaged in exploratory boring and shall examine persons who supervise or oversee exploratory boring.

Sec. 28. Minnesota Statutes 2016, section 103I.505, subdivision 1, is amended to read:

Subdivision 1. **Reciprocity authorized.** The commissioner may issue a license or ~~register~~ certify a person under this chapter, without giving an examination, if the person is licensed or ~~registered~~ certified in another state and:

(1) the requirements for licensing or ~~registration~~ certification under which the well or boring contractor was licensed or ~~registered~~ person was certified do not conflict with this chapter;

(2) the requirements are of a standard not lower than that specified by the rules adopted under this chapter; and

(3) equal reciprocal privileges are granted to licensees or ~~registrants~~ certified persons of this state.

Sec. 29. Minnesota Statutes 2016, section 103I.505, subdivision 2, is amended to read:

Subd. 2. **Fees required.** A well or boring contractor or certified person must apply for the license or ~~registration~~ certification and pay the fees under the provisions of this chapter to receive a license or ~~registration~~ certification under this section.

Sec. 30. Minnesota Statutes 2016, section 103I.515, is amended to read:

103I.515 LICENSES NOT TRANSFERABLE.

A license or ~~registration~~ certification issued under this chapter is not transferable.

Sec. 31. Minnesota Statutes 2016, section 103I.525, subdivision 1, is amended to read:

Subdivision 1. **Certification application.** (a) A person must file an application and application fee with the commissioner to represent a well contractor.

(b) The application must state the applicant's qualifications for certification as a representative, and other information required by the commissioner. The application must be on forms prescribed by the commissioner.

~~(c) A person may apply as an individual if the person:~~

~~(1) is not representing a firm, sole proprietorship, partnership, association, corporation, or other entity including the United States government, any interstate body, the state, and an agency, department, or political subdivision of the state; and~~

~~(2) meets the well contractor certification and license requirements under this chapter.~~

Sec. 32. Minnesota Statutes 2016, section 103I.525, subdivision 2, is amended to read:

Subd. 2. **Certification fee.** (a) The application fee for certification as a representative of a well contractor is $75. The commissioner may not act on an application until the application fee is paid.

(b) The renewal fee for certification as a representative of a well contractor is $75. The commissioner may not renew a certification until the renewal fee is paid.

(c) A certified representative must file an application and a renewal application fee to renew the certification by the date stated in the certification. The renewal application must include information that the certified representative has met continuing education requirements established by the commissioner by rule.

Sec. 33. Minnesota Statutes 2016, section 103I.525, subdivision 5, is amended to read:

Subd. 5. **Bond.** (a) As a condition of being issued a well contractor's license, the applicant~~, except a person applying for an individual well contractor's license,~~ must submit a corporate surety bond for $25,000 approved by the commissioner. The bond must be conditioned to pay the state on performance of work in this state that is not in compliance with this chapter or rules adopted under this chapter. The bond is in lieu of other license bonds required by a political subdivision of the state.

(b) From proceeds of the bond, the commissioner may compensate persons injured or suffering financial loss because of a failure of the applicant to perform work or duties in compliance with this chapter or rules adopted under this chapter.

Sec. 34. Minnesota Statutes 2016, section 103I.525, subdivision 6, is amended to read:

Subd. 6. **License fee.** The fee for a well contractor's license is $250~~, except the fee for an individual well contractor's license is $75~~.

Sec. 35. Minnesota Statutes 2016, section 103I.525, subdivision 8, is amended to read:

Subd. 8. **Renewal.** (a) A licensee must file an application and a renewal application fee to renew the license by the date stated in the license.

(b) The renewal application fee for a well contractor's license is $250~~, except the fee for an individual well contractor's license is $75~~.

(c) The renewal application must include information that the certified representative of the applicant has met continuing education requirements established by the commissioner by rule.

(d) At the time of the renewal, the commissioner must have on file all properly completed well and boring construction reports, well and boring sealing reports, reports of elevator borings, water sample analysis reports, well and boring permits, and well notifications for work conducted by the licensee since the last license renewal.

Sec. 36. Minnesota Statutes 2016, section 103I.531, subdivision 2, is amended to read:

Subd. 2. **Certification fee.** (a) The application fee for certification as a representative of a limited well/boring contractor is $75. The commissioner may not act on an application until the application fee is paid.

(b) The renewal fee for certification as a representative of a limited well/boring contractor is $75. The commissioner may not renew a certification until the renewal fee is paid.

(c) The fee for three or more limited well/boring contractor certifications is $225.

(d) A certified representative must file an application and a renewal application fee to renew the certification by the date stated in the certification. The renewal application must include information that the certified representative has met continuing education requirements established by the commissioner by rule.

Sec. 37. Minnesota Statutes 2016, section 103I.531, subdivision 5, is amended to read:

Subd. 5. **Bond.** (a) As a condition of being issued a limited well/boring contractor's license for ~~constructing, repairing, and sealing drive point wells or dug wells,~~ sealing wells ~~or~~ and borings, constructing, repairing, and sealing dewatering wells, or constructing, repairing, and sealing bored geothermal heat exchangers, the applicant must submit a corporate surety bond for $10,000 approved by the commissioner. As a condition of being issued a limited well/boring contractor's license for installing ~~or~~, repairing, and modifying well pumps and pumping equipment, well screens ~~or~~, pitless units ~~or~~ and pitless adaptors,

and well casings from the pitless adaptor or pitless unit to the upper termination of the well casing, ~~or installing well pumps or pumping equipment,~~ the applicant must submit a corporate surety bond for $2,000 approved by the commissioner. The bonds required in this paragraph must be conditioned to pay the state on performance of work in this state that is not in compliance with this chapter or rules adopted under this chapter. The bonds are in lieu of other license bonds required by a political subdivision of the state.

(b) From proceeds of a bond required in paragraph (a), the commissioner may compensate persons injured or suffering financial loss because of a failure of the applicant to perform work or duties in compliance with this chapter or rules adopted under this chapter.

Sec. 38. Minnesota Statutes 2016, section 103I.535, subdivision 2, is amended to read:

Subd. 2. **Certification fee.** (a) The application fee for certification as a representative of an elevator boring contractor is $75. The commissioner may not act on an application until the application fee is paid.

(b) The renewal fee for certification as a representative of an elevator boring contractor is $75. The commissioner may not renew a certification until the renewal fee is paid.

(c) A certified representative must file an application and a renewal application fee to renew the certification by the date stated in the certification. The renewal application must include information that the certified representative has met continuing education requirements established by the commissioner by rule.

Sec. 39. Minnesota Statutes 2016, section 103I.535, subdivision 6, is amended to read:

Subd. 6. **License fee.** The fee for an elevator ~~shaft~~ boring contractor's license is $75.

Sec. 40. Minnesota Statutes 2016, section 103I.541, subdivision 1, is amended to read:

Subdivision 1. ~~**Registration**~~ **Certification.** A person seeking ~~registration as a monitoring~~ certification to represent an environmental well contractor must meet examination and experience requirements adopted by the commissioner by rule.

Sec. 41. Minnesota Statutes 2016, section 103I.541, subdivision 2, is amended to read:

Subd. 2. **Validity.** ~~A monitoring~~ An environmental well contractor's ~~registration~~ certification is valid until the date prescribed in the ~~registration~~ certification by the commissioner.

Sec. 42. Minnesota Statutes 2016, section 103I.541, subdivision 2a, is amended to read:

Subd. 2a. **Certification application.** (a) An individual must submit an application and application fee to the commissioner to apply for certification as a representative of ~~a monitoring~~ an environmental well contractor.

(b) The application must be on forms prescribed by the commissioner. The application must state the applicant's qualifications for the certification, and other information required by the commissioner.

Sec. 43. Minnesota Statutes 2016, section 103I.541, subdivision 2b, is amended to read:

Subd. 2b. **Issuance of ~~registration~~ license.** If a person employs a certified representative, submits the bond under subdivision 3, and pays the ~~registration~~ license fee of $75 for ~~a monitoring~~ an environmental well contractor ~~registration~~ license, the commissioner shall issue ~~a monitoring~~ an environmental well contractor ~~registration~~ license to the applicant. The fee for an individual registration is $75. The commissioner may not act on an application until the application fee is paid.

Sec. 44. Minnesota Statutes 2016, section 103I.541, subdivision 2c, is amended to read:

Subd. 2c. **Certification fee.** (a) The application fee for certification as a representative of ~~a monitoring~~ an environmental well contractor is $75. The commissioner may not act on an application until the application fee is paid.

(b) The renewal fee for certification as a representative of ~~a monitoring~~ an environmental well contractor is $75. The commissioner may not renew a certification until the renewal fee is paid.

(c) A certified representative must file an application and a renewal application fee to renew the certification by the date stated in the certification. The renewal application must include information that the certified representative has met continuing education requirements established by the commissioner by rule.

Sec. 45. Minnesota Statutes 2016, section 103I.541, subdivision 2e, is amended to read:

Subd. 2e. **Issuance of certification.** If the applicant meets the experience requirements established by rule and passes the examination as determined by the commissioner, the commissioner shall issue the applicant a certification to represent ~~a monitoring~~ an environmental well contractor.

Sec. 46. Minnesota Statutes 2016, section 103I.541, subdivision 3, is amended to read:

Subd. 3. **Bond.** (a) As a condition of being issued ~~a monitoring~~ an environmental well contractor's ~~registration~~ license, the applicant must submit a corporate surety bond for $10,000 approved by the commissioner. The bond must be conditioned to pay the state on performance of work in this state that is not in compliance with this chapter or rules adopted under this chapter. The bond is in lieu of other license bonds required by a political subdivision of the state.

(b) From proceeds of the bond, the commissioner may compensate persons injured or suffering financial loss because of a failure of the applicant to perform work or duties in compliance with this chapter or rules adopted under this chapter.

Sec. 47. Minnesota Statutes 2016, section 103I.541, subdivision 4, is amended to read:

Subd. 4. **License renewal.** (a) A person must file an application and a renewal application fee to renew the ~~registration~~ license by the date stated in the ~~registration~~ license.

(b) The renewal application fee for ~~a monitoring~~ an environmental well contractor's ~~registration~~ license is $75.

(c) The renewal application must include information that the certified representative of the applicant has met continuing education requirements established by the commissioner by rule.

(d) At the time of the renewal, the commissioner must have on file all well and boring construction reports, well and boring sealing reports, well permits, and notifications for work conducted by the ~~registered~~ licensed person since the last ~~registration~~ license renewal.

Sec. 48. Minnesota Statutes 2016, section 103I.541, subdivision 5, is amended to read:

Subd. 5. **Incomplete or late renewal.** If a ~~registered~~ licensed person submits a renewal application after the required renewal date:

(1) the ~~registered~~ licensed person must include a late fee of $75; and

(2) the ~~registered~~ licensed person may not conduct activities authorized by the ~~monitoring~~ environmental well contractor's ~~registration~~ license until the renewal application, renewal application fee, late fee, and all other information required in subdivision 4 are submitted.

Sec. 49. Minnesota Statutes 2016, section 103I.545, is amended to read:

103I.545 REGISTRATION OF DRILLING MACHINES AND HOISTS REQUIRED.

Subdivision 1. **Drilling machine.** (a) A person may not use a drilling machine such as a cable tool, rotary tool, hollow rod tool, or auger for a drilling activity requiring a license ~~or registration~~ under this chapter unless the drilling machine is registered with the commissioner.

(b) A person must apply for the registration on forms prescribed by the commissioner and submit a $75 registration fee.

(c) A registration is valid for one year.

Subd. 2. **Hoist.** (a) A person may not use a machine such as a hoist for an activity requiring a license ~~or registration~~ under this chapter to repair wells or borings, seal wells or borings, or install pumps unless the machine is registered with the commissioner.

(b) A person must apply for the registration on forms prescribed by the commissioner and submit a $75 registration fee.

(c) A registration is valid for one year.

Sec. 50. **[103I.550] LIMITED PUMP, PITLESS, OR DUG WELL/DRIVE POINT CONTRACTOR.**

Subdivision 1. **Limited pump or pitless license or certification.** A person with a limited well/boring contractor's license or certification to install well pumps and pumping equipment; or a person with a limited well/boring contractor's license or certification to install, repair, and modify pitless units and pitless adapters, well casings above the pitless unit or pitless adapter, and well screens and well diameters, will be issued a combined license or certification to: (1) install well pumps and pumping equipment; and (2) install, repair, and modify pitless units and pitless adapters, well casings above the pitless unit or pitless adapter, well screens, and well diameters.

Subd. 2. **Limited dug well/drive point license or certification.** A person with a limited well/boring contractor's license or certification to construct, repair, and seal drive point wells and dug wells will be issued a well contractor's license or certification.

Sec. 51. Minnesota Statutes 2016, section 103I.601, subdivision 2, is amended to read:

Subd. 2. **License required to make borings.** (a) Except as provided in paragraph (d), a person must not make an exploratory boring without an explorer's license. The fee for an explorer's license is $75. The explorer's license is valid until the date prescribed in the license by the commissioner.

(b) A person must file an application and renewal application fee to renew the explorer's license by the date stated in the license. The renewal application fee is $75.

(c) If the licensee submits an application fee after the required renewal date, the licensee:

(1) must include a late fee of $75; and

(2) may not conduct activities authorized by an explorer's license until the renewal application, renewal application fee, late fee, and sealing reports required in subdivision 9 are submitted.

(d) An explorer must designate a responsible individual to supervise and oversee the making of exploratory borings.

(1) Before an individual supervises or oversees an exploratory boring, the individual must file an application and application fee of $75 to qualify as a certified responsible individual.

(2) The individual must take and pass an examination relating to construction, location, and sealing of exploratory borings. A professional engineer or geoscientist licensed under sections 326.02 to 326.15 or a professional geologist certified by the American Institute of Professional Geologists is not required to take the examination required in this subdivision, but must be certified as a responsible individual to supervise an exploratory boring.

(3) The individual must file an application and a renewal fee of $75 to renew the responsible individual's certification by the date stated in the certification. If the certified responsible individual submits an application fee after the renewal date, the certified responsible individual must include a late fee of $75 and may not supervise or oversee exploratory borings until the renewal application, application fee, and late fee are submitted.

Sec. 52. Minnesota Statutes 2016, section 103I.601, subdivision 4, is amended to read:

Subd. 4. **Notification and map of borings.** (a) By ten days before beginning exploratory boring, an explorer must submit to the commissioner of health a notification of the proposed boring on a form prescribed by the commissioner, and a fee of $275 for each exploratory boring.

(b) By ten days before beginning exploratory boring, an explorer must submit to the commissioners of health and natural resources a county road map having a scale of one-half inch equal to one mile, as prepared by the Department of Transportation, or a 7.5 minute series topographic map (1:24,000 scale), as prepared by the United States Geological Survey, showing the location of each proposed exploratory boring to the nearest estimated 40 acre parcel. Exploratory boring that is proposed on the map may not be commenced later than 180 days after submission of the map, unless a new map is submitted.

Sec. 53. Minnesota Statutes 2016, section 103I.711, subdivision 1, is amended to read:

Subdivision 1. **Impoundment.** The commissioner may apply to district court for a warrant authorizing seizure and impoundment of all drilling machines or hoists owned or used by a person. The court shall issue an impoundment order upon the commissioner's showing that a person is constructing, repairing, or sealing wells or borings or installing pumps or pumping equipment or excavating holes for installing elevator ~~shafts~~ borings without a license ~~or registration~~ as required under this chapter. A sheriff on receipt of the warrant must seize and impound all drilling machines and hoists owned or used by the person. A person from whom equipment is seized under this subdivision may file an action in district court for the purpose of establishing that the equipment was wrongfully seized.

Sec. 54. Minnesota Statutes 2016, section 103I.715, subdivision 2, is amended to read:

Subd. 2. **Gross misdemeanors.** A person is guilty of a gross misdemeanor who:

(1) willfully violates a provision of this chapter or order of the commissioner;

(2) engages in the business of drilling or making wells, sealing wells, installing pumps or pumping equipment, or constructing elevator ~~shafts~~ borings without a license required by this chapter; or

(3) engages in the business of exploratory boring without an exploratory borer's license under this chapter.

Sec. 55. **[144.0572] CRIMINAL HISTORY BACKGROUND CHECKS ON APPLICANTS, LICENSEES, AND OTHER OCCUPATIONS REGULATED BY COMMISSIONER OF HEALTH.**

Subdivision 1. **Criminal history background check requirements.** (a) Beginning January 1, 2018, an applicant for initial licensure, temporary licensure, or relicensure after a lapse in licensure as an occupational therapist, occupational therapy assistant, audiologist, or speech-language pathologist, or an applicant for initial certification as a hearing instrument

dispenser, must submit to a criminal history records check of state data completed by the Bureau of Criminal Apprehension (BCA) and a national criminal history records check, including a search of the records of the Federal Bureau of Investigation (FBI).

(b) Beginning January 1, 2020, an applicant for a renewal license or certificate as an occupational therapist, occupational therapy assistant, audiologist, speech-language pathologist, or hearing instrument dispenser who was licensed or obtained a certificate before January 1, 2018, must submit to a criminal history records check of state data completed by the BCA and a national criminal history records check, including a search of the records of the FBI.

(c) An applicant must submit to a background study under chapter 245C.

(d) The criminal history records check must be structured so that any new crimes that an applicant or licensee or certificate holder commits after the initial background check are flagged in the BCA's or FBI's database and reported back to the commissioner of human services.

Subd. 2. **Procedures.** (a) The commissioner shall contract with the Department of Human Services to process the criminal history background check requirements through NETStudy 2.0, as defined in section 245C.02.

(b) The Department of Human Services shall conduct the criminal history background checks according to section 144.057, except that:

(1) all applicants must submit to a fingerprint-based criminal history records check of state data completed by the BCA and a national criminal history records check, including a search of the records of the FBI;

(2) the Department of Human Services shall complete the check and the study and notify the commissioner of health if the applicant, licensee, or certificate holder has a criminal history as defined in section 245C.15; and

(3) the Department of Human Services shall simultaneously conduct a background study on each applicant according to chapter 245C.

(c) When making a determination whether to issue a license, deny a license, or issue a conditional license or other credential to practice an occupation regulated by the Department of Health, the commissioner or the commissioner's designee shall evaluate a criminal conviction, guilty plea, Alford plea, judicial determination, or preponderance of evidence to determine an applicant's risk of harm using the criteria in section 364.03.

(d) Before taking disciplinary action against an applicant or a licensee based on a criminal conviction, judicial determination, admission in court, Alford plea, or preponderance of evidence, the commissioner of health shall provide the applicant or licensee an opportunity to complete or challenge the accuracy of the criminal history information. The applicant or licensee shall have 30 calendar days following notice from the commissioner of the intent to deny licensure or take disciplinary action to request an opportunity to correct or complete the record prior to the commissioner taking disciplinary action. The commissioner shall provide the applicant up to 180 days to challenge the accuracy or completeness of the report with the agency responsible for the record. This subdivision does not affect the right of the subject of the data to contest the accuracy or completeness under section 13.04, subdivision 4.

(e) The checks and studies must be structured so that any new crimes that an applicant or licensee commits after the initial background check are flagged in the BCA's or FBI's database and reported back to the commissioner of human services.

Subd. 3. **Applicant, licensee, or other regulated individual's responsibilities.** (a) Applicants, licensees, and individuals seeking a credential to practice one of the public health occupations listed in subdivision 1 must submit a complete criminal history records check consent form, a complete background study consent form, and a full set of fingerprints as required by the Department of Human Services in section 245C.05.

(b) The applicant or license holder is responsible for paying to the Department of Human Services all fees associated with the preparation of the fingerprints, the criminal records check consent form, and the criminal background check.

Sec. 56. Minnesota Statutes 2016, section 144.122, is amended to read:

144.122 LICENSE, PERMIT, AND SURVEY FEES.

(a) The state commissioner of health, by rule, may prescribe procedures and fees for filing with the commissioner as prescribed by statute and for the issuance of original and renewal permits, licenses, registrations, and certifications issued under authority of the commissioner. The expiration dates of the various licenses, permits, registrations, and certifications as prescribed by the rules shall be plainly marked thereon. Fees may include application and examination fees and a penalty fee for renewal applications submitted after the expiration date of the previously issued permit, license, registration, and certification. The commissioner may also prescribe, by rule, reduced fees for permits, licenses, registrations, and certifications when the application therefor is submitted during the last three months of the permit, license, registration, or certification period. Fees proposed to

be prescribed in the rules shall be first approved by the Department of Management and Budget. All fees proposed to be prescribed in rules shall be reasonable. The fees shall be in an amount so that the total fees collected by the commissioner will, where practical, approximate the cost to the commissioner in administering the program. All fees collected shall be deposited in the state treasury and credited to the state government special revenue fund unless otherwise specifically appropriated by law for specific purposes.

(b) The commissioner may charge a fee for voluntary certification of medical laboratories and environmental laboratories, and for environmental and medical laboratory services provided by the department, without complying with paragraph (a) or chapter 14. Fees charged for environment and medical laboratory services provided by the department must be approximately equal to the costs of providing the services.

(c) The commissioner may develop a schedule of fees for diagnostic evaluations conducted at clinics held by the services for children with disabilities program. All receipts generated by the program are annually appropriated to the commissioner for use in the maternal and child health program.

(d) The commissioner shall set license fees for hospitals and nursing homes that are not boarding care homes at the following levels:

Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and American Osteopathic Association (AOA) hospitals	$7,655 plus $16 per bed
Non-JCAHO and non-AOA hospitals	$5,280 plus $250 per bed
Nursing home	$183 plus ~~$91~~ $100 per bed between July 1, 2017, and June 30, 2019. $183 plus $105 per bed beginning July 1, 2019.

The commissioner shall set license fees for outpatient surgical centers, boarding care homes, and supervised living facilities at the following levels:

Outpatient surgical centers	$3,712
Boarding care homes	$183 plus $91 per bed
Supervised living facilities	$183 plus $91 per bed.

Fees collected under this paragraph are nonrefundable. The fees are nonrefundable even if received before July 1, 2017, for licenses or registrations being issued effective July 1, 2017, or later.

(e) Unless prohibited by federal law, the commissioner of health shall charge applicants the following fees to cover the cost of any initial certification surveys required to determine a provider's eligibility to participate in the Medicare or Medicaid program:

Prospective payment surveys for hospitals		$	900
Swing bed surveys for nursing homes		$	1,200
Psychiatric hospitals		$	1,400
Rural health facilities		$	1,100
Portable x-ray providers		$	500
Home health agencies		$	1,800
Outpatient therapy agencies		$	800
End stage renal dialysis providers		$	2,100
Independent therapists		$	800
Comprehensive rehabilitation outpatient facilities		$	1,200
Hospice providers		$	1,700
Ambulatory surgical providers		$	1,800
Hospitals		$	4,200
Other provider categories or additional resurveys required to complete initial certification	Actual surveyor costs: average surveyor cost x number of hours for the survey process.		

These fees shall be submitted at the time of the application for federal certification and shall not be refunded. All fees collected after the date that the imposition of fees is not prohibited by federal law shall be deposited in the state treasury and credited to the state government special revenue fund.

Sec. 57. Minnesota Statutes 2016, section 144.3831, subdivision 1, is amended to read:

Subdivision 1. **Fee setting.** The commissioner of health may assess an annual fee of ~~$6.36~~ $9 for every service connection to a public water supply that is owned or operated by a home rule charter city, a statutory city, a city of the first class, or a town. The commissioner of health may also assess an annual fee for every service connection served by a water user district defined in section 110A.02.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 58. Minnesota Statutes 2016, section 144A.472, subdivision 7, is amended to read:

Subd. 7. **Fees; application, change of ownership, and renewal.** (a) An initial applicant seeking temporary home care licensure must submit the following application fee to the commissioner along with a completed application:

(1) for a basic home care provider, $2,100; or

(2) for a comprehensive home care provider, $4,200.

(b) A home care provider who is filing a change of ownership as required under subdivision 5 must submit the following application fee to the commissioner, along with the documentation required for the change of ownership:

(1) for a basic home care provider, $2,100; or

(2) for a comprehensive home care provider, $4,200.

(c) A home care provider who is seeking to renew the provider's license shall pay a fee to the commissioner based on revenues derived from the provision of home care services during the calendar year prior to the year in which the application is submitted, according to the following schedule for the period between July 1, 2017, and June 30, 2019:

License Renewal Fee

Provider Annual Revenue	Fee
greater than $1,500,000	~~$6,625~~ $7,287
greater than $1,275,000 and no more than $1,500,000	~~$5,797~~ $6,376
greater than $1,100,000 and no more than $1,275,000	~~$4,969~~ $5,466
greater than $950,000 and no more than $1,100,000	~~$4,141~~ $4,555
greater than $850,000 and no more than $950,000	~~$3,727~~ $4,099
greater than $750,000 and no more than $850,000	~~$3,313~~ $3,644
greater than $650,000 and no more than $750,000	~~$2,898~~ $3,188
greater than $550,000 and no more than $650,000	~~$2,485~~ $2,733
greater than $450,000 and no more than $550,000	~~$2,070~~ $2,277
greater than $350,000 and no more than $450,000	~~$1,656~~ $1,822
greater than $250,000 and no more than $350,000	~~$1,242~~ $1,366
greater than $100,000 and no more than $250,000	~~$828~~ $911
greater than $50,000 and no more than $100,000	~~$500~~ $550
greater than $25,000 and no more than $50,000	~~$400~~ $440
no more than $25,000	~~$200~~ $220

(d) Beginning July 1, 2019, a home care provider who is seeking to renew the provider's license shall pay a fee to the commissioner based on revenues derived from the provision of home care services during the calendar year prior to the year in which the application is submitted, according to the following schedule:

License Renewal Fee

Provider Annual Revenue	Fee
greater than $1,500,000	$7,651
greater than $1,275,000 and no more than $1,500,000	$6,695
greater than $1,100,000 and no more than $1,275,000	$5,739
greater than $950,000 and no more than $1,100,000	$4,783
greater than $850,000 and no more than $950,000	$4,304
greater than $750,000 and no more than $850,000	$3,826
greater than $650,000 and no more than $750,000	$3,347
greater than $550,000 and no more than $650,000	$2,870
greater than $450,000 and no more than $550,000	$2,391
greater than $350,000 and no more than $450,000	$1,913
greater than $250,000 and no more than $350,000	$1,434
greater than $100,000 and no more than $250,000	$957
greater than $50,000 and no more than $100,000	$577
greater than $25,000 and no more than $50,000	$462
no more than $25,000	$231

~~(d)~~ (e) If requested, the home care provider shall provide the commissioner information to verify the provider's annual revenues or other information as needed, including copies of documents submitted to the Department of Revenue.

~~(e)~~ (f) At each annual renewal, a home care provider may elect to pay the highest renewal fee for its license category, and not provide annual revenue information to the commissioner.

~~(f)~~ (g) A temporary license or license applicant, or temporary licensee or licensee that knowingly provides the commissioner incorrect revenue amounts for the purpose of paying a lower license fee, shall be subject to a civil penalty in the amount of double the fee the provider should have paid.

~~(g)~~ (h) Fees and penalties collected under this section shall be deposited in the state treasury and credited to the state government special revenue fund. All fees are nonrefundable. Fees collected under paragraphs (c) and (d) are nonrefundable even if

received before July 1, 2017, for temporary licenses or licenses being issued effective July 1, 2017, or later.

~~(h) The license renewal fee schedule in this subdivision is effective July 1, 2016.~~

Sec. 59. Minnesota Statutes 2016, section 146B.02, subdivision 2, is amended to read:

Subd. 2. **Requirements and term of license.** (a) Each application for an initial mobile or fixed-site establishment license and for renewal must be submitted to the commissioner on a form provided by the commissioner accompanied with the applicable fee required under section 146B.10. The application must contain:

(1) the name(s) of the owner(s) and operator(s) of the establishment;

(2) the location of the establishment;

(3) verification of compliance with all applicable local and state codes;

(4) a description of the general nature of the business; and

(5) any other relevant information deemed necessary by the commissioner.

(b) If the information submitted is complete and complies with the requirements of this chapter, the commissioner shall issue a provisional establishment license. The provisional license is effective until the commissioner determines, after inspection, that the applicant has met the requirements of this chapter. Upon approval, the commissioner shall issue a body art establishment license ~~effective for three years~~.

(c) An establishment license must be renewed every two years.

Sec. 60. Minnesota Statutes 2016, section 146B.02, subdivision 3, is amended to read:

Subd. 3. **Inspection.** (a) ~~Within the period of the provisional establishment license, and~~ The commissioner must inspect an establishment issued a provisional license within one year of the date the license was issued. Thereafter at least one time during each ~~three-year~~ two-year licensure period, the commissioner shall conduct an inspection of the body art establishment and a review of any records necessary to ensure that the standards required under this chapter are met.

(b) The commissioner shall have the authority to enter a premises to make an inspection. Refusal to permit an inspection constitutes valid grounds for licensure denial or revocation.

(c) If the establishment seeking licensure is new construction or if a licensed establishment is remodeling, the establishment must meet all local building and zoning codes.

Sec. 61. Minnesota Statutes 2016, section 146B.02, subdivision 5, is amended to read:

Subd. 5. **Transfer of ownership, relocation, and display of license.** (a) A body art establishment license must be issued to a specific person and location and is not transferable. A license must be prominently displayed in a public area of the establishment.

(b) An owner who has purchased a body art establishment licensed under the previous owner must submit an application to license the establishment within two weeks of the date of sale. Notwithstanding subdivision 1, the new owner may continue to operate for 60 days after the sale while waiting for a new license to be issued.

(c) An owner of a licensed body art establishment who is relocating the establishment must submit an application for the new location. The owner may request that the new application become effective at a specified date in the future. If the relocation is not accomplished by the date expected, and the license at the existing location expires, the owner may apply for a temporary event permit to continue to operate at the old location. The owner may apply for no more than four temporary event permits to continue operating at the old location.

Sec. 62. Minnesota Statutes 2016, section 146B.02, is amended by adding a subdivision to read:

Subd. 7a. **Supervisors.** (a) Only a technician who has been licensed as a body artist for at least two years in Minnesota or in a jurisdiction with which Minnesota has reciprocity may supervise a temporary technician.

(b) Any technician who agrees to supervise more than two temporary technicians during the same time period must explain, to the satisfaction of the commissioner, how the technician will provide supervision to each temporary technician in accordance with section 146B.01, subdivision 28.

(c) The commissioner may refuse to approve as a supervisor a technician who has been disciplined in Minnesota or in another jurisdiction.

Sec. 63. Minnesota Statutes 2016, section 146B.02, subdivision 8, is amended to read:

Subd. 8. **Temporary ~~events~~ event permit.** (a) An ~~owner or operator of a~~ applicant for a permit to hold a temporary body art ~~establishment~~ event shall submit an application ~~for a temporary events permit~~ to the commissioner. The application must be received at least 14 days before the start of the event. The application must include the specific days and hours

of operation. ~~The owner or operator~~ An applicant issued a temporary event permit shall comply with the requirements of this chapter.

(b) Applications received less than 14 days prior to the start of the event may be processed if the commissioner determines it is possible to conduct ~~the~~ all required work, including an inspection.

(c) The temporary ~~events~~ event permit must be prominently displayed in a public area at the location.

(d) The temporary ~~events~~ event permit, if approved, is valid for the specified dates and hours listed on the application. No temporary events permit shall be issued for longer than a 21-day period, and may not be extended.

(e) No individual who does not hold a current body art establishment license may be issued a temporary event permit more than four times within the same calendar year.

(f) No individual who has been disciplined for a serious violation of this chapter within three years preceding the intended start date of a temporary event may be issued a license for a temporary event. Violations that preclude issuance of a temporary event permit include unlicensed practice; practice in an unlicensed location; any of the conditions listed in section 146B.05, clauses (1) to (8), (12), or (13); 146B.08, subdivision 3, clauses (4), (5), and (10) to (12); or any other violation that places the health or safety of a client at risk.

Sec. 64. Minnesota Statutes 2016, section 146B.02, is amended by adding a subdivision to read:

Subd. 10. **Licensure precluded.** (a) The commissioner may choose to deny a body art establishment license to an applicant who has been disciplined for a serious violation under this chapter. Violations that constitute grounds for denial of license are any of the conditions listed in section 146B.05, subdivision 1, clauses (1) to (8), (12), or (13); 146B.08, subdivision 3, clauses (4), (5), or (10) to (12); or any other violation that places the health or safety of a client at risk.

(b) In considering whether to grant a license to an applicant who has been disciplined for a violation described in this subdivision, the commissioner shall consider evidence of rehabilitation, including the nature and seriousness of the violation, circumstances relative to the violation, the length of time elapsed since the violation, and evidence that demonstrates that the applicant has maintained safe, ethical, and responsible body art practice since the time of the most recent violation.

Sec. 65. Minnesota Statutes 2016, section 146B.02, is amended by adding a subdivision to read:

Subd. 11. **Penalties.** Any person who violates the provisions of subdivision 1 or who performs body art in an unlicensed location is guilty of a gross misdemeanor.

Sec. 66. Minnesota Statutes 2016, section 146B.03, subdivision 6, is amended to read:

Subd. 6. **Licensure term; renewal.** (a) A technician's license is valid for two years from the date of issuance and may be renewed upon payment of the renewal fee established under section 146B.10.

(b) At renewal, a licensee must submit proof of continuing education approved by the commissioner in the areas identified in subdivision 4.

(c) The commissioner shall notify the technician of the pending expiration of a technician license at least 60 days prior to license expiration.

(d) A technician previously licensed in Minnesota whose license has lapsed for less than six years may apply to renew. A technician previously licensed in Minnesota whose license has lapsed for less than ten years and who was licensed in another jurisdiction or jurisdictions during the entire time of lapse may apply to renew, but must submit proof of licensure in good standing in all other jurisdictions in which the technician was licensed as a body artist during the time of lapse. A technician previously licensed in Minnesota whose license has lapsed for more than six years and who was not continuously licensed in another jurisdiction during the period of Minnesota lapse must reapply for licensure under subdivision 4.

Sec. 67. Minnesota Statutes 2016, section 146B.03, subdivision 7, is amended to read:

Subd. 7. **Temporary licensure.** (a) The commissioner may issue a temporary license to an applicant who submits to the commissioner on a form provided by the commissioner:

(1) proof that the applicant is over the age of 18;

(2) all fees required under section 148B.10; and

(3) a letter from a licensed technician who has agreed to provide the supervision to meet the supervised experience requirement under subdivision 4.

(b) Upon completion of the required supervised experience, the temporary licensee shall submit documentation of satisfactorily completing the requirements under subdivision 4, and the applicable fee under section 146B.10. The commissioner shall issue a new license in accordance with subdivision 4.

(c) A temporary license issued under this subdivision is valid for one year and may be renewed ~~for one additional year~~ twice.

Sec. 68. Minnesota Statutes 2016, section 146B.07, subdivision 2, is amended to read:

Subd. 2. **Parent or legal guardian consent; prohibitions.** (a) A technician may perform body piercings on an individual under the age of 18 if:

(1) the individual's parent or legal guardian is present;

(2) the individual's parent or legal guardian provides personal identification by using one of the methods described in subdivision 1, paragraph (a), clauses (1) to (5), and provides documentation that reasonably establishes that the individual is the parent or legal guardian of the individual who is seeking the body piercing;

(3) the individual seeking the body piercing provides proof of identification by using one of the methods described in subdivision 1, paragraph (a), clauses (1) to (5), a current student identification, or another official source that includes the name and a photograph of the individual;

(4) a consent form and the authorization form under subdivision 1, paragraph (b) is signed by the parent or legal guardian in the presence of the technician; and

(5) the piercing is not prohibited under paragraph (c).

(b) ~~No technician shall tattoo any~~ Tattooing an individual under the age of 18 is a gross misdemeanor, regardless of parental or guardian consent.

(c) No nipple or genital piercing, branding, scarification, suspension, subdermal implantation, microdermal, or tongue bifurcation shall be performed by any technician on any individual under the age of 18 regardless of parental or guardian consent.

(d) No technician shall perform body art procedures on any individual who appears to be under the influence of alcohol, controlled substances as defined in section 152.01, subdivision 4, or hazardous substances as defined in rules adopted under chapter 182.

(e) No technician shall perform body art procedures while under the influence of alcohol, controlled substances as defined under section 152.01, subdivision 4, or hazardous substances as defined in the rules adopted under chapter 182.

(f) No technician shall administer anesthetic injections or other medications.

Sec. 69. Minnesota Statutes 2016, section 146B.07, subdivision 4, is amended to read:

Subd. 4. **Client record maintenance.** (a) For each client, the body art establishment operator shall maintain proper records of each procedure. The records of the procedure must be kept for three years and must be available for inspection by the commissioner upon request. The record must include the following:

(1) the date of the procedure;

(2) the information on the required picture identification showing the name, age, and current address of the client;

(3) a copy of the authorization form signed and dated by the client required under subdivision 1, paragraph (b);

(4) a description of the body art procedure performed;

(5) the name and license number of the technician performing the procedure;

(6) a copy of the consent form required under subdivision 3; and

(7) if the client is under the age of 18 years, a copy of the consent form signed by the parent or legal guardian as required under subdivision 2.

(b) Each body artist shall maintain a copy of the informed consent required under subdivision 3 for three years.

Sec. 70. Minnesota Statutes 2016, section 146B.10, subdivision 1, is amended to read:

Subdivision 1. **Licensing fees.** (a) The fee for the initial technician licensure and biennial licensure renewal is ~~$100~~ $420.

(b) The fee for temporary technician licensure is ~~$100~~ $240.

(c) The fee for the temporary guest artist license is ~~$50~~ $140.

(d) The fee for a dual body art technician license is ~~$100~~ $420.

(e) The fee for a provisional establishment license is ~~$1,000~~ $1,500.

(f) The fee for an initial establishment license and the ~~three-year~~ two-year license renewal period required in section 146B.02, subdivision 2, paragraph (b), is ~~$1,000~~ $1,500.

(g) The fee for a temporary body art establishment event permit is ~~$75~~ $200.

(h) The commissioner shall prorate the initial two-year technician license fee ~~and the initial three-year body art establishment license fee~~ based on the number of months in the initial licensure period. The commissioner shall prorate the first renewal fee for the

establishment license based on the number of months from issuance of the provisional license to the first renewal.

(i) The fee for verification of licensure to other states is $25.

(j) The fee to reissue a provisional establishment license that relocates prior to inspection and removal of provisional status is $350. The expiration date of the provisional license does not change.

(k) The fee to change an establishment name or establishment type, such as tattoo, piercing, or dual, is $50.

Sec. 71. Minnesota Statutes 2016, section 146B.10, subdivision 2, is amended to read:

Subd. 2. **~~Penalty for~~ Late ~~renewals~~ renewal fee.** (a) The ~~penalty~~ fee for late submission ~~for~~ of a technician renewal ~~applications~~ application is ~~$75~~ $150.

(b) The fee for late submission of an establishment renewal application is $300.

Sec. 72. Minnesota Statutes 2016, section 146B.10, is amended by adding a subdivision to read:

Subd. 2a. **Technical violation fee for practice after lapse.** (a) The technical violation fee for practicing body art after a body art license has expired and before it is renewed is $200 for any part of the first month, plus $200 for any part of any subsequent month up to one year. Continued practice or operation after one year becomes a disciplinary violation.

(b) The technical violation fee for practicing body art after a temporary body art license has expired and before it is renewed is $100 for any part of the first month, plus $100 for any part of any subsequent month up to six months. Continued practice or operation after six months becomes a disciplinary violation.

(c) The technical violation fee for operating a body art establishment after the license has expired and before it is renewed is $300 for any part of the first month, plus $300 for any part of any subsequent month up to six months. Continued practice or operation after six months becomes a disciplinary violation.

Sec. 73. Minnesota Statutes 2016, section 148.514, subdivision 1, is amended to read:

Subdivision 1. **General licensure procedures.** An applicant for licensure must:

(1) submit an application as required under section 148.519, subdivision 1; ~~and~~

(2) submit all fees required under section 148.5194~~.~~; and

(3) consent to a fingerprint-based background check as required under section 148.519.

Sec. 74. Minnesota Statutes 2016, section 148.519, subdivision 1, is amended to read:

Subdivision 1. **Applications for licensure.** (a) An applicant for licensure must:

(1) submit a completed application for licensure on forms provided by the commissioner. The application must include the applicant's name, certification number under chapter 153A, if applicable, business address and telephone number, or home address and telephone number if the applicant practices speech-language pathology or audiology out of the home, and a description of the applicant's education, training, and experience, including previous work history for the five years immediately preceding the date of application. The commissioner may ask the applicant to provide additional information necessary to clarify information submitted in the application; and

(2) submit documentation of the certificate of clinical competence issued by the American Speech-Language-Hearing Association, board certification by the American Board of Audiology, or satisfy the following requirements:

(i) submit a transcript showing the completion of a master's or doctoral degree or its equivalent meeting the requirements of section 148.515, subdivision 2;

(ii) submit documentation of the required hours of supervised clinical training;

(iii) submit documentation of the postgraduate clinical or doctoral clinical experience meeting the requirements of section 148.515, subdivision 4; and

(iv) submit documentation of receiving a qualifying score on an examination meeting the requirements of section 148.515, subdivision 6.

(b) In addition, an applicant must:

(1) sign a statement that the information in the application is true and correct to the best of the applicant's knowledge and belief;

(2) submit with the application all fees required by section 148.5194; ~~and~~

(3) sign a waiver authorizing the commissioner to obtain access to the applicant's records in this or any other state in which the applicant has engaged in the practice of speech-language pathology or audiology~~.~~; and

(4) consent to a fingerprint-based criminal history background check as required under section 144.0572, pay all required fees, and cooperate with all requests for information. An

applicant must complete a new criminal history background check if more than one year has elapsed since the applicant last applied for a license.

Sec. 75. Minnesota Statutes 2016, section 148.519, subdivision 2, is amended to read:

Subd. 2. **Action on applications for licensure.** (a) The commissioner shall act on an application for licensure according to paragraphs (b) to ~~(d)~~ (e).

(b) The commissioner shall determine if the applicant meets the requirements for licensure. The commissioner or advisory council may investigate information provided by an applicant to determine whether the information is accurate and complete.

(c) The commissioner shall not issue a license to an applicant who refuses to consent to a background study within 90 days after submission of an application or fails to submit fingerprints to the Department of Human Services. Any fees paid by the applicant to the Department of Health shall be forfeited if the applicant refuses to consent to the background study.

~~(c)~~ (d) The commissioner shall notify an applicant, via certified mail, of action taken on the application and of the grounds for denying licensure if licensure is denied.

~~(d)~~ (e) An applicant denied licensure may make a written request to the commissioner, within 30 days of the date of notification to the applicant, for reconsideration of the denial. Individuals requesting reconsideration may submit information that the applicant wants considered in the reconsideration. After reconsideration of the commissioner's determination to deny licensure, the commissioner shall determine whether the original determination should be affirmed or modified. An applicant may make only one request in any one biennial license period for reconsideration of the commissioner's determination to deny licensure.

Sec. 76. Minnesota Statutes 2016, section 148.5194, subdivision 2, is amended to read:

Subd. 2. **Speech-language pathologist ~~biennial~~ licensure ~~fee~~ fees.** (a) The fee for initial licensure ~~and biennial licensure, clinical fellowship licensure, temporary licensure, or renewal~~ for a speech-language pathologist is ~~$200~~ $210.50.

(b) The fee for clinical fellowship licensure, doctoral externship, temporary license, or renewal for a speech-language pathologist is $200.

Sec. 77. Minnesota Statutes 2016, section 148.5194, subdivision 3, is amended to read:

Subd. 3. **~~Biennial~~ Licensure ~~fee~~ fees for dual licensure as a speech-language pathologist and audiologist.** (a) The fee for initial dual licensure ~~and biennial licensure,~~

~~clinical fellowship licensure, doctoral externship, temporary license, or renewal~~ as a speech-language pathologist and audiologist is ~~$435~~ $523.

(b) The fee for clinical fellowship licensure, doctoral externship, temporary license, or renewal for dual licensure as a speech-language pathologist and audiologist is $510.

Sec. 78. Minnesota Statutes 2016, section 148.5194, subdivision 4, is amended to read:

Subd. 4. **Penalty fee for late renewals.** The penalty fee for late submission of a renewal application is ~~$45~~ $60.

Sec. 79. Minnesota Statutes 2016, section 148.5194, subdivision 7, is amended to read:

Subd. 7. **Audiologist biennial licensure fee.** ~~(a)~~ The licensure fee for initial applicants is $523. The biennial licensure fee for audiologists for clinical fellowship, doctoral externship, temporary, ~~initial applicants,~~ and renewal ~~licensees~~ licenses is ~~$435~~ $510.

~~(b) The audiologist fee is for practical examination costs greater than audiologist exam fee receipts and for complaint investigation, enforcement action, and consumer information and assistance expenditures related to hearing instrument dispensing.~~

Sec. 80. Minnesota Statutes 2016, section 148.5194, is amended by adding a subdivision to read:

Subd. 7a. **Surcharge.** Speech-language pathologists who were licensed prior to January 1, 2018, shall pay a onetime surcharge of $10.50 to renew when their license first expires after January 1, 2020. Audiologists who were licensed before January 1, 2018, shall pay a onetime surcharge of $13 to renew when their license first expires after January 1, 2020. The surcharge shall cover the commissioner's costs associated with criminal background checks.

Sec. 81. Minnesota Statutes 2016, section 148.5195, subdivision 2, is amended to read:

Subd. 2. **Rights of applicants and licensees.** The rights of an applicant denied licensure are stated in section 148.519, subdivision 2, paragraph ~~(d)~~ (e). A licensee shall not be subjected to disciplinary action under this section without first having an opportunity for a contested case hearing under chapter 14.

Sec. 82. Minnesota Statutes 2016, section 148.6405, is amended to read:

148.6405 LICENSURE APPLICATION REQUIREMENTS: PROCEDURES AND QUALIFICATIONS.

(a) An applicant for licensure must comply with the application requirements in section 148.6420. To qualify for licensure, an applicant must satisfy one of the requirements in paragraphs (b) to (f) and not be subject to denial of licensure under section 148.6448.

(b) A person who applies for licensure as an occupational therapist and who has not been credentialed by the National Board for Certification in Occupational Therapy or another jurisdiction must meet the requirements in section 148.6408.

(c) A person who applies for licensure as an occupational therapy assistant and who has not been credentialed by the National Board for Certification in Occupational Therapy or another jurisdiction must meet the requirements in section 148.6410.

(d) A person who is certified by the National Board for Certification in Occupational Therapy may apply for licensure by equivalency and must meet the requirements in section 148.6412.

(e) A person who is credentialed in another jurisdiction may apply for licensure by reciprocity and must meet the requirements in section 148.6415.

(f) A person who applies for temporary licensure must meet the requirements in section 148.6418.

(g) A person who applies for licensure under paragraph (b), (c), or (f) more than two and less than four years after meeting the requirements in section 148.6408 or 148.6410 must submit the following:

(1) a completed and signed application for licensure on forms provided by the commissioner;

(2) the license application fee required under section 148.6445;

(3) consent to a fingerprint-based criminal history records check required under section 148.6420;

~~(3)~~ (4) if applying for occupational therapist licensure, proof of having met a minimum of 24 contact hours of continuing education in the two years preceding licensure application, or if applying for occupational therapy assistant licensure, proof of having met a minimum of 18 contact hours of continuing education in the two years preceding licensure application;

~~(4)~~ (5) verified documentation of successful completion of 160 hours of supervised practice approved by the commissioner under a limited license specified in section 148.6425, subdivision 3, paragraph (c); and

~~(5)~~ (6) additional information as requested by the commissioner to clarify information in the application, including information to determine whether the individual has engaged in conduct warranting disciplinary action under section 148.6448. The information must be submitted within 30 days after the commissioner's request.

(h) A person who applied for licensure under paragraph (b), (c), or (f) four years or more after meeting the requirements in section 148.6408 or 148.6410 must meet all the requirements in paragraph (g) except clauses ~~(3)~~ (4) and ~~(4)~~ (5), submit documentation of having retaken and passed the credentialing examination for occupational therapist or occupational therapy assistant, or of having completed an occupational therapy refresher program that contains both a theoretical and clinical component approved by the commissioner, and verified documentation of successful completion of 480 hours of supervised practice approved by the commissioner under a limited license specified in section 148.6425, subdivision 3, paragraph (c). The 480 hours of supervised practice must be completed in six months and may be completed at the applicant's place of work. Only refresher courses completed within one year prior to the date of application qualify for approval.

Sec. 83. Minnesota Statutes 2016, section 148.6420, subdivision 1, is amended to read:

Subdivision 1. **Applications for licensure.** An applicant for licensure must:

(1) submit a completed application for licensure on forms provided by the commissioner and must supply the information requested on the application, including:

(i) the applicant's name, business address and business telephone number, business setting, and daytime telephone number;

(ii) the name and location of the occupational therapy program the applicant completed;

(iii) a description of the applicant's education and training, including a list of degrees received from educational institutions;

(iv) the applicant's work history for the six years preceding the application, including the number of hours worked;

(v) a list of all credentials currently and previously held in Minnesota and other jurisdictions;

(vi) a description of any jurisdiction's refusal to credential the applicant;

(vii) a description of all professional disciplinary actions initiated against the applicant in any jurisdiction;

(viii) information on any physical or mental condition or chemical dependency that impairs the person's ability to engage in the practice of occupational therapy with reasonable judgment or safety;

(ix) a description of any misdemeanor or felony conviction that relates to honesty or to the practice of occupational therapy;

(x) a description of any state or federal court order, including a conciliation court judgment or a disciplinary order, related to the individual's occupational therapy practice; and

(xi) a statement indicating the physical agent modalities the applicant will use and whether the applicant will use the modalities as an occupational therapist or an occupational therapy assistant under direct supervision;

(2) submit with the application all fees required by section 148.6445;

(3) sign a statement that the information in the application is true and correct to the best of the applicant's knowledge and belief;

(4) sign a waiver authorizing the commissioner to obtain access to the applicant's records in this or any other state in which the applicant holds or previously held a credential for the practice of an occupation, has completed an accredited occupational therapy education program, or engaged in the practice of occupational therapy;

(5) ~~submit additional information as requested by the commissioner~~ consent to a fingerprint-based criminal background records check required under section 144.0572, pay all required fees, and cooperate with all requests for information. An applicant must complete a new criminal background check if more than one year has elapsed since the applicant last applied for a license; and

(6) submit the additional information required for licensure by equivalency, licensure by reciprocity, and temporary licensure as specified in sections 148.6408 to 148.6418.

Sec. 84. Minnesota Statutes 2016, section 148.6420, subdivision 5, is amended to read:

Subd. 5. **Action on applications for licensure.** (a) The commissioner shall approve, approve with conditions, or deny licensure. The commissioner shall act on an application for licensure according to paragraphs (b) to (d).

(b) The commissioner shall determine if the applicant meets the requirements for licensure. The commissioner, or the advisory council at the commissioner's request, may

investigate information provided by an applicant to determine whether the information is accurate and complete.

(c) The commissioner shall notify an applicant of action taken on the application and, if licensure is denied or approved with conditions, the grounds for the commissioner's determination.

(d) An applicant denied licensure or granted licensure with conditions may make a written request to the commissioner, within 30 days of the date of the commissioner's determination, for reconsideration of the commissioner's determination. Individuals requesting reconsideration may submit information which the applicant wants considered in the reconsideration. After reconsideration of the commissioner's determination to deny licensure or grant licensure with conditions, the commissioner shall determine whether the original determination should be affirmed or modified. An applicant is allowed no more than one request in any one biennial licensure period for reconsideration of the commissioner's determination to deny licensure or approve licensure with conditions.

(e) The commissioner shall not issue a license to an applicant who refuses to consent to a background study within 90 days after submission of an application or fails to submit fingerprints to the Department of Human Services. Any fees paid by the applicant to the Department of Health shall be forfeited if the applicant refuses to consent to the background study.

Sec. 85. Minnesota Statutes 2016, section 148.6445, subdivision 1, is amended to read:

Subdivision 1. **Initial licensure fee.** The initial licensure fee for occupational therapists is ~~$145~~ $188.50. The initial licensure fee for occupational therapy assistants is ~~$80~~ $112.50. The commissioner shall prorate fees based on the number of quarters remaining in the biennial licensure period.

Sec. 86. Minnesota Statutes 2016, section 148.6445, subdivision 2, is amended to read:

Subd. 2. **Licensure renewal fee.** The biennial licensure renewal fee for occupational therapists is ~~$145~~ $173. The biennial licensure renewal fee for occupational therapy assistants is ~~$80~~ $96.

Sec. 87. Minnesota Statutes 2016, section 148.6445, subdivision 3, is amended to read:

Subd. 3. **Late fee.** The fee for late submission of a renewal application is ~~$25~~ $32.

Sec. 88. Minnesota Statutes 2016, section 148.6445, is amended by adding a subdivision to read:

Subd. 10a. **Surcharge.** Practitioners who were licensed before January 1, 2018, shall pay a onetime surcharge of $16.50 to renew when their license first expires after January 1, 2020. The surcharge shall cover the commissioner's costs associated with criminal background checks.

Sec. 89. Minnesota Statutes 2016, section 148.997, subdivision 1, is amended to read:

Subdivision 1. **Fees.** (a) The application fee is ~~$130~~ $185.

(b) The criminal background check fee is ~~$6~~ $15.

Sec. 90. Minnesota Statutes 2016, section 153A.14, subdivision 1, is amended to read:

Subdivision 1. **Application for certificate.** An applicant must:

(1) be 21 years of age or older;

(2) apply to the commissioner for a certificate to dispense hearing instruments on application forms provided by the commissioner;

(3) at a minimum, provide the applicant's name, Social Security number, business address and phone number, employer, and information about the applicant's education, training, and experience in testing human hearing and fitting hearing instruments;

(4) include with the application a statement that the statements in the application are true and correct to the best of the applicant's knowledge and belief;

(5) include with the application a written and signed authorization that authorizes the commissioner to make inquiries to appropriate regulatory agencies in this or any other state where the applicant has sold hearing instruments;

(6) submit certification to the commissioner that the applicant's audiometric equipment has been calibrated to meet current ANSI standards within 12 months of the date of the application;

(7) submit evidence of continuing education credits, if required; ~~and~~

(8) submit all fees as required under section 153A.17~~.~~; and

(9) consent to a fingerprint-based criminal history records check required under section 144.0572, pay all required fees, and cooperate with all requests for information. An applicant

must complete a new criminal background check if more than one year has elapsed since the applicant last applied for a license.

Sec. 91. Minnesota Statutes 2016, section 153A.14, subdivision 2, is amended to read:

Subd. 2. **Issuance of certificate.** (a) The commissioner shall issue a certificate to each dispenser of hearing instruments who applies under subdivision 1 if the commissioner determines that the applicant is in compliance with this chapter, has passed an examination administered by the commissioner, has met the continuing education requirements, if required, and has paid the fee set by the commissioner. The commissioner may reject or deny an application for a certificate if there is evidence of a violation or failure to comply with this chapter.

(b) The commissioner shall not issue a certificate to an applicant who refuses to consent to a criminal history background check as required by section 144.0572 within 90 days after submission of an application or fails to submit fingerprints to the Department of Human Services. Any fees paid by the applicant to the Department of Health shall be forfeited if the applicant refuses to consent to the background study.

Sec. 92. Minnesota Statutes 2016, section 153A.17, is amended to read:

153A.17 EXPENSES; FEES.

(a) The expenses for administering the certification requirements, including the complaint handling system for hearing aid dispensers in sections 153A.14 and 153A.15, and the Consumer Information Center under section 153A.18, must be paid from initial application and examination fees, renewal fees, penalties, and fines. The commissioner shall only use fees collected under this section for the purposes of administering this chapter. The legislature must not transfer money generated by these fees from the state government special revenue fund to the general fund. Surcharges collected by the commissioner of health under section 16E.22 are not subject to this paragraph.

(b) The fees are as follows:

(1) the initial ~~and annual renewal~~ certification application fee is ~~$600~~ $772.50;

(2) ~~the initial examination fee for the written portion is $500, and for each time it is taken, thereafter~~ the annual renewal certification application fee is $750;

(3) the initial examination fee for the practical portion is $1,200, and $600 for each time it is taken, thereafter; for individuals meeting the requirements of section 148.515, subdivision

2, the fee for the practical portion of the hearing instrument dispensing examination is ~~$250~~ $600 each time it is taken;

(4) the trainee application fee is ~~$200~~ $230;

(5) the penalty fee for late submission of a renewal application is ~~$200~~ $260; and

(6) the fee for verification of certification to other jurisdictions or entities is $25.

(c) The commissioner may prorate the certification fee for new applicants based on the number of quarters remaining in the annual certification period.

(d) All fees are nonrefundable. All fees, penalties, and fines received must be deposited in the state government special revenue fund.

(e) ~~Beginning July 1, 2009, until June 30, 2016, a surcharge of $100 shall be paid at the time of initial certification application or renewal to recover the commissioner's accumulated direct expenditures for administering the requirements of this chapter.~~ Hearing instrument dispensers who were certified before January 1, 2018, shall pay a onetime surcharge of $22.50 to renew their certification when it expires after October 31, 2020. The surcharge shall cover the commissioner's costs associated with criminal background checks.

Sec. 93. Minnesota Statutes 2016, section 157.16, subdivision 1, is amended to read:

Subdivision 1. **License required annually.** A license is required annually for every person, firm, or corporation engaged in the business of conducting a food and beverage service establishment, youth camp, hotel, motel, lodging establishment, public pool, or resort. Any person wishing to operate a place of business licensed in this section shall first make application, pay the required fee specified in this section, and receive approval for operation, including plan review approval. Special event food stands are not required to submit plans. Nonprofit organizations operating a special event food stand with multiple locations at an annual one-day event shall be issued only one license. Application shall be made on forms provided by the commissioner and shall require the applicant to state the full name and address of the owner of the building, structure, or enclosure, the lessee and manager of the food and beverage service establishment, hotel, motel, lodging establishment, public pool, or resort; the name under which the business is to be conducted; and any other information as may be required by the commissioner to complete the application for license. All fees collected under this section shall be deposited in the state government special revenue fund.

Sec. 94. Minnesota Statutes 2016, section 157.16, subdivision 3, is amended to read:

Subd. 3. **Establishment fees; definitions.** (a) The following fees are required for food and beverage service establishments, youth camps, hotels, motels, lodging establishments, public pools, and resorts licensed under this chapter. Food and beverage service establishments must pay the highest applicable fee under paragraph (d), clause (1), (2), (3), or (4)~~, and establishments serving alcohol must pay the highest applicable fee under paragraph (d), clause (6) or (7)~~. The license fee for new operators previously licensed under this chapter for the same calendar year is one-half of the appropriate annual license fee, plus any penalty that may be required. The license fee for operators opening on or after October 1 is one-half of the appropriate annual license fee, plus any penalty that may be required.

(b) All food and beverage service establishments, except special event food stands, and all hotels, motels, lodging establishments, public pools, and resorts shall pay an annual base fee of ~~$150~~ $165.

(c) A special event food stand shall pay a flat fee of ~~$50~~ $55 annually. "Special event food stand" means a fee category where food is prepared or served in conjunction with celebrations, county fairs, or special events from a special event food stand as defined in section 157.15.

(d) In addition to the base fee in paragraph (b), each food and beverage service establishment, other than a special event food stand and a school concession stand, and each hotel, motel, lodging establishment, public pool, and resort shall pay an additional annual fee for each fee category, additional food service, or required additional inspection specified in this paragraph:

(1) ~~Limited food menu selection, $60. "Limited food menu selection"~~ Category 1 establishment, $110. "Category 1 establishment" means a fee category that provides one or more of the following items or is one of the listed establishments or facilities:

(i) serves prepackaged food that ~~receives heat treatment and~~ is served in the package;

(ii) ~~frozen pizza that is heated and served;~~

~~(iii)~~ serves a continental breakfast such as rolls, coffee, juice, milk, and cold cereal;

~~(iv)~~ (iii) serves soft drinks, coffee, or nonalcoholic beverages; ~~or~~

~~(v)~~ (iv) provides cleaning for eating, drinking, or cooking utensils, when the only food served is prepared off site~~.~~;

(v) a food establishment where the method of food preparation meets the definition of a low-risk establishment in section 157.20; or

(vi) operates as a child care facility licensed under section 245A.03 and Minnesota Rules, chapter 9503.

~~(2) Small establishment, including boarding establishments, $120. "Small establishment" means a fee category that has no salad bar and meets one or more of the following:~~

~~(i) possesses food service equipment that consists of no more than a deep fat fryer, a grill, two hot holding containers, and one or more microwave ovens;~~

~~(ii) serves dipped ice cream or soft serve frozen desserts;~~

~~(iii) serves breakfast in an owner-occupied bed and breakfast establishment;~~

~~(iv) is a boarding establishment; or~~

~~(v) meets the equipment criteria in clause (3), item (i) or (ii), and has a maximum patron seating capacity of not more than 50.~~

~~(3) Medium establishment, $310. "Medium establishment"~~ (2) Category 2 establishment, $245. "Category 2 establishment" means ~~a fee category that meets one or more of the following~~ an establishment that is not a Category 1 establishment and is either:

(i) ~~possesses food service equipment that includes a range, oven, steam table, salad bar, or salad preparation area;~~ a food establishment where the method of food preparation meets the definition of a medium-risk establishment in section 157.20; or

(ii) ~~possesses food service equipment that includes more than one deep fat fryer, one grill, or two hot holding containers; or~~ an elementary or secondary school as defined in section 120A.05.

~~(iii) is an establishment where food is prepared at one location and served at one or more separate locations.~~

~~Establishments meeting criteria in clause (2), item (v), are not included in this fee category.~~

~~(4) Large establishment, $540. "Large establishment"~~ (3) Category 3 establishment, $385. "Category 3 establishment" means an establishment that is not a Category 1 or Category 2 establishment and is either:

(i) ~~a fee category that (A) meets the criteria in clause (3), items (i) or (ii), for a medium establishment, (B) seats more than 175 people, and (C) offers the full menu selection an~~

~~average of five or more days a week during the weeks of operation~~ a food establishment where the method of food preparation meets the definition of a high-risk establishment in section 157.20; or

(ii) ~~a fee category that (A) meets the criteria in clause (3), item (iii), for a medium establishment, and (B) prepares and serves 500 or more meals per day.~~ an establishment where 500 or more meals are prepared per day and served at one or more separate locations.

~~(5)~~ (4) Other food and beverage service, including food carts, mobile food units, seasonal temporary food stands, and seasonal permanent food stands, ~~$60~~ $85.

~~(6) Beer or wine table service, $60. "Beer or wine table service" means a fee category where the only alcoholic beverage service is beer or wine, served to customers seated at tables.~~

~~(7) Alcoholic beverage service, other than beer or wine table service, $165.~~

~~"Alcohol beverage service, other than beer or wine table service" means a fee category where alcoholic mixed drinks are served or where beer or wine are served from a bar.~~

~~(8)~~ (5) Lodging per sleeping accommodation unit, ~~$10~~ $11, including hotels, motels, lodging establishments, and resorts, up to a maximum of ~~$1,000~~ $1,100. "Lodging per sleeping accommodation unit" means a fee category including the number of guest rooms, cottages, or other rental units of a hotel, motel, lodging establishment, or resort; or the number of beds in a dormitory.

~~(9)~~ (6) First public pool, ~~$325~~ $355; each additional public pool, ~~$175~~ $200. "Public pool" means a fee category that has the meaning given in section 144.1222, subdivision 4.

~~(10)~~ (7) First spa, ~~$175~~ $200; each additional spa, ~~$100~~ $110. "Spa pool" means a fee category that has the meaning given in Minnesota Rules, part 4717.0250, subpart 9.

~~(11)~~ (8) Private sewer or water, $60. "Individual private water" means a fee category with a water supply other than a community public water supply as defined in Minnesota Rules, chapter 4720. "Individual private sewer" means a fee category with an individual sewage treatment system which uses subsurface treatment and disposal.

~~(12)~~ (9) Additional food service, ~~$150~~ $175. "Additional food service" means a location at a food service establishment, other than the primary food preparation and service area, used to prepare or serve beverages or food to the public. Additional food service does not apply to school concession stands.

~~(13)~~ (10) Additional inspection fee, ~~$360~~ $250. "Additional inspection fee" means a fee to conduct the second inspection each year for elementary and secondary education facility school lunch programs when required by the Richard B. Russell National School Lunch Act.

(11) HACCP verification, $175. "HACCP verification" means an annual fee category for a business that performs one or more specialized process that requires an HACCP plan as required in chapter 31 and Minnesota Rules, chapter 4626.

(e) A fee for review of construction plans must accompany the initial license application for restaurants, hotels, motels, lodging establishments, resorts, seasonal food stands, and mobile food units. A fee for review of an HACCP plan for specialized processing must be submitted and approved prior to preparing and serving the specialized processed food for human consumption. The ~~fee~~ fees for ~~this~~ construction plan ~~review is~~ reviews and HACCP plan reviews are as follows:

Service Area	**Type**	**Fee**
Food	~~limited food menu~~	~~$275~~
	~~small~~ category 1 establishment	$400
	~~medium~~ category 2 establishment	$450
	~~large~~ category 3 food establishment	$500
		~~$150~~
	additional food service	$250
	HACCP Plan Review	$500
Transient food service	food cart	$250
	seasonal permanent food stand	$250
	seasonal temporary food stand	$250
	mobile food unit	$350
~~Alcohol~~	~~beer or wine table service~~	~~$150~~
	~~alcohol service from bar~~	~~$250~~
Lodging	less than 25 rooms	$375
	25 to less than 100 rooms	$400
	100 rooms or more	$500
	less than five cabins	$350
	five to less than ten cabins	$400
	ten cabins or more	$450

(f) When existing food and beverage service establishments, hotels, motels, lodging establishments, resorts, seasonal food stands, and mobile food units are extensively

remodeled, a fee must be submitted with the remodeling plans. The fee for this construction plan review is as follows:

Service Area	Type	Fee
Food	~~limited food menu~~	~~$250~~
	~~small~~ category 1 establishment	$300
	~~medium~~ category 2 establishment	$350
	~~large food~~ category 3 establishment	$400
	~~additional food service~~	~~$150~~ $250
Transient food service	food cart	$250
	seasonal permanent food stand	$250
	seasonal temporary food stand	$250
	mobile food unit	$250
~~Alcohol~~	~~beer or wine table service~~	~~$150~~
	~~alcohol service from bar~~	~~$250~~
Lodging	less than 25 rooms	$250
	25 to less than 100 rooms	$300
	100 rooms or more	$450
	less than five cabins	$250
	five to less than ten cabins	$350
	ten cabins or more	$400

(g) Special event food stands are not required to submit construction or remodeling plans for review.

(h) Youth camps shall pay an annual single fee for food and lodging as follows:

(1) camps with up to 99 campers, $325;

(2) camps with 100 to 199 campers, $550; and

(3) camps with 200 or more campers, $750.

(i) A youth camp which pays fees under paragraph (d) is not required to pay fees under paragraph (h).

Sec. 95. Minnesota Statutes 2016, section 157.16, subdivision 3a, is amended to read:

Subd. 3a. **Statewide hospitality fee.** Every person, firm, or corporation that operates a licensed boarding establishment, food and beverage service establishment, seasonal temporary or permanent food stand, special event food stand, mobile food unit, food cart, resort, hotel, motel, or lodging establishment in Minnesota must submit to the commissioner a ~~$35~~ $40

annual statewide hospitality fee for each licensed activity. The fee for establishments licensed by the Department of Health is required at the same time the licensure fee is due. For establishments licensed by local governments, the fee is due by July 1 of each year.

Sec. 96. Minnesota Statutes 2016, section 245C.10, is amended by adding a subdivision to read:

Subd. 2a. **Occupations regulated by commissioner of health.** The commissioner shall set fees to recover the cost of combined background studies and criminal background checks initiated by applicants, licensees, and certified practitioners regulated under sections 148.511 to 148.5198 and 148.6401 to 148.6450 and chapter 153A. The fees collected under this subdivision shall be deposited in the special revenue fund and are appropriated to the commissioner for the purpose of conducting background studies and criminal background checks.

Sec. 97. Minnesota Statutes 2016, section 327.15, subdivision 3, is amended to read:

Subd. 3. **Fees, manufactured home parks and recreational camping areas.** (a) The following fees are required for manufactured home parks and recreational camping areas licensed under this chapter. Fees collected under this section shall be deposited in the state government special revenue fund. Recreational camping areas and manufactured home parks shall pay the highest applicable base fee under paragraph (b). The license fee for new operators of a manufactured home park or recreational camping area previously licensed under this chapter for the same calendar year is one-half of the appropriate annual license fee, plus any penalty that may be required. The license fee for operators opening on or after October 1 is one-half of the appropriate annual license fee, plus any penalty that may be required.

(b) All manufactured home parks and recreational camping areas shall pay the following annual base fee:

(1) a manufactured home park, ~~$150~~ $165; and

(2) a recreational camping area with:

(i) 24 or less sites, ~~$50~~ $55;

(ii) 25 to 99 sites, ~~$212~~ $230; and

(iii) 100 or more sites, ~~$300~~ $330.

In addition to the base fee, manufactured home parks and recreational camping areas shall pay ~~$4~~ $5 for each licensed site. This paragraph does not apply to special event recreational camping areas. Operators of a manufactured home park or a recreational camping area also licensed under section 157.16 for the same location shall pay only one base fee, whichever is the highest of the base fees found in this section or section 157.16.

(c) In addition to the fee in paragraph (b), each manufactured home park or recreational camping area shall pay an additional annual fee for each fee category specified in this paragraph:

(1) Manufactured home parks and recreational camping areas with public swimming pools and spas shall pay the appropriate fees specified in section 157.16.

(2) Individual private sewer or water, $60. "Individual private water" means a fee category with a water supply other than a community public water supply as defined in Minnesota Rules, chapter 4720. "Individual private sewer" means a fee category with a subsurface sewage treatment system which uses subsurface treatment and disposal.

(d) The following fees must accompany a plan review application for initial construction of a manufactured home park or recreational camping area:

(1) for initial construction of less than 25 sites, $375;

(2) for initial construction of 25 to 99 sites, $400; and

(3) for initial construction of 100 or more sites, $500.

(e) The following fees must accompany a plan review application when an existing manufactured home park or recreational camping area is expanded:

(1) for expansion of less than 25 sites, $250;

(2) for expansion of 25 to 99 sites, $300; and

(3) for expansion of 100 or more sites, $450.

Sec. 98. Minnesota Statutes 2016, section 364.09, is amended to read:

364.09 EXCEPTIONS.

(a) This chapter does not apply to the licensing process for peace officers; to law enforcement agencies as defined in section 626.84, subdivision 1, paragraph (f); to fire protection agencies; to eligibility for a private detective or protective agent license; to the licensing and background study process under chapters 245A and 245C; to the licensing and background investigation process under chapter 240; to eligibility for school bus driver

endorsements; to eligibility for special transportation service endorsements; to eligibility for a commercial driver training instructor license, which is governed by section 171.35 and rules adopted under that section; to emergency medical services personnel, or to the licensing by political subdivisions of taxicab drivers, if the applicant for the license has been discharged from sentence for a conviction within the ten years immediately preceding application of a violation of any of the following:

(1) sections 609.185 to 609.2114, 609.221 to 609.223, 609.342 to 609.3451, or 617.23, subdivision 2 or 3; or Minnesota Statutes 2012, section 609.21;

(2) any provision of chapter 152 that is punishable by a maximum sentence of 15 years or more; or

(3) a violation of chapter 169 or 169A involving driving under the influence, leaving the scene of an accident, or reckless or careless driving.

This chapter also shall not apply to eligibility for juvenile corrections employment, where the offense involved child physical or sexual abuse or criminal sexual conduct.

(b) This chapter does not apply to a school district or to eligibility for a license issued or renewed by the Board of Teaching or the commissioner of education.

(c) Nothing in this section precludes the Minnesota Police and Peace Officers Training Board or the state fire marshal from recommending policies set forth in this chapter to the attorney general for adoption in the attorney general's discretion to apply to law enforcement or fire protection agencies.

(d) This chapter does not apply to a license to practice medicine that has been denied or revoked by the Board of Medical Practice pursuant to section 147.091, subdivision 1a.

(e) This chapter does not apply to any person who has been denied a license to practice chiropractic or whose license to practice chiropractic has been revoked by the board in accordance with section 148.10, subdivision 7.

(f) This chapter does not apply to any license, registration, or permit that has been denied or revoked by the Board of Nursing in accordance with section 148.261, subdivision 1a.

(g) This chapter does not apply to any license, registration, permit, or certificate that has been denied or revoked by the commissioner of health according to section 148.5195, subdivision 5; 148.6448, subdivision 3; or 153A.15, subdivision 2.

~~(g)~~ (h) This chapter does not supersede a requirement under law to conduct a criminal history background investigation or consider criminal history records in hiring for particular types of employment.

Sec. 99. **REPEALER.**

Minnesota Statutes 2016, sections 103I.005, subdivisions 8, 14, and 15; 103I.451; and 144.0571, are repealed.

ARTICLE 11

HEALTH LICENSING BOARDS

Section 1. Minnesota Statutes 2016, section 144E.35, subdivision 1, is amended to read:

Subdivision 1. **Repayment for volunteer education.** A licensed ambulance service shall be reimbursed by the board for the necessary expense of the initial education of a volunteer ambulance attendant upon successful completion by the attendant of an EMT education course, or ~~a continuing~~ renewal education ~~course~~ for EMT care, or both, which has been approved by the board, pursuant to section 144E.285. Reimbursement may include tuition, transportation, food, lodging, hourly payment for the time spent ~~in~~ at the education ~~course~~, and other necessary expenditures, except that in no instance shall a volunteer ambulance attendant be reimbursed more than ~~$600~~ $900 for successful completion of an initial education course, and ~~$275~~ $350 for successful completion of ~~a continuing~~ renewal education ~~course~~.

Sec. 2. Minnesota Statutes 2016, section 147.01, subdivision 7, is amended to read:

Subd. 7. **Physician application ~~fee~~ and license fees.** (a) The board may charge ~~a~~ the following nonrefundable application and license fees processed pursuant to sections 147.02, 147.03, 147.037, 147.0375, and 147.38:

(1) physician application fee ~~of~~, $200~~.~~;

(2) physician annual registration renewal fee, $192;

(3) physician endorsement to other states, $40;

(4) physician emeritus license, $50;

(5) physician temporary licenses, $60;

(6) physician late fee, $60;

(7) duplicate license fee, $20;

(8) certification letter fee, $25;

(9) education or training program approval fee, $100;

(10) report creation and generation fee, $60;

(11) examination administration fee (half day), $50;

(12) examination administration fee (full day), $80; and

(13) fees developed by the Interstate Commission for determining physician qualification to register and participate in the interstate medical licensure compact, as established in rules authorized in and pursuant to section 147.38, not to exceed $1,000.

(b) The board may prorate the initial annual license fee. All licensees are required to pay the full fee upon license renewal. The revenue generated from the fee must be deposited in an account in the state government special revenue fund.

Sec. 3. Minnesota Statutes 2016, section 147.02, subdivision 1, is amended to read:

Subdivision 1. **United States or Canadian medical school graduates.** The board shall issue a license to practice medicine to a person not currently licensed in another state or Canada and who meets the requirements in paragraphs (a) to (i).

(a) An applicant for a license shall file a written application on forms provided by the board, showing to the board's satisfaction that the applicant is of good moral character and satisfies the requirements of this section.

(b) The applicant shall present evidence satisfactory to the board of being a graduate of a medical or osteopathic medical school located in the United States, its territories or Canada, and approved by the board based upon its faculty, curriculum, facilities, accreditation by a recognized national accrediting organization approved by the board, and other relevant data, or is currently enrolled in the final year of study at the school.

(c) The applicant must have passed an examination as described in clause (1) or (2).

(1) The applicant must have passed a comprehensive examination for initial licensure prepared and graded by the National Board of Medical Examiners, the Federation of State Medical Boards, the Medical Council of Canada, the National Board of Osteopathic Examiners, or the appropriate state board that the board determines acceptable. The board shall by rule determine what constitutes a passing score in the examination.

(2) The applicant taking the United States Medical Licensing Examination (USMLE) or Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA) must

have passed steps or levels one, two, and three. Step or level three must be passed within five years of passing step or level two, or before the end of residency training. The applicant must pass each of steps or levels one, two, and three with passing scores as recommended by the USMLE program or National Board of Osteopathic Medical Examiners within three attempts. The applicant taking combinations of Federation of State Medical Boards, National Board of Medical Examiners, and USMLE may be accepted only if the combination is approved by the board as comparable to existing comparable examination sequences and all examinations are completed prior to the year 2000.

(d) The applicant shall present evidence satisfactory to the board of the completion of one year of graduate, clinical medical training in a program accredited by a national accrediting organization approved by the board or other graduate training approved in advance by the board as meeting standards similar to those of a national accrediting organization.

(e) The applicant may make arrangements with the executive director to appear in person before the board or its designated representative to show that the applicant satisfies the requirements of this section. The board may establish as internal operating procedures the procedures or requirements for the applicant's personal presentation.

(f) The applicant shall pay a nonrefundable fee established by the board ~~by rule~~. ~~The fee may not be refunded.~~ Upon application or notice of license renewal, the board must provide notice to the applicant and to the person whose license is scheduled to be issued or renewed of any additional fees, surcharges, or other costs which the person is obligated to pay as a condition of licensure. The notice must:

(1) state the dollar amount of the additional costs; and

(2) clearly identify to the applicant the payment schedule of additional costs.

(g) The applicant must not be under license suspension or revocation by the licensing board of the state or jurisdiction in which the conduct that caused the suspension or revocation occurred.

(h) The applicant must not have engaged in conduct warranting disciplinary action against a licensee, or have been subject to disciplinary action other than as specified in paragraph (g). If the applicant does not satisfy the requirements stated in this paragraph, the board may issue a license only on the applicant's showing that the public will be protected through issuance of a license with conditions and limitations the board considers appropriate.

(i) If the examination in paragraph (c) was passed more than ten years ago, the applicant must either:

(1) pass the special purpose examination of the Federation of State Medical Boards with a score of 75 or better within three attempts; or

(2) have a current certification by a specialty board of the American Board of Medical Specialties, of the American Osteopathic Association, the Royal College of Physicians and Surgeons of Canada, or of the College of Family Physicians of Canada.

Sec. 4. Minnesota Statutes 2016, section 147.03, subdivision 1, is amended to read:

Subdivision 1. **Endorsement; reciprocity.** (a) The board may issue a license to practice medicine to any person who satisfies the requirements in paragraphs (b) to (f).

(b) The applicant shall satisfy all the requirements established in section 147.02, subdivision 1, paragraphs (a), (b), (d), (e), and (f).

(c) The applicant shall:

(1) have passed an examination prepared and graded by the Federation of State Medical Boards, the National Board of Medical Examiners, or the United States Medical Licensing Examination (USMLE) program in accordance with section 147.02, subdivision 1, paragraph (c), clause (2); the National Board of Osteopathic Medical Examiners; or the Medical Council of Canada; and

(2) have a current license from the equivalent licensing agency in another state or Canada and, if the examination in clause (1) was passed more than ten years ago, either:

(i) pass the Special Purpose Examination of the Federation of State Medical Boards with a score of 75 or better within three attempts; or

(ii) have a current certification by a specialty board of the American Board of Medical Specialties, of the American Osteopathic Association, the Royal College of Physicians and Surgeons of Canada, or of the College of Family Physicians of Canada; or

(3) if the applicant fails to meet the requirement established in section 147.02, subdivision 1, paragraph (c), clause (2), because the applicant failed to pass each of steps one, two, and three of the USMLE within the required three attempts, the applicant may be granted a license provided the applicant:

(i) has passed each of steps one, two, and three with passing scores as recommended by the USMLE program within no more than four attempts for any of the three steps;

(ii) is currently licensed in another state; and

(iii) has current certification by a specialty board of the American Board of Medical Specialties, the American Osteopathic Association Bureau of Professional Education, the Royal College of Physicians and Surgeons of Canada, or the College of Family Physicians of Canada.

~~(d) The applicant shall pay a fee established by the board by rule. The fee may not be refunded.~~

~~(e)~~ (d) The applicant must not be under license suspension or revocation by the licensing board of the state or jurisdiction in which the conduct that caused the suspension or revocation occurred.

~~(f)~~ (e) The applicant must not have engaged in conduct warranting disciplinary action against a licensee, or have been subject to disciplinary action other than as specified in paragraph (e). If an applicant does not satisfy the requirements stated in this paragraph, the board may issue a license only on the applicant's showing that the public will be protected through issuance of a license with conditions or limitations the board considers appropriate.

~~(g)~~ (f) Upon the request of an applicant, the board may conduct the final interview of the applicant by teleconference.

Sec. 5. **[147A.28] PHYSICIAN ASSISTANT APPLICATION AND LICENSE FEES.**

(a) The board may charge the following nonrefundable fees:

(1) physician assistant application fee, $120;

(2) physician assistant annual registration renewal fee (prescribing authority), $135;

(3) physician assistant annual registration renewal fee (no prescribing authority), $115;

(4) physician assistant temporary registration, $115;

(5) physician assistant temporary permit, $60;

(6) physician assistant locum tenens permit, $25;

(7) physician assistant late fee, $50;

(8) duplicate license fee, $20;

(9) certification letter fee, $25;

(10) education or training program approval fee, $100; and

(11) report creation and generation fee, $60.

(b) The board may prorate the initial annual license fee. All licensees are required to pay the full fee upon license renewal. The revenue generated from the fees must be deposited in an account in the state government special revenue fund.

Sec. 6. Minnesota Statutes 2016, section 147B.08, is amended by adding a subdivision to read:

Subd. 4. **Acupuncturist application and license fees.** (a) The board may charge the following nonrefundable fees:

(1) acupuncturist application fee, $150;

(2) acupuncturist annual registration renewal fee, $150;

(3) acupuncturist temporary registration fee, $60;

(4) acupuncturist inactive status fee, $50;

(5) acupuncturist late fee, $50;

(6) duplicate license fee, $20;

(7) certification letter fee, $25;

(8) education or training program approval fee, $100; and

(9) report creation and generation fee, $60.

(b) The board may prorate the initial annual license fee. All licensees are required to pay the full fee upon license renewal. The revenue generated from the fees must be deposited in an account in the state government special revenue fund.

Sec. 7. Minnesota Statutes 2016, section 147C.40, is amended by adding a subdivision to read:

Subd. 5. **Respiratory therapist application and license fees.** (a) The board may charge the following nonrefundable fees:

(1) respiratory therapist application fee, $100;

(2) respiratory therapist annual registration renewal fee, $90;

(3) respiratory therapist inactive status fee, $50;

(4) respiratory therapist temporary registration fee, $90;

(5) respiratory therapist temporary permit, $60;

(6) respiratory therapist late fee, $50;

(7) duplicate license fee, $20;

(8) certification letter fee, $25;

(9) education or training program approval fee, $100; and

(10) report creation and generation fee, $60.

(b) The board may prorate the initial annual license fee. All licensees are required to pay the full fee upon license renewal. The revenue generated from the fees must be deposited in an account in the state government special revenue fund.

Sec. 8. Minnesota Statutes 2016, section 148.59, is amended to read:

148.59 LICENSE RENEWAL; LICENSE AND REGISTRATION FEES.

A licensed optometrist shall pay to the state Board of Optometry a fee as set by the board in order to renew a license as provided by board rule. No fees shall be refunded. Fees may not exceed the following amounts but may be adjusted lower by board direction and are for the exclusive use of the board:

(1) optometry licensure application, $160;

(2) optometry annual licensure renewal, ~~$135~~ $170;

(3) optometry late penalty fee, $75;

(4) annual license renewal card, $10;

(5) continuing education provider application, $45;

(6) emeritus registration, $10;

(7) endorsement/reciprocity application, $160;

(8) replacement of initial license, $12; ~~and~~

(9) license verification, $50~~.~~;

(10) jurisprudence state examination, $75;

(11) Optometric Education Continuing Education data bank registration, $20; and

(12) data requests and labels, $50.

Sec. 9. Minnesota Statutes 2016, section 148E.180, is amended to read:

148E.180 FEE AMOUNTS.

Subdivision 1. **Application fees.** Nonrefundable application fees for licensure ~~are as follows~~ may not exceed the following amounts but may be adjusted lower by board action:

(1) for a licensed social worker, ~~$45~~ $75;

(2) for a licensed graduate social worker, ~~$45~~ $75;

(3) for a licensed independent social worker, ~~$45~~ $75;

(4) for a licensed independent clinical social worker, ~~$45~~ $75;

(5) for a temporary license, $50; and

(6) for a ~~licensure~~ license by endorsement, ~~$85~~ $115.

The fee for criminal background checks is the fee charged by the Bureau of Criminal Apprehension. The criminal background check fee must be included with the application fee as required according to section 148E.055.

Subd. 2. **License fees.** Nonrefundable license fees ~~are as follows~~ may not exceed the following amounts but may be adjusted lower by board action:

(1) for a licensed social worker, ~~$81~~ $115;

(2) for a licensed graduate social worker, ~~$144~~ $210;

(3) for a licensed independent social worker, ~~$216~~ $305;

(4) for a licensed independent clinical social worker, ~~$238.50~~ $335;

(5) for an emeritus inactive license, ~~$43.20~~ $65;

(6) for an emeritus active license, one-half of the renewal fee specified in subdivision 3; and

(7) for a temporary leave fee, the same as the renewal fee specified in subdivision 3.

If the licensee's initial license term is less or more than 24 months, the required license fees must be prorated proportionately.

Subd. 3. **Renewal fees.** Nonrefundable renewal fees for ~~licensure are as follows~~ the two-year renewal term may not exceed the following amounts but may be adjusted lower by board action:

(1) for a licensed social worker, ~~$81~~ $115;

(2) for a licensed graduate social worker, ~~$144~~ $210;

(3) for a licensed independent social worker, ~~$216~~ $305; and

(4) for a licensed independent clinical social worker, ~~$238.50~~ $335.

Subd. 4. **Continuing education provider fees.** Continuing education provider fees are ~~as follows~~ the following nonrefundable amounts:

(1) for a provider who offers programs totaling one to eight clock hours in a one-year period according to section 148E.145, $50;

(2) for a provider who offers programs totaling nine to 16 clock hours in a one-year period according to section 148E.145, $100;

(3) for a provider who offers programs totaling 17 to 32 clock hours in a one-year period according to section 148E.145, $200;

(4) for a provider who offers programs totaling 33 to 48 clock hours in a one-year period according to section 148E.145, $400; and

(5) for a provider who offers programs totaling 49 or more clock hours in a one-year period according to section 148E.145, $600.

Subd. 5. **Late fees.** Late fees are ~~as follows~~ the following nonrefundable amounts:

(1) renewal late fee, one-fourth of the renewal fee specified in subdivision 3;

(2) supervision plan late fee, $40; and

(3) license late fee, $100 plus the prorated share of the license fee specified in subdivision 2 for the number of months during which the individual practiced social work without a license.

Subd. 6. **License cards and wall certificates.** (a) The fee for a license card as specified in section 148E.095 is $10.

(b) The fee for a license wall certificate as specified in section 148E.095 is $30.

Subd. 7. **Reactivation fees.** Reactivation fees are ~~as follows~~ the following nonrefundable amounts:

(1) reactivation from a temporary leave or emeritus status, the prorated share of the renewal fee specified in subdivision 3; and

(2) reactivation of an expired license, 1-1/2 times the renewal fees specified in subdivision 3.

Sec. 10. **REPEALER.**

(a) Minnesota Statutes 2016, sections 147A.21; 147B.08, subdivisions 1, 2, and 3; and 147C.40, subdivisions 1, 2, 3, and 4, are repealed.

(b) Minnesota Rules, part 5600.2500, is repealed.

ARTICLE 12

APPROPRIATIONS

Section 1. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are appropriated to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2018" and "2019" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2018, or June 30, 2019, respectively. "The first year" is fiscal year 2018. "The second year" is fiscal year 2019. "The biennium" is fiscal years 2018 and 2019.

	APPROPRIATIONS	
	Available for the Year	
	Ending June 30	
	2018	**2019**

Sec. 2. **COMMISSIONER OF HUMAN SERVICES**

Subdivision 1. **Total Appropriation**	**$**	**7,591,115,000**	**$** **7,941,222,000**

Appropriations by Fund

	2018	2019
General	6,663,399,000	7,027,393,000
State Government Special Revenue	8,194,000	7,994,000
Health Care Access	639,575,000	643,442,000
Federal TANF	278,051,000	260,497,000
Lottery Prize	1,896,000	1,896,000

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **TANF Maintenance of Effort**

(a) The commissioner shall ensure that sufficient qualified nonfederal expenditures are made each year to meet the state's maintenance of effort (MOE) requirements of the TANF block grant specified under Code of Federal Regulations, title 45, section 263.1. In order to meet these basic TANF/MOE requirements, the commissioner may report as TANF/MOE expenditures only nonfederal money expended for allowable activities listed in the following clauses:

(1) MFIP cash, diversionary work program, and food assistance benefits under Minnesota Statutes, chapter 256J;

(2) the child care assistance programs under Minnesota Statutes, sections 119B.03 and 119B.05, and county child care administrative costs under Minnesota Statutes, section 119B.15;

(3) state and county MFIP administrative costs under Minnesota Statutes, chapters 256J and 256K;

(4) state, county, and tribal MFIP employment services under Minnesota Statutes, chapters 256J and 256K;

(5) expenditures made on behalf of legal noncitizen MFIP recipients who qualify for the MinnesotaCare program under Minnesota Statutes, chapter 256L;

(6) qualifying working family credit expenditures under Minnesota Statutes, section 290.0671;

(7) qualifying Minnesota education credit expenditures under Minnesota Statutes, section 290.0674; and

(8) qualifying Head Start expenditures under Minnesota Statutes, section 119A.50.

(b) For the activities listed in paragraph (a), clauses (2) to (8), the commissioner may report only expenditures that are excluded from the definition of assistance under Code of Federal Regulations, title 45, section 260.31.

(c) The commissioner shall ensure that the MOE used by the commissioner of management and budget for the February and November forecasts required under Minnesota Statutes, section 16A.103, contains expenditures under paragraph (a), clause (1), equal to at least 16 percent of the total required under Code of Federal Regulations, title 45, section 263.1.

(d) The commissioner may not claim an amount of TANF/MOE in excess of the 75 percent standard in Code of Federal Regulations, title 45, section 263.1(a)(2), except:

(1) to the extent necessary to meet the 80 percent standard under Code of Federal Regulations, title 45, section 263.1(a)(1), if it is determined by the commissioner that the state will not meet the TANF work participation target rate for the current year;

(2) to provide any additional amounts under Code of Federal Regulations, title 45, section 264.5, that relate to replacement of TANF funds due to the operation of TANF penalties; and

(3) to provide any additional amounts that may contribute to avoiding or reducing TANF work participation penalties through the operation of the excess MOE provisions of Code of Federal Regulations, title 45, section 261.43 (a)(2).

(e) For the purposes of paragraph (d), the commissioner may supplement the MOE claim with working family credit expenditures or other qualified expenditures to the extent such expenditures are otherwise available after considering the expenditures allowed in this subdivision.

(f) The requirement in Minnesota Statutes, section 256.011, subdivision 3, that federal grants or aids secured or obtained under that subdivision be used to reduce any direct appropriations provided by law, does not apply if the grants or aids are federal TANF funds.

(g) **IT Appropriations Generally.** This appropriation includes funds for information technology projects, services, and support. Notwithstanding Minnesota Statutes, section 16E.0466, funding for information technology project costs shall be incorporated into the service level agreement and paid to the Office of MN.IT Services by the Department of Human Services under the rates and mechanism specified in that agreement.

(h) **Receipts for Systems Project.** Appropriations and federal receipts for information systems projects for MAXIS, PRISM, MMIS, ISDS, METS, and SSIS must be deposited in the state systems account authorized in Minnesota Statutes, section 256.014. Money appropriated for computer projects approved by the commissioner of the Office of MN.IT Services, funded by the legislature, and approved by the commissioner of management and budget may be transferred from one project to another and from development to operations as the commissioner of human services considers necessary. Any unexpended balance in the appropriation for these projects does not cancel and is available for ongoing development and operations.

Subd. 3. **Central Office; Operations**

	Appropriations by Fund	
General	133,248,000	133,652,000
State Government Special Revenue	8,069,000	7,869,000
Health Care Access	23,618,000	21,516,000
Federal TANF	100,000	100,000

(a) **Administrative Recovery; Set-Aside.** The commissioner may invoice local entities through the SWIFT accounting system as an alternative means to recover the actual cost of administering the following provisions:

(1) Minnesota Statutes, section 125A.744, subdivision 3;

(2) Minnesota Statutes, section 245.495, paragraph (b);

(3) Minnesota Statutes, section 256B.0625, subdivision 20, paragraph (k);

(4) Minnesota Statutes, section 256B.0924, subdivision 6, paragraph (g);

(5) Minnesota Statutes, section 256B.0945, subdivision 4, paragraph (d); and

(6) Minnesota Statutes, section 256F.10, subdivision 6, paragraph (b).

(b) **Base Level Adjustments.** The general fund base is $139,064,000 in fiscal year 2020 and $139,010,000 in fiscal year 2021.

Subd. 4. **Central Office; Children and Families**

	Appropriations by Fund	
General	10,520,000	10,331,000
Federal TANF	2,582,000	2,582,000

(a) **Financial Institution Data Match and Payment of Fees.** The commissioner is authorized to allocate up to $310,000 each year in fiscal year 2018 and fiscal year 2019 from the systems special revenue account to make payments to financial institutions in exchange for performing data matches between account information held by financial institutions and the public authority's database of child support obligors as authorized by Minnesota Statutes, section 13B.06, subdivision 7.

(b) **Base Level Adjustment.** The general fund base is $11,129,000 in fiscal year 2020 and $11,042,000 in fiscal year 2021.

Subd. 5. **Central Office; Health Care**

	Appropriations by Fund	
General	21,709,000	21,714,000
Health Care Access	33,931,000	23,984,000

Rates Study. $350,000 in fiscal year 2018 is for the medical assistance payment rate study required under article 4, section 64. This is a onetime appropriation.

Trust Guide. $200,000 in fiscal year 2018 and $150,000 in fiscal year 2019 are for the development of a special needs trust guide that directs the state medical assistance program's trust recovery process and establishes guidelines for the public. This is a onetime appropriation.

Base Level Adjustments. The general fund base is $21,470,000 in fiscal year 2020 and $21,515,000 in fiscal year 2021. The health care access fund base is $24,000,000 in fiscal year 2020 and $24,000,000 in fiscal year 2021.

Subd. 6. **Central Office; Continuing Care for Older Adults**

	Appropriations by Fund	
General	17,652,000	18,089,000
State Government Special Revenue	125,000	125,000

Base Level Adjustment. The general fund base is $21,352,000 in fiscal year 2020 and $17,045,000 in fiscal year 2021.

Assisted Living Report Card. Of these amounts, $4,402,000 in fiscal year 2020 is to collect data from residents of housing with services establishments with an assisted living designation on quality of life and quality of care to produce a report card under Minnesota Statutes, section 144G.02, subdivision 2. $4,402,000 is the base in each even year starting in fiscal year 2022.

Subd. 7. **Central Office; Community Supports**

	Appropriations by Fund	
General	31,028,000	28,675,000
Lottery Prize	163,000	163,000

Transportation Study. $250,000 in fiscal year 2018 and $250,000 in fiscal year 2019 are for the transportation study required under article 1, section 36. This is a onetime appropriation.

Waiver Consolidation Study. $110,000 in fiscal year 2018 and $140,000 in fiscal year 2019 are to conduct a study on consolidating the four disability home and community-based services waivers into one program. The commissioner of human services shall submit recommendations to the chairs and ranking minority members of the legislative committees with oversight over health and human services by January 15, 2019. This is a onetime appropriation.

Children's Mental Health Study. $125,000 in fiscal year 2018 and $125,000 in fiscal year 2019 are for children's mental health study under article 8, section 60. This is a onetime appropriation.

Substance Use Disorder System Study. $150,000 in fiscal year 2018 and $150,000 in fiscal year 2019 are for the substance use disorder system study required under article 8, section 59. This is a onetime appropriation.

Base Level Adjustment. The general fund base is $28,381,000 in fiscal year 2020 and $27,705,000 in fiscal year 2021. Of these amounts, $500,000 in fiscal year 2020 is to study and develop an individual budgeting

model for disability waiver recipients and those accessing services through consumer-directed community supports. The commissioner shall submit recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over these programs by January 15, 2021. This is a onetime appropriation.

Subd. 8. **Forecasted Programs; MFIP/DWP**

	Appropriations by Fund	
General	88,930,000	106,340,000
Federal TANF	92,732,000	75,025,000

Subd. 9. **Forecasted Programs; MFIP Child Care Assistance** 115,067,000 142,287,000

Subd. 10. **Forecasted Programs; General Assistance** 56,650,000 58,365,000

(a) **General Assistance Standard.** The commissioner shall set the monthly standard of assistance for general assistance units consisting of an adult recipient who is childless and unmarried or living apart from parents or a legal guardian at $203. The commissioner may reduce this amount according to Laws 1997, chapter 85, article 3, section 54.

(b) **Emergency General Assistance.** The amount appropriated for emergency general assistance is limited to no more than $6,729,812 in fiscal year 2018 and $6,729,812 in fiscal year 2019. Funds to counties shall be allocated by the commissioner using the allocation method under Minnesota Statutes, section 256D.06.

Subd. 11. **Forecasted Programs; Minnesota Supplemental Aid** 40,484,000 41,634,000

Subd. 12. **Forecasted Programs; Group Residential Housing** 167,426,000 177,460,000

Subd. 13. **Forecasted Programs; Northstar Care for Children** 83,622,000 111,432,000

Subd. 14. **Forecasted Programs; MinnesotaCare** 9,652,000 10,798,000

This appropriation is from the health care access fund.

Subd. 15. **Forecasted Programs; Medical Assistance**

Appropriations by Fund		
General	4,988,270,000	5,221,647,000
Health Care Access	568,159,000	582,929,000

(a) **Behavioral Health Services.** $1,000,000 each fiscal year is for behavioral health services provided by hospitals identified under Minnesota Statutes, section 256.969, subdivision 2b, paragraph (a), clause (4). The increase in payments shall be made by increasing the adjustment under Minnesota Statutes, section 256.969, subdivision 2b, paragraph (e), clause (2).

(b) **Base Level Adjustment.** The health care access fund base for medical assistance is $798,429,000 in fiscal year 2020 and $798,429,000 in fiscal year 2021.

Subd. 16. **Forecasted Programs; Alternative Care** 44,442,000 45,123,000

Alternative Care Transfer. Any money allocated to the alternative care program that is not spent for the purposes indicated does not cancel but must be transferred to the medical assistance account.

Subd. 17. **Forecasted Programs; Chemical Dependency Treatment Fund** 111,844,000 131,445,000

Subd. 18. **Grant Programs; Support Services Grants**

	Appropriations by Fund		
General	8,715,000	8,715,000	
Federal TANF	96,311,000	96,311,000	

Subd. 19. **Grant Programs; Basic Sliding Fee Child Care Assistance Grants** 55,879,000 68,609,000

Base Level Adjustment. The general fund base is $63,813,000 in fiscal year 2020 and $63,943,000 in fiscal year 2021.

Subd. 20. **Grant Programs; Child Care Development Grants** 1,737,000 1,737,000

Subd. 21. **Grant Programs; Child Support Enforcement Grants** 50,000 50,000

Subd. 22. **Grant Programs; Children's Services Grants**

Appropriations by Fund		
General	39,965,000	39,165,000
Federal TANF	140,000	140,000

(a) **Title IV-E Adoption Assistance.** Additional federal reimbursement to the state as a result of the Fostering Connections to Success and Increasing Adoptions Act's expanded eligibility for title IV-E adoption assistance is appropriated to the commissioner for postadoption services, including a parent-to-parent support network.

(b) **Adoption Assistance Incentive Grants.** Federal funds available during fiscal years 2018 and 2019 for adoption incentive grants are appropriated to the commissioner for postadoption services, including a parent-to-parent support network.

(c) **American Indian Child Welfare Initiative.** $800,000 in fiscal year 2018 is for planning efforts to expand the American Indian Child Welfare Initiative under

Minnesota Statutes, section 256.01, subdivision 14b. Of this amount, $400,000 is for a grant to the Mille Lacs Band of Ojibwe and $400,000 is for a grant to the Red Lake Nation. This is a onetime appropriation.

Subd. 23. **Grant Programs; Children and Community Service Grants**	58,201,000	58,201,000
Subd. 24. **Grant Programs; Children and Economic Support Grants**	32,430,000	32,640,000

(a) **Minnesota Food Assistance Program.** Unexpended funds for the Minnesota food assistance program for fiscal year 2018 do not cancel but are available for this purpose in fiscal year 2019.

(b) **Community Living Infrastructure.** $1,400,000 in fiscal year 2018 and $1,400,000 in fiscal year 2019 are for community living infrastructure grant allocations under article 2, section 17.

(c) **Housing Web Site Grant.** $150,000 in fiscal year 2018 and $150,000 in fiscal year 2019 are for a grant to a public or private entity to create and maintain a Web site and application to track real-time housing openings for people with disabilities.

(d) **Housing Benefit Web Site.** $130,000 in fiscal year 2018 and $130,000 in fiscal year 2019 are to operate the housing benefit 101 Web site to help people who need affordable housing, and supports to maintain that housing, understand the range of housing options and support services available.

(e) **Child Care Inspections.** $2,400,000 in fiscal year 2018 and $2,400,000 in fiscal year 2019 are for grants to counties to conduct

annual inspections of family child care providers licensed under Minnesota Statutes, chapter 245A, and Minnesota Rules, chapter 9502.

(f) **Base Level Adjustment.** The general fund base is $32,740,000 in fiscal year 2020 and $33,840,000 in fiscal year 2021.

Subd. 25. **Grant Programs; Health Care Grants**

	Appropriations by Fund	
General	4,244,000	3,961,000
Health Care Access	3,465,000	3,465,000

Health Information Exchanges. $125,000 in fiscal year 2018 and $250,000 in fiscal year 2019 are for the nonfederal share of health information exchange grants to eligible health care providers.

Navigator Payments. The health care access fund base for navigator grants is decreased by $1,000,000 in fiscal year 2018 and $1,000,000 in fiscal year 2019. The health care access fund base for navigator grants is increased by $1,000,000 in fiscal year 2018 and $1,000,000 in fiscal year 2019 for increased navigator payments as required under article 4, section 5.

Subd. 26. **Grant Programs; Other Long-Term Care Grants** 1,500,000 1,925,000

Subd. 27. **Grant Programs; Aging and Adult Services Grants** 31,339,000 32,594,000

Individual Provider Registry. $375,000 in fiscal year 2018 and $375,000 in fiscal year 2019 are for the registry of individual providers of direct support services as defined in Minnesota Statutes, section 256B.0711, subdivision 1.

Base Level Adjustment. The general fund base is $33,403,000 in fiscal year 2020 and $33,152,000 in fiscal year 2021. Of these amounts, $334,000 in fiscal year 2020 and $477,000 in fiscal year 2021 are appropriated to the Minnesota Board on Aging for self-directed caregiver grants under article 3, section 7.

Subd. 28. **Grant Programs; Deaf and Hard-of-Hearing Grants** 2,675,000 2,675,000

Expanded Services Grants. $800,000 in fiscal year 2018 and $800,000 in fiscal year 2019 are for deaf and hard-of-hearing grants. The funds must be used to:

(1) provide linguistically and culturally appropriate mental health services for children who are deaf, children who are deafblind, and children who are hard-of-hearing in northwestern and northeastern Minnesota;

(2) provide psychiatric services statewide for people who are deaf, people who are deafblind, and people who are hard-of-hearing; and

(3) provide services and assistive technology for people who are deafblind throughout Minnesota.

Subd. 29. **Grant Programs; Disabilities Grants** 21,372,000 24,122,000

Training of Direct Support Services Providers. $400,000 in fiscal year 2018 and $400,000 in fiscal year 2019 are for training and orientation of individual providers of direct support services as defined in Minnesota Statutes, section 256B.0711, subdivision 1. This is a onetime appropriation. This

appropriation is not available until the labor agreement between the state of Minnesota and the Service Employees International Union Healthcare Minnesota under Minnesota Statutes, section 179A.54, is implemented under Minnesota Statutes, sections 3.855 and 179A.22. The funding is available in either year of the biennium and is available until June 30, 2021.

Stipends for Direct Support Services Providers. $2,750,000 in fiscal year 2019 is for training of individual providers of direct support services as defined in Minnesota Statutes, section 256B.0711, subdivision 1. Of this amount, $2,500,000 shall only be used for stipends of $500 for up to 5,000 individual providers who have completed designated, voluntary trainings. Up to $250,000 may be used by the grantee for grant administration. This appropriation is not available until the labor agreement between the state of Minnesota and the Service Employees International Union Healthcare Minnesota under Minnesota Statutes, section 179A.54, is implemented under Minnesota Statutes, sections 3.855 and 179A.22. If made available, this appropriation is onetime and is available until June 30, 2021.

Base Level Adjustment. The general fund base is $20,972,000 in fiscal year 2020 and $20,972,000 in fiscal year 2021.

Subd. 30. **Grant Programs; Adult Mental Health Grants**

	Appropriations by Fund	
General	82,622,000	82,622,000

Health Care Access	750,000	750,000	

Community Mental Health Grants. $2,820,000 in fiscal year 2018 and $2,820,000 in fiscal year 2019 are for grants to counties to build and expand community-based mental health infrastructure under Minnesota Statutes, section 245.4661, subdivision 9.

Subd. 31. **Grant Programs; Child Mental Health Grants** 20,761,000 20,826,000

Subd. 32. **Grant Programs; Chemical Dependency Treatment Support Grants**

Appropriations by Fund		
General	2,136,000	2,136,000
Lottery Prize	1,733,000	1,733,000

Problem Gambling. $225,000 in fiscal year 2018 and $225,000 in fiscal year 2019 are from the lottery prize fund for a grant to the state affiliate recognized by the National Council on Problem Gambling. The affiliate must provide services to increase public awareness of problem gambling, education, and training for individuals and organizations providing effective treatment services to problem gamblers and their families, and research related to problem gambling.

Subd. 33. **Direct Care and Treatment - Generally**

(a) **Transfer Authority.** Money appropriated to budget activities under subdivisions 34, 35, 36, 37, and 38 may be transferred between budget activities and between years of the biennium with the approval of the commissioner of management and budget.

(b) **Dedicated Receipts Available.** Of the revenue received under Minnesota Statutes, section 246.18, subdivision 8, paragraph (a),

up to $1,000,000 each year is available for the purposes of Minnesota Statutes, section 246.18, subdivision 8, paragraph (b), clause (1); and up to $2,713,000 each year is available for the purposes of Minnesota Statutes, section 246.18, subdivision 8, paragraph (b), clause (2).

Subd. 34. **Direct Care and Treatment - Mental Health and Substance Abuse** 119,711,000 123,004,000

DCT Operating Adjustment (CARE). $431,000 in fiscal year 2018 and $835,000 in fiscal year 2019 are from the general fund for Community Addiction Recover Enterprise (CARE) operating adjustments. The commissioner must transfer $431,000 in fiscal year 2018 and $835,000 in fiscal year 2019 to the enterprise fund for CARE.

Base Level Adjustment. The general fund base is $128,143,000 in fiscal year 2020 and $128,143,000 in fiscal year 2021.

Subd. 35. **Direct Care and Treatment - Community-Based Services** 25,806,000 23,099,000

DCT Operating Adjustment (MSOCS). $2,284,000 in fiscal year 2018 and $4,448,000 in fiscal year 2019 are from the general fund for Minnesota State Operated Community Services (MSOCS) operating adjustments. The commissioner must transfer $2,284,000 in fiscal year 2018 and $4,448,000 in fiscal year 2019 to the enterprise fund for MSOCS.

MSOCS Sustainability. $7,697,000 in fiscal year 2018 and $2,588,000 in fiscal year 2019 are from the general fund for the Minnesota State Operated Community Services program. Of this amount, the commissioner must

transfer $6,697,000 in fiscal year 2018 and $1,588,000 in fiscal year 2019 to the enterprise fund for Minnesota State Operated Community Services. $1,000,000 is available each year of the biennium for start-up expenses for new residential homes to be operated by Minnesota State Operated Community Services.

Base Level Adjustment. The general fund base is $23,099,000 in fiscal year 2020 and $21,511,000 in fiscal year 2021.

Subd. 36. **Direct Care and Treatment - Forensic Services**	103,080,000	109,567,000

Base Level Adjustment. The general fund base is $112,437,000 in fiscal year 2020 and $115,046,000 in fiscal year 2021.

Subd. 37. **Direct Care and Treatment - Sex Offender Program**	91,283,000	93,137,000

Transfer Authority. Money appropriated for the Minnesota sex offender program may be transferred between fiscal years of the biennium with the approval of the commissioner of management and budget.

Minnesota State Industries Enterprise Fund. Funds remaining in the Minnesota state industries enterprise fund on September 30, 2017, shall be transferred to the Minnesota sex offender program vocational work program established under Minnesota Statutes, section 246B.05.

Subd. 38. **Direct Care and Treatment - Operations**	49,001,000	50,415,000

Base Level Adjustment. The general fund base is $51,202,000 in fiscal year 2020 and $51,463,000 in fiscal year 2021.

Subd. 39. **Technical Activities**	86,186,000	86,339,000

(a) This appropriation is from the federal TANF fund.

(b) **Base Level Adjustment.** The TANF fund appropriation is $86,346,000 in fiscal year 2020 and $86,355,000 in fiscal year 2021.

Sec. 3. **COMMISSIONER OF HEALTH**

Subdivision 1. **Total Appropriation**		**$**	**216,850,000**	**$** **220,396,000**

Appropriations by Fund

	2018	2019
General	112,229,000	114,430,000
State Government Special Revenue	56,265,000	57,995,000
Health Care Access	36,643,000	36,258,000
Federal TANF	11,713,000	11,713,000

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Health Improvement**

Appropriations by Fund

General	87,066,000	88,388,000
State Government Special Revenue	6,319,000	6,286,000
Health Care Access	36,643,000	36,258,000
Federal TANF	11,713,000	11,713,000

(a) **Home Visiting for Pregnant and Parenting Teens.** $12,478,000 in fiscal year 2018 and $18,522,000 in fiscal year 2019 are from the general fund for home visiting services to pregnant and parenting teens.

(b) **Opioid Overdose Prevention.** $4,000,000 in fiscal year 2018 is from the general fund for a root-cause approach to reduce opioid misuse in American Indian communities. This is a onetime appropriation.

(c) **Community-Driven Data.** $1,000,000 in fiscal year 2018 is from the general fund to align public health data with community needs. This is a onetime appropriation.

(d) **Medical Cannabis.** $150,000 in fiscal year 2018 and $150,000 in fiscal year 2019 are added to the general fund appropriation for the medical cannabis program.

(e) **TANF Appropriations.** (1) $1,156,000 of the TANF fund is appropriated each year of the biennium to the commissioner for family planning grants under Minnesota Statutes, section 145.925.

(2) $3,579,000 of the TANF fund is appropriated each year of the biennium to the commissioner for home visiting and nutritional services listed under Minnesota Statutes, section 145.882, subdivision 7, clauses (6) and (7). Funds must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1.

(3) $2,000,000 of the TANF fund is appropriated each year of the biennium to the commissioner for decreasing racial and ethnic disparities in infant mortality rates under Minnesota Statutes, section 145.928, subdivision 7.

(4) $4,978,000 of the TANF fund is appropriated each year of the biennium to the commissioner for the family home visiting grant program according to Minnesota Statutes, section 145A.17. $4,000,000 of the funding must be distributed to community health boards according to Minnesota Statutes,

section 145A.131, subdivision 1. $978,000 of the funding must be distributed to tribal governments as provided in Minnesota Statutes, section 145A.14, subdivision 2a.

(5) The commissioner may use up to 6.23 percent of the funds appropriated each fiscal year to conduct the ongoing evaluations required under Minnesota Statutes, section 145A.17, subdivision 7, and training and technical assistance as required under Minnesota Statutes, section 145A.17, subdivisions 4 and 5.

(f) **TANF Carryforward.** Any unexpended balance of the TANF appropriation in the first year of the biennium does not cancel but is available for the second year.

(g) **Base Level Adjustments.** The general fund base is $95,316,000 in fiscal year 2020 and $95,366,000 in fiscal year 2021. The health care access fund base is $36,858,000 in fiscal year 2020 and $36,258,000 in fiscal year 2021.

Subd. 3. **Health Protection**

	Appropriations by Fund	
General	15,700,000	16,207,000
State Government Special Revenue	49,946,000	51,709,000

(a) **Water Infrastructure Review.** $230,000 in fiscal year 2018 and $230,000 in fiscal year 2019 are from the general fund for reviewing and inspecting drinking water improvement projects.

(b) **Vulnerable Adults in Health Care Settings.** $633,000 in fiscal year 2018 and

$559,000 in fiscal year 2019 are added to the appropriation from the general fund for regulating health care and home care settings.

(c) **Base Level Adjustment.** The general fund base is $16,596,000 in fiscal year 2020 and $16,506,000 in fiscal year 2021. The state government special revenue fund base is $52,083,000 in fiscal year 2020 and $52,119,000 in fiscal year 2021.

Subd. 4. **Health Operations**

	Appropriations by Fund	
General	9,463,000	9,835,000

Sec. 4. **HEALTH-RELATED BOARDS**

Subdivision 1. **Total Appropriation**	**$ 25,126,000**	**$ 23,319,000**

This appropriation is from the state government special revenue fund. The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Board of Chiropractic Examiners**	565,000	571,000

Base Level Adjustment. The base is $576,000 in fiscal year 2020 and $576,000 in fiscal year 2021.

Subd. 3. **Board of Dentistry**	1,396,000	1,408,000
Subd. 4. **Board of Dietetics and Nutrition Practice**	130,000	132,000
Subd. 5. **Board of Marriage and Family Therapy**	360,000	357,000

Base Level Adjustment. The base is $360,000 in fiscal year 2020 and $361,000 in fiscal year 2021.

Subd. 6. **Board of Medical Practice**	5,207,000	5,243,000

This appropriation includes $955,000 in fiscal year 2018 and $964,000 in fiscal year 2019 for the health professional services program.

The base for this program is $924,000 in fiscal year 2020 and $924,000 in fiscal year 2021.

Base Level Adjustment. The base is $5,205,000 in fiscal year 2020 and $5,205,000 in fiscal year 2021.

Subd. 7. **Board of Nursing**	6,380,000	4,783,000
Subd. 8. **Board of Nursing Home Administrators**	3,397,000	3,202,000

(a) **Administrative Services Unit - Operating Costs.** Of this appropriation, $2,260,000 in fiscal year 2018 and $2,287,000 in fiscal year 2019 are for operating costs of the administrative services unit. The administrative services unit may receive and expend reimbursements for services it performs for other agencies.

(b) **Administrative Services Unit - Volunteer Health Care Provider Program.** Of this appropriation, $150,000 in fiscal year 2018 and $150,000 in fiscal year 2019 are to pay for medical professional liability coverage required under Minnesota Statutes, section 214.40.

(c) **Administrative Services Unit - Retirement Costs.** Of this appropriation, $378,000 in fiscal year 2019 is a onetime appropriation to the administrative services unit to pay for the retirement costs of health-related board employees. This funding may be transferred to the health board incurring retirement costs. Any board that has an unexpended balance for an amount transferred under this paragraph shall transfer the unexpended amount to the administrative

services unit. These funds are available either year of the biennium.

(d) **Administrative Services Unit - Health-Related Licensing Boards Operating Costs.** Of this appropriation, $194,000 in fiscal year 2018 and $350,000 in fiscal year 2019 shall be transferred to the health-related boards funded under this section for operating costs. The administrative services unit shall determine transfer amounts in consultation with the health-related boards funded under this section.

(e) **Administrative Services Unit - Contested Cases and Other Legal Proceedings.** Of this appropriation, $200,000 in fiscal year 2018 and $200,000 in fiscal year 2019 are for costs of contested case hearings and other unanticipated costs of legal proceedings involving health-related boards funded under this section. Upon certification by a health-related board to the administrative services unit that costs will be incurred and that there is insufficient money available to pay for the costs out of money currently available to that board, the administrative services unit is authorized to transfer money from this appropriation to the board for payment of those costs with the approval of the commissioner of management and budget. The commissioner of management and budget must require any board that has an unexpended balance for an amount transferred under this paragraph to transfer the unexpended amount to the administrative services unit to be

deposited in the state government special revenue fund.

Subd. 9. **Board of Optometry**	173,000	174,000
Subd. 10. **Board of Pharmacy**	3,254,000	3,294,000

Base Level Adjustment. The base is $3,319,000 in fiscal year 2020 and $3,356,000 in fiscal year 2021.

Subd. 11. **Board of Physical Therapy**	507,000	508,000

Base Level Adjustment. The base is $510,000 in fiscal year 2020 and $512,000 in fiscal year 2021.

Subd. 12. **Board of Podiatric Medicine**	198,000	198,000
Subd. 13. **Board of Psychology**	1,220,000	1,240,000

Base Level Adjustment. The base is $1,247,000 in fiscal year 2020 and $1,247,000 in fiscal year 2021.

Subd. 14. **Board of Social Work**	1,254,000	1,246,000

Base Level Adjustment. The base is $1,248,000 in fiscal year 2020 and $1,250,000 in fiscal year 2021.

Subd. 15. **Board of Veterinary Medicine**	314,000	320,000

Base Level Adjustment. The base is $327,000 in fiscal year 2020 and $333,000 in fiscal year 2021.

Subd. 16. **Board of Behavioral Health and Therapy**	771,000	643,000

Sec. 5. **EMERGENCY MEDICAL SERVICES REGULATORY BOARD**	**$ 4,159,000**	**$ 4,088,000**

(a) **Cooper/Sams Volunteer Ambulance Program.** $950,000 in fiscal year 2018 and $950,000 in fiscal year 2019 are for the Cooper/Sams volunteer ambulance program under Minnesota Statutes, section 144E.40.

(1) Of this amount, $861,000 in fiscal year 2018 and $861,000 in fiscal year 2019 are for the ambulance service personnel longevity award and incentive program under Minnesota Statutes, section 144E.40.

(2) Of this amount, $89,000 in fiscal year 2018 and $89,000 in fiscal year 2019 are for the operations of the ambulance service personnel longevity award and incentive program under Minnesota Statutes, section 144E.40.

(b) **EMSRB Board Operations.** $1,954,000 in fiscal year 2018 and $1,883,000 in fiscal year 2019 are for board operations. The base for this program is $1,885,000 in fiscal year 2020 and $1,885,000 in fiscal year 2021.

(c) **Base Level Adjustment.** The base is $4,090,000 in fiscal year 2020 and $4,090,000 in fiscal year 2021.

(d) **Regional Grants.** $785,000 in fiscal year 2018 and $785,000 in fiscal year 2019 are for regional emergency medical services programs, to be distributed equally to the eight emergency medical service regions under Minnesota Statutes, section 144E.52.

(e) **Ambulance Training Grant.** $470,000 in fiscal year 2018 and $470,000 in fiscal year 2019 are for training grants under Minnesota Statutes, section 144E.35.

Sec. 6. **COUNCIL ON DISABILITY** **$ 1,002,000 $ 1,002,000**

Base Level Adjustment. The base is $966,000 in fiscal year 2020 and $968,000 in fiscal year 2021.

Sec. 7. **OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES** **$ 2,307,000 $ 2,327,000**

Sec. 8. **OMBUDSPERSONS FOR FAMILIES** **$ 543,000 $ 551,000**

Sec. 9. **TRANSFERS.**

Subdivision 1. **Grants.** The commissioner of human services, with the approval of the commissioner of management and budget, may transfer unencumbered appropriation balances for the biennium ending June 30, 2019, within fiscal years among the MFIP, general assistance, medical assistance, MinnesotaCare, MFIP child care assistance under Minnesota Statutes, section 119B.05, Minnesota supplemental aid, and group residential housing programs, the entitlement portion of Northstar Care for Children under Minnesota Statutes, chapter 256N, and the entitlement portion of the chemical dependency consolidated treatment fund, and between fiscal years of the biennium. The commissioner shall inform the chairs and ranking minority members of the senate Health and Human Services Finance Division and the house of representatives Health and Human Services Finance Committee quarterly about transfers made under this subdivision.

Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative money may be transferred within the Departments of Health and Human Services as the commissioners consider necessary, with the advance approval of the commissioner of management and budget. The commissioner shall inform the chairs and ranking minority members of the senate Health and Human Services Finance Division and the house of representatives Health and Human Services Finance Committee quarterly about transfers made under this subdivision.

Sec. 10. **INDIRECT COSTS NOT TO FUND PROGRAMS.**

The commissioners of health and human services shall not use indirect cost allocations to pay for the operational costs of any program for which they are responsible.

Sec. 11. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2019, unless a different expiration date is explicit.

Sec. 12. **EFFECTIVE DATE.**

This article is effective July 1, 2017, unless a different effective date is specified.

APPENDIX
Article locations in 17-2331

103I.005 DEFINITIONS.

Subd. 8. **Environmental bore hole.** "Environmental bore hole" means a hole or excavation in the ground that penetrates a confining layer or is greater than 25 feet in depth and enters or goes through a water bearing layer and is used to monitor or measure physical, chemical, radiological, or biological parameters without extracting water. An environmental bore hole also includes bore holes constructed for vapor recovery or venting systems. An environmental bore hole does not include a well, elevator shaft, exploratory boring, or monitoring well.

Subd. 14. **Monitoring well.** "Monitoring well" means an excavation that is drilled, cored, bored, washed, driven, dug, jetted, or otherwise constructed to extract groundwater for physical, chemical, or biological testing. "Monitoring well" includes a groundwater quality sampling well.

Subd. 15. **Monitoring well contractor.** "Monitoring well contractor" means a person who is registered by the commissioner to construct monitoring wells.

103I.451 ENVIRONMENTAL BORE HOLES.

An environmental bore hole must be constructed, sealed, and reported as prescribed by rule of the commissioner by a well contractor or a monitoring well contractor.

119B.07 USE OF MONEY.

(a) Money for persons listed in sections 119B.03, subdivision 3, and 119B.05, subdivision 1, shall be used to reduce the costs of child care for students, including the costs of child care for students while employed if enrolled in an eligible education program at the same time and making satisfactory progress towards completion of the program. Counties may not limit the duration of child care subsidies for a person in an employment or educational program, except when the person is found to be ineligible under the child care fund eligibility standards. Any limitation must be based on a person's employment plan in the case of an MFIP participant, and county policies included in the child care fund plan. The maximum length of time a student is eligible for child care assistance under the child care fund for education and training is no more than the time necessary to complete the credit requirements for an associate or baccalaureate degree as determined by the educational institution, excluding basic or remedial education programs needed to prepare for postsecondary education or employment.

(b) To be eligible, the student must be in good standing and be making satisfactory progress toward the degree. Time limitations for child care assistance do not apply to basic or remedial educational programs needed to prepare for postsecondary education or employment. These programs include: high school, general equivalency diploma, and English as a second language. Programs exempt from this time limit must not run concurrently with a postsecondary program. If an MFIP participant who is receiving MFIP child care assistance under this chapter moves to another county, continues to participate in educational or training programs authorized in their employment plans, and continues to be eligible for MFIP child care assistance under this chapter, the MFIP participant must receive continued child care assistance from the county responsible for their current employment plan, under section 256G.07.

119B.125 PROVIDER REQUIREMENTS.

Subd. 5. **Provisional payment.** After a county receives a completed application from a provider, the county may issue provisional authorization and payment to the provider during the time needed to determine whether to give final authorization to the provider.

119B.16 FAIR HEARING PROCESS.

Subd. 2. **Informal conference.** The county agency shall offer an informal conference to applicants and recipients adversely affected by an agency action to attempt to resolve the dispute. The county agency shall offer an informal conference to providers to whom the county agency has assigned responsibility for an overpayment in an attempt to resolve the dispute. The county agency or the provider may ask the family in whose case the overpayment arose to participate in the informal conference, but the family may refuse to do so. The county agency shall advise

adversely affected applicants, recipients, and providers that a request for a conference with the agency is optional and does not delay or replace the right to a fair hearing.

144.0571 INCLUSION OF OTHER HEALTH-RELATED OCCUPATIONS TO CRIMINAL BACKGROUND CHECKS.

(a) If the Department of Health is not reviewed by the Sunset Advisory Commission according to the schedule in section 3D.21, the commissioner of health, as the regulator for occupational therapy practitioners, speech-language pathologists, audiologists, and hearing instrument dispensers, shall require applicants for licensure or renewal to submit to a criminal history records check as required under section 214.075 for other health-related licensed occupations regulated by the health-related licensing boards.

(b) Any statutory changes necessary to include the commissioner of health to section 214.075 shall be included in the plan required in section 214.075, subdivision 8.

147A.21 RULEMAKING AUTHORITY.

The board shall adopt rules:

(1) setting license fees;

(2) setting renewal fees;

(3) setting fees for temporary licenses; and

(4) establishing renewal dates.

147B.08 FEES.

Subdivision 1. **Annual registration fee.** The board shall establish the fee of $150 for initial licensure and $150 annual licensure renewal. The board may prorate the initial licensure fee.

Subd. 2. **Penalty fee for late renewals.** The penalty fee for late submission for renewal application is $50.

Subd. 3. **Deposit.** Fees collected by the board under this section must be deposited in the state government special revenue fund.

147C.40 FEES.

Subdivision 1. **Fees.** The board shall adopt rules setting:

(1) licensure fees;

(2) renewal fees;

(3) late fees;

(4) inactive status fees; and

(5) fees for temporary permits.

Subd. 2. **Proration of fees.** The board may prorate the initial annual license fee. All licensees are required to pay the full fee upon license renewal.

Subd. 3. **Penalty fee for late renewals.** An application for license renewal submitted after the deadline must be accompanied by a late fee in addition to the required fees.

Subd. 4. **Nonrefundable fees.** All of the fees in subdivision 1 are nonrefundable.

245A.1915 OPIOID ADDICTION TREATMENT EDUCATION REQUIREMENT FOR PROVIDERS LICENSED TO PROVIDE CHEMICAL DEPENDENCY TREATMENT SERVICES.

All programs serving persons with substance use issues licensed by the commissioner must provide educational information concerning: treatment options for opioid addiction, including the use of a medication for the use of opioid addiction; and recognition of and response to opioid overdose and the use and administration of naloxone, to clients identified as having or seeking treatment for opioid addiction. The commissioner shall develop educational materials that are supported by research and updated periodically that must be used by programs to comply with this requirement.

245A.192 PROVIDERS LICENSED TO PROVIDE TREATMENT OF OPIOID ADDICTION.

Subdivision 1. **Scope.** (a) This section applies to services licensed under this chapter to provide treatment for opioid addiction. In addition to the requirements under Minnesota Rules,

parts 9530.6405 to 9530.6505, a program licensed to provide treatment of opioid addiction must meet the requirements in this section.

(b) Where a standard in this section differs from a standard in an otherwise applicable administrative rule, the standards of this section apply.

(c) When federal guidance or interpretations have been issued on federal standards or requirements also required under this section, the federal guidance or interpretations shall apply.

Subd. 2. **Definitions.** (a) For purposes of this section, the terms defined in this subdivision have the meanings given them.

(b) "Diversion" means the use of a medication for the treatment of opioid addiction being diverted from its intended use.

(c) "Guest dose or dosing" means the practice of administering a medication used for the treatment of opioid addiction to a person who is not a client of the program that is administering or dispensing the medication.

(d) "Medical director" means a physician, licensed to practice medicine in the jurisdiction in which the opioid treatment program is located, who assumes responsibility for administering all medical services performed by the program, either by performing them directly or by delegating specific responsibility to authorized program physicians and health care professionals functioning under the medical director's direct supervision.

(e) "Medication used for the treatment of opioid addiction" means a medication approved by the Food and Drug Administration for the treatment of opioid addiction.

(f) "Opioid treatment program" has the meaning given in Code of Federal Regulations, title 42, section 8.12, and includes programs licensed under Minnesota Rules, part 9530.6500.

(g) "Program" means an entity that is licensed under Minnesota Rules, part 9530.6500.

(h) "Unsupervised use" means the use of a medication for the treatment of opioid addiction dispensed for use by a client outside of the program setting. This is also referred to as a "take-home" dose.

(i) "Placing authority" has the meaning given in Minnesota Rules, part 9530.6605, subpart 21a.

(j) "Minnesota health care programs" has the meaning given in section 256B.0636.

Subd. 3. **Medication orders.** Prior to the program administering or dispensing a medication used for the treatment of opioid addiction:

(1) a client-specific order must be received from an appropriately credentialed physician who is enrolled as a Minnesota health care programs provider and meets all applicable provider standards;

(2) the signed order must be documented in the client's record; and

(3) if the physician that issued the order is not able to sign the order when issued, the unsigned order must be entered in the client record at the time it was received, and the physician must review the documentation and sign the order in the client's record within 72 hours of the medication being ordered. The license holder must report to the commissioner any medication error that endangers a patient's health, as determined by the medical director.

Subd. 3a. **High dose requirements.** A client being administered or dispensed a dose beyond that set forth in subdivision 5, paragraph (a), clause (1), that exceeds 150 milligrams of methadone or 24 milligrams of buprenorphine daily, and for each subsequent increase, must meet face-to-face with a prescribing physician. The meeting must occur before the administering or dispensing of the increased dose.

Subd. 4. **Drug testing.** Each client enrolled in the program must receive a minimum of eight random drug abuse tests per 12 months of treatment. These tests must be reasonably disbursed over the 12-month period. A license holder may elect to conduct more drug abuse tests.

Subd. 5. **Criteria for unsupervised use.** (a) To limit the potential for diversion of medication used for the treatment of opioid addiction to the illicit market, any such medications dispensed to patients for unsupervised use shall be subject to the following requirements:

(1) any patient in an opioid treatment program may receive a single take-home dose for a day that the clinic is closed for business, including Sundays and state and federal holidays; and

(2) treatment program decisions on dispensing medications used to treat opioid addiction to patients for unsupervised use beyond that set forth in clause (1) shall be determined by the medical director.

(b) A physician with authority to prescribe must consider the criteria in this subdivision in determining whether a client may be permitted unsupervised or take-home use of such medications. The criteria must also be considered when determining whether dispensing medication for a client's unsupervised use is appropriate to increase or to extend the amount of time between visits to the program. The criteria include:

(1) absence of recent abuse of drugs including but not limited to opioids, nonnarcotics, and alcohol;

(2) regularity of program attendance;

(3) absence of serious behavioral problems at the program;

(4) absence of known recent criminal activity such as drug dealing;

(5) stability of the client's home environment and social relationships;

(6) length of time in comprehensive maintenance treatment;

(7) reasonable assurance that take-home medication will be safely stored within the client's home; and

(8) whether the rehabilitative benefit the client derived from decreasing the frequency of program attendance outweighs the potential risks of diversion or unsupervised use.

(c) The determination, including the basis of the determination, must be consistent with the criteria in this subdivision and must be documented in the client's medical record.

Subd. 6. **Restrictions for unsupervised or take-home use of methadone hydrochloride.** (a) In cases where it is determined that a client meets the criteria in subdivision 5 and may be dispensed a medication used for the treatment of opioid addiction, the restrictions in paragraphs (b) to (g) must be followed when the medication to be dispensed is methadone hydrochloride.

(b) During the first 90 days of treatment, the take-home supply must be limited to a maximum of a single dose each week and the client shall ingest all other doses under direct supervision.

(c) In the second 90 days of treatment, the take-home supply must be limited to two doses per week.

(d) In the third 90 days of treatment, the take-home supply must not exceed three doses per week.

(e) In the remaining months of the first year, a client may be given a maximum six-day supply of take-home medication.

(f) After one year of continuous treatment, a client may be given a maximum two-week supply of take-home medication.

(g) After two years of continuous treatment, a client may be given a maximum one-month supply of take-home medication, but must make monthly visits.

Subd. 7. **Restriction exceptions.** When a license holder has reason to accelerate the number of unsupervised or take-home doses of methadone hydrochloride, the license holder must comply with the requirements of Code of Federal Regulations, title 42, section 8.12, the criteria for unsupervised use in subdivision 5, and must use the exception process provided by the federal Center for Substance Abuse Treatment Division of Pharmacologic Therapies. For the purposes of enforcement of this subdivision, the commissioner has the authority to monitor for compliance with these federal regulations and may issue licensing actions according to sections 245A.05, 245A.06, and 245A.07 based on the commissioner's determination of noncompliance.

Subd. 8. **Guest dosing.** In order to receive a guest dose, the client must be enrolled in an opioid treatment program elsewhere in the state or country and be receiving the medication on a temporary basis because the client is not able to receive the medication at the program in which the client is enrolled. Such arrangements shall not exceed 30 consecutive days in any one program and must not be for the convenience or benefit of either program. Guest dosing may also occur when the client's primary clinic is not open and the client is not receiving take-home doses.

Subd. 9. **Data and reporting.** The license holder must submit data concerning medication used for the treatment of opioid addiction to a central registry. The data must be submitted in a method determined by the commissioner and must be submitted for each client at the time of admission and discharge. The program must document the date the information was submitted. This requirement is effective upon implementation of changes to the Drug and Alcohol Abuse Normative Evaluation System (DAANES) or development of an electronic system by which to submit the data.

Subd. 10. **Nonmedication treatment services; documentation.** (a) The program must offer at least 50 consecutive minutes of individual or group therapy treatment services as defined in Minnesota Rules, part 9530.6430, subpart 1, item A, subitem (1), per week, for the first ten weeks following admission, and at least 50 consecutive minutes per month thereafter. As clinically appropriate, the program may offer these services cumulatively and not consecutively in increments of no less than 15 minutes over the required time period, and for a total of 60 minutes of treatment services over the time period, and must document the reason for providing services cumulatively in the client's record. The program may offer additional levels of service when deemed clinically necessary.

(b) Notwithstanding the requirements of comprehensive assessments in Minnesota Rules, part 9530.6422, the assessment must be completed within 21 days of service initiation.

(c) Notwithstanding the requirements of individual treatment plans set forth in Minnesota Rules, part 9530.6425:

(1) treatment plan contents for maintenance clients are not required to include goals the client must reach to complete treatment and have services terminated;

(2) treatment plans for clients in a taper or detox status must include goals the client must reach to complete treatment and have services terminated;

(3) for the initial ten weeks after admission for all new admissions, readmissions, and transfers, progress notes must be entered in a client's file at least weekly and be recorded in each of the six dimensions upon the development of the treatment plan and thereafter. Subsequently, the counselor must document progress no less than one time monthly, recorded in the six dimensions or when clinical need warrants more frequent notations; and

(4) upon the development of the treatment plan and thereafter, treatment plan reviews must occur weekly, or after each treatment service, whichever is less frequent, for the first ten weeks after the treatment plan is developed. Following the first ten weeks of treatment plan reviews, reviews may occur monthly, unless the client has needs that warrant more frequent revisions or documentation.

Subd. 11. **Prescription monitoring program.** (a) The program must develop and maintain a policy and procedure that requires the ongoing monitoring of the data from the prescription monitoring program for each client. The policy and procedure must include how the program will meet the requirements in paragraph (b).

(b) If a medication used for the treatment of opioid addiction is administered or dispensed to a client, the license holder shall be subject to the following requirements:

(1) upon admission to a methadone clinic outpatient treatment program, clients must be notified in writing that the commissioner of human services and the medical director will monitor the prescription monitoring program to review the prescribed controlled drugs the clients have received;

(2) the medical director or the medical director's delegate must review the data from the Minnesota Board of Pharmacy prescription monitoring program (PMP) established under section 152.126 prior to the client being ordered any controlled substance, as defined under section 152.126, subdivision 1, paragraph (c), including medications used for the treatment of opioid addiction, and subsequent reviews of the PMP data must occur at least every 90 days;

(3) a copy of the PMP data reviewed must be maintained in the client file;

(4) when the PMP data contains a recent history of multiple prescribers or multiple prescriptions for controlled substances, the physician's review of the data and subsequent actions must be documented in the client's individual file within 72 hours and must contain the medical director's determination of whether or not the prescriptions place the client at risk of harm and the actions to be taken in response to the PMP findings. In addition, the provider must conduct subsequent reviews of the PMP on a monthly basis; and

(5) if at any time the medical director believes the use of the controlled substances places the client at risk of harm, the program must seek the client's consent to discuss the client's opioid treatment with other prescribers and must seek consent for the other prescriber to disclose to the opioid treatment program's medical director the client's condition that formed the basis of the other prescriptions. If the information is not obtained within seven days, the medical director must document whether or not changes to the client's medication dose or number of take-home doses are necessary until the information is obtained.

(c) The commissioner shall collaborate with the Minnesota Board of Pharmacy to develop and implement an electronic system through which the commissioner shall routinely access the data from the Minnesota Board of Pharmacy prescription monitoring program established under section 152.126 for the purpose of determining whether any client enrolled in an opioid addiction treatment program licensed according to this section has also been prescribed or dispensed a controlled substance in addition to that administered or dispensed by the opioid addiction treatment program. When the commissioner determines there have been multiple prescribers or multiple prescriptions of controlled substances, the commissioner shall:

(1) inform the medical director of the opioid treatment program only that the commissioner determined the existence of multiple prescribers or multiple prescriptions of controlled substances; and

(2) direct the medical director of the opioid treatment program to access the data directly, review the effect of the multiple prescribers or multiple prescriptions, and document the review.

(d) If determined necessary, the commissioner shall seek a federal waiver of, or exception to, any applicable provision of Code of Federal Regulations, title 42, section 2.34(c), prior to implementing this subdivision.

Subd. 12. **Policies and procedures.** (a) License holders must develop and maintain the policies and procedures required in this subdivision.

(b) For programs that are not open every day of the year, the license holder must maintain a policy and procedure that permits clients to receive a single unsupervised use of medication used for the treatment of opioid addiction for days that the program is closed for business, including, but not limited to, Sundays and state and federal holidays as required under subdivision 5, paragraph (a), clause (1).

(c) The license holder must maintain a policy and procedure that includes specific measures to reduce the possibility of medication used for the treatment of opioid addiction being diverted from its intended treatment use. The policy and procedure must:

(1) specifically identify and define the responsibilities of the medical and administrative staff for carrying out diversion control measures; and

(2) include a process for contacting no less than five percent of clients who have unsupervised use of medication used for the treatment of opioid addiction, excluding those approved solely under subdivision 5, paragraph (a), clause (1), to require them to physically return to the program each month. The system must require clients to return to the program within a stipulated time frame and turn in all unused medication containers related to opioid addiction treatment. The license holder must document all related contacts on a central log and the outcome of the contact for each client in the individual client's record.

(d) Medications used for the treatment of opioid addictions must be ordered, administered, and dispensed according to applicable state and federal regulations and the standards set by applicable accreditation entities. In addition, when an order requires assessment by the person administering or dispensing the medication to determine the amount to be administered or dispensed, the assessment must be completed by an individual whose professional scope of practice permits such assessment. For the purposes of enforcement of this paragraph, the commissioner has the authority to monitor for compliance with these state and federal regulations and the relevant standards of the license holder's accreditation agency and may issue licensing actions according to sections 245A.05, 245A.06, and 245A.07 based on the commissioner's determination of noncompliance.

Subd. 13. **Quality improvement plan.** The license holder must develop and maintain a quality improvement process and plan. The plan must:

(1) include evaluation of the services provided to clients with the goal of identifying issues that may improve service delivery and client outcomes;

(2) include goals for the program to accomplish based on the evaluation;

(3) be reviewed annually by the management of the program to determine whether the goals were met and, if not, whether additional action is required;

(4) be updated at least annually to include new or continued goals based on an updated evaluation of services; and

(5) identify two specific goal areas, in addition to others identified by the program, including:

(i) a goal concerning oversight and monitoring of the premises around and near the exterior of the program to reduce the possibility of medication used for the treatment of opioid addiction being inappropriately used by clients, including but not limited to the sale or transfer of the medication to others; and

(ii) a goal concerning community outreach, including but not limited to communications with local law enforcement and county human services agencies, with the goal of increasing coordination of services and identification of areas of concern to be addressed in the plan.

Subd. 14. **Placing authorities.** Programs must provide certain notification and client-specific updates to placing authorities for clients who are enrolled in Minnesota health care programs. At the request of the placing authority, the program must provide client-specific updates, including but not limited to informing the placing authority of positive drug screenings and changes in medications used for the treatment of opioid addiction ordered for the client.

Subd. 15. **A program's duty to report suspected drug diversion.** (a) To the fullest extent permitted under Code of Federal Regulations, title 42, sections 2.1 to 2.67, a program shall report to law enforcement any credible evidence that the program or its personnel knows, or reasonably should know, that is directly related to a diversion crime on the premises of the program, or a threat to commit a diversion crime.

(b) "Diversion crime," for the purposes of this section, means diverting, attempting to divert, or conspiring to divert Schedule I, II, III, or IV drugs, as defined in section 152.02, on the program's premises.

(c) The program must document its compliance with the requirement in paragraph (a) in either a client's record or an incident report.

(d) Failure to comply with the duty in paragraph (a) may result in sanctions as provided in sections 245A.06 and 245A.07.

Subd. 16. **Variance.** The commissioner may grant a variance to the requirements of this section.

245C.11 BACKGROUND STUDY; COUNTY AGENCIES.

Subd. 4. **Background study.** A county agency may accept a background study completed by the commissioner under this chapter in place of the background study required under section 245A.16, subdivision 3, for educational programs that train individuals by providing direct contact services in licensed programs.

245C.16 DISQUALIFIED INDIVIDUAL'S RISK OF HARM.

Subd. 3. **County agency.** (a) County licensing agencies performing duties under this section may develop an alternative system for determining the subject's immediate risk of harm to persons served by the program, providing the notices under subdivision 2, paragraph (b), and documenting the action taken by the county licensing agency.

(b) Each county licensing agency's implementation of the alternative system is subject to approval by the commissioner.

(c) Notwithstanding this alternative system, county licensing agencies shall complete the requirements of section 245C.17.

245C.17 NOTICE OF BACKGROUND STUDY RESULTS.

Subd. 4. **Disqualification notice to family child care or foster care provider.** For studies on individuals pertaining to a license to provide family child care or group family child care, foster care for children in the provider's own home, or foster care or day care services for adults in the provider's own home, the commissioner is not required to provide a separate notice of the background study results to the individual who is the subject of the study unless the study results in a disqualification of the individual.

245E.03 DUTY TO PROVIDE ACCESS.

Subd. 3. **Notice of denial or termination.** When a provider fails to provide access, a 15-day notice of denial or termination must be issued to the provider, which prohibits the provider from participating in the child care assistance program. Notice must be sent to recipients whose children are under the provider's care pursuant to Minnesota Rules, part 3400.0185.

245E.06 ADMINISTRATIVE SANCTIONS.

Subd. 4. **Consolidated hearings with licensing sanction.** If a financial misconduct sanction has an appeal hearing right and it is timely appealed, and a licensing sanction exists for which there is an appeal hearing right and the sanction is timely appealed, and the overpayment recovery action and licensing sanction involve the same set of facts, the overpayment recovery action and licensing sanction must be consolidated in the contested case hearing related to the licensing sanction.

Subd. 5. **Effect of department's administrative determination or sanction.** Unless a timely and proper appeal is received by the department, the department's administrative determination or sanction shall be considered a final department determination.

246B.06 VOCATIONAL WORK PROGRAM.

Subdivision 1. **Establishment; purpose.** (a) The commissioner of human services may establish, equip, maintain, and operate a vocational work program at any Minnesota sex offender program facility under this chapter. The commissioner may establish vocational activities for sex offender treatment for civilly committed sex offenders as the commissioner deems necessary and suitable to the meaningful work skills training, educational training, and development of proper work habits and extended treatment services for civilly committed sex offenders consistent with the requirements in section 246B.05. The industrial and commercial activities authorized by this section are designated Minnesota State Industries and must be for the primary purpose of sustaining and ensuring Minnesota State Industries' self-sufficiency, providing educational training, meaningful employment, and the teaching of proper work habits to the individuals in

the Minnesota sex offender program under this chapter, and not solely as competitive business ventures.

(b) The net profits from the vocational work program must be used for the benefit of the civilly committed sex offenders as it relates to building education and self-sufficiency skills. Prior to the establishment of any vocational activity, the commissioner of human services shall consult with stakeholders including representatives of business, industry, organized labor, the commissioner of education, the state Apprenticeship Council, the commissioner of labor and industry, the commissioner of employment and economic development, the commissioner of administration, and other stakeholders the commissioner deems qualified. The purpose of the stakeholder consultation is to determine the quantity and nature of the goods, wares, merchandise, and services to be made or provided, and the types of processes to be used in their manufacture, processing, repair, and production consistent with the greatest opportunity for the reform and educational training of the civilly committed sex offenders, and with the best interests of the state, business, industry, and labor.

(c) The commissioner of human services shall, at all times in the conduct of any vocational activity authorized by this section, utilize civilly committed sex offender labor to the greatest extent feasible, provided that the commissioner may employ all administrative, supervisory, and other skilled workers necessary to the proper instruction of the civilly committed sex offenders and the efficient operation of the vocational activities authorized by this section.

(d) The commissioner of human services may authorize the director of any Minnesota sex offender treatment facility under the commissioner's control to accept work projects from outside sources for processing, fabrication, or repair, provided that preference is given to the performance of work projects for state departments and agencies.

Subd. 2. **Revolving fund.** As described in section 246B.05, subdivision 2, there is established a vocational work program revolving fund under the control of the commissioner of human services. The revolving fund must be used for the vocational work program authorized under this section, including, but not limited to, the purchase of equipment and raw materials, the payment of salaries and wages, and other necessary expenses as determined by the commissioner of human services. The purchase of services, materials, and commodities used in and held for resale are not subject to the competitive bidding procedures of section 16C.06, but are subject to all other provisions of chapters 16B and 16C. When practical, purchases must be made from small targeted group businesses designated under section 16C.16. Additionally, the expenses of client educational training and self-sufficiency skills may be financed from the revolving fund in an amount to be determined by the commissioner or designee. The proceeds and income from all vocational work program activities conducted at the Minnesota sex offender treatment facilities must be deposited in the revolving fund subject to disbursement under subdivision 3. The commissioner of human services may request that money in the fund be invested pursuant to section 11A.25. Proceeds from the investment not currently needed must be accounted for separately and credited to the revolving fund.

Subd. 3. **Disbursement from fund.** The vocational work program revolving fund must be deposited in the state treasury and paid out only on proper vouchers as authorized and approved by the commissioner of human services, and in the same manner and under the same restrictions as are now provided by law for the disbursement of funds by the commissioner. An amount deposited in the state treasury equal to six months of net operating cash as determined by the prior 12 months of revenue and cash flow statements must be restricted for use only by the vocational work program as described under subdivision 2. For purposes of this subdivision, "net operating cash" means net income, minus sales, plus cost of goods sold. Cost of goods sold include all direct costs of products attributable to the goods' production.

Subd. 4. **Revolving fund; borrowing.** The commissioner of human services is authorized to borrow sums of money as the commissioner deems necessary to meet current demands on the vocational work program revolving fund. The sums borrowed must not exceed, in any calendar year, six months of net operating cash as determined by the previous 12 months of the vocational program's revenue and cash flow statements. If the commissioner of human services determines that borrowing of funds is necessary, the commissioner of human services shall certify this need to the commissioner of management and budget. Funds may be borrowed from general fund appropriations to the Minnesota sex offender program with the authorization of the commissioner of management and budget. Upon authorization of the commissioner of management and budget, the transfer must be made and credited to the vocational work program revolving fund. The sum transferred to the vocational work program revolving fund must be repaid by the commissioner of human services from the revolving fund to the fund from which it was transferred in a time period specified by the commissioner of management and budget, but by no later than the end of the biennium, as defined in section 16A.011, in which the loan is made. When any transfer

is made to the vocational work program revolving fund, the commissioner of management and budget shall notify the commissioner of human services of the amount transferred to the fund and the date the transfer is to be repaid.

Subd. 5. **Federal grant fund transfers.** Grants received by the commissioner of human services from the federal government for any vocational training program or for administration by the commissioner of human services must (1) be credited to a federal grant fund and then (2) be transferred from the federal grant fund to the credit of the commissioner of human services in the appropriate account upon certification by the commissioner of human services that the amounts requested to be transferred have been earned or are required for the purposes of this section. Funds received by the federal grant fund need not be budgeted as such, provided transfers from the fund are budgeted for allotment purposes in the appropriate appropriation.

Subd. 6. **Wages.** Notwithstanding section 177.24 or any other law to the contrary, the commissioner of human services has the discretion to set the pay rate for individuals participating in the vocational work program. The commissioner has the authority to retain up to 50 percent of any payments made to an individual participating in the vocational work program for the purpose of reducing state costs associated with operating the Minnesota sex offender program.

Subd. 7. **Status of civilly committed sex offenders.** Civilly committed sex offenders participating in the vocational work program are not employees of the Minnesota sex offender program, the Department of Human Services, or the state, and are not subject to fair labor standards under sections 177.21 to 177.35; workers compensation under sections 176.011 to 176.862; the Minnesota Human Rights Act under sections 363A.01 to 363A.41; laws governing state employees under chapter 43A; labor relations under chapter 179A; or the successors to any of these sections and any other laws pertaining to employees and employment.

Subd. 8. **Claims.** Claims and demands arising out of injury to or death of a civilly committed sex offender while that individual is participating in the vocational work program or performing a work assignment maintaining the facility must be presented to, heard by, and determined exclusively by the legislature as provided in section 3.738.

252.41 DEFINITIONS.

Subd. 8. **Supported employment.** "Supported employment" means employment of a person with a disability so severe that the person needs ongoing training and support to get and keep a job in which:

(1) the person engages in paid work at a work site where individuals without disabilities who do not require public subsidies also may be employed;

(2) public funds are necessary to provide ongoing training and support services throughout the period of the person's employment; and

(3) the person has the opportunity for social interaction with individuals who do not have disabilities and who are not paid caregivers.

252.451 BUSINESS AGREEMENTS; SUPPORT AND SUPERVISION OF DISABLED PERSONS.

Subdivision 1. **Definition.** For the purposes of this section, "qualified business" means a business that employs primarily nondisabled persons and will employ persons with developmental disabilities. For purposes of this section, licensed providers of residential services for persons with developmental disabilities are not a qualified business. A qualified business and its employees are exempt from Minnesota Rules, parts 9525.1800 to 9525.1930.

Subd. 2. **Vendor participation and reimbursement.** Notwithstanding requirements in chapters 245A and 245D, and sections 252.28, 252.41 to 252.46, and 256B.501, vendors of day training and habilitation services may enter into written agreements with qualified businesses to provide additional training and supervision needed by individuals to maintain their employment.

Subd. 3. **Agreement specifications.** Agreements must include the following:

(1) the type and amount of supervision and support to be provided by the business to the individual in accordance with their needs as identified in their individual service plan;

(2) the methods used to periodically assess the individual's satisfaction with their work, training, and support;

(3) the measures taken by the qualified business and the vendor to ensure the health, safety, and protection of the individual during working hours, including the reporting of abuse and neglect under state law and rules;

(4) the training and support services the vendor will provide to the qualified business, including the frequency of on-site supervision and support; and

(5) any payment to be made to the qualified business by the vendor. Payment to the business must be limited to:

(i) additional costs of training coworkers and managers that exceed ordinary and customary training costs and are a direct result of employing a person with a developmental disability; and

(ii) additional costs for training, supervising, and assisting the person with a developmental disability that exceed normal and customary costs required for performing similar tasks or duties.

Payments made to a qualified business under this section must not include incentive payments to the qualified business or salary supplementation for the person with a developmental disability.

Subd. 4. **Client protection.** Persons receiving training and support under this section may not be denied their rights or procedural protections under section 256.045, subdivision 4a, or 256B.092, including the county agency's responsibility to arrange for appropriate services, as necessary, in the event that persons lose their job or the contract with the qualified business is terminated.

Subd. 5. **Vendor payment.** (a) For purposes of this section, the vendor shall bill and the commissioner shall reimburse the vendor for full-day or partial-day services to a client that would otherwise have been paid to the vendor for providing direct services, provided that both of the following criteria are met:

(1) the vendor provides services and payments to the qualified business that enable the business to perform support and supervision services for the client that the vendor would otherwise need to perform; and

(2) the client for whom a rate will be billed will receive full-day or partial-day services from the vendor and the rate to be paid the vendor will allow the client to work with this support and supervision at the qualified business instead of receiving these services from the vendor.

(b) Medical assistance reimbursement of services provided to persons receiving day training and habilitation services under this section is subject to the limitations on reimbursement for vocational services under federal law and regulation.

254A.02 DEFINITIONS.

Subd. 4. **Drug abuse or abuse of drugs.** "Drug abuse or abuse of drugs" is the use of any psychoactive or mood altering chemical substance, without compelling medical reason, in such a manner as to induce mental, emotional or physical impairment and cause socially dysfunctional or socially disordering behavior and which results in psychological or physiological dependency as a function of continued use.

256.9692 EFFECT OF INTEGRATION AGREEMENT ON DIVISION OF COST.

Beginning in the first calendar month after there is a definitive integration agreement affecting the University of Minnesota hospital and clinics and Fairview hospital and health care services, Fairview hospital and health care services shall pay the University of Minnesota $505,000 on the 15th of each month, after receiving the state payment, provided that the University of Minnesota has fulfilled the requirements of section 256B.19, subdivision 1c.

256B.0625 COVERED SERVICES.

Subd. 25a. **Prior authorization of diagnostic imaging services.** (a) Effective January 1, 2010, the commissioner shall require prior authorization or decision support for the ordering providers at the time the service is ordered for the following outpatient diagnostic imaging services: computerized tomography (CT), magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), positive emission tomography (PET), cardiac imaging, and ultrasound diagnostic imaging.

(b) Prior authorization under this subdivision is not required for diagnostic imaging services performed as part of a hospital emergency room visit, inpatient hospitalization, or if concurrent with or on the same day as an urgent care facility visit.

(c) This subdivision does not apply to services provided to recipients who are enrolled in Medicare, the prepaid medical assistance program, or the MinnesotaCare program.

(d) The commissioner may contract with a private entity to provide the prior authorization or decision support required under this subdivision. The contracting entity must incorporate clinical guidelines that are based on evidence-based medical literature, if available. By January 1,

2012, the contracting entity shall report to the commissioner the results of prior authorization or decision support.

256B.0659 PERSONAL CARE ASSISTANCE PROGRAM.

Subd. 22. **Annual review for personal care providers.** (a) All personal care assistance provider agencies shall resubmit, on an annual basis, the information specified in subdivision 21, in a format determined by the commissioner, and provide a copy of the personal care assistance provider agency's most current version of its grievance policies and procedures along with a written record of grievances and resolutions of the grievances that the personal care assistance provider agency has received in the previous year and any other information requested by the commissioner.

(b) The commissioner shall send annual review notification to personal care assistance provider agencies 30 days prior to renewal. The notification must:

(1) list the materials and information the personal care assistance provider agency is required to submit;

(2) provide instructions on submitting information to the commissioner; and

(3) provide a due date by which the commissioner must receive the requested information. Personal care assistance provider agencies shall submit required documentation for annual review within 30 days of notification from the commissioner. If no documentation is submitted, the personal care assistance provider agency enrollment number must be terminated or suspended.

(c) Personal care assistance provider agencies also currently licensed under section 144A.471, subdivision 6 or 7, or currently certified for participation in Medicare as a home health agency are deemed in compliance with the personal care assistance requirements for enrollment, annual review process, and documentation.

256B.4914 HOME AND COMMUNITY-BASED SERVICES WAIVERS; RATE SETTING.

Subd. 16. **Budget neutrality adjustments.** (a) The commissioner shall use the following adjustments to the rate generated by the framework to assure budget neutrality until the rate information is available to implement paragraph (b). The rate generated by the framework shall be multiplied by the appropriate factor, as designated below:

(1) for residential services: 1.003;

(2) for day services: 1.000;

(3) for unit-based services with programming: 0.941; and

(4) for unit-based services without programming: 0.796.

(b) Within 12 months of January 1, 2014, the commissioner shall compare estimated spending for all home and community-based waiver services under the new payment rates defined in subdivisions 6 to 9 with estimated spending for the same recipients and services under the rates in effect on July 1, 2013. This comparison must distinguish spending under each of subdivisions 6, 7, 8, and 9. The comparison must be based on actual recipients and services for one or more service months after the new rates have gone into effect. The commissioner shall consult with the commissioner of management and budget on this analysis to ensure budget neutrality. If estimated spending under the new rates for services under one or more subdivisions differs in this comparison by 0.3 percent or more, the commissioner shall assure aggregate budget neutrality across all service areas by adjusting the budget neutrality factor in paragraph (a) in each subdivision so that total estimated spending for each subdivision under the new rates matches estimated spending under the rates in effect on July 1, 2013.

256B.64 ATTENDANTS TO VENTILATOR-DEPENDENT RECIPIENTS.

A ventilator-dependent recipient of medical assistance who has been receiving the services of a home care nurse or personal care assistant in the recipient's home may continue to have a home care nurse or personal care assistant present upon admission to a hospital licensed under chapter 144. The personal care assistant or home care nurse shall perform only the services of communicator or interpreter for the ventilator-dependent patient during a transition period of up to 120 hours to assure adequate training of the hospital staff to communicate with the patient and to understand the unique comfort, safety, and personal care needs of the patient. The personal care assistant or home care nurse may offer nonbinding advice to the health care professionals in charge of the ventilator-dependent patient's care and treatment on matters pertaining to the comfort and safety of the patient. Within 36 hours of the end of the 120-hour transition period, an assessment may be made by the ventilator-dependent recipient, the attending physician, and

the hospital staff caring for the recipient. If the persons making the assessment determine that additional communicator or interpreter services are medically necessary, the hospital must contact the commissioner 24 hours prior to the end of the 120-hour transition period and submit the assessment information to the commissioner. The commissioner shall review the request and determine if it is medically necessary to continue the interpreter services or if the hospital staff has had sufficient opportunity to adequately determine the needs of the patient. The commissioner shall determine if continued service is necessary and appropriate and whether or not payments shall continue. The commissioner may not authorize services beyond the limits of the available appropriations for this section. The commissioner may adopt rules necessary to implement this section. Reimbursement under this section must be at the payment rate and in a manner consistent with the payment rate and manner used in reimbursing these providers for home care services for the ventilator-dependent recipient under the medical assistance program.

256B.69 PREPAID HEALTH PLANS.

Subdivision 1. **Purpose.** The commissioner of human services shall establish a medical assistance demonstration project to determine whether prepayment combined with better management of health care services is an effective mechanism to ensure that all eligible individuals receive necessary health care in a coordinated fashion while containing costs. For the purposes of this project, waiver of certain statutory provisions is necessary in accordance with this section.

Subd. 2. **Definitions.** For the purposes of this section, the following terms have the meanings given.

(a) "Commissioner" means the commissioner of human services. For the remainder of this section, the commissioner's responsibilities for methods and policies for implementing the project will be proposed by the project advisory committees and approved by the commissioner.

(b) "Demonstration provider" means a health maintenance organization, community integrated service network, or accountable provider network authorized and operating under chapter 62D, 62N, or 62T that participates in the demonstration project according to criteria, standards, methods, and other requirements established for the project and approved by the commissioner. For purposes of this section, a county board, or group of county boards operating under a joint powers agreement, is considered a demonstration provider if the county or group of county boards meets the requirements of section 256B.692.

(c) "Eligible individuals" means those persons eligible for medical assistance benefits as defined in sections 256B.055, 256B.056, and 256B.06.

(d) "Limitation of choice" means suspending freedom of choice while allowing eligible individuals to choose among the demonstration providers.

Subd. 3. **Geographic area.** The commissioner shall designate the geographic areas in which eligible individuals may be included in the medical assistance prepayment programs.

Subd. 3a. **County authority.** (a) The commissioner, when implementing the medical assistance prepayment program within a county, must include the county board in the process of development, approval, and issuance of the request for proposals to provide services to eligible individuals within the proposed county. County boards must be given reasonable opportunity to make recommendations regarding the development, issuance, review of responses, and changes needed in the request for proposals. The commissioner must provide county boards the opportunity to review each proposal based on the identification of community needs under chapters 145A and 256E and county advocacy activities. If a county board finds that a proposal does not address certain community needs, the county board and commissioner shall continue efforts for improving the proposal and network prior to the approval of the contract. The county board shall make recommendations regarding the approval of local networks and their operations to ensure adequate availability and access to covered services. The provider or health plan must respond directly to county advocates and the state prepaid medical assistance ombudsperson regarding service delivery and must be accountable to the state regarding contracts with medical assistance funds. The county board may recommend a maximum number of participating health plans after considering the size of the enrolling population; ensuring adequate access and capacity; considering the client and county administrative complexity; and considering the need to promote the viability of locally developed health plans. The county board or a single entity representing a group of county boards and the commissioner shall mutually select health plans for participation at the time of initial implementation of the prepaid medical assistance program in that county or group of counties and at the time of contract renewal. The commissioner shall also seek input for contract requirements from the county or single entity representing a group of county boards at each contract renewal and incorporate those recommendations into the contract negotiation process.

(b) At the option of the county board, the board may develop contract requirements related to the achievement of local public health goals to meet the health needs of medical assistance enrollees. These requirements must be reasonably related to the performance of health plan functions and within the scope of the medical assistance benefit set. If the county board and the commissioner mutually agree to such requirements, the department shall include such requirements in all health plan contracts governing the prepaid medical assistance program in that county at initial implementation of the program in that county and at the time of contract renewal. The county board may participate in the enforcement of the contract provisions related to local public health goals.

(c) For counties in which a prepaid medical assistance program has not been established, the commissioner shall not implement that program if a county board submits an acceptable and timely preliminary and final proposal under section 256B.692, until county-based purchasing is no longer operational in that county. For counties in which a prepaid medical assistance program is in existence on or after September 1, 1997, the commissioner must terminate contracts with health plans according to section 256B.692, subdivision 5, if the county board submits and the commissioner accepts a preliminary and final proposal according to that subdivision. The commissioner is not required to terminate contracts that begin on or after September 1, 1997, according to section 256B.692 until two years have elapsed from the date of initial enrollment.

(d) In the event that a county board or a single entity representing a group of county boards and the commissioner cannot reach agreement regarding: (i) the selection of participating health plans in that county; (ii) contract requirements; or (iii) implementation and enforcement of county requirements including provisions regarding local public health goals, the commissioner shall resolve all disputes after taking into account the recommendations of a three-person mediation panel. The panel shall be composed of one designee of the president of the association of Minnesota counties, one designee of the commissioner of human services, and one person selected jointly by the designee of the commissioner of human services and the designee of the Association of Minnesota Counties. Within a reasonable period of time before the hearing, the panelists must be provided all documents and information relevant to the mediation. The parties to the mediation must be given 30 days' notice of a hearing before the mediation panel.

(e) If a county which elects to implement county-based purchasing ceases to implement county-based purchasing, it is prohibited from assuming the responsibility of county-based purchasing for a period of five years from the date it discontinues purchasing.

(f) The commissioner shall not require that contractual disputes between county-based purchasing entities and the commissioner be mediated by a panel that includes a representative of the Minnesota Council of Health Plans.

(g) At the request of a county-purchasing entity, the commissioner shall adopt a contract reprocurement or renewal schedule under which all counties included in the entity's service area are reprocured or renewed at the same time.

(h) The commissioner shall provide a written report under section 3.195 to the chairs of the legislative committees having jurisdiction over human services in the senate and the house of representatives describing in detail the activities undertaken by the commissioner to ensure full compliance with this section. The report must also provide an explanation for any decisions of the commissioner not to accept the recommendations of a county or group of counties required to be consulted under this section. The report must be provided at least 30 days prior to the effective date of a new or renewed prepaid or managed care contract in a county.

Subd. 3b. **Provision of data to county boards.** The commissioner, in consultation with representatives of county boards of commissioners shall identify program information and data necessary on an ongoing basis for county boards to: (1) make recommendations to the commissioner related to state purchasing under the prepaid medical assistance program; and (2) effectively administer county-based purchasing. This information and data must include, but is not limited to, county-specific, individual-level fee-for-service and prepaid health plan claims information.

Subd. 4. **Limitation of choice.** (a) The commissioner shall develop criteria to determine when limitation of choice may be implemented in the experimental counties. The criteria shall ensure that all eligible individuals in the county have continuing access to the full range of medical assistance services as specified in subdivision 6.

(b) The commissioner shall exempt the following persons from participation in the project, in addition to those who do not meet the criteria for limitation of choice:

(1) persons eligible for medical assistance according to section 256B.055, subdivision 1;

(2) persons eligible for medical assistance due to blindness or disability as determined by the Social Security Administration or the state medical review team, unless:

(i) they are 65 years of age or older; or

(ii) they reside in Itasca County or they reside in a county in which the commissioner conducts a pilot project under a waiver granted pursuant to section 1115 of the Social Security Act;

(3) recipients who currently have private coverage through a health maintenance organization;

(4) recipients who are eligible for medical assistance by spending down excess income for medical expenses other than the nursing facility per diem expense;

(5) recipients who receive benefits under the Refugee Assistance Program, established under United States Code, title 8, section 1522(e);

(6) children who are both determined to be severely emotionally disturbed and receiving case management services according to section 256B.0625, subdivision 20, except children who are eligible for and who decline enrollment in an approved preferred integrated network under section 245.4682;

(7) adults who are both determined to be seriously and persistently mentally ill and received case management services according to section 256B.0625, subdivision 20;

(8) persons eligible for medical assistance according to section 256B.057, subdivision 10; and

(9) persons with access to cost-effective employer-sponsored private health insurance or persons enrolled in a non-Medicare individual health plan determined to be cost-effective according to section 256B.0625, subdivision 15.

Children under age 21 who are in foster placement may enroll in the project on an elective basis. Individuals excluded under clauses (1), (6), and (7) may choose to enroll on an elective basis. The commissioner may enroll recipients in the prepaid medical assistance program for seniors who are (1) age 65 and over, and (2) eligible for medical assistance by spending down excess income.

(c) The commissioner may allow persons with a one-month spenddown who are otherwise eligible to enroll to voluntarily enroll or remain enrolled, if they elect to prepay their monthly spenddown to the state.

(d) The commissioner may require those individuals to enroll in the prepaid medical assistance program who otherwise would have been excluded under paragraph (b), clauses (1), (3), and (8), and under Minnesota Rules, part 9500.1452, subpart 2, items H, K, and L.

(e) Before limitation of choice is implemented, eligible individuals shall be notified and after notification, shall be allowed to choose only among demonstration providers. The commissioner may assign an individual with private coverage through a health maintenance organization, to the same health maintenance organization for medical assistance coverage, if the health maintenance organization is under contract for medical assistance in the individual's county of residence. After initially choosing a provider, the recipient is allowed to change that choice only at specified times as allowed by the commissioner. If a demonstration provider ends participation in the project for any reason, a recipient enrolled with that provider must select a new provider but may change providers without cause once more within the first 60 days after enrollment with the second provider.

(f) An infant born to a woman who is eligible for and receiving medical assistance and who is enrolled in the prepaid medical assistance program shall be retroactively enrolled to the month of birth in the same managed care plan as the mother once the child is enrolled in medical assistance unless the child is determined to be excluded from enrollment in a prepaid plan under this section.

Subd. 4b. **Individualized education program and individualized family service plan services.** The commissioner shall amend the federal waiver allowing the state to separate out individualized education program and individualized family service plan services for children enrolled in the prepaid medical assistance program and the MinnesotaCare program. Medical assistance coverage of eligible individualized education program and individualized family service plan services shall not be included in the capitated services for children enrolled in health plans through the prepaid medical assistance program and the MinnesotaCare program. Local school districts shall bill the commissioner for these services, and claims shall be paid on a fee-for-service basis.

Subd. 5. **Prospective per capita payment.** The commissioner shall establish the method and amount of payments for services. The commissioner shall annually contract with demonstration providers to provide services consistent with these established methods and amounts for payment.

If allowed by the commissioner, a demonstration provider may contract with an insurer, health care provider, nonprofit health service plan corporation, or the commissioner, to provide insurance or similar protection against the cost of care provided by the demonstration provider or to provide coverage against the risks incurred by demonstration providers under this section. The recipients enrolled with a demonstration provider are a permissible group under group insurance laws and chapter 62C, the Nonprofit Health Service Plan Corporations Act. Under this type of

contract, the insurer or corporation may make benefit payments to a demonstration provider for services rendered or to be rendered to a recipient. Any insurer or nonprofit health service plan corporation licensed to do business in this state is authorized to provide this insurance or similar protection.

The commissioner shall complete development of capitation rates for payments before delivery of services under this section is begun. The commissioner shall contract with an independent actuary to establish prepayment rates.

Beginning July 1, 2004, the commissioner may include payments for elderly waiver services and 180 days of nursing home care in capitation payments for the prepaid medical assistance program for recipients age 65 and older.

Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section and section 256L.12 shall be entered into or renewed on a calendar year basis. The commissioner may issue separate contracts with requirements specific to services to medical assistance recipients age 65 and older.

(b) A prepaid health plan providing covered health services for eligible persons pursuant to chapters 256B and 256L is responsible for complying with the terms of its contract with the commissioner. Requirements applicable to managed care programs under chapters 256B and 256L established after the effective date of a contract with the commissioner take effect when the contract is next issued or renewed.

(c) The commissioner shall withhold five percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program pending completion of performance targets. Each performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. Clinical or utilization performance targets and their related criteria must consider evidence-based research and reasonable interventions when available or applicable to the populations served, and must be developed with input from external clinical experts and stakeholders, including managed care plans, county-based purchasing plans, and providers. The managed care or county-based purchasing plan must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance target is accurate. The commissioner shall periodically change the administrative measures used as performance targets in order to improve plan performance across a broader range of administrative services. The performance targets must include measurement of plan efforts to contain spending on health care services and administrative activities. The commissioner may adopt plan-specific performance targets that take into account factors affecting only one plan, including characteristics of the plan's enrollee population. The withheld funds must be returned no sooner than July of the following year if performance targets in the contract are achieved. The commissioner may exclude special demonstration projects under subdivision 23.

(d) The commissioner shall require that managed care plans use the assessment and authorization processes, forms, timelines, standards, documentation, and data reporting requirements, protocols, billing processes, and policies consistent with medical assistance fee-for-service or the Department of Human Services contract requirements consistent with medical assistance fee-for-service or the Department of Human Services contract requirements for all personal care assistance services under section 256B.0659.

(e) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the health plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. For 2012, the reduction shall be based on the health plan's utilization in 2009. To earn the return of the withhold each subsequent year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than ten percent of the plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, compared to the previous measurement year until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a reduction in the utilization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of

the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph shall continue for each consecutive contract period until the plan's emergency room utilization rate for state health care program enrollees is reduced by 25 percent of the plan's emergency room utilization rate for medical assistance and MinnesotaCare enrollees for calendar year 2009. Hospitals shall cooperate with the health plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved.

(f) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the plan's hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than five percent of the plan's hospital admission rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, compared to the previous calendar year until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that this reduction in the hospitalization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph shall continue until there is a 25 percent reduction in the hospital admission rate compared to the hospital admission rates in calendar year 2011, as determined by the commissioner. The hospital admissions in this performance target do not include the admissions applicable to the subsequent hospital admission performance target under paragraph (g). Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved.

(g) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the plan's hospitalization admission rates for subsequent hospitalizations within 30 days of a previous hospitalization of a patient regardless of the reason, for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of the subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, of no less than five percent compared to the previous calendar year until the final performance target is reached.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a qualifying reduction in the subsequent hospitalization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph must continue for each consecutive contract period until the plan's subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar year 2011. Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that must be returned to the hospitals if the performance target is achieved.

(h) Effective for services rendered on or after January 1, 2013, through December 31, 2013, the commissioner shall withhold 4.5 percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

(i) Effective for services rendered on or after January 1, 2014, the commissioner shall withhold three percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

(j) A managed care plan or a county-based purchasing plan under section 256B.692 may include as admitted assets under section 62D.044 any amount withheld under this section that is reasonably expected to be returned.

(k) Contracts between the commissioner and a prepaid health plan are exempt from the set-aside and preference provisions of section 16C.16, subdivisions 6, paragraph (a), and 7.

(l) The return of the withhold under paragraphs (h) and (i) is not subject to the requirements of paragraph (c).

(m) Managed care plans and county-based purchasing plans shall maintain current and fully executed agreements for all subcontractors, including bargaining groups, for administrative services that are expensed to the state's public health care programs. Subcontractor agreements determined to be material, as defined by the commissioner after taking into account state contracting and relevant statutory requirements, must be in the form of a written instrument or electronic document containing the elements of offer, acceptance, consideration, payment terms, scope, duration of the contract, and how the subcontractor services relate to state public health care programs. Upon request, the commissioner shall have access to all subcontractor documentation under this paragraph. Nothing in this paragraph shall allow release of information that is nonpublic data pursuant to section 13.02.

Subd. 5b. **Prospective reimbursement rates.** (a) For prepaid medical assistance program contract rates set by the commissioner under subdivision 5, capitation rates for nonmetropolitan counties shall on a weighted average be no less than 87 percent of the capitation rates for metropolitan counties, excluding Hennepin County. The commissioner shall make a pro rata adjustment in capitation rates paid to counties other than nonmetropolitan counties in order to make this provision budget neutral. The commissioner, in consultation with a health care actuary, shall evaluate the regional rate relationships based on actual health plan costs for Minnesota health care programs. The commissioner may establish, based on the actuary's recommendation, new rate regions that recognize metropolitan areas outside of the seven-county metropolitan area.

(b) This subdivision shall not affect the nongeographically based risk adjusted rates established under section 62Q.03, subdivision 5a.

Subd. 5c. **Medical education and research fund.** (a) The commissioner of human services shall transfer each year to the medical education and research fund established under section 62J.692, an amount specified in this subdivision. The commissioner shall calculate the following:

(1) an amount equal to the reduction in the prepaid medical assistance payments as specified in this clause. After January 1, 2002, the county medical assistance capitation base rate prior to plan specific adjustments is reduced 6.3 percent for Hennepin County, two percent for the remaining metropolitan counties, and 1.6 percent for nonmetropolitan Minnesota counties. Nursing facility and elderly waiver payments and demonstration project payments operating under subdivision 23 are excluded from this reduction. The amount calculated under this clause shall not be adjusted for periods already paid due to subsequent changes to the capitation payments;

(2) beginning July 1, 2003, $4,314,000 from the capitation rates paid under this section;

(3) beginning July 1, 2002, an additional $12,700,000 from the capitation rates paid under this section; and

(4) beginning July 1, 2003, an additional $4,700,000 from the capitation rates paid under this section.

(b) This subdivision shall be effective upon approval of a federal waiver which allows federal financial participation in the medical education and research fund. The amount specified under paragraph (a), clauses (1) to (4), shall not exceed the total amount transferred for fiscal year 2009. Any excess shall first reduce the amounts specified under paragraph (a), clauses (2) to (4). Any excess following this reduction shall proportionally reduce the amount specified under paragraph (a), clause (1).

(c) Beginning September 1, 2011, of the amount in paragraph (a), the commissioner shall transfer $21,714,000 each fiscal year to the medical education and research fund.

(d) Beginning September 1, 2011, of the amount in paragraph (a), following the transfer under paragraph (c), the commissioner shall transfer to the medical education research fund $23,936,000 in fiscal years 2012 and 2013 and $49,552,000 in fiscal year 2014 and thereafter.

Subd. 5d. **Modification of payment dates effective January 1, 2001.** Effective for services rendered on or after January 1, 2001, capitation payments under this section for services provided in the month of June shall be made no earlier than the first day after the month of service.

Subd. 5f. **Capitation rates.** (a) Beginning July 1, 2002, the capitation rates paid under this section are increased by $12,700,000 per year. Beginning July 1, 2003, the capitation rates paid under this section are increased by $4,700,000 per year.

(b) Beginning July 1, 2009, the capitation rates paid under this section are increased each year by the lesser of $21,714,000 or an amount equal to the difference between the estimated value of the reductions described in subdivision 5c, paragraph (a), clause (1), and the amount of the limit described in subdivision 5c, paragraph (b).

Subd. 5g. **Payment for covered services.** For services rendered on or after January 1, 2003, the total payment made to managed care plans for providing covered services under the medical assistance program is reduced by .5 percent from their current statutory rates. This provision excludes payments for nursing home services, home and community-based waivers, payments to demonstration projects for persons with disabilities, and mental health services added as covered benefits after December 31, 2007.

Subd. 5h. **Payment reduction.** In addition to the reduction in subdivision 5g, the total payment made to managed care plans under the medical assistance program is reduced 1.0 percent for services provided on or after October 1, 2003, and an additional 1.0 percent for services provided on or after January 1, 2004. This provision excludes payments for nursing home services, home and community-based waivers, payments to demonstration projects for persons with disabilities, and mental health services added as covered benefits after December 31, 2007.

Subd. 5i. **Administrative expenses.** (a) Administrative costs paid to managed care plans and county-based purchasing plans under this section, section 256B.692, and section 256L.12 must not exceed 6.6 percent of total payments made to all managed care plans and county-based purchasing plans in aggregate across all state public health care programs, based on payments expected to be made at the beginning of each calendar year. The commissioner may reduce or eliminate administrative requirements to meet the administrative cost limit. For purposes of this paragraph, administrative costs do not include premium taxes paid under section 297I.05, subdivision 5, provider surcharges paid under section 256.9657, subdivision 3, and health insurance fees under section 9010 of the Affordable Care Act.

(b) The following expenses are not allowable administrative expenses for rate-setting purposes under this section:

(1) charitable contributions made by the managed care plan or the county-based purchasing plan;

(2) compensation of individuals within the organization in excess of $200,000 such that the allocation of compensation for an individual across all state public health care programs in total cannot exceed $200,000;

(3) any penalties or fines assessed against the managed care plan or county-based purchasing plan;

(4) any indirect marketing or advertising expenses of the managed care plan or county-based purchasing plan, including but not limited to costs to promote the managed care or county-based purchasing plan, costs of facilities used for special events, and costs of displays, demonstrations, donations, and promotional items such as memorabilia, models, gifts, and souvenirs. The commissioner may classify an item listed in this clause as an allowable administrative expense for rate-setting purposes, if the commissioner determines that the expense is incidental to an activity related to state public health care programs that is an allowable cost for purposes of rate setting;

(5) any lobbying and political activities, events, or contributions;

(6) administrative expenses related to the provision of services not covered under the state plan or waiver;

(7) alcoholic beverages and related costs;

(8) membership in any social, dining, or country club or organization; and

(9) entertainment, including amusement, diversion, and social activities, and any costs directly associated with these costs, including but not limited to tickets to shows or sporting events, meals, lodging, rentals, transportation, and gratuities.

For the purposes of this subdivision, compensation includes salaries, bonuses and incentives, other reportable compensation on an IRS 990 form, retirement and other deferred compensation, and nontaxable benefits. Charitable contributions under clause (1) include payments for or to any organization or entity selected by the managed care plan or county-based purchasing plan that is operated for charitable, educational, political, religious, or scientific purposes, that are not related to medical and administrative services covered under state public health care programs.

(c) Payments to a quality improvement organization are an allowable administrative expense for rate-setting purposes under this section, to the extent they are allocated to a state public health care program and approved by the commissioner.

(d) Where reasonably possible, expenses for an administrative item shall be directly allocated so as to assign costs for an item to an individual state public health care program when the cost can be specifically identified with and benefits the individual state public health care program. For administrative services expensed to the state's public health care programs, managed care plans and county-based purchasing plans must clearly identify and separately record expense items listed under paragraph (b) in their accounting systems in a manner that allows for independent verification of unallowable expenses for purposes of determining payment rates for state public health care programs.

(e) Notwithstanding paragraph (a), the commissioner shall reduce administrative expenses paid to managed care plans and county-based purchasing plans by .50 of a percentage point for contracts beginning January 1, 2016, and ending December 31, 2017. To meet the administrative reductions under this paragraph, the commissioner may reduce or eliminate administrative requirements, exclude additional unallowable administrative expenses identified under this section and resulting from the financial audits conducted under subdivision 9d, and utilize competitive bidding to gain efficiencies through economies of scale from increased enrollment. If the total reduction cannot be achieved through administrative reduction, the commissioner may limit total rate increases on payments to managed care plans and county-based purchasing plans.

Subd. 5j. **Treatment of investment earnings.** Capitation rates shall treat investment income and interest earnings as income to the same extent that investment-related expenses are treated as administrative expenditures.

Subd. 5k. **Actuarial soundness.** (a) Rates paid to managed care plans and county-based purchasing plans shall satisfy requirements for actuarial soundness. In order to comply with this subdivision, the rates must:

(1) be neither inadequate nor excessive;

(2) satisfy federal requirements;

(3) in the case of contracts with incentive arrangements, not exceed 105 percent of the approved capitation payments attributable to the enrollees or services covered by the incentive arrangement;

(4) be developed in accordance with generally accepted actuarial principles and practices;

(5) be appropriate for the populations to be covered and the services to be furnished under the contract; and

(6) be certified as meeting the requirements of federal regulations by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

(b) Each year within 30 days of the establishment of plan rates the commissioner shall report to the chairs and ranking minority members of the senate Health and Human Services Budget Division and the house of representatives Health Care and Human Services Finance Division to certify how each of these conditions have been met by the new payment rates.

Subd. 6. **Service delivery.** (a) Each demonstration provider shall be responsible for the health care coordination for eligible individuals. Demonstration providers:

(1) shall authorize and arrange for the provision of all needed health services including but not limited to the full range of services listed in sections 256B.02, subdivision 8, and 256B.0625 in order to ensure appropriate health care is delivered to enrollees. Notwithstanding section 256B.0621, demonstration providers that provide nursing home and community-based services under this section shall provide relocation service coordination to enrolled persons age 65 and over;

(2) shall accept the prospective, per capita payment from the commissioner in return for the provision of comprehensive and coordinated health care services for eligible individuals enrolled in the program;

(3) may contract with other health care and social service practitioners to provide services to enrollees; and

(4) shall institute recipient grievance procedures according to the method established by the project, utilizing applicable requirements of chapter 62D. Disputes not resolved through this process shall be appealable to the commissioner as provided in subdivision 11.

(b) Demonstration providers must comply with the standards for claims settlement under section 72A.201, subdivisions 4, 5, 7, and 8, when contracting with other health care and social service practitioners to provide services to enrollees. A demonstration provider must pay a clean claim, as defined in Code of Federal Regulations, title 42, section 447.45(b), within 30 business days of the date of acceptance of the claim.

Subd. 6a. **Nursing home services.** (a) Notwithstanding Minnesota Rules, part 9500.1457, subpart 1, item B, up to 180 days of nursing facility services as defined in section 256B.0625, subdivision 2, which are provided in a nursing facility certified by the Minnesota Department of

Health for services provided and eligible for payment under Medicaid, shall be covered under the prepaid medical assistance program for individuals who are not residing in a nursing facility at the time of enrollment in the prepaid medical assistance program. The commissioner may develop a schedule to phase in implementation of the 180-day provision.

(b) For individuals enrolled in the Minnesota senior health options project or in other demonstrations authorized under subdivision 23, nursing facility services shall be covered according to the terms and conditions of the federal agreement governing that demonstration project.

(c) For individuals enrolled in demonstrations authorized under subdivision 23, services in an intermediate care facility for persons with developmental disabilities shall be covered according to the terms and conditions of the federal agreement governing the demonstration project.

Subd. 6b. **Home and community-based waiver services.** (a) For individuals enrolled in the Minnesota senior health options project authorized under subdivision 23, elderly waiver services shall be covered according to the terms and conditions of the federal agreement governing that demonstration project.

(b) For individuals under age 65 enrolled in demonstrations authorized under subdivision 23, home and community-based waiver services shall be covered according to the terms and conditions of the federal agreement governing that demonstration project.

(c) The commissioner of human services shall issue requests for proposals for collaborative service models between counties and managed care organizations to integrate the home and community-based elderly waiver services and additional nursing home services into the prepaid medical assistance program.

(d) Notwithstanding Minnesota Rules, part 9500.1457, subpart 1, item C, elderly waiver services shall be covered statewide under the prepaid medical assistance program for all individuals who are eligible according to section 256B.0915. The commissioner may develop a schedule to phase in implementation of these waiver services, including collaborative service models under paragraph (c). The commissioner shall phase in implementation beginning with those counties participating under section 256B.692, and those counties where a viable collaborative service model has been developed. In consultation with counties and all managed care organizations that have expressed an interest in participating in collaborative service models, the commissioner shall evaluate the models. The commissioner shall consider the evaluation in selecting the most appropriate models for statewide implementation.

Subd. 6d. **Prescription drugs.** The commissioner may exclude or modify coverage for prescription drugs from the prepaid managed care contracts entered into under this section in order to increase savings to the state by collecting additional prescription drug rebates. The contracts must maintain incentives for the managed care plan to manage drug costs and utilization and may require that the managed care plans maintain an open drug formulary. In order to manage drug costs and utilization, the contracts may authorize the managed care plans to use preferred drug lists and prior authorization. This subdivision is contingent on federal approval of the managed care contract changes and the collection of additional prescription drug rebates.

Subd. 7. **Enrollee benefits.** All eligible individuals enrolled by demonstration providers shall receive all needed health care services as defined in subdivision 6.

All enrolled individuals have the right to appeal if necessary services are not being authorized as defined in subdivision 11.

Subd. 8. **Preadmission screening waiver.** Except as applicable to the project's operation, the provisions of sections 256.975 and 256B.0911 are waived for the purposes of this section for recipients enrolled with demonstration providers or in the prepaid medical assistance program for seniors.

Subd. 9. **Reporting.** (a) Each demonstration provider shall submit information as required by the commissioner, including data required for assessing client satisfaction, quality of care, cost, and utilization of services for purposes of project evaluation. The commissioner shall also develop methods of data reporting and collection in order to provide aggregate enrollee information on encounters and outcomes to determine access and quality assurance. Required information shall be specified before the commissioner contracts with a demonstration provider.

(b) Aggregate nonpersonally identifiable health plan encounter data, aggregate spending data for major categories of service as reported to the commissioners of health and commerce under section 62D.08, subdivision 3, clause (a), and criteria for service authorization and service use are public data that the commissioner shall make available and use in public reports. The commissioner shall require each health plan and county-based purchasing plan to provide:

(1) encounter data for each service provided, using standard codes and unit of service definitions set by the commissioner, in a form that the commissioner can report by age, eligibility groups, and health plan; and

(2) criteria, written policies, and procedures required to be disclosed under section 62M.10, subdivision 7, and Code of Federal Regulations, title 42, part 438.210 (b)(1), used for each type of service for which authorization is required.

(c) Each demonstration provider shall report to the commissioner on the extent to which providers employed by or under contract with the demonstration provider use patient-centered decision-making tools or procedures designed to engage patients early in the decision-making process and the steps taken by the demonstration provider to encourage their use.

Subd. 9a. **Administrative expense reporting.** Within the limit of available appropriations, the commissioner shall work with the commissioner of health to identify and collect data on administrative spending for state health care programs reported to the commissioner of health by managed care plans under section 62D.08 and county-based purchasing plans under section 256B.692, provided that such data are consistent with guidelines and standards for administrative spending that are developed by the commissioner of health, and reported to the legislature under Laws 2008, chapter 364, section 12. Data provided to the commissioner under this subdivision are nonpublic data as defined under section 13.02.

Subd. 9c. **Managed care financial reporting.** (a) The commissioner shall collect detailed data regarding financials, provider payments, provider rate methodologies, and other data as determined by the commissioner. The commissioner, in consultation with the commissioners of health and commerce, and in consultation with managed care plans and county-based purchasing plans, shall set uniform criteria, definitions, and standards for the data to be submitted, and shall require managed care and county-based purchasing plans to comply with these criteria, definitions, and standards when submitting data under this section. In carrying out the responsibilities of this subdivision, the commissioner shall ensure that the data collection is implemented in an integrated and coordinated manner that avoids unnecessary duplication of effort. To the extent possible, the commissioner shall use existing data sources and streamline data collection in order to reduce public and private sector administrative costs. Nothing in this subdivision shall allow release of information that is nonpublic data pursuant to section 13.02.

(b) Effective January 1, 2014, each managed care and county-based purchasing plan must quarterly provide to the commissioner the following information on state public programs, in the form and manner specified by the commissioner, according to guidelines developed by the commissioner in consultation with managed care plans and county-based purchasing plans under contract:

(1) an income statement by program;

(2) financial statement footnotes;

(3) quarterly profitability by program and population group;

(4) a medical liability summary by program and population group;

(5) received but unpaid claims report by program;

(6) services versus payment lags by program for hospital services, outpatient services, physician services, other medical services, and pharmaceutical benefits;

(7) utilization reports that summarize utilization and unit cost information by program for hospitalization services, outpatient services, physician services, and other medical services;

(8) pharmaceutical statistics by program and population group for measures of price and utilization of pharmaceutical services;

(9) subcapitation expenses by population group;

(10) third-party payments by program;

(11) all new, active, and closed subrogation cases by program;

(12) all new, active, and closed fraud and abuse cases by program;

(13) medical loss ratios by program;

(14) administrative expenses by category and subcategory by program that reconcile to other state and federal regulatory agencies, including Minnesota Supplement Report #1A;

(15) revenues by program, including investment income;

(16) nonadministrative service payments, provider payments, and reimbursement rates by provider type or service category, by program, paid by the managed care plan under this section or the county-based purchasing plan under section 256B.692 to providers and vendors for administrative services under contract with the plan, including but not limited to:

(i) individual-level provider payment and reimbursement rate data;

(ii) provider reimbursement rate methodologies by provider type, by program, including a description of alternative payment arrangements and payments outside the claims process;

(iii) data on implementation of legislatively mandated provider rate changes; and

(iv) individual-level provider payment and reimbursement rate data and plan-specific provider reimbursement rate methodologies by provider type, by program, including alternative

payment arrangements and payments outside the claims process, provided to the commissioner under this subdivision are nonpublic data as defined in section 13.02;

(17) data on the amount of reinsurance or transfer of risk by program; and

(18) contribution to reserve, by program.

(c) In the event a report is published or released based on data provided under this subdivision, the commissioner shall provide the report to managed care plans and county-based purchasing plans 15 days prior to the publication or release of the report. Managed care plans and county-based purchasing plans shall have 15 days to review the report and provide comment to the commissioner.

The quarterly reports shall be submitted to the commissioner no later than 60 days after the end of the previous quarter, except the fourth-quarter report, which shall be submitted by April 1 of each year. The fourth-quarter report shall include audited financial statements, parent company audited financial statements, an income statement reconciliation report, and any other documentation necessary to reconcile the detailed reports to the audited financial statements.

(d) Managed care plans and county-based purchasing plans shall certify to the commissioner for the purpose of financial reporting for state public health care programs under this subdivision that costs reported for state public health care programs include:

(1) only services covered under the state plan and waivers, and related allowable administrative expenses; and

(2) the dollar value of unallowable and nonstate plan services, including both medical and administrative expenditures, that have been excluded.

Subd. 9d. **Financial and quality assurance audits.** (a) The commissioner shall require, in the request for bids and resulting contracts with managed care plans and county-based purchasing plans under this section and section 256B.692, that each managed care plan and county-based purchasing plan submit to and fully cooperate with the independent third-party financial audits by the legislative auditor under subdivision 9e of the information required under subdivision 9c, paragraph (b). Each contract with a managed care plan or county-based purchasing plan under this section or section 256B.692 must provide the commissioner, the legislative auditor, and vendors contracting with the legislative auditor, access to all data required to complete audits under subdivision 9e.

(b) Each managed care plan and county-based purchasing plan providing services under this section shall provide to the commissioner biweekly encounter data and claims data for state public health care programs and shall participate in a quality assurance program that verifies the timeliness, completeness, accuracy, and consistency of the data provided. The commissioner shall develop written protocols for the quality assurance program and shall make the protocols publicly available. The commissioner shall contract for an independent third-party audit to evaluate the quality assurance protocols as to the capacity of the protocols to ensure complete and accurate data and to evaluate the commissioner's implementation of the protocols.

(c) Upon completion of the evaluation under paragraph (b), the commissioner shall provide copies of the report to the legislative auditor and the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and financing.

(d) Any actuary under contract with the commissioner to provide actuarial services must meet the independence requirements under the professional code for fellows in the Society of Actuaries and must not have provided actuarial services to a managed care plan or county-based purchasing plan that is under contract with the commissioner pursuant to this section and section 256B.692 during the period in which the actuarial services are being provided. An actuary or actuarial firm meeting the requirements of this paragraph must certify and attest to the rates paid to the managed care plans and county-based purchasing plans under this section and section 256B.692, and the certification and attestation must be auditable.

(e) The commissioner, to the extent of available funding, shall conduct ad hoc audits of state public health care program administrative and medical expenses reported by managed care plans and county-based purchasing plans. This includes: financial and encounter data reported to the commissioner under subdivision 9c, including payments to providers and subcontractors; supporting documentation for expenditures; categorization of administrative and medical expenses; and allocation methods used to attribute administrative expenses to state public health care programs. These audits also must monitor compliance with data and financial report certification requirements established by the commissioner for the purposes of managed care capitation payment rate-setting. The managed care plans and county-based purchasing plans shall fully cooperate with the audits in this subdivision. The commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by February 1, 2016, and each February 1 thereafter, the number of ad hoc audits conducted in the past calendar year and the results of these audits.

(f) Nothing in this subdivision shall allow the release of information that is nonpublic data pursuant to section 13.02.

Subd. 9e. **Financial audits.** (a) The legislative auditor shall conduct or contract with vendors to conduct independent third-party financial audits of the information required to be provided by managed care plans and county-based purchasing plans under subdivision 9c, paragraph (b). The audits by the vendors shall be conducted as vendor resources permit and in accordance with generally accepted government auditing standards issued by the United States Government Accountability Office. The contract with the vendors shall be designed and administered so as to render the independent third-party audits eligible for a federal subsidy, if available. The contract shall require the audits to include a determination of compliance with the federal Medicaid rate certification process.

(b) For purposes of this subdivision, "independent third-party" means a vendor that is independent in accordance with government auditing standards issued by the United States Government Accountability Office.

Subd. 10. **Information.** Notwithstanding any law or rule to the contrary, the commissioner may allow disclosure of the recipient's identity solely for the purposes of (a) allowing demonstration providers to provide the information to the recipient regarding services, access to services, and other provider characteristics, and (b) facilitating monitoring of recipient satisfaction and quality of care. The commissioner shall develop and implement measures to protect recipients from invasions of privacy and from harassment.

Subd. 11. **Appeals.** A recipient may appeal to the commissioner a demonstration provider's delay or refusal to provide services, according to section 256.045.

Subd. 16. **Project extension.** Minnesota Rules, parts 9500.1450; 9500.1451; 9500.1452; 9500.1453; 9500.1454; 9500.1455; 9500.1457; 9500.1458; 9500.1459; 9500.1460; 9500.1461; 9500.1462; 9500.1463; and 9500.1464, are extended.

Subd. 17. **Continuation of prepaid medical assistance.** The commissioner may continue the provisions of this section in any or all of the participating counties if necessary federal authority is granted. The commissioner may adopt permanent rules to continue prepaid medical assistance in these areas.

Subd. 18. **Services pending appeal.** If the recipient appeals in writing to the state agency on or before the tenth day after the decision of the prepaid health plan to reduce, suspend, or terminate services which the recipient had been receiving, and the treating physician or another plan physician orders the services to be continued at the previous level, the prepaid health plan must continue to provide services at a level equal to the level ordered by the plan's physician until the state agency renders its decision.

Subd. 19. **Limitation on reimbursement; providers not with prepaid health plan.** A prepaid health plan may limit any reimbursement it may be required to pay to providers not employed by or under contract with the prepaid health plan to the medical assistance rates for medical assistance enrollees paid by the commissioner of human services to providers for services to recipients not enrolled in a prepaid health plan.

Subd. 20. **Ombudsperson.** The commissioner shall designate an ombudsperson to advocate for persons required to enroll in prepaid health plans under this section. The ombudsperson shall advocate for recipients enrolled in prepaid health plans through complaint and appeal procedures and ensure that necessary medical services are provided either by the prepaid health plan directly or by referral to appropriate social services. At the time of enrollment in a prepaid health plan, the local agency shall inform recipients about the ombudsperson program and their right to a resolution of a complaint by the prepaid health plan if they experience a problem with the plan or its providers.

Subd. 21. **Prepayment coordinator.** The county board shall designate a prepayment coordinator to assist the state agency in implementing this section. Assistance must include educating recipients about available health care options, enrolling recipients under subdivision 5, providing necessary eligibility and enrollment information to health plans and the state agency, and coordinating complaints and appeals with the ombudsman established in subdivision 18.

Subd. 22. **Impact on public or teaching hospitals and community clinics.** (a) Before implementing prepaid programs in counties with a county operated or affiliated public teaching hospital or a hospital or clinic operated by the University of Minnesota, the commissioner shall consider the risks the prepaid program creates for the hospital and allow the county or hospital the opportunity to participate in the program, provided the terms of participation in the program are competitive with the terms of other participants.

(b) Prepaid health plans serving counties with a nonprofit community clinic or community health services agency must contract with the clinic or agency to provide services to clients who

choose to receive services from the clinic or agency, if the clinic or agency agrees to payment rates that are competitive with rates paid to other health plan providers for the same or similar services.

(c) For purposes of this subdivision, "nonprofit community clinic" includes, but is not limited to, a community mental health center as defined in sections 245.62 and 256B.0625, subdivision 5.

Subd. 23. **Alternative services; elderly and disabled persons.** (a) The commissioner may implement demonstration projects to create alternative integrated delivery systems for acute and long-term care services to elderly persons and persons with disabilities as defined in section 256B.77, subdivision 7a, that provide increased coordination, improve access to quality services, and mitigate future cost increases. The commissioner may seek federal authority to combine Medicare and Medicaid capitation payments for the purpose of such demonstrations and may contract with Medicare-approved special needs plans that are offered by a demonstration provider or by an entity that is directly or indirectly wholly owned or controlled by a demonstration provider to provide Medicaid services. Medicare funds and services shall be administered according to the terms and conditions of the federal contract and demonstration provisions. For the purpose of administering medical assistance funds, demonstrations under this subdivision are subject to subdivisions 1 to 22. The provisions of Minnesota Rules, parts 9500.1450 to 9500.1464, apply to these demonstrations, with the exceptions of parts 9500.1452, subpart 2, item B; and 9500.1457, subpart 1, items B and C, which do not apply to persons enrolling in demonstrations under this section. All enforcement and rulemaking powers available under chapters 62D, 62M, and 62Q are hereby granted to the commissioner of health with respect to Medicare-approved special needs plans with which the commissioner contracts to provide Medicaid services under this section. An initial open enrollment period may be provided. Persons who disenroll from demonstrations under this subdivision remain subject to Minnesota Rules, parts 9500.1450 to 9500.1464. When a person is enrolled in a health plan under these demonstrations and the health plan's participation is subsequently terminated for any reason, the person shall be provided an opportunity to select a new health plan and shall have the right to change health plans within the first 60 days of enrollment in the second health plan. Persons required to participate in health plans under this section who fail to make a choice of health plan shall not be randomly assigned to health plans under these demonstrations. Notwithstanding section 256L.12, subdivision 5, and Minnesota Rules, part 9505.5220, subpart 1, item A, if adopted, for the purpose of demonstrations under this subdivision, the commissioner may contract with managed care organizations, including counties, to serve only elderly persons eligible for medical assistance, elderly and disabled persons, or disabled persons only. For persons with a primary diagnosis of developmental disability, serious and persistent mental illness, or serious emotional disturbance, the commissioner must ensure that the county authority has approved the demonstration and contracting design. Enrollment in these projects for persons with disabilities shall be voluntary. The commissioner shall not implement any demonstration project under this subdivision for persons with a primary diagnosis of developmental disabilities, serious and persistent mental illness, or serious emotional disturbance, without approval of the county board of the county in which the demonstration is being implemented.

(b) MS 2009 Supplement [Expired, 2003 c 47 s 4; 2007 c 147 art 7 s 60]

(c) Before implementation of a demonstration project for disabled persons, the commissioner must provide information to appropriate committees of the house of representatives and senate and must involve representatives of affected disability groups in the design of the demonstration projects.

(d) A nursing facility reimbursed under the alternative reimbursement methodology in section 256B.434 may, in collaboration with a hospital, clinic, or other health care entity provide services under paragraph (a). The commissioner shall amend the state plan and seek any federal waivers necessary to implement this paragraph.

(e) The commissioner, in consultation with the commissioners of commerce and health, may approve and implement programs for all-inclusive care for the elderly (PACE) according to federal laws and regulations governing that program and state laws or rules applicable to participating providers. A PACE provider is not required to be licensed or certified as a health plan company as defined in section 62Q.01, subdivision 4. Persons age 55 and older who have been screened by the county and found to be eligible for services under the elderly waiver or community access for disability inclusion or who are already eligible for Medicaid but meet level of care criteria for receipt of waiver services may choose to enroll in the PACE program. Medicare and Medicaid services will be provided according to this subdivision and federal Medicare and Medicaid requirements governing PACE providers and programs. PACE enrollees will receive Medicaid home and community-based services through the PACE provider as an alternative to services for which they would otherwise be eligible through home and community-based waiver

programs and Medicaid State Plan Services. The commissioner shall establish Medicaid rates for PACE providers that do not exceed costs that would have been incurred under fee-for-service or other relevant managed care programs operated by the state.

(f) The commissioner shall seek federal approval to expand the Minnesota disability health options (MnDHO) program established under this subdivision in stages, first to regional population centers outside the seven-county metro area and then to all areas of the state. Until July 1, 2009, expansion for MnDHO projects that include home and community-based services is limited to the two projects and service areas in effect on March 1, 2006. Enrollment in integrated MnDHO programs that include home and community-based services shall remain voluntary. Costs for home and community-based services included under MnDHO must not exceed costs that would have been incurred under the fee-for-service program. Notwithstanding whether expansion occurs under this paragraph, in determining MnDHO payment rates and risk adjustment methods, the commissioner must consider the methods used to determine county allocations for home and community-based program participants. If necessary to reduce MnDHO rates to comply with the provision regarding MnDHO costs for home and community-based services, the commissioner shall achieve the reduction by maintaining the base rate for contract year 2010 for services provided under the community access for disability inclusion waiver at the same level as for contract year 2009. The commissioner may apply other reductions to MnDHO rates to implement decreases in provider payment rates required by state law. Effective January 1, 2011, enrollment and operation of the MnDHO program in effect during 2010 shall cease. The commissioner may reopen the program provided all applicable conditions of this section are met. In developing program specifications for expansion of integrated programs, the commissioner shall involve and consult the state-level stakeholder group established in subdivision 28, paragraph (d), including consultation on whether and how to include home and community-based waiver programs. Plans to reopen MnDHO projects shall be presented to the chairs of the house of representatives and senate committees with jurisdiction over health and human services policy and finance prior to implementation.

(g) Notwithstanding section 256B.0621, health plans providing services under this section are responsible for home care targeted case management and relocation targeted case management. Services must be provided according to the terms of the waivers and contracts approved by the federal government.

Subd. 25. **Continuation of payments through discharge.** In the event a medical assistance recipient or beneficiary enrolled in a health plan under this section is denied nursing facility services after residing in the facility for more than 180 days, any denial of medical assistance payment to a provider under this section shall be prospective only and payments to the provider shall continue until the resident is discharged or 30 days after the effective date of the service denial, whichever is sooner.

Subd. 26. **American Indian recipients.** (a) For American Indian recipients of medical assistance who are required to enroll with a demonstration provider under subdivision 4 or in a county-based purchasing entity, if applicable, under section 256B.692, medical assistance shall cover health care services provided at Indian health services facilities and facilities operated by a tribe or tribal organization under funding authorized by United States Code, title 25, sections 450f to 450n, or title III of the Indian Self-Determination and Education Assistance Act, Public Law 93-638, if those services would otherwise be covered under section 256B.0625. Payments for services provided under this subdivision shall be made on a fee-for-service basis, and may, at the option of the tribe or tribal organization, be made according to rates authorized under sections 256.969, subdivision 16, and 256B.0625, subdivision 34. Implementation of this purchasing model is contingent on federal approval.

(b) The commissioner of human services, in consultation with the tribal governments, shall develop a plan for tribes to assist in the enrollment process for American Indian recipients enrolled in the prepaid medical assistance program under this section. This plan also shall address how tribes will be included in ensuring the coordination of care for American Indian recipients between Indian health service or tribal providers and other providers.

(c) For purposes of this subdivision, "American Indian" has the meaning given to persons to whom services will be provided for in Code of Federal Regulations, title 42, section 36.12.

Subd. 27. **Information for persons with limited English-language proficiency.** Managed care contracts entered into under this section and section 256L.12 must require demonstration providers to provide language assistance to enrollees that ensures meaningful access to its programs and services according to Title VI of the Civil Rights Act and federal regulations adopted under that law or any guidance from the United States Department of Health and Human Services.

Subd. 28. **Medicare special needs plans; medical assistance basic health care.** (a) The commissioner may contract with demonstration providers and current or former sponsors of

qualified Medicare-approved special needs plans, to provide medical assistance basic health care services to persons with disabilities, including those with developmental disabilities. Basic health care services include:

(1) those services covered by the medical assistance state plan except for ICF/DD services, home and community-based waiver services, case management for persons with developmental disabilities under section 256B.0625, subdivision 20a, and personal care and certain home care services defined by the commissioner in consultation with the stakeholder group established under paragraph (d); and

(2) basic health care services may also include risk for up to 100 days of nursing facility services for persons who reside in a noninstitutional setting and home health services related to rehabilitation as defined by the commissioner after consultation with the stakeholder group.

The commissioner may exclude other medical assistance services from the basic health care benefit set. Enrollees in these plans can access any excluded services on the same basis as other medical assistance recipients who have not enrolled.

(b) The commissioner may contract with demonstration providers and current and former sponsors of qualified Medicare special needs plans, to provide basic health care services under medical assistance to persons who are dually eligible for both Medicare and Medicaid and those Social Security beneficiaries eligible for Medicaid but in the waiting period for Medicare. The commissioner shall consult with the stakeholder group under paragraph (d) in developing program specifications for these services. Payment for Medicaid services provided under this subdivision for the months of May and June will be made no earlier than July 1 of the same calendar year.

(c) Notwithstanding subdivision 4, beginning January 1, 2012, the commissioner shall enroll persons with disabilities in managed care under this section, unless the individual chooses to opt out of enrollment. The commissioner shall establish enrollment and opt out procedures consistent with applicable enrollment procedures under this section.

(d) The commissioner shall establish a state-level stakeholder group to provide advice on managed care programs for persons with disabilities, including both MnDHO and contracts with special needs plans that provide basic health care services as described in paragraphs (a) and (b). The stakeholder group shall provide advice on program expansions under this subdivision and subdivision 23, including:

(1) implementation efforts;

(2) consumer protections; and

(3) program specifications such as quality assurance measures, data collection and reporting, and evaluation of costs, quality, and results.

(e) Each plan under contract to provide medical assistance basic health care services shall establish a local or regional stakeholder group, including representatives of the counties covered by the plan, members, consumer advocates, and providers, for advice on issues that arise in the local or regional area.

(f) The commissioner is prohibited from providing the names of potential enrollees to health plans for marketing purposes. The commissioner shall mail no more than two sets of marketing materials per contract year to potential enrollees on behalf of health plans, at the health plan's request. The marketing materials shall be mailed by the commissioner within 30 days of receipt of these materials from the health plan. The health plans shall cover any costs incurred by the commissioner for mailing marketing materials.

Subd. 29. **Prepaid health plan rates.** In negotiating prepaid health plan contract rates, the commissioner of human services shall take into consideration, and the rates shall reflect, the anticipated savings in the medical assistance program due to extending medical assistance coverage to services provided in licensed birth centers, the anticipated use of these services within the medical assistance population, and the reduced medical assistance costs associated with the use of birth centers for normal, low-risk deliveries.

Subd. 30. **Provision of required materials in alternative formats.** (a) For the purposes of this subdivision, "alternative format" means a medium other than paper and "prepaid health plan" means managed care plans and county-based purchasing plans.

(b) A prepaid health plan may provide in an alternative format a provider directory and certificate of coverage, or materials otherwise required to be available in writing under Code of Federal Regulations, title 42, section 438.10, or under the commissioner's contract with the prepaid health plan, if the following conditions are met:

(1) the prepaid health plan, local agency, or commissioner, as applicable, informs the enrollee that:

(i) an alternative format is available and the enrollee affirmatively requests of the prepaid health plan that the provider directory, certificate of coverage, or materials otherwise required

under Code of Federal Regulations, title 42, section 438.10, or under the commissioner's contract with the prepaid health plan be provided in an alternative format; and

(ii) a record of the enrollee request is retained by the prepaid health plan in the form of written direction from the enrollee or a documented telephone call followed by a confirmation letter to the enrollee from the prepaid health plan that explains that the enrollee may change the request at any time;

(2) the materials are sent to a secure electronic mailbox and are made available at a password-protected secure electronic Web site or on a data storage device if the materials contain enrollee data that is individually identifiable;

(3) the enrollee is provided a customer service number on the enrollee's membership card that may be called to request a paper version of the materials provided in an alternative format; and

(4) the materials provided in an alternative format meets all other requirements of the commissioner regarding content, size of the typeface, and any required time frames for distribution. "Required time frames for distribution" must permit sufficient time for prepaid health plans to distribute materials in alternative formats upon receipt of enrollees' requests for the materials.

(c) A prepaid health plan may provide in an alternative format its primary care network list to the commissioner and to local agencies within its service area. The commissioner or local agency, as applicable, shall inform a potential enrollee of the availability of a prepaid health plan's primary care network list in an alternative format. If the potential enrollee requests an alternative format of the prepaid health plan's primary care network list, a record of that request shall be retained by the commissioner or local agency. The potential enrollee is permitted to withdraw the request at any time.

The prepaid health plan shall submit sufficient paper versions of the primary care network list to the commissioner and to local agencies within its service area to accommodate potential enrollee requests for paper versions of the primary care network list.

(d) A prepaid health plan may provide in an alternative format materials otherwise required to be available in writing under Code of Federal Regulations, title 42, section 438.10, or under the commissioner's contract with the prepaid health plan, if the conditions of paragraphs (b) and (c) are met for persons who are eligible for enrollment in managed care.

(e) The commissioner shall consult with managed care plans, county-based purchasing plans, counties, and other interested parties to determine how materials required to be made available to enrollees under Code of Federal Regulations, title 42, section 438.10, or under the commissioner's contract with a prepaid health plan may be provided in an alternative format on the basis that the enrollee has not opted in to receive the alternative format. The commissioner shall consult with managed care plans, county-based purchasing plans, counties, and other interested parties to develop recommendations relating to the conditions that must be met for an opt-out process to be granted.

Subd. 31. **Payment reduction.** (a) Beginning September 1, 2011, the commissioner shall reduce payments and limit future rate increases paid to managed care plans and county-based purchasing plans. The limits in paragraphs (a) to (f) shall be achieved on a statewide aggregate basis by program. The commissioner may use competitive bidding, payment reductions, or other reductions to achieve the reductions and limits in this subdivision.

(b) Beginning September 1, 2011, the commissioner shall reduce payments to managed care plans and county-based purchasing plans as follows:

(1) 2.0 percent for medical assistance elderly basic care. This shall not apply to Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver services;

(2) 2.82 percent for medical assistance families and children;

(3) 10.1 percent for medical assistance adults without children; and

(4) 6.0 percent for MinnesotaCare families and children.

(c) Beginning January 1, 2012, the commissioner shall limit rates paid to managed care plans and county-based purchasing plans for calendar year 2012 to a percentage of the rates in effect on August 31, 2011, as follows:

(1) 98 percent for medical assistance elderly basic care. This shall not apply to Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver services;

(2) 97.18 percent for medical assistance families and children;

(3) 89.9 percent for medical assistance adults without children; and

(4) 94 percent for MinnesotaCare families and children.

(d) Beginning January 1, 2013, to December 31, 2013, the commissioner shall limit the maximum annual trend increases to rates paid to managed care plans and county-based purchasing plans as follows:

(1) 7.5 percent for medical assistance elderly basic care. This shall not apply to Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver services;

(2) 5.0 percent for medical assistance special needs basic care;

(3) 2.0 percent for medical assistance families and children;

(4) 3.0 percent for medical assistance adults without children;

(5) 3.0 percent for MinnesotaCare families and children; and

(6) 3.0 percent for MinnesotaCare adults without children.

(e) The commissioner may limit trend increases to less than the maximum. Beginning July 1, 2014, the commissioner shall limit the maximum annual trend increases to rates paid to managed care plans and county-based purchasing plans as follows for calendar years 2014 and 2015:

(1) 7.5 percent for medical assistance elderly basic care. This shall not apply to Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver services;

(2) 5.0 percent for medical assistance special needs basic care;

(3) 2.0 percent for medical assistance families and children;

(4) 3.0 percent for medical assistance adults without children;

(5) 3.0 percent for MinnesotaCare families and children; and

(6) 4.0 percent for MinnesotaCare adults without children.

The commissioner may limit trend increases to less than the maximum. For calendar year 2014, the commissioner shall reduce the maximum aggregate trend increases by $47,000,000 in state and federal funds to account for the reductions in administrative expenses in subdivision 5i.

Subd. 32a. **Initiatives to improve early screening, diagnosis, and treatment of children with autism spectrum disorder and other developmental conditions.** (a) The commissioner shall require managed care plans and county-based purchasing plans, as a condition of contract, to implement strategies that facilitate access for young children between the ages of one and three years to periodic developmental and social-emotional screenings, as recommended by the Minnesota Interagency Developmental Screening Task Force, and that those children who do not meet milestones are provided access to appropriate evaluation and assessment, including treatment recommendations, expected to improve the child's functioning, with the goal of meeting milestones by age five.

(b) The following information from encounter data provided to the commissioner shall be reported on the department's public Web site for each managed care plan and county-based purchasing plan annually by July 31 of each year beginning in 2014:

(1) the number of children who received a diagnostic assessment;

(2) the total number of children ages one to six with a diagnosis of autism spectrum disorder who received treatments;

(3) the number of children identified under clause (2) reported by each 12-month age group beginning with age one and ending with age six; and

(4) the types of treatments provided to children identified under clause (2) listed by billing code, including the number of units billed for each child.

(c) The managed care plans and county-based purchasing plans shall also report on any barriers to providing screening, diagnosis, and treatment of young children between the ages of one and three years, any strategies implemented to address those barriers, and make recommendations on how to measure and report on the effectiveness of the strategies implemented to facilitate access for young children to provide developmental and social-emotional screening, diagnosis, and treatment as described in paragraph (a).

Subd. 33. **Competitive bidding.** (a) For managed care contracts effective on or after January 1, 2014, the commissioner may utilize a competitive price bidding program for nonelderly, nondisabled adults and children in medical assistance and MinnesotaCare in the seven-county metropolitan area. The program must allow a minimum of two managed care plans to serve the metropolitan area.

(b) In designing the competitive bid program, the commissioner shall consider, and incorporate where appropriate, the procedures and criteria used in the competitive bidding pilot authorized under Laws 2011, First Special Session chapter 9, article 6, section 96. The pilot program operating in Hennepin County under the authority of section 256B.0756 shall continue to be exempt from competitive bid.

(c) The commissioner shall use past performance data as a factor in selecting vendors and shall consider this information, along with competitive bid and other information, in determining whether to contract with a managed care plan under this subdivision. Where possible, the assessment of past performance in serving persons on public programs shall be based on encounter data submitted to the commissioner. The commissioner shall evaluate past performance based on both the health outcomes of care and success rates in securing participation in recommended preventive and early diagnostic care. Data provided by managed care plans must be provided

in a uniform manner as specified by the commissioner and must include only data on medical assistance and MinnesotaCare enrollees. The data submitted must include health outcome measures on reducing the incidence of low birth weight established by the managed care plan under subdivision 32.

Subd. 34. **Supplemental recovery program.** The commissioner shall conduct a supplemental recovery program for third-party liabilities identified through coordination of benefits not recovered by managed care plans and county-based purchasing plans for state public health programs. Any third-party liability identified through coordination of benefits and recovered by the commissioner more than eight months after the date a managed care plan or county-based purchasing plan adjudicates a health care claim shall be retained by the commissioner and deposited in the general fund. The commissioner shall establish a mechanism, including a reconciliation process, for managed care plans and county-based purchasing plans to coordinate third-party liability collections efforts resulting from coordination of benefits under this subdivision with the commissioner to ensure there is no duplication of efforts. The coordination mechanism must be consistent with the reporting requirements in subdivision 9c. The commissioner shall share accurate and timely third-party liability data with managed care plans and county-based purchasing plans.

Subd. 35. **Statewide procurement.** (a) For calendar year 2015, the commissioner may extend a demonstration provider's contract under this section for a sixth year after the most recent procurement. For calendar year 2015, section 16B.98, subdivision 5, paragraph (b), and section 16C.05, subdivision 2, paragraph (b), shall not apply to contracts under this section.

(b) For calendar year 2016 contracts under this section, the commissioner shall procure through a statewide procurement, which includes all 87 counties, demonstration providers, and participating entities as defined in section 256L.01, subdivision 7. The commissioner shall publish a request for proposals by January 5, 2015. As part of the procurement process, the commissioner shall:

(1) seek each individual county's input;

(2) organize counties into regional groups, and consider single counties for the largest and most diverse counties; and

(3) seek regional and county input regarding the respondent's ability to fully and adequately deliver required health care services, offer an adequate provider network, provide care coordination with county services, and serve special populations, including enrollees with language and cultural needs.

256C.23 DEFINITIONS.

Subd. 3. **Regional service center.** "Regional service center" means a facility designed to provide an entry point for deaf, deafblind, and hard-of-hearing persons of that region in need of education, employment, social, human, or other services.

256C.25 INTERPRETER SERVICES.

Subd. 2. **Duties.** Interpreting or interpreter referral services must include:

(1) statewide access to interpreter referral and direct interpreting services, coordinated with the regional service centers;

(2) maintenance of a statewide directory of qualified interpreters;

(3) assessment of the present and projected supply and demand for interpreter services statewide; and

(4) coordination with the regional service centers on projects to train interpreters and advocate for and evaluate interpreter services.

3400.0185 TERMINATION AND ADVERSE ACTIONS; NOTICE REQUIRED.

Subp. 5. **Notice to providers of actions adverse to the provider.** The county must give a provider written notice of the following actions adverse to the provider: a denial of authorization, a termination of authorization, a reduction in the number of hours of care with that provider, and a determination that the provider has an overpayment. The notice must include the following information:

A. a description of the adverse action;

B. the effective date of the adverse action; and

C. a statement that unless a family appeals the adverse action before the effective date or the provider appeals the overpayment determination, the adverse action will occur on the effective date. The notice must be mailed to the provider at least 15 calendar days before the effective date of the adverse action.

5600.2500 FEES.

The fees charged by the board are fixed at the following rates:

A. physician application fee, $200;

B. physician annual license, $192;

C. physician endorsement to other states, $40;

D. physician emeritus license, $50;

E. physician temporary licenses, $60;

F. physician late fee, $60;

G. physician assistant application fee, $120;

H. physician assistant annual registration (prescribing), $135;

I. physician assistant annual registration (nonprescribing), $115;

J. physician assistant temporary registration, $115;

K. physician assistant temporary permit, $60;

L. physician assistant locum tenens permit, $25;

M. physician assistant late fee, $50;

N. acupuncture temporary permit, $60;

O. acupuncture inactive status fee, $50;

P. respiratory care annual registration, $90;

Q. respiratory care application fee, $100;

R. respiratory care late fee, $50;

S. respiratory care inactive status, $50;

T. respiratory care temporary permit, $60;

U. respiratory care temporary registration, $90;

V. duplicate license or registration fee, $20;

W. certification letter, $25;

X. verification of status, $10;

Y. education or training program approval fee, $100;

Z. report creation and generation, $60 per hour billed in quarter-hour increments with a quarter-hour minimum; and

AA. examination administrative fee:

(1) half day, $50; and

(2) full day, $80.

The renewal cycle for physician assistants under items H and I begins July 1. The duration of the permit issued under item L is one year.

9503.0145 FOOD AND WATER.

Subp. 6. **Food allergy information.** Information about food allergies of the children in the center must be available in the area where food is prepared or served to children with allergies. All staff providing care to the child must be informed of the allergy.

9530.6405 DEFINITIONS.

Subpart 1. **Scope.** As used in parts 9530.6405 to 9530.6505, the following terms have the meanings given to them.

9530.6405 DEFINITIONS.

Subp. 1a. **Administration of medications.** "Administration of medications" means performing a task to provide medications to a client, and includes the following tasks, performed in the following order:

A. checking the client's medication record;

B. preparing the medication for administration;

C. administering the medication to the client;

D. documenting the administration, or the reason for not administering medications as prescribed; and

E. reporting information to a licensed practitioner or a nurse regarding problems with the administration of the medication or the client's refusal to take the medication.

9530.6405 DEFINITIONS.

Subp. 2. **Adolescent.** "Adolescent" means an individual under 18 years of age.

9530.6405 DEFINITIONS.

Subp. 3. **Alcohol and drug counselor.** "Alcohol and drug counselor" has the meaning given in Minnesota Statutes, section 148C.01, subdivision 2.

9530.6405 DEFINITIONS.

Subp. 4. **Applicant.** "Applicant" means an individual, corporation, partnership, voluntary association, controlling individual, or other organization that has applied for licensure under this chapter.

9530.6405 DEFINITIONS.

Subp. 5. **Capacity management system.** "Capacity management system" means a database operated by the Department of Human Services to compile and make information available to the public about the waiting list status and current admission capability of each program serving intravenous drug abusers.

9530.6405 DEFINITIONS.

Subp. 6. **Central registry.** "Central registry" means a database maintained by the department that collects identifying information from two or more programs about individuals applying for maintenance treatment or detoxification treatment for addiction to opiates for the purpose of avoiding an individual's concurrent enrollment in more than one program.

9530.6405 DEFINITIONS.

Subp. 7. **Chemical.** "Chemical" means alcohol, solvents, controlled substances as defined by Minnesota Statutes, section 152.01, subdivision 4, and other mood altering substances.

9530.6405 DEFINITIONS.

Subp. 7a. **Chemical dependency treatment.** "Chemical dependency treatment" means treatment of a substance use disorder, including the process of assessment of a client's needs, development of planned interventions or services to address those needs, provision of services, facilitation of services provided by other service providers, and reassessment by a qualified professional. The goal of treatment is to assist or support the client's efforts to recover from substance use disorder.

9530.6405 DEFINITIONS.

Subp. 8. **Client.** "Client" means an individual accepted by a license holder for assessment or treatment of a substance use disorder. An individual remains a client until the license holder no longer provides or plans to provide the individual with treatment services.

9530.6405 DEFINITIONS.

Subp. 9. **Commissioner.** "Commissioner" means the commissioner of the Department of Human Services or the commissioner's designee.

9530.6405 DEFINITIONS.

Subp. 10. **Co-occurring or co-occurring client.** "Co-occurring" or "co-occurring client" means a diagnosis that indicates a client suffers from a substance use disorder and a mental health problem.

9530.6405 DEFINITIONS.

Subp. 11. **Department.** "Department" means the Department of Human Services.

9530.6405 DEFINITIONS.

Subp. 12. **Direct client contact.** "Direct client contact" has the meaning given for "direct contact" in Minnesota Statutes, section 245C.02, subdivision 11.

9530.6405 DEFINITIONS.

Subp. 13. **License.** "License" means a certificate issued by the commissioner authorizing the license holder to provide a specific program for a specified period of time in accordance with the terms of the license and the rules of the commissioner.

9530.6405 DEFINITIONS.

Subp. 14. **License holder.** "License holder" means an individual, corporation, partnership, voluntary organization, or other organization that is legally responsible for the operation of the program, has been granted a license by the commissioner under this chapter, and is a controlling individual.

9530.6405 DEFINITIONS.

Subp. 14a. **Licensed practitioner.** "Licensed practitioner" means a person who is authorized to prescribe as defined in Minnesota Statutes, section 151.01, subdivision 23.

9530.6405 DEFINITIONS.

Subp. 15. **Licensed professional in private practice.** "Licensed professional in private practice" means an individual who meets the following criteria:

A. is licensed under Minnesota Statutes, chapter 148C, or is exempt from licensure under that chapter but is otherwise licensed to provide alcohol and drug counseling services;

B. practices solely within the permissible scope of the individual's license as defined in the law authorizing licensure; and

C. does not affiliate with other licensed or unlicensed professionals for the purpose of providing alcohol and drug counseling services. Affiliation does not include conferring with other professionals or making client referrals.

9530.6405 DEFINITIONS.

Subp. 15a. **Nurse.** "Nurse" means a person licensed and currently registered to practice professional or practical nursing as defined in Minnesota Statutes, section 148.171, subdivisions 14 and 15.

9530.6405 DEFINITIONS.

Subp. 16. **Paraprofessional.** "Paraprofessional" means an employee, agent, or independent contractor of the license holder who performs tasks in support of the provision of treatment services. Paraprofessionals may be referred to by a variety of titles including technician, case aide, or counselor assistant. An individual may not be a paraprofessional employed by the license holder if the individual is a client of the license holder.

9530.6405 DEFINITIONS.

Subp. 17. **Program serving intravenous drug abusers.** "Program serving intravenous drug abusers" means a program whose primary purpose is providing agonist medication-assisted therapy to clients who are narcotic dependent, regardless of whether the client's narcotic use was intravenous or by other means.

9530.6405 DEFINITIONS.

Subp. 17a. **Student intern.** "Student intern" means a person who is enrolled in an alcohol and drug counselor education program at an accredited school or educational program and is earning a minimum of nine semester credits per calendar year toward the completion of an associate's, bachelor's, master's, or doctorate degree requirements. Degree requirements must include an additional 18 semester credits or 270 hours of alcohol and drug counseling related course work and 440 hours of practicum.

9530.6405 DEFINITIONS.

Subp. 17b. **Substance.** "Substance" means a "chemical" as defined in subpart 7.

9530.6405 DEFINITIONS.

Subp. 17c. **Substance use disorder.** "Substance use disorder" means a pattern of substance use as defined in the Diagnostic and Statistical Manual of Mental Disorders-IV-TR (DSM), et seq. The DSM-IV-TR is incorporated by reference. The DSM was published by the American Psychiatric Association in 1994, in Washington D.C., and is not subject to frequent change. The DSM-IV-TR is available through the Minitex interlibrary loan system.

9530.6405 DEFINITIONS.

Subp. 18. **Target population.** "Target population" means individuals experiencing problems with a substance use disorder having the specified characteristics that a license holder proposes to serve.

9530.6405 DEFINITIONS.

Subp. 20. **Treatment director.** "Treatment director" means an individual who meets the qualifications specified under part 9530.6450, subparts 1 and 3, and is designated by the license holder to be responsible for all aspects of the delivery of treatment services.

9530.6405 DEFINITIONS.

Subp. 21. **Treatment service.** "Treatment service" means a therapeutic intervention or series of interventions.

9530.6410 APPLICABILITY.

Subpart 1. **Applicability.** Except as provided in subparts 2 and 3, no person, corporation, partnership, voluntary association, controlling individual, or other organization may provide chemical dependency treatment services to an individual who has a substance use disorder unless licensed by the commissioner.

Subp. 2. **Activities exempt from license requirement.** Parts 9530.6405 to 9530.6505 do not apply to organizations whose primary functions are information, referral, diagnosis, case management, and assessment for the purposes of placement, education, support group services, or self-help programs. Parts 9530.6405 to 9530.6505do not apply to the activities of licensed professionals in private practice which are not paid for by the consolidated chemical dependency treatment fund.

Subp. 3. **Certain hospitals excluded from license requirement.** Parts 9530.6405 to 9530.6505 do not apply to chemical dependency treatment provided by hospitals licensed under Minnesota Statutes, chapter 62J, or under Minnesota Statutes, sections 144.50 to 144.56, unless the hospital accepts funds for chemical dependency treatment under the consolidated chemical dependency treatment fund under Minnesota Statutes, chapter 254B, medical assistance under Minnesota Statutes, chapter 256B, MinnesotaCare or health care cost containment under Minnesota Statutes, chapter 256L, or general assistance medical care under Minnesota Statutes, chapter 256D.

Subp. 4. **Applicability of chapter 2960.** Beginning July 1, 2005, residential adolescent chemical dependency treatment programs must be licensed according to chapter 2960.

9530.6415 LICENSING REQUIREMENTS.

Subpart 1. **General application and license requirements.** An applicant for a license to provide treatment must comply with the general requirements in Minnesota Statutes, chapters 245A and 245C, and Minnesota Statutes, sections 626.556 and 626.557.

Subp. 2. **Contents of application.** Prior to issuance of a license, an applicant must submit, on forms provided by the commissioner, any documents the commissioner requires to demonstrate the following:

A. compliance with parts 9530.6405 to 9530.6505;

B. compliance with applicable building, fire and safety codes, health rules, zoning ordinances, and other applicable rules and regulations or documentation that a waiver has been granted. The granting of a waiver does not constitute modification of any requirement of parts 9530.6405 to 9530.6505;

C. completion of an assessment of need for a new or expanded program according to part 9530.6800; and

D. insurance coverage, including bonding, sufficient to cover all client funds, property, and interests.

Subp. 3. **Changes in license terms.**

A. A license holder must notify the commissioner before one of the following occurs and the commissioner must determine the need for a new license:

(1) a change in the Department of Health's licensure of the program;

(2) a change in whether the license holder provides services specified in parts 9530.6485 to 9530.6505;

(3) a change in location; or

(4) a change in capacity if the license holder meets the requirements of part 9530.6505.

B. A license holder must notify the commissioner and must apply for a new license if there is a change in program ownership.

9530.6420 INITIAL SERVICES PLAN.

The license holder must complete an initial services plan during or immediately following the intake interview. The plan must address the client's immediate health and safety concerns, identify the issues to be addressed in the first treatment sessions, and make treatment suggestions for the client during the time between intake and completion of the treatment plan. The initial services plan must include a determination whether a client is a vulnerable adult as defined in Minnesota Statutes, section 626.5572, subdivision 21. All adult clients of a residential program are vulnerable adults. An individual abuse prevention plan, according to Minnesota Statutes, sections 245A.65, subdivision 2, paragraph (b), and 626.557, subdivision 14, paragraph (b), is required for all clients who meet the definition of "vulnerable adult."

9530.6422 COMPREHENSIVE ASSESSMENT.

Subpart 1. **Comprehensive assessment of substance use disorder.** A comprehensive assessment of the client's substance use disorder must be coordinated by an alcohol and drug counselor and completed within three calendar days after service initiation for a residential program or three sessions of the client's initiation to services for all other programs. The alcohol and drug counselor may rely on current information provided by a referring agency or other sources as a supplement when information is available. Information gathered more than 45 days before the date of admission is not current. If the comprehensive assessment cannot be completed in the time specified, the treatment plan must indicate how and when it will be completed. The assessment must include sufficient information to complete the assessment summary according to subpart 2 and part 9530.6425. The comprehensive assessment must include information about the client's problems that relate to chemical use and personal strengths that support recovery, including:

A. age, sex, cultural background, sexual orientation, living situation, economic status, and level of education;

B. circumstances of service initiation;

C. previous attempts at treatment for chemical use or dependency, compulsive gambling, or mental illness;

D. chemical use history including amounts and types of chemicals used, frequency and duration of use, periods of abstinence, and circumstances of relapse, if any. For each chemical used within the previous 30 days, the information must include the date and time of the most recent use and any previous experience with withdrawal;

E. specific problem behaviors exhibited by the client when under the influence of chemicals;

F. current family status, family history, including history or presence of physical or sexual abuse, level of family support, and chemical use, abuse, or dependency among family members and significant others;

G. physical concerns or diagnoses, the severity of the concerns, and whether or not the concerns are being addressed by a health care professional;

H. mental health history and current psychiatric status, including symptoms, disability, current treatment supports, and psychotropic medication needed to maintain stability;

I. arrests and legal interventions related to chemical use;

J. ability to function appropriately in work and educational settings;

K. ability to understand written treatment materials, including rules and client rights;

L. risk-taking behavior, including behavior that puts the client at risk of exposure to blood borne or sexually transmitted diseases;

M. social network in relation to expected support for recovery and leisure time activities that have been associated with chemical use;

N. whether the client is pregnant and if so, the health of the unborn child and current involvement in prenatal care; and

O. whether the client recognizes problems related to substance use and is willing to follow treatment recommendations.

Subp. 2. **Assessment summary.** An alcohol and drug counselor must prepare an assessment summary within three calendar days for a residential program or within three treatment sessions of service initiation. The narrative summary of the comprehensive assessment results must meet the requirements of items A and B:

A. An assessment summary must be prepared by an alcohol and drug counselor and include:

(1) a risk description according to part 9530.6622 for each dimension listed in item B;

(2) narrative supporting the risk descriptions; and

(3) a determination of whether the client meets the DSM criteria for a person with a substance use disorder.

B. Contain information relevant to treatment planning and recorded in the dimensions in subitems (1) to (6):

(1) Dimension 1, acute intoxication/withdrawal potential. The license holder must consider the client's ability to cope with withdrawal symptoms and current state of intoxication.

(2) Dimension 2, biomedical conditions and complications. The license holder must consider the degree to which any physical disorder would interfere with treatment for substance abuse, and the client's ability to tolerate any related discomfort. The license holder must determine the impact of continued chemical use on the unborn child if the client is pregnant.

(3) Dimension 3, emotional, behavioral, and cognitive conditions and complications. The license holder must determine the degree to which any condition or complications are likely to interfere with treatment for substance abuse or with functioning in significant life areas and the likelihood of risk of harm to self or others.

(4) Dimension 4, readiness for change. The license holder must also consider the amount of support and encouragement necessary to keep the client involved in treatment.

(5) Dimension 5, relapse, continued use, and continued problem potential. The license holder must consider the degree to which the client recognizes relapse issues and has the skills to prevent relapse of either substance use or mental health problems.

(6) Dimension 6, recovery environment. The license holder must consider the degree to which key areas of the client's life are supportive of or antagonistic to treatment participation and recovery.

9530.6425 INDIVIDUAL TREATMENT PLANS.

Subpart 1. **General.** Individual treatment plans for clients in treatment must be completed within seven calendar days of completion of the assessment summary. Treatment plans must continually be updated, based on new information gathered about the client's condition and on whether planned treatment interventions have had the intended effect. Treatment planning must include ongoing assessment in each of the six dimensions according to part 9530.6422, subpart 2. The plan must provide for the involvement of the client's family and those people selected by the client as being important to the success of the treatment experience at the earliest opportunity,

consistent with the client's treatment needs and written consent. The plan must be developed after completion of the comprehensive assessment and is subject to amendment until services to the client are terminated. The client must have an opportunity to have active, direct involvement in selecting the anticipated outcomes of the treatment process and in developing the individual treatment plan. The individual treatment plan must be signed by the client and the alcohol and drug counselor. The individual treatment plan may be a continuation of the initial services plan required in part 9530.6420.

Subp. 2. **Plan contents.** An individual treatment plan must be recorded in the six dimensions listed in part 9530.6422, subpart 2, item B, and address each problem identified in the assessment summary, and include:

A. specific methods to be used to address identified problems, including amount, frequency, and anticipated duration of treatment service. The methods must be appropriate to the client's language, reading skills, cultural background, and strengths;

B. resources to which the client is being referred for problems when problems are to be addressed concurrently by another provider; and

C. goals the client must reach to complete treatment and have services terminated.

Subp. 3. **Progress notes and plan review.**

A. Progress notes must be entered in a client's file weekly or after each treatment service, whichever is less frequent, by the staff person providing the service. The note must reference the treatment plan. Progress notes must be recorded and address each of the six dimensions listed in part 9530.6422, subpart 2, item B. Progress notes must:

(1) be entered immediately following any significant event. Significant events include those events which have an impact on the client's relationship with other clients, staff, the client's family, or the client's treatment plan;

(2) indicate the type and amount of each treatment service the client has received;

(3) include monitoring of any physical and mental health problems and the participation of others in the treatment plan;

(4) document the participation of others; and

(5) document that the client has been notified of each treatment plan change and that the client either does or does not agree with the change.

B. Treatment plan review must:

(1) occur weekly or after each treatment service, whichever is less frequent;

(2) address each goal in the treatment plan that has been worked on since the last review;

(3) address whether the strategies to address the goals are effective, and if not, must include changes to the treatment plan; and

(4) include a review and evaluation of the individual abuse prevention plan according to Minnesota Statutes, section 245A.65.

C. All entries in a client's record must be legible, signed, and dated. Late entries must be clearly labeled "late entry." Corrections to an entry must be made in a way in which the original entry can still be read.

Subp. 3a. **Documentation.** Progress notes and plan review do not require separate documentation if the information in the client file meets the requirements of subpart 3, items A and B.

Subp. 4. **Summary at termination of services.** An alcohol and drug counselor must write a discharge summary for each client. The summary must be completed within five days of the client's service termination or within five days from the client's or program's decision to terminate services, whichever is earlier.

A. The summary at termination of services must be recorded in the six dimensions listed in part 9530.6422, subpart 2, item B, and include the following information:

(1) client's problems, strengths, and needs while participating in treatment, including services provided;

(2) client's progress toward achieving each of the goals identified in the individual treatment plan;

(3) reasons for and circumstances of service termination; and

(4) risk description according to part 9530.6622.

B. For clients who successfully complete treatment, the summary must also include:

(1) living arrangements upon discharge;

(2) continuing care recommendations, including referrals made with specific attention to continuity of care for mental health problems, as needed;

(3) service termination diagnosis; and

(4) client's prognosis.

9530.6430 TREATMENT SERVICES.

Subpart 1. **Treatment services offered by license holder.**

A. A license holder must offer the following treatment services unless clinically inappropriate and the justifying clinical rationale is documented:

(1) individual and group counseling to help the client identify and address problems related to chemical use and develop strategies to avoid inappropriate chemical use after discharge;

(2) client education strategies to avoid inappropriate chemical use and health problems related to chemical use and the necessary changes in lifestyle to regain and maintain health. Client education must include information concerning the human immunodeficiency virus, according to Minnesota Statutes, section 245A.19, other sexually transmitted diseases, drug and alcohol use during pregnancy, hepatitis, and tuberculosis;

(3) transition services to help the client integrate gains made during treatment into daily living and to reduce reliance on the license holder's staff for support;

(4) services to address issues related to co-occurring mental illness, including education for clients on basic symptoms of mental illness, the possibility of comorbidity, and the need for continued medication compliance while working on recovery from substance use disorder. Groups must address co-occurring mental illness issues, as needed. When treatment for mental health problems is indicated, it is integrated into the client's treatment plan; and

(5) service coordination to help the client obtain the services and to support the client's need to establish a lifestyle free of the harmful effects of substance use disorder.

B. Treatment services provided to individual clients must be provided according to the individual treatment plan and must address cultural differences and special needs of all clients.

Subp. 2. **Additional treatment services.** A license holder may provide or arrange the following additional treatment services as a part of the individual treatment plan:

A. relationship counseling provided by a qualified professional to help the client identify the impact of the client's substance use disorder on others and to help the client and persons in the client's support structure identify and change behaviors that contribute to the client's substance use disorder;

B. therapeutic recreation to provide the client with an opportunity to participate in recreational activities without the use of mood-altering chemicals and to learn to plan and select leisure activities that do not involve the inappropriate use of chemicals;

C. stress management and physical well-being to help the client reach and maintain an acceptable level of health, physical fitness, and well-being;

D. living skills development to help the client learn basic skills necessary for independent living;

E. employment or educational services to help the client become financially independent;

F. socialization skills development to help the client live and interact with others in a positive and productive manner; and

G. room, board, and supervision provided at the treatment site to give the client a safe and appropriate environment in which to gain and practice new skills.

Subp. 3. **Counselors to provide treatment services.** Treatment services, including therapeutic recreation, must be provided by alcohol and drug counselors qualified according to part 9530.6450, unless the individual providing the service is specifically qualified according to the accepted standards of that profession. Therapeutic recreation does not include planned leisure activities.

Subp. 4. **Location of service provision.** A client of a license holder may only receive services at any of the license holder's licensed locations or at the client's home, except that services under subpart 1, item A, subitems (3) and (5), and subpart 2, items B and E, may be provided in another suitable location.

9530.6435 MEDICAL SERVICES.

Subpart 1. **Health care services description.** An applicant or license holder must maintain a complete description of the health care services, nursing services, dietary services, and emergency physician services offered by the license holder.

Subp. 1a. **Procedures.** The applicant or license holder must have written procedures for obtaining medical interventions when needed for a client, that are approved in writing by a physician who is licensed under Minnesota Statutes, chapter 147, unless:

A. the license holder does not provide services under part 9530.6505; and

B. all medical interventions are referred to 911, the emergency telephone number, or the client's physician.

Subp. 2. **Consultation services.** The license holder must have access to and document the availability of a licensed mental health professional to provide diagnostic assessment and treatment planning assistance.

Subp. 3. **Administration of medications and assistance with self-medication.** A license holder must meet the requirements in items A and B if services include medication administration.

A. A staff member, other than a licensed practitioner or nurse, who is delegated by a licensed practitioner or a registered nurse the task of administration of medication or assistance with self-medication must:

(1) document that the staff member has successfully completed a medication administration training program for unlicensed personnel through an accredited Minnesota postsecondary educational institution. Completion of the course must be documented in writing and placed in the staff member's personnel file; or

(2) be trained according to a formalized training program which is taught by a registered nurse and offered by the license holder. Completion of the course must be documented in writing and placed in the staff member's personnel records; or

(3) demonstrate to a registered nurse competency to perform the delegated activity.

B. A registered nurse must be employed or contracted to develop the policies and procedures for medication administration or assistance with self-administration of medication or both. A registered nurse must provide supervision as defined in part 6321.0100. The registered nurse supervision must include monthly on-site supervision or more often as warranted by client health needs. The policies and procedures must include:

(1) a provision that delegations of administration of medication are limited to administration of those medications which are oral, suppository, eye drops, ear drops, inhalant, or topical;

(2) a provision that each client's file must include documentation indicating whether staff will be administering medication or the client will be doing self-administration or a combination of both;

(3) a provision that clients may carry emergency medication such as nitroglycerin as instructed by their physician;

(4) a provision for medication to be self-administered when a client is scheduled not to be at the facility;

(5) a provision that if medication is to be self-administered at a time when the client is present in the facility, medication will be self-administered under observation of a trained staff person;

(6) a provision that when a license holder serves clients who are parents with children, the parent may only administer medication to the child under staff supervision;

(7) requirements for recording the client's use of medication, including staff signatures with date and time;

(8) guidelines for when to inform a registered nurse of problems with self-administration, including failure to administer, client refusal of a medication, adverse reactions, or errors; and

(9) procedures for acceptance, documentation, and implementation of prescriptions, whether written, verbal, telephonic, or electronic.

Subp. 4. **Control of drugs.** A license holder must have in place and implement written policies and procedures developed by a registered nurse that contains the following provisions:

A. a requirement that all drugs must be stored in a locked compartment. Schedule II drugs, as defined by Minnesota Statutes, section 152.02, must be stored in a separately locked compartment, permanently affixed to the physical plant or medication cart;

B. a system which accounts for all scheduled drugs each shift;

C. a procedure for recording the client's use of medication, including the signature of the administrator of the medication with the time and date;

D. a procedure for destruction of discontinued, outdated, or deteriorated medications;

E. a statement that only authorized personnel are permitted to have access to the keys to the locked drug compartments; and

F. a statement that no legend drug supply for one client will be given to another client.

9530.6440 CLIENT RECORDS.

Subpart 1. **Client records required.** A license holder must maintain a file of current client records on the premises where the treatment services are provided or coordinated. The content and format of client records must be uniform and entries in each case must be signed and dated by the staff member making the entry. Client records must be protected against loss, tampering, or unauthorized disclosure in compliance with Minnesota Statutes, section 254A.09, Code of Federal Regulations, title 42, chapter 1, part 2, subpart B, sections 2.1 to 2.67, and Code of Federal Regulations, title 45, parts 160 to 164, and, if applicable, Minnesota Statutes, chapter 13.

Subp. 2. **Records retention.** Records of discharged clients must be retained by a license holder for seven years. License holders that cease to provide treatment services must retain client records for seven years from the date of facility closure and must notify the commissioner of the location of the records and the name of a person responsible for maintaining the records.

Subp. 3. **Client records, contents.** Client records must contain the following:

A. documentation that the client was given information on client rights, responsibilities, grievance procedures, tuberculosis, and HIV, and that the client was provided an orientation to the program abuse prevention plan as required under Minnesota Statutes, section 245A.65, subdivision 2, paragraph (a), clause (4);

B. an initial services plan completed according to part 9530.6420;

C. a comprehensive assessment completed according to part 9530.6422;

D. an assessment summary completed according to part 9530.6422, subpart 2;

E. an individual abuse prevention plan that complies with Minnesota Statutes, sections 245A.65, subdivision 2, and 626.557, subdivision 14, when applicable;

F. an individual treatment plan, as required under part 9530.6425, subparts 1 and 2;

G. progress notes, as required in part 9530.6425, subpart 3; and

H. a summary of termination of services, written according to part 9530.6425, subpart 4.

Subp. 4. **Electronic records.** A license holder who intends to use electronic record keeping or electronic signatures to comply with parts 9530.6405 to 9530.6505 must first obtain written permission from the commissioner. The commissioner must grant permission after the license holder provides documentation demonstrating the license holder's use of a system for ensuring security of electronic records. Use of electronic record keeping or electronic signatures does not alter the license holder's obligations under state or federal law, regulation, or rule.

9530.6445 STAFFING REQUIREMENTS.

Subpart 1. **Treatment director required.** A license holder must have a treatment director.

Subp. 2. **Alcohol and drug counselor supervisor requirements.** A license holder must employ an alcohol and drug counselor supervisor who meets the requirements under part 9530.6450, subpart 4. An individual may be simultaneously employed as a treatment director, alcohol and drug counselor supervisor, and an alcohol and drug counselor if the individual meets the qualifications for each position. If an alcohol and drug counselor is simultaneously an alcohol and drug counselor supervisor or treatment director, that individual must be considered a 0.5 full-time equivalent alcohol and drug counselor for purposes of meeting the staffing requirements under subpart 4.

Subp. 3. **Responsible staff person.** A treatment director must designate a staff member who, when present in the facility, is responsible for the delivery of treatment services. A license holder must have a designated staff person during all hours of operation. A license holder providing room and board and treatment at the same site must have a responsible staff person

on duty 24 hours a day. The designated staff person must know and understand the implications of parts 9530.6405 to 9530.6505 and Minnesota Statutes, sections 245A.65, 626.556, 626.557, and 626.5572.

Subp. 4. **Staffing requirements.** At least 25 percent of a counselor's scheduled work hours must be allocated to indirect services, including documentation of client services, coordination of services with others, treatment team meetings, and other duties. A counseling group shall not exceed an average of 16 clients during any 30 consecutive calendar days. It is the responsibility of the license holder to determine an acceptable group size based on the client's needs. A counselor in a program treating intravenous drug abusers must not supervise more than 50 clients. The license holder must maintain a record that documents compliance with this subpart.

Subp. 5. **Medical emergencies.** When clients are present, a license holder must have at least one staff person on the premises who has a current American Red Cross standard first aid certificate or an equivalent certificate and at least one staff person on the premises who has a current American Red Cross community, American Heart Association, or equivalent CPR certificate. A single staff person with both certifications satisfies this requirement.

9530.6450 STAFF QUALIFICATIONS.

Subpart 1. **Qualifications of all staff members with direct client contact.** All staff members who have direct client contact must be at least 18 years of age. At the time of hiring, all staff members must meet the qualifications in item A or B. A chemical use problem for purposes of this subpart is a problem listed by the license holder in the personnel policies and procedures according to part 9530.6460, subpart 1, item E.

A. Treatment directors, supervisors, nurses, counselors, and other professionals must be free of chemical use problems for at least the two years immediately preceding their hiring and must sign a statement attesting to that fact.

B. Paraprofessionals and all other staff members with direct client contact must be free of chemical use problems for at least one year immediately preceding their hiring and must sign a statement attesting to that fact.

Subp. 2. **Employment; prohibition on chemical use problems.** Staff members with direct client contact must be free from chemical use problems as a condition of employment, but are not required to sign additional statements. Staff members with direct client contact who are not free from chemical use problems must be removed from any responsibilities that include direct client contact for the time period specified in subpart 1. The time period begins to run on the date the employee begins receiving treatment services or the date of the last incident as described in the list developed according to part 9530.6460, subpart 1, item E.

Subp. 3. **Treatment director qualifications.** In addition to meeting the requirements of subpart 1, a treatment director must know and understand the implications of parts 9530.6405 to 9530.6505 and Minnesota Statutes, chapter 245A, and sections 626.556, 626.557, and 626.5572. A treatment director must:

A. have at least one year of work experience in direct service to individuals with chemical use problems or one year of work experience in the management or administration of direct service to individuals with chemical use problems; and

B. have a baccalaureate degree or three years of work experience in administration or personnel supervision in human services.

Subp. 4. **Alcohol and drug counselor supervisor qualifications.** In addition to meeting the requirements of subpart 1, an alcohol and drug counselor supervisor must meet the following qualifications:

A. the individual is competent in the areas specified in subpart 5;

B. the individual has three or more years of experience providing individual and group counseling to chemically dependent clients except that, prior to January 1, 2005, an individual employed in a program formerly licensed under parts 9530.5000 to 9530.6400is required to have one or more years experience; and

C. the individual knows and understands the implications of parts 9530.6405 to 9530.6505 and Minnesota Statutes, sections 245A.65, 626.556, 626.557, and 626.5572.

Subp. 5. **Alcohol and drug counselor qualifications.** In addition to meeting the requirements of subpart 1, an alcohol and drug counselor must be either licensed or exempt from licensure under Minnesota Statutes, chapter 148C. An alcohol and drug counselor must document competence in screening for and working with clients with mental health problems, through education, training, and experience.

APPENDIX
Repealed Minnesota Rule: 17-2331

A. Alcohol and drug counselors licensed under Minnesota Statutes, chapter 148C, must comply with rules adopted under Minnesota Statutes, chapter 148C.

B. Counselors exempt under Minnesota Statutes, chapter 148C, must be competent, as evidenced by one of the following:

(1) completion of at least a baccalaureate degree with a major or concentration in social work, nursing, sociology, human services, or psychology, or licensure as a registered nurse; successful completion of a minimum of 120 hours of classroom instruction in which each of the core functions listed in Minnesota Statutes, chapter 148C, is covered; and successful completion of 440 hours of supervised experience as an alcohol and drug counselor, either as a student or as a staff member;

(2) completion of 270 hours of alcohol and drug counselor training in which each of the core functions listed in Minnesota Statutes, chapter 148C, is covered, and successful completion of 880 hours of supervised experience as an alcohol and drug counselor, either as a student, or as a staff member;

(3) current certification as an alcohol and drug counselor or alcohol and drug counselor reciprocal, through the evaluation process established by the International Certification and Reciprocity Consortium Alcohol and Other Drug Abuse, Inc., and published in the Case Presentation Method Trainer's Manual, copyright 1993. The manual is incorporated by reference. It is available at the State Law Library, Judicial Center, 25 Reverend Dr. Martin Luther King Jr. Blvd., St. Paul, Minnesota 55155;

(4) completion of a bachelor's degree including 480 hours of alcohol and drug counseling education from an accredited school or educational program and 880 hours of alcohol and drug counseling practicum; or

(5) employment in a program formerly licensed under parts 9530.5000 to 9530.6400 and successful completion of 6,000 hours of supervised work experience in a licensed program as an alcohol and drug counselor prior to January 1, 2005.

Subp. 6. **Paraprofessional qualifications and duties.** A paraprofessional must comply with subpart 1 and have knowledge of client rights, outlined in Minnesota Statutes, section 148F.165, and of staff responsibilities. A paraprofessional may not admit, transfer, or discharge clients but may be the person responsible for the delivery of treatment services as required in part 9530.6445, subpart 3.

Subp. 7. **Volunteers.** Volunteers may provide treatment services when they are supervised and can be seen or heard by a staff member meeting the criteria in subpart 4 or 5, but may not practice alcohol and drug counseling unless qualified under subpart 5.

Subp. 8. **Student interns.** A qualified staff person must supervise and be responsible for all treatment services performed by student interns and must review and sign all assessments, progress notes, and treatment plans prepared by the intern. Student interns must meet the requirements in subpart 1, item A, and receive the orientation and training required in part 9530.6460, subpart 1, item G, and subpart 2.

Subp. 9. **Individuals with temporary permit.** Individuals with a temporary permit from the Board of Behavioral Health and Therapy may provide chemical dependency treatment services under the conditions in either item A or B.

A. The individual is supervised by a licensed alcohol and drug counselor assigned by the license holder. The licensed alcohol and drug counselor must document the amount and type of supervision at least weekly. The supervision must relate to clinical practices. One licensed alcohol and drug counselor may not supervise more than three individuals with temporary permits, according to Minnesota Statutes, section 148C.01, subdivision 12a.

B. The individual is supervised by a clinical supervisor approved by the Board of Behavioral Health and Therapy. The supervision must be documented and meet the requirements of Minnesota Statutes, section 148C.044, subdivision 4.

9530.6455 PROVIDER POLICIES AND PROCEDURES.

License holders must develop a written policy and procedures manual indexed according to Minnesota Statutes, section 245A.04, subdivision 14, paragraph (c), so that staff may have immediate access to all policies and procedures and so that consumers of the services and other authorized parties may have access to all policies and procedures. The manual must contain the following materials:

A. assessment and treatment planning policies, which include screening for mental health concerns, and the inclusion of treatment objectives related to identified mental health concerns in the client's treatment plan;

B. policies and procedures regarding HIV that comply with Minnesota Statutes, section 245A.19;

C. the methods and resources used by the license holder to provide information on tuberculosis and tuberculosis screening to all clients and to report known cases of tuberculosis infection according to Minnesota Statutes, section 144.4804;

D. personnel policies that comply with part 9530.6460;

E. policies and procedures that protect client rights as required under part 9530.6470;

F. a medical services plan that complies with part 9530.6435;

G. emergency procedures that comply with part 9530.6475;

H. policies and procedures for maintaining client records under part 9530.6440;

I. procedures for reporting the maltreatment of minors under Minnesota Statutes, section 626.556, and vulnerable adults under Minnesota Statutes, sections 245A.65, 626.557, and 626.5572;

J. a description of treatment services including the amount and type of client services provided;

K. the methods used to achieve desired client outcomes; and

L. the hours of operation and target population served.

9530.6460 PERSONNEL POLICIES AND PROCEDURES.

Subpart 1. **Policy requirements.** License holders must have written personnel policies and must make them available to each staff member. The policies must:

A. assure that staff member retention, promotion, job assignment, or pay are not affected by a good faith communication between a staff member and the Department of Health, the Department of Human Services, the ombudsman for mental health and developmental disabilities, law enforcement, or local agencies for the investigation of complaints regarding a client's rights, health, or safety;

B. contain job descriptions for each position specifying responsibilities, degree of authority to execute job responsibilities, and qualifications;

C. provide for job performance evaluations based on standards of job performance to be conducted on a regular and continuing basis, including a written annual review;

D. describe behavior that constitutes grounds for disciplinary action, suspension or dismissal, including policies that address chemical use problems and meet the requirements of part 9530.6450, subpart 1, policies prohibiting personal involvement with clients in violation of Minnesota Statutes, chapter 604, and policies prohibiting client abuse as specified under Minnesota Statutes, sections 245A.65, 626.556, 626.557, and 626.5572;

E. list behaviors or incidents that are considered chemical use problems. The list must include:

(1) receiving treatment for chemical use within the period specified for the position in the staff qualification requirements;

(2) chemical use that has a negative impact on the staff member's job performance;

(3) chemical use that affects the credibility of treatment services with clients, referral sources, or other members of the community; and

(4) symptoms of intoxication or withdrawal on the job;

F. include a chart or description of the organizational structure indicating lines of authority and responsibilities;

G. include orientation within 24 working hours of starting for all new staff based on a written plan that, at a minimum, must provide for training related to the specific job functions for which the staff member was hired, policies and procedures, client confidentiality, the human immunodeficiency virus minimum standards, and client needs; and

H. policies outlining the license holder's response to staff members with behavior problems that interfere with the provision of treatment services.

Subp. 2. **Staff development.** A license holder must ensure that each staff person has the training required in items A to E.

A. All staff must be trained every two years in client confidentiality rules and regulations and client ethical boundaries.

B. All staff must be trained every two years in emergency procedures and client rights as specified in Minnesota Statutes, sections 144.651, 148F.165, and 253B.03.

C. All staff with direct client contact must be trained every year on mandatory reporting as specified under Minnesota Statutes, sections 245A.65, 626.556, 626.5561, 626.5563, 626.557, and 626.5572, including specific training covering the facility's policies concerning obtaining client releases of information.

D. All staff with direct client contact must receive training upon hiring and annually thereafter on the human immunodeficiency virus minimum standards according to Minnesota Statutes, section 245A.19.

E. Treatment directors, supervisors, nurses, and counselors must obtain 12 hours of training in co-occurring mental health problems and substance use disorder that includes competencies related to philosophy, screening, assessment, diagnosis and treatment planning, documentation, programming, medication, collaboration, mental health consultation, and discharge planning. Staff employed by a license holder on the date this rule is adopted must obtain the training within 12 months of the date of adoption. New staff who have not obtained such training must obtain it within 12 months of the date this rule is adopted or within six months of hire, whichever is later. Staff may request, and the license holder may grant credit for, relevant training obtained prior to January 1, 2005.

Subp. 3. **Personnel files.** The license holder must maintain a separate personnel file for each staff member. At a minimum, the personnel file must be maintained to meet the requirements under parts 9530.6405 to 9530.6505 and contain the following:

A. a completed application for employment signed by the staff member and containing the staff member's qualifications for employment;

B. documentation related to the applicant's background study data, as defined in Minnesota Statutes, chapter 245C;

C. for staff members who will be providing psychotherapy services, employer names and addresses for the past five years for which the staff member provided psychotherapy services, and documentation of an inquiry made to these former employers regarding substantiated sexual contact with a client as required by Minnesota Statutes, chapter 604;

D. documentation of completed orientation and training;

E. documentation demonstrating compliance with parts 9530.6450 and 9530.6485, subpart 2; and

F. documentation demonstrating compliance with part 9530.6435, subpart 3, for staff members who administer medications.

9530.6465 SERVICE INITIATION AND TERMINATION POLICIES.

Subpart 1. **Service initiation policy.** A license holder must have a written service initiation policy containing service initiation preferences which comply with this rule and Code of Federal Regulations, title 45, part 96.131, and specific service initiation criteria. The license holder must not initiate services for individuals who do not meet the service initiation criteria. The service initiation criteria must be either posted in the area of the facility where services for clients are initiated, or given to all interested persons upon request. Titles of all staff members authorized to initiate services for clients must be listed in the services initiation and termination policies. A license holder that serves intravenous drug abusers must have a written policy that provides service initiation preference as required by Code of Federal Regulations, title 45, part 96.131.

Subp. 2. **License holder responsibilities; terminating or denying services.** A license holder has specific responsibilities when terminating services or denying treatment service initiation to clients for reasons of health, behavior, or criminal activity.

A. The license holder must have and comply with a written protocol for assisting clients in need of care not provided by the license holder, and for clients who pose a substantial likelihood of harm to themselves or others, if the behavior is beyond the behavior management capabilities of the staff. All service terminations and denials of service initiation which pose an immediate threat to the health of any individual or require immediate medical intervention must be referred to a medical facility capable of admitting the individual.

B. All service termination policies and denials of service initiation that involve the commission of a crime against a license holder's staff member or on a license holder's property, as provided under Code of Federal Regulations, title 42, section 2.12(c)(5), and Code of Federal

Regulations, title 45, parts 160 to 164, must be reported to a law enforcement agency with proper jurisdiction.

Subp. 3. **Service termination and transfer policies.** A license holder must have a written policy specifying the conditions under which clients must be discharged. The policy must include:

A. procedures for individuals whose services have been terminated under subpart 2;

B. a description of client behavior that constitutes reason for a staff-requested service termination and a process for providing this information to clients;

C. procedures consistent with Minnesota Statutes, section 253B.16, subdivision 2, that staff must follow when a client admitted under Minnesota Statutes, chapter 253B, is to have services terminated;

D. procedures staff must follow when a client leaves against staff or medical advice and when the client may be dangerous to self or others;

E. procedures for communicating staff-approved service termination criteria to clients, including the expectations in the client's individual treatment plan according to part 9530.6425; and

F. titles of staff members authorized to terminate client services must be listed in the service initiation and termination policies.

9530.6470 POLICIES AND PROCEDURES THAT PROTECT CLIENT RIGHTS.

Subpart 1. **Client rights; explanation.** Clients have the rights identified in Minnesota Statutes, sections 144.651, 148F.165, and 253B.03, as applicable. The license holder must give each client upon service initiation a written statement of client's rights and responsibilities. Staff must review the statement with clients at that time.

Subp. 2. **Grievance procedure.** Upon service initiation, the license holder must explain the grievance procedure to the client or their representative. The grievance procedure must be posted in a place visible to clients, and made available upon a client's request. The grievance procedure must also be made available to former clients upon request. The grievance procedure must require that:

A. staff help the client develop and process a grievance;

B. telephone numbers and addresses of the Department of Human Services, licensing division; the Office of Ombudsman for Mental Health and Developmental Disabilities; the Minnesota Department of Health, Office of Alcohol and Drug Counselor Licensing Program, and Office of Health Facilities Complaints; when applicable, be made available to clients; and

C. a license holder be obligated to respond to the client's grievance within three days of a staff member's receipt of the grievance, and the client be permitted to bring the grievance to the highest level of authority in the program if not resolved by other staff members.

Subp. 3. **Photographs of client.** All photographs, video tapes, and motion pictures of clients taken in the provision of treatment services are considered client records. Photographs for identification and recordings by video and audio tape for the purpose of enhancing either therapy or staff supervision may be required of clients, but may only be available for use as communications within a program. Clients must be informed when their actions are being recorded by camera or tape, and have the right to deny any taping or photography, except as authorized by this subpart.

9530.6475 BEHAVIORAL EMERGENCY PROCEDURES.

A. A license holder or applicant must have written procedures that staff must follow when responding to a client who exhibits behavior that is threatening to the safety of the client or others. The procedures must include:

(1) a plan designed to prevent the client from hurting themselves or others;

(2) contact information for emergency resources that staff must consult when a client's behavior cannot be controlled by the procedures established in the plan;

(3) types of procedures that may be used;

(4) circumstances under which emergency procedures may be used; and

(5) staff members authorized to implement emergency procedures.

B. Behavioral emergency procedures must not be used to enforce facility rules or for the convenience of staff. Behavioral emergency procedures must not be part of any client's treatment plan, or used at any time for any reason except in response to specific current behaviors that

threaten the safety of the client or others. Behavioral emergency procedures may not include the use of seclusion or restraint.

9530.6480 EVALUATION.

Subpart 1. **Participation in drug and alcohol abuse normative evaluation system.** License holders must participate in the drug and alcohol abuse normative evaluation system by submitting information about each client to the commissioner in a format specified by the commissioner.

Subp. 2. **Commissioner requests.** A license holder must submit additional information requested by the commissioner that is necessary to meet statutory or federal funding requirements.

9530.6485 LICENSE HOLDERS SERVING ADOLESCENTS.

Subpart 1. **License holders serving adolescents.** A residential treatment program that serves persons under 18 years of age must be licensed as a residential program for children in out-of-home placement by the department unless the license holder is exempt under Minnesota Statutes, section 245A.03, subdivision 2.

Subp. 2. **Alcohol and drug counselor qualifications.** In addition to the requirements specified in part 9530.6450, subparts 1 and 5, an alcohol and drug counselor providing treatment services to adolescents must have:

A. an additional 30 hours of classroom instruction or one three-credit semester college course in adolescent development. This training need only be completed one time; and

B. at least 150 hours of supervised experience as an adolescent counselor, either as a student or as a staff member.

Subp. 3. **Staffing ratios.** At least 25 percent of a counselor's scheduled work hours must be allocated to indirect services, including documentation of client services, coordination of services with others, treatment team meetings, and other duties. A counseling group consisting entirely of adolescents must not exceed 16 clients. It is the responsibility of the license holder to determine an acceptable group size based on the needs of the clients.

Subp. 4. **Academic program requirements.** Clients who are required to attend school must be enrolled and attending an educational program that has been approved by the Minnesota Department of Education.

Subp. 5. **Program requirements.** In addition to the requirements specified in the client's treatment plan under part 9530.6425, programs serving adolescents must include the following:

A. coordination with the school system to address the client's academic needs;

B. when appropriate, a plan that addresses the client's leisure activities without chemical use; and

C. a plan that addresses family involvement in the adolescent's treatment.

9530.6490 LICENSE HOLDERS SERVING CLIENTS WITH CHILDREN.

Subpart 1. **Health license requirements.** In addition to the requirements of parts 9530.6405 to 9530.6480, all license holders that offer supervision of children of clients are subject to the requirements of this part. License holders providing room and board for clients and their children must have an appropriate facility license from the Minnesota Department of Health.

Subp. 2. **Supervision of children defined.** "Supervision of children" means a caregiver is within sight or hearing of an infant, toddler, or preschooler at all times so that the caregiver can intervene to protect the health and safety of the child. For the school age child it means a caregiver is available to help and care for the child so that the child's health and safety is protected.

Subp. 3. **Policy and schedule required.** License holders must meet the following requirements:

A. license holders must have a policy and schedule delineating the times and circumstances under which the license holder is responsible for supervision of children in the program and when the child's parents are responsible for child supervision. The policy must explain how the program will communicate its policy about child supervision responsibility to the parents; and

B. license holders must have written procedures addressing the actions to be taken by staff if children are neglected or abused including while the children are under the supervision of their parents.

Subp. 4. **Additional licensing requirements.** During the times the license holder is responsible for the supervision of children, the license holder must meet the following standards:

A. child and adult ratios in part 9502.0367;

B. day care training in Minnesota Statutes, section 245A.50;

C. behavior guidance in part 9502.0395;

D. activities and equipment in part 9502.0415;

E. physical environment in part 9502.0425; and

F. water, food, and nutrition in part 9502.0445, unless the license holder has a license from the Minnesota Department of Health.

9530.6495 LICENSE HOLDERS SERVING PERSONS WITH SUBSTANCE USE AND MENTAL HEALTH DISORDERS.

In addition to meeting the requirements of parts 9530.6405 to 9530.6490, license holders specializing in the treatment of persons with substance use disorder and mental health problems must:

A. demonstrate that staffing levels are appropriate for treating clients with substance use disorder and mental health problems, and that there is adequate staff with mental health training;

B. have continuing access to a medical provider with appropriate expertise in prescribing psychotropic medications;

C. have a mental health professional available for staff supervision and consultation;

D. determine group size, structure, and content with consideration for the special needs of those with substance use disorder and mental health disorders;

E. have documentation of active interventions to stabilize mental health symptoms present in treatment plans and progress notes;

F. have continuing documentation of collaboration with continuing care mental health providers, and involvement of those providers in treatment planning meetings;

G. have available program materials adapted to individuals with mental health problems;

H. have policies that provide flexibility for clients who may lapse in treatment or may have difficulty adhering to established treatment rules as a result of a mental illness, with the goal of helping clients successfully complete treatment; and

I. have individual psychotherapy and case management available during the treatment process.

9530.6500 PROGRAMS SERVING INTRAVENOUS DRUG ABUSERS.

Subpart 1. **Additional requirements.** In addition to the requirements of parts 9530.6405 to 9530.6505, programs serving intravenous drug abusers must comply with the requirements of this part.

Subp. 2. **Capacity management and waiting list system compliance.** A program serving intravenous drug abusers must notify the department within seven days of when the program reaches both 90 and 100 percent of the program's capacity to care for clients. Each week, the program must report its capacity, current enrolled dosing clients, and any waiting list. A program reporting 90 percent of capacity must also notify the department when its census has increased or decreased from the 90 percent level.

Subp. 3. **Waiting list.** A program serving intravenous drug abusers must have a waiting list system. Each person seeking admission must be placed on the waiting list if the person cannot be admitted within 14 days of the date of application, unless the applicant is assessed by the program and found not to be eligible for admission according to parts 9530.6405 to 9530.6505, and Code of Federal Regulations, title 42, part 1, subchapter A, section 8.12(e), and Code of Federal Regulations, title 45, parts 160 to 164. The waiting list must assign a unique patient identifier for each intravenous drug abuser seeking treatment while awaiting admission. An applicant on a waiting list who receives no services under part 9530.6430, subpart 1, must not be considered a "client" as defined in part 9530.6405, subpart 8.

Subp. 4. **Client referral.** Programs serving intravenous drug abusers must consult the capacity management system so that persons on waiting lists are admitted at the earliest time to a program providing appropriate treatment within a reasonable geographic area. If the patient has been referred through a public payment system and if the program is not able to serve the client within 14 days of the date of application for admission, the program must contact and

inform the referring agency of any available treatment capacity listed in the state capacity management system.

Subp. 5. **Outreach.** Programs serving intravenous drug abusers must carry out activities to encourage individuals in need of treatment to undergo treatment. The program's outreach model must:

A. select, train, and supervise outreach workers;

B. contact, communicate, and follow up with high risk substance abusers, their associates, and neighborhood residents within the constraints of federal and state confidentiality requirements, including Code of Federal Regulations, title 42, sections 2.1 to 2.67, and Code of Federal Regulations, title 45, parts 160 to 164;

C. promote awareness among injecting drug abusers about the relationship between injecting drug abuse and communicable diseases such as HIV; and

D. recommend steps that can be taken to ensure that HIV transmission does not occur.

Subp. 6. **Central registry.** Programs serving intravenous drug abusers must comply with requirements to submit information and necessary consents to the state central registry for each client admitted, as specified by the commissioner. The client's failure to provide the information will prohibit involvement in an opiate treatment program. The information submitted must include the client's:

A. full name and all aliases;

B. date of admission;

C. date of birth;

D. Social Security number or INS number, if any;

E. enrollment status in other current or last known opiate treatment programs;

F. government-issued photo-identification card number; and

G. driver's license number, if any.

The information in items A to G must be submitted in a format prescribed by the commissioner, with the original kept in the client's chart, whenever a client is accepted for treatment, the client's type or dosage of a drug is changed, or the client's treatment is interrupted, resumed, or terminated.

9530.6505 REQUIREMENTS FOR LICENSED RESIDENTIAL TREATMENT.

Subpart 1. **Applicability.** A license holder who provides supervised room and board at the licensed program site as a treatment component is defined as a residential program according to Minnesota Statutes, section 245A.02, subdivision 14, and is subject to this part.

Subp. 2. **Visitors.** Clients must be allowed to receive visitors at times prescribed by the license holder. The license holder must set and post a notice of visiting rules and hours, including both day and evening times. A client's right to receive visitors other than a personal physician, religious advisor, county case manager, parole or probation officer, or attorney may be subject to visiting hours established by the license holder for all clients. The treatment director or designee may impose limitations as necessary for the welfare of a client provided that limitations and the reasons for them are documented in the client's file. Clients must be allowed to receive visits at all reasonable times from their personal physicians, religious advisors, county case managers, parole or probation officers, and attorneys.

Subp. 3. **Client property management.** A license holder who provides room and board and treatment services to clients in the same facility, and any license holder that accepts client property must meet the requirements in Minnesota Statutes, section 245A.04, subdivision 13, for handling resident funds and property. In the course of client property management, license holders:

A. may establish policies regarding the use of personal property to assure that treatment activities and the rights of other patients are not infringed;

B. may take temporary custody of property for violation of facility policies;

C. must retain the client's property for a minimum of seven days after discharge if the client does not reclaim property upon service termination, or for a minimum of 30 days if the client does not reclaim property upon service termination and has received room and board services from the license holder; and

D. must return all property held in trust to the client upon service termination regardless of the client's service termination status, except:

(1) drugs, drug paraphernalia, and drug containers that are forfeited under Minnesota Statutes, section 609.5316, must be destroyed by staff or given over to the custody of a local law enforcement agency, according to Code of Federal Regulations, title 42, chapter 1, part 2, subpart B, sections 2.1 to 2.67, and Code of Federal Regulations, title 45, parts 160 to 164;

(2) weapons, explosives, and other property which can cause serious harm to self or others must be given over to the custody of a local law enforcement agency, and the client must be notified of the transfer and of the right to reclaim any lawful property transferred; and

(3) medications that have been determined by a physician to be harmful after examining the client, except when the client's personal physician approves the medication for continued use.

Subp. 4. **Health facility license.** A license holder who provides room and board and treatment services in the same facility must have the appropriate license from the Department of Health.

Subp. 5. **Facility abuse prevention plan.** A license holder must establish and enforce an ongoing facility abuse prevention plan consistent with Minnesota Statutes, sections 245A.65 and 626.557, subdivision 14.

Subp. 6. **Individual abuse prevention plan.** A license holder must prepare an individual abuse prevention plan for each client as specified under Minnesota Statutes, sections 245A.65, subdivision 2, and 626.557, subdivision 14.

Subp. 7. **Health services.** License holders must have written procedures for assessing and monitoring client health, including a standardized data collection tool for collecting health-related information about each client. The policies and procedures must be approved and signed by a registered nurse.

Subp. 8. **Administration of medications.** License holders must meet the administration of medications requirements of part 9530.6435, subpart 3.