

**SENATE
STATE OF MINNESOTA
NINETY-FIRST SESSION**

S.F. No. 2302

(SENATE AUTHORS: MARTY)

DATE	D-PG	OFFICIAL STATUS
03/11/2019	771	Introduction and first reading Referred to Human Services Reform Finance and Policy
04/03/2019		Comm report: To pass as amended and re-refer to Health and Human Services Finance and Policy

1.1

A bill for an act

1.2 relating to state government; establishing the health and human services budget;
1.3 modifying provisions governing children and family services, operations, direct
1.4 care and treatment, continuing care for older adults, disability services, chemical
1.5 and mental health, uniform service standards, health care, opioids, health-related
1.6 licensing boards, Department of Health programs, adult protection, and medical
1.7 cannabis; establishing OneCare Buy-In; establishing consumer protections for
1.8 residents of assisted living; requiring licensure of assisted living; establishing
1.9 dementia care services; making changes to home care licensing; requiring reports;
1.10 making technical changes; establishing controlled substance registration requirement
1.11 and registration fee; establishing councils; establishing OneCare Buy-In reserve
1.12 account; modifying penalties; providing for rulemaking; modifying and making
1.13 fees; making forecast adjustments; appropriating money; amending Minnesota
1.14 Statutes 2018, sections 13.69, subdivision 1; 15C.02; 16A.724, subdivision 2;
1.15 62A.152, subdivision 3; 62A.3094, subdivision 1; 62J.497, subdivision 1; 119B.011,
1.16 subdivisions 19, 20, by adding a subdivision; 119B.02, subdivision 7; 119B.025,
1.17 subdivision 1; 119B.03, subdivision 9; 119B.09, subdivisions 1, 7; 119B.095,
1.18 subdivision 2, by adding a subdivision; 119B.125, subdivision 6; 119B.13,
1.19 subdivisions 1, 6, 7; 119B.16, subdivisions 1, 1a, 1b, by adding subdivisions;
1.20 144.0724, subdivisions 4, 5, 8; 144.3831, subdivision 1; 144A.071, subdivisions
1.21 1a, 2, 3, 4a, 4c, 5a; 144A.073, subdivision 3c; 144A.43, subdivision 6; 144A.44,
1.22 subdivisions 1, 2; 144A.441; 144A.442; 144A.471, subdivisions 1, 5, 9; 144A.472,
1.23 subdivision 7; 144A.474, subdivisions 9, 11; 144A.475, subdivisions 3b, 5;
1.24 144A.476, subdivision 1; 144A.4791, subdivision 10; 144A.4799; 144D.01,
1.25 subdivision 4; 144D.015; 144D.04, subdivision 2; 147D.27, by adding a
1.26 subdivision; 147E.40, subdivision 1; 147F.17, subdivision 1; 148.59; 148.6445,
1.27 subdivisions 1, 2, 2a, 3, 4, 5, 6, 10; 148.7815, subdivision 1; 148B.5301, subdivision
1.28 2; 148E.0555, subdivision 6; 148E.120, subdivision 2; 148E.180; 148F.11,
1.29 subdivision 1; 150A.06, by adding subdivisions; 150A.091, by adding subdivisions;
1.30 151.01, by adding subdivisions; 151.065, subdivisions 1, 2, 3, 6, by adding a
1.31 subdivision; 151.252, subdivision 1; 151.47, by adding a subdivision; 152.01, by
1.32 adding a subdivision; 152.10; 152.11, subdivisions 1, 1a, 2, 2a, 2b, 2c; 152.12,
1.33 subdivisions 1, 2, 3, 4; 152.125, subdivisions 2, 3, 4; 152.22, subdivision 13;
1.34 152.25, subdivision 1c; 152.27, subdivisions 3, 4, 5, 6; 152.28, subdivision 1;
1.35 152.29, subdivision 3; 152.32, subdivision 2; 152.33, subdivisions 1, 2; 214.25,
1.36 subdivision 2; 237.50, subdivisions 4a, 6a, 10a, 11, by adding subdivisions; 237.51,
1.37 subdivisions 1, 5a; 237.52, subdivision 5; 237.53; 245.462, subdivisions 6, 8, 9,
1.38 14, 17, 18, 21, 23, by adding a subdivision; 245.4661, subdivision 9; 245.467,

2.1 subdivisions 2, 3; 245.469, subdivisions 1, 2; 245.470, subdivision 1; 245.4712,
2.2 subdivision 2; 245.472, subdivision 2; 245.4863; 245.4871, subdivisions 9a, 10,
2.3 11a, 17, 21, 26, 27, 29, 32, 34; 245.4876, subdivisions 2, 3; 245.4879, subdivisions
2.4 1, 2; 245.488, subdivision 1; 245.4889, subdivision 1; 245.696, by adding a
2.5 subdivision; 245.735, subdivision 3; 245A.02, subdivisions 5a, 18; 245A.04, by
2.6 adding a subdivision; 245A.14, subdivisions 4, 8, by adding subdivisions;
2.7 245A.151; 245A.16, subdivision 1; 245A.40; 245A.41; 245A.50; 245A.51,
2.8 subdivision 3, by adding subdivisions; 245A.66, subdivisions 2, 3; 245C.02,
2.9 subdivision 6a, by adding subdivisions; 245C.03, subdivision 1, by adding a
2.10 subdivision; 245C.05, subdivisions 5, 5a; 245C.08, subdivisions 1, 3; 245C.10,
2.11 by adding a subdivision; 245C.24, by adding a subdivision; 245C.30, subdivisions
2.12 1, 2, 3; 245D.03, subdivision 1; 245D.071, subdivision 1; 245D.081, subdivision
2.13 3; 245E.06, subdivision 3; 245H.01, by adding subdivisions; 245H.03, by adding
2.14 a subdivision; 245H.07; 245H.10, subdivision 1; 245H.11; 245H.12; 245H.13,
2.15 subdivision 5, by adding subdivisions; 245H.14, subdivisions 1, 3, 4, 5, 6; 245H.15,
2.16 subdivision 1; 246B.10; 252.275, subdivision 3; 252.41, subdivisions 3, 4, 5, 6,
2.17 7, 9; 252.42; 252.43; 252.44; 252.45; 254A.03, subdivision 3; 254B.02, subdivision
2.18 1; 254B.03, subdivisions 2, 4; 254B.04, subdivision 1; 254B.05, subdivisions 1a,
2.19 5; 254B.06, subdivisions 1, 2; 256.01, subdivision 14b; 256.478; 256.9365; 256.962,
2.20 subdivision 5; 256.969, subdivision 9; 256B.04, subdivisions 21, 22; 256B.055,
2.21 subdivision 2; 256B.056, subdivision 3; 256B.0615, subdivision 1; 256B.0616,
2.22 subdivisions 1, 3; 256B.0622, subdivisions 1, 2, 3a, 4, 5a, 7, 7a, 7b, 7d; 256B.0623,
2.23 subdivisions 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 12; 256B.0624, subdivisions 2, 4, 5, 6,
2.24 8, 9, 10, 11; 256B.0625, subdivisions 3b, 5, 5l, 13, 13e, 13f, 17, 19c, 23, 24, 42,
2.25 45a, 48, 49, 56a, 57, 61, 62, 65, by adding subdivisions; 256B.064, subdivision
2.26 1a; 256B.0644; 256B.0659, subdivision 21; 256B.0915, subdivisions 3a, 3b;
2.27 256B.092, subdivision 13; 256B.0941, subdivision 1; 256B.0943, subdivisions 1,
2.28 2, 3, 4, 5, 6, 7, 8, 9, 11; 256B.0944, subdivisions 1, 3, 4, 5, 6, 7, 8, 9; 256B.0946,
2.29 subdivisions 1, 1a, 2, 3, 4, 6; 256B.0947, subdivisions 1, 2, 3, 3a, 5, 6, 7a;
2.30 256B.0949, subdivision 2, by adding a subdivision; 256B.49, subdivision 24;
2.31 256B.4914, subdivisions 2, 3, 5, 6, 7, 8, 9, 10, 10a; 256B.69, subdivision 6d;
2.32 256B.76, subdivisions 2, 4; 256B.766; 256B.767; 256B.85, subdivision 3; 256I.04,
2.33 subdivisions 1, 2f; 256I.06, subdivision 8; 256L.03, by adding a subdivision;
2.34 256L.11, subdivision 7; 256R.02, subdivisions 8, 19; 256R.16, subdivision 1;
2.35 256R.21, by adding a subdivision; 256R.23, subdivision 5; 256R.24, subdivision
2.36 3; 256R.25; 256R.26; 256R.44; 256R.47; 256R.50, subdivision 6; 260C.007,
2.37 subdivision 18, by adding a subdivision; 260C.178, subdivision 1; 260C.201,
2.38 subdivisions 1, 2, 6; 260C.212, subdivision 2; 260C.452, subdivision 4; 260C.503,
2.39 subdivision 1; 518A.32, subdivision 3; Laws 2003, First Special Session chapter
2.40 14, article 13C, section 2, subdivision 6, as amended; Laws 2017, First Special
2.41 Session chapter 6, article 3, section 49; article 8, sections 71; 72; article 18, section
2.42 2, subdivisions 1, 3, 5, 15; proposing coding for new law in Minnesota Statutes,
2.43 chapters 119B; 144; 144A; 145; 148; 151; 245; 245A; 245D; 256; 256B; 256L;
2.44 256M; 256R; 260C; proposing coding for new law as Minnesota Statutes, chapters
2.45 144I; 245I; 256T; repealing Minnesota Statutes 2018, sections 119B.16, subdivision
2.46 2; 144A.071, subdivision 4d; 144A.472, subdivision 4; 144D.01, subdivisions 2a,
2.47 3a, 6; 144D.04, subdivision 2a; 144D.045; 144D.06; 144D.09; 144D.10; 144G.01;
2.48 144G.02; 144G.03; 144G.04; 144G.05; 144G.06; 214.17; 214.18; 214.19; 214.20;
2.49 214.21; 214.22; 214.23; 214.24; 245.462, subdivision 4a; 245E.06, subdivisions
2.50 2, 4, 5; 246.18, subdivisions 8, 9; 252.41, subdivision 8; 252.431; 252.451; 254B.03,
2.51 subdivision 4a; 256B.0615, subdivisions 2, 4, 5; 256B.0616, subdivisions 2, 4, 5;
2.52 256B.0659, subdivision 22; 256B.0705; 256B.0943, subdivision 10; 256B.0944,
2.53 subdivision 10; 256B.0946, subdivision 5; 256B.0947, subdivision 9; 256B.431,
2.54 subdivisions 3a, 3f, 3g, 3i, 13, 15, 17, 17a, 17c, 17d, 17e, 18, 21, 22, 30, 45;
2.55 256B.434, subdivisions 4, 4f, 4i, 4j; 256L.11, subdivision 6a; 256R.36; 256R.40;
2.56 256R.41; Laws 2010, First Special Session chapter 1, article 25, section 3,
2.57 subdivision 10; Minnesota Rules, parts 2960.3030, subpart 3; 3400.0185, subpart
2.58 5; 6400.6970; 7200.6100; 7200.6105; 9502.0425, subparts 4, 16, 17; 9503.0155,

subpart 8; 9505.0370; 9505.0371; 9505.0372; 9520.0010; 9520.0020; 9520.0030;
9520.0040; 9520.0050; 9520.0060; 9520.0070; 9520.0080; 9520.0090; 9520.0100;
9520.0110; 9520.0120; 9520.0130; 9520.0140; 9520.0150; 9520.0160; 9520.0170;
9520.0180; 9520.0190; 9520.0200; 9520.0210; 9520.0230; 9549.0057; 9549.0060,
subparts 4, 5, 6, 7, 10, 11, 14.

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

ARTICLE 1

CHILDREN AND FAMILIES SERVICES

Section 1. Minnesota Statutes 2018, 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 Homeless Assistance Act and United States Code, title 42, section 11302, paragraph (a).

EFFECTIVE DATE. This section is effective September 21, 2020.

Sec. 2. Minnesota Statutes 2018, 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 legal child care services as defined licensed to provide child care under section 245A-03, chapter 245A when operating within the terms of the license; or

(2) a license exempt center required to be certified under chapter 245H;

(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 July 1, 2019.

4.1 Sec. 3. Minnesota Statutes 2018, section 119B.011, subdivision 20, is amended to read:

4.2 Subd. 20. **Transition year families.** "Transition year families" means families who have
4.3 received MFIP assistance, or who were eligible to receive MFIP assistance after choosing
4.4 to discontinue receipt of the cash portion of MFIP assistance under section 256J.31,
4.5 subdivision 12, or families who have received DWP assistance under section 256J.95 for
4.6 at least three one of the last six months before losing eligibility for MFIP or DWP.

4.7 Notwithstanding Minnesota Rules, parts 3400.0040, subpart 10, and 3400.0090, subpart 2,
4.8 transition year child care may be used to support employment, approved education or training
4.9 programs, or job search that meets the requirements of section 119B.10. Transition year
4.10 child care is not available to families who have been disqualified from MFIP or DWP due
4.11 to fraud.

4.12 **EFFECTIVE DATE.** This section is effective March 23, 2020.

4.13 Sec. 4. Minnesota Statutes 2018, section 119B.02, subdivision 7, is amended to read:

4.14 Subd. 7. **Child care market rate survey.** Biennially, The commissioner shall conduct
4.15 the next survey of prices charged by child care providers in Minnesota in state fiscal year
4.16 2021 and every three years thereafter to determine the 75th percentile for like-care
4.17 arrangements in county price clusters.

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

4.19 Sec. 5. Minnesota Statutes 2018, section 119B.025, subdivision 1, is amended to read:

4.20 Subdivision 1. **Applications.** (a) Except as provided in paragraph (c), clause (4), the
4.21 county shall verify the following at all initial child care applications using the universal
4.22 application:

4.23 (1) identity of adults;

4.24 (2) presence of the minor child in the home, if questionable;

4.25 (3) relationship of minor child to the parent, stepparent, legal guardian, eligible relative
4.26 caretaker, or the spouses of any of the foregoing;

4.27 (4) age;

4.28 (5) immigration status, if related to eligibility;

4.29 (6) Social Security number, if given;

4.30 (7) counted income;

5.1 (8) spousal support and child support payments made to persons outside the household;

5.2 (9) residence; and

5.3 (10) inconsistent information, if related to eligibility.

5.4 (b) The county must mail a notice of approval or denial of assistance to the applicant
5.5 within 30 calendar days after receiving the application. The county may extend the response
5.6 time by 15 calendar days if the applicant is informed of the extension.

5.7 (c) For an applicant who declares that the applicant is homeless and who meets the
5.8 definition of homeless in section 119B.011, subdivision 13b, the county must:

5.9 (1) if information is needed to determine eligibility, send a request for information to
5.10 the applicant within five working days after receiving the application;

5.11 (2) if the applicant is eligible, send a notice of approval of assistance within five working
5.12 days after receiving the application;

5.13 (3) if the applicant is ineligible, send a notice of denial of assistance within 30 days after
5.14 receiving the application. The county may extend the response time by 15 calendar days if
5.15 the applicant is informed of the extension;

5.16 (4) not require verifications required by paragraph (a) before issuing the notice of approval
5.17 or denial; and

5.18 (5) follow limits set by the commissioner for how frequently expedited application
5.19 processing may be used for an applicant under this paragraph.

5.20 (d) An applicant who declares that the applicant is homeless must submit proof of
5.21 eligibility within three months of the date the application was received. If proof of eligibility
5.22 is not submitted within three months, eligibility ends. A 15-day adverse action notice is
5.23 required to end eligibility.

5.24 **EFFECTIVE DATE.** This section is effective September 21, 2020.

5.25 Sec. 6. Minnesota Statutes 2018, section 119B.03, subdivision 9, is amended to read:

5.26 **Subd. 9. Portability pool.** (a) The commissioner shall establish a pool of up to five
5.27 percent of the annual appropriation for the basic sliding fee program to provide continuous
5.28 child care assistance for eligible families who move between Minnesota counties. At the
5.29 end of each allocation period, any unspent funds in the portability pool must be used for
5.30 assistance under the basic sliding fee program. If expenditures from the portability pool

6.1 exceed the amount of money available, the reallocation pool must be reduced to cover these
6.2 shortages.

6.3 (b) ~~To be eligible for portable basic sliding fee assistance~~, A family that has moved from
6.4 a county in which it was receiving basic sliding fee assistance to a county with a waiting
6.5 list for the basic sliding fee program must:

6.6 (1) meet the income and eligibility guidelines for the basic sliding fee program; and

6.7 (2) notify ~~the new county of residence within 60 days of moving and submit information~~
6.8 ~~to the new county of residence to verify eligibility for the basic sliding fee program~~ the
6.9 family's previous county of residence of the family's move to a new county of residence.

6.10 (c) The receiving county must:

6.11 (1) accept administrative responsibility for applicants for portable basic sliding fee
6.12 assistance at the end of the two months of assistance under the Unitary Residency Act;

6.13 (2) continue portability pool basic sliding fee assistance ~~for the lesser of six months or~~
6.14 until the family is able to receive assistance under the county's regular basic sliding program;
6.15 and

6.16 (3) notify the commissioner through the quarterly reporting process of any family that
6.17 meets the criteria of the portable basic sliding fee assistance pool.

6.18 EFFECTIVE DATE. This section is effective December 2, 2019.

6.19 Sec. 7. Minnesota Statutes 2018, section 119B.09, subdivision 1, is amended to read:

6.20 Subdivision 1. **General eligibility requirements.** (a) Child care services must be
6.21 available to families who need child care to find or keep employment or to obtain the training
6.22 or education necessary to find employment and who:

6.23 (1) have household income less than or equal to 67 percent of the state median income,
6.24 adjusted for family size, at application and redetermination, and meet the requirements of
6.25 section 119B.05; receive MFIP assistance; and are participating in employment and training
6.26 services under chapter 256J; or

6.27 (2) have household income less than or equal to 47 percent of the state median income,
6.28 adjusted for family size, at application and less than or equal to 67 percent of the state
6.29 median income, adjusted for family size, at redetermination.

6.30 (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) If a family has one child with a child care authorization and the child reaches 13 years of age or the child has a disability and reaches 15 years of age, the family remains eligible until the redetermination.

EFFECTIVE DATE. This section is effective June 29, 2020.

Sec. 8. Minnesota Statutes 2018, section 119B.09, subdivision 7, is amended to read:

Subd. 7. Date of eligibility for assistance. (a) The date of eligibility for child care assistance under this chapter is the later of the date the application was received by the county; the beginning date of employment, education, or training; the date the infant is born for applicants to the at-home infant care program; or the date a determination has been made that the applicant is a participant in employment and training services under Minnesota Rules, part 3400.0080, or chapter 256J.

(b) Payment ceases for a family under the at-home infant child care program when a family has used a total of 12 months of assistance as specified under section 119B.035. Payment of child care assistance for employed persons on MFIP is effective the date of employment or the date of MFIP eligibility, whichever is later. Payment of child care assistance for MFIP or DWP participants in employment and training services is effective the date of commencement of the services or the date of MFIP or DWP eligibility, whichever is later. Payment of child care assistance for transition year child care must be made retroactive to the date of eligibility for transition year child care.

(c) Notwithstanding paragraph (b), payment of child care assistance for participants eligible under section 119B.05 may only be made retroactive for a maximum of six three months from the date of application for child care assistance.

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

8.1 Sec. 9. Minnesota Statutes 2018, section 119B.095, subdivision 2, is amended to read:

8.2 **Subd. 2. Maintain steady child care authorizations.** (a) Notwithstanding Minnesota
8.3 Rules, chapter 3400, the amount of child care authorized under section 119B.10 for
8.4 employment, education, or an MFIP or DWP employment plan shall continue at the same
8.5 number of hours or more hours until redetermination, including:

8.6 (1) when the other parent moves in and is employed or has an education plan under
8.7 section 119B.10, subdivision 3, or has an MFIP or DWP employment plan; or

8.8 (2) when the participant's work hours are reduced or a participant temporarily stops
8.9 working or attending an approved education program. Temporary changes include, but are
8.10 not limited to, a medical leave, seasonal employment fluctuations, or a school break between
8.11 semesters.

8.12 (b) The county may increase the amount of child care authorized at any time if the
8.13 participant verifies the need for increased hours for authorized activities.

8.14 (c) The county may reduce the amount of child care authorized if a parent requests a
8.15 reduction or because of a change in:

8.16 (1) the child's school schedule;

8.17 (2) the custody schedule; or

8.18 (3) the provider's availability.

8.19 (d) The amount of child care authorized for a family subject to subdivision 1, paragraph
8.20 (b), must change when the participant's activity schedule changes. Paragraph (a) does not
8.21 apply to a family subject to subdivision 1, paragraph (b).

8.22 (e) When a child reaches 13 years of age or a child with a disability reaches 15 years of
8.23 age, the amount of child care authorized shall continue at the same number of hours or more
8.24 hours until redetermination.

8.25 **EFFECTIVE DATE.** This section is effective June 29, 2020.

8.26 Sec. 10. Minnesota Statutes 2018, section 119B.095, is amended by adding a subdivision
8.27 to read:

8.28 Subd. 3. Assistance for persons who are homeless. An applicant who is homeless and
8.29 eligible for child care assistance is exempt from the activity participation requirements under
8.30 this chapter for three months. The applicant under this subdivision is eligible for 60 hours
8.31 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 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 September 21, 2020.

Sec. 11. Minnesota Statutes 2018, 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:

(1) keep accurate and legible daily attendance records at the site where services are delivered for children receiving child care assistance; and

must (2) make those records available immediately to the county or the commissioner upon request. Any records not provided to a county or the commissioner at the date and time of the request are deemed inadmissible if offered as evidence by the provider in any proceeding to contest an overpayment or disqualification of the provider.

The (b) As a condition of payment, 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.

(c) 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 (d) 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.

(d) To calculate an attendance record overpayment under this subdivision, the commissioner or county agency shall subtract the maximum daily rate from the total amount

10.1 paid to a provider for each day that a child's attendance record is missing, unavailable,
10.2 incomplete, illegible, inaccurate, or otherwise inadequate.

10.3 (e) The commissioner shall develop criteria for a county to determine an attendance
10.4 record overpayment under this subdivision.

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

10.6 Sec. 12. Minnesota Statutes 2018, section 119B.13, subdivision 1, is amended to read:

10.7 **Subdivision 1. Subsidy restrictions.** (a) ~~Beginning February 3, 2014,~~ The maximum
10.8 rate paid for child care assistance in any county or county price cluster under the child care
10.9 fund shall be the greater of the 25th percentile of the ~~2011~~ most recent child care provider
10.10 rate survey under section 119B.02, subdivision 7, or the ~~maximum rate effective November~~
10.11 28, 2011 rates in effect at the time of the update. The first maximum rate update must be
10.12 based on the 2018 rate survey and take effect September 20, 2019. Thereafter, maximum
10.13 rate updates are effective the first biweekly period following September 1 after the most
10.14 recent rate survey. For a child care provider located within the boundaries of a city located
10.15 in two or more of the counties of Benton, Sherburne, and Stearns, the maximum rate paid
10.16 for child care assistance shall be equal to the maximum rate paid in the county with the
10.17 highest maximum reimbursement rates or the provider's charge, whichever is less. The
10.18 commissioner may: (1) assign a county with no reported provider prices to a similar price
10.19 cluster; and (2) consider county level access when determining final price clusters.

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

10.22 (c) The department shall monitor the effect of this paragraph on provider rates. The
10.23 county shall pay the provider's full charges for every child in care up to the maximum
10.24 established. The commissioner shall determine the maximum rate for each type of care on
10.25 an hourly, full-day, and weekly basis, including special needs and disability care.

10.26 (d) If a child uses one provider, the maximum payment for one day of care must not
10.27 exceed the daily rate. The maximum payment for one week of care must not exceed the
10.28 weekly rate.

10.29 (e) If a child uses two providers under section 119B.097, the maximum payment must
10.30 not exceed:

10.31 (1) the daily rate for one day of care;

10.32 (2) the weekly rate for one week of care by the child's primary provider; and

11.1 (3) two daily rates during two weeks of care by a child's secondary provider.

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

11.5 (g) If the provider charge is greater than the maximum provider rate allowed, the parent
11.6 is responsible for payment of the difference in the rates in addition to any family co-payment
11.7 fee.

11.8 (h) All maximum provider rates changes shall be implemented on the Monday following
11.9 the effective date of the maximum provider rate.

11.10 (i) ~~Notwithstanding Minnesota Rules, part 3400.0130, subpart 7, maximum registration~~
11.11 ~~fees in effect on January 1, 2013, shall remain in effect. The maximum registration fee paid~~
11.12 ~~for child care assistance in any county or county price cluster under the child care fund shall~~
11.13 ~~be the greater of the 25th percentile of the most recent child care provider rate survey under~~
11.14 ~~section 119B.02, subdivision 7, or the registration fee in effect at the time of the update.~~
11.15 ~~The first maximum registration fee update must be based on the 2018 rate survey and is~~
11.16 ~~effective September 23, 2019. Thereafter, maximum registration fee updates are effective~~
11.17 ~~the first biweekly period following September 1 after the most recent rate survey. Maximum~~
11.18 ~~registration fees must be set for licensed family child care and for child care centers. For a~~
11.19 ~~child care provider located within the boundaries of a city located in two or more of the~~
11.20 ~~counties of Benton, Sherburne, and Stearns, the maximum registration fee paid for child~~
11.21 ~~care assistance shall be equal to the maximum registration fee paid in the county with the~~
11.22 ~~highest maximum registration fee or the provider's charge, whichever is less.~~

11.23 **EFFECTIVE DATE.** Paragraph (a) is effective September 20, 2019. Paragraph (i) is
11.24 effective September 23, 2019.

11.25 Sec. 13. Minnesota Statutes 2018, section 119B.13, subdivision 6, is amended to read:

11.26 Subd. 6. **Provider payments.** (a) A provider shall bill only for services documented
11.27 according to section 119B.125, subdivision 6. The provider shall bill for services provided
11.28 within ten days of the end of the service period. Payments under the child care fund shall
11.29 be made within 21 days of receiving a complete bill from the provider. Counties or the state
11.30 may establish policies that make payments on a more frequent basis.

11.31 (b) If a provider has received an authorization of care and been issued a billing form for
11.32 an eligible family, the bill must be submitted within 60 days of the last date of service on
11.33 the bill. A bill submitted more than 60 days after the last date of service must be paid if the

12.1 county determines that the provider has shown good cause why the bill was not submitted
12.2 within 60 days. Good cause must be defined in the county's child care fund plan under
12.3 section 119B.08, subdivision 3, and the definition of good cause must include county error.
12.4 Any bill submitted more than a year after the last date of service on the bill must not be
12.5 paid.

12.6 (c) If a provider provided care for a time period without receiving an authorization of
12.7 care and a billing form for an eligible family, payment of child care assistance may only be
12.8 made retroactively for a maximum of six months from the date the provider is issued an
12.9 authorization of care and billing form.

12.10 (d) A county or the commissioner may refuse to issue a child care authorization to a
12.11 licensed or legal nonlicensed provider, revoke an existing child care authorization to a
12.12 licensed or legal nonlicensed provider, stop payment issued to a licensed or legal nonlicensed
12.13 provider, or refuse to pay a bill submitted by a licensed or legal nonlicensed provider if:

12.14 (1) the provider admits to intentionally giving the county materially false information
12.15 on the provider's billing forms;

12.16 (2) a county or the commissioner finds by a preponderance of the evidence that the
12.17 provider intentionally gave the county materially false information on the provider's billing
12.18 forms, or provided false attendance records to a county or the commissioner;

12.19 (3) the provider is in violation of child care assistance program rules, until the agency
12.20 determines those violations have been corrected;

12.21 (4) the provider is operating after:

12.22 (i) an order of suspension of the provider's license issued by the commissioner;

12.23 (ii) an order of revocation of the provider's license; or

12.24 (iii) a final order of conditional license issued by the commissioner for as long as the
12.25 conditional license is in effect;

12.26 (5) the provider submits false attendance reports or refuses to provide documentation
12.27 of the child's attendance upon request; or

12.28 (6) the provider gives false child care price information; or

12.29 (7) the provider fails to report decreases in a child's attendance, as required under section
12.30 119B.125, subdivision 9.

13.1 (e) For purposes of paragraph (d), clauses (3), (5), and (6), and (7), the county or the
13.2 commissioner may withhold the provider's authorization or payment for a period of time
13.3 not to exceed three months beyond the time the condition has been corrected.

13.4 (f) A county's payment policies must be included in the county's child care plan under
13.5 section 119B.08, subdivision 3. If payments are made by the state, in addition to being in
13.6 compliance with this subdivision, the payments must be made in compliance with section
13.7 16A.124.

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

13.9 Sec. 14. Minnesota Statutes 2018, section 119B.13, subdivision 7, is amended to read:

13.10 Subd. 7. **Absent days.** (a) Licensed child care providers and license-exempt centers
13.11 must not be reimbursed for more than 25 full-day absent days per child, excluding holidays,
13.12 in a fiscal calendar year, or for more than ten consecutive full-day absent days. "Absent
13.13 day" means any day that the child is authorized and scheduled to be in care with a licensed
13.14 provider or license exempt center, and the child is absent from the care for the entire day.
13.15 Legal nonlicensed family child care providers must not be reimbursed for absent days. If a
13.16 child attends for part of the time authorized to be in care in a day, but is absent for part of
13.17 the time authorized to be in care in that same day, the absent time must be reimbursed but
13.18 the time must not count toward the absent days limit. Child care providers must only be
13.19 reimbursed for absent days if the provider has a written policy for child absences and charges
13.20 all other families in care for similar absences.

13.21 (b) Notwithstanding paragraph (a), children with documented medical conditions that
13.22 cause more frequent absences may exceed the 25 absent days limit, or ten consecutive
13.23 full-day absent days limit. Absences due to a documented medical condition of a parent or
13.24 sibling who lives in the same residence as the child receiving child care assistance do not
13.25 count against the absent days limit in a fiscal calendar year. Documentation of medical
13.26 conditions must be on the forms and submitted according to the timelines established by
13.27 the commissioner. A public health nurse or school nurse may verify the illness in lieu of a
13.28 medical practitioner. If a provider sends a child home early due to a medical reason,
13.29 including, but not limited to, fever or contagious illness, the child care center director or
13.30 lead teacher may verify the illness in lieu of a medical practitioner.

13.31 (c) Notwithstanding paragraph (a), children in families may exceed the absent days limit
13.32 if at least one parent: (1) is under the age of 21; (2) does not have a high school diploma or
13.33 commissioner of education-selected high school equivalency certification; and (3) is a
13.34 student in a school district or another similar program that provides or arranges for child

14.1 care, parenting support, social services, career and employment supports, and academic
14.2 support to achieve high school graduation, upon request of the program and approval of the
14.3 county. If a child attends part of an authorized day, payment to the provider must be for the
14.4 full amount of care authorized for that day.

14.5 (d) Child care providers must be reimbursed for up to ten federal or state holidays or
14.6 designated holidays per year when the provider charges all families for these days and the
14.7 holiday or designated holiday falls on a day when the child is authorized to be in attendance.
14.8 Parents may substitute other cultural or religious holidays for the ten recognized state and
14.9 federal holidays. Holidays do not count toward the absent days limit.

14.10 (e) A family or child care provider must not be assessed an overpayment for an absent
14.11 day payment unless (1) there was an error in the amount of care authorized for the family,
14.12 (2) all of the allowed full-day absent payments for the child have been paid, or (3) the family
14.13 or provider did not timely report a change as required under law.

14.14 (f) The provider and family shall receive notification of the number of absent days used
14.15 upon initial provider authorization for a family and ongoing notification of the number of
14.16 absent days used as of the date of the notification.

14.17 (g) For purposes of this subdivision, "absent days limit" means 25 full-day absent days
14.18 per child, excluding holidays, in a ~~fiscal calendar~~ year; and ten consecutive full-day absent
14.19 days.

14.20 (h) For purposes of this subdivision, "holidays limit" means ten full-day holidays per
14.21 child, excluding absent days, in a calendar year.

14.22 (i) If a day meets the criteria of an absent day or a holiday under this subdivision, the
14.23 provider must bill that day as an absent day or holiday. A provider's failure to properly bill
14.24 an absent day or a holiday results in an overpayment, regardless of whether the child reached,
14.25 or is exempt from, the absent days limit or holidays limit for the calendar year.

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

14.27 Sec. 15. Minnesota Statutes 2018, section 119B.16, subdivision 1, is amended to read:

14.28 Subdivision 1. **Fair hearing allowed for applicants and recipients.** (a) An applicant
14.29 or recipient adversely affected by an action of a county agency ~~action or the commissioner,~~
14.30 for an action taken directly against the applicant or recipient, may request and receive a fair
14.31 hearing in accordance with this subdivision and section 256.045. An applicant or recipient
14.32 does not have a right to a fair hearing if a county agency or the commissioner takes action
14.33 against a provider.

15.1 (b) A county agency must offer an informal conference to an applicant or recipient who
15.2 is entitled to a fair hearing under this section. A county agency must advise an applicant or
15.3 recipient that a request for a conference is optional and does not delay or replace the right
15.4 to a fair hearing.

15.5 (c) If a provider's authorization is suspended, denied, or revoked, a county agency or
15.6 the commissioner must mail notice to each child care assistance program recipient receiving
15.7 care from the provider.

15.8 **EFFECTIVE DATE.** This section is effective February 26, 2021.

15.9 Sec. 16. Minnesota Statutes 2018, section 119B.16, subdivision 1a, is amended to read:

15.10 Subd. 1a. **Fair hearing allowed for providers.** (a) This subdivision applies to providers
15.11 caring for children receiving child care assistance.

15.12 (b) ~~A provider to whom a county agency has assigned responsibility for an overpayment
15.13 may request a fair hearing in accordance with section 256.045 for the limited purpose of
15.14 challenging the assignment of responsibility for the overpayment and the amount of the
15.15 overpayment. The scope of the fair hearing does not include the issues of whether the
15.16 provider wrongfully obtained public assistance in violation of section 256.98 or was properly
15.17 disqualified under section 256.98, subdivision 8, paragraph (e), unless the fair hearing has
15.18 been combined with an administrative disqualification hearing brought against the provider
15.19 under section 256.046.~~

15.20 (b) A provider may request a fair hearing according to sections 256.045 and 256.046
15.21 only if a county agency or the commissioner:

15.22 (1) denies or revokes a provider's authorization, unless the action entitles the provider
15.23 to an administrative review under section 119B.161;

15.24 (2) assigns responsibility for an overpayment to a provider under section 119B.11,
15.25 subdivision 2a;

15.26 (3) establishes an overpayment for failure to comply with section 119B.125, subdivision
15.27 6;

15.28 (4) seeks monetary recovery or recoupment under section 245E.02, subdivision 4,
15.29 paragraph (c), clause (2);

15.30 (5) initiates an administrative fraud disqualification hearing; or

15.31 (6) issues a payment and the provider disagrees with the amount of the payment.

16.1 (c) A provider may request a fair hearing by submitting a written request to the
16.2 Department of Human Services, Appeals Division. A provider's request must be received
16.3 by the Appeals Division no later than 30 days after the date a county or the commissioner
16.4 mails the notice.

16.5 (d) The provider's appeal request must contain the following:
16.6 (1) each disputed item, the reason for the dispute, and, if applicable, an estimate of the
16.7 dollar amount involved for each disputed item;
16.8 (2) the computation the provider believes to be correct, if applicable;
16.9 (3) the statute or rule relied on for each disputed item; and
16.10 (4) the name, address, and telephone number of the person at the provider's place of
16.11 business with whom contact may be made regarding the appeal.

16.12 **EFFECTIVE DATE.** This section is effective February 26, 2021.

16.13 Sec. 17. Minnesota Statutes 2018, section 119B.16, subdivision 1b, is amended to read:
16.14 Subd. 1b. **Joint fair hearings.** ~~When a provider requests a fair hearing under subdivision~~
16.15 ~~1a, the family in whose case the overpayment was created must be made a party to the fair~~
16.16 ~~hearing. All other issues raised by the family must be resolved in the same proceeding.~~
16.17 ~~When a family requests a fair hearing and claims that the county should have assigned~~
16.18 ~~responsibility for an overpayment to a provider, the provider must be made a party to the~~
16.19 ~~fair hearing.~~ The human services judge assigned to a fair hearing may join a family or a
16.20 provider as a party to the fair hearing whenever joinder of that party is necessary to fully
16.21 and fairly resolve ~~overpayment~~ issues raised in the appeal.

16.22 **EFFECTIVE DATE.** This section is effective February 26, 2021.

16.23 Sec. 18. Minnesota Statutes 2018, section 119B.16, is amended by adding a subdivision
16.24 to read:

16.25 Subd. 1c. **Notice to providers.** (a) Before taking an action appealable under subdivision
16.26 1a, paragraph (b), a county agency or the commissioner must mail written notice to the
16.27 provider against whom the action is being taken. Unless otherwise specified under chapter
16.28 119B or 245E or Minnesota Rules, chapter 3400, a county agency or the commissioner must
16.29 mail the written notice at least 15 calendar days before the adverse action's effective date.

16.30 (b) The notice shall state (1) the factual basis for the department's determination, (2) the
16.31 action the department intends to take, (3) the dollar amount of the monetary recovery or

17.1 recoupment, if known, and (4) the provider's right to appeal the department's proposed
17.2 action.

17.3 **EFFECTIVE DATE.** This section is effective February 26, 2021.

17.4 Sec. 19. Minnesota Statutes 2018, section 119B.16, is amended by adding a subdivision
17.5 to read:

17.6 Subd. 3. **Fair hearing stayed.** (a) If a county agency or the commissioner denies or
17.7 revokes a provider's authorization based on a licensing action under section 245A.07, and
17.8 the provider appeals, the provider's fair hearing must be stayed until the commissioner issues
17.9 an order as required under section 245A.08, subdivision 5.

17.10 (b) If the commissioner denies or revokes a provider's authorization based on
17.11 decertification under section 245H.07, and the provider appeals, the provider's fair hearing
17.12 must be stayed until the commissioner issues a final order as required under section 245H.07.

17.13 **EFFECTIVE DATE.** This section is effective February 26, 2021.

17.14 Sec. 20. Minnesota Statutes 2018, section 119B.16, is amended by adding a subdivision
17.15 to read:

17.16 Subd. 4. **Final department action.** Unless the commissioner receives a timely and
17.17 proper request for an appeal, a county agency's or the commissioner's action shall be
17.18 considered a final department action.

17.19 **EFFECTIVE DATE.** This section is effective February 26, 2021.

17.20 Sec. 21. **[119B.161] ADMINISTRATIVE REVIEW.**

17.21 Subdivision 1. **Applicability.** A provider has the right to an administrative review under
17.22 this section if (1) a payment was suspended under chapter 245E, or (2) the provider's
17.23 authorization was denied or revoked under section 119B.13, subdivision 6, paragraph (d),
17.24 clause (1) or (2).

17.25 Subd. 2. **Notice.** (a) A county agency or the commissioner must mail written notice to
17.26 a provider within five days of suspending payment or denying or revoking the provider's
17.27 authorization under subdivision 1.

17.28 (b) The notice must:

17.29 (1) state the provision under which a county agency or the commissioner is denying,
17.30 revoking, or suspending the provider's authorization or suspending payment to the provider;

18.1 (2) set forth the general allegations leading to the denial, revocation, or suspension of
18.2 the provider's authorization. The notice need not disclose any specific information concerning
18.3 an ongoing investigation;

18.4 (3) state that the denial, revocation, or suspension of the provider's authorization is for
18.5 a temporary period and explain the circumstances under which the action expires; and

18.6 (4) inform the provider of the right to submit written evidence and argument for
18.7 consideration by the commissioner.

18.8 (c) Notwithstanding Minnesota Rules, part 3400.0185, if a county agency or the
18.9 commissioner suspends payment to a provider under chapter 245E or denies or revokes a
18.10 provider's authorization under section 119B.13, subdivision 6, paragraph (d), clause (1) or
18.11 (2), a county agency or the commissioner must send notice of service authorization closure
18.12 to each affected family. The notice sent to an affected family is effective on the date the
18.13 notice is created.

18.14 Subd. 3. **Duration.** If a provider's payment is suspended under chapter 245E or a
18.15 provider's authorization is denied or revoked under section 119B.13, subdivision 6, paragraph
18.16 (d), clause (1) or (2), the provider's denial, revocation, temporary suspension, or payment
18.17 suspension remains in effect until:

18.18 (1) the commissioner or a law enforcement authority determines that there is insufficient
18.19 evidence warranting the action and a county agency or the commissioner does not pursue
18.20 an additional administrative remedy under chapter 245E or section 256.98; or

18.21 (2) all criminal, civil, and administrative proceedings related to the provider's alleged
18.22 misconduct conclude and any appeal rights are exhausted.

18.23 Subd. 4. **Good cause exception.** The commissioner may find that good cause exists not
18.24 to deny, revoke, or suspend a provider's authorization, or not to continue a denial, revocation,
18.25 or suspension of a provider's authorization if any of the following are applicable:

18.26 (1) a law enforcement authority specifically requested that a provider's authorization
18.27 not be denied, revoked, or suspended because that action may compromise an ongoing
18.28 investigation;

18.29 (2) the commissioner determines that the denial, revocation, or suspension should be
18.30 removed based on the provider's written submission; or

18.31 (3) the commissioner determines that the denial, revocation, or suspension is not in the
18.32 best interests of the program.

19.1 **EFFECTIVE DATE.** This section is effective February 26, 2021.

19.2 Sec. 22. Minnesota Statutes 2018, section 245A.04, is amended by adding a subdivision
19.3 to read:

19.4 **Subd. 9a. Child foster home variances for capacity.** (a) The commissioner, or the
19.5 commissioner of corrections under section 241.021, may grant a variance for a licensed
19.6 family foster parent to allow additional foster children if:

19.7 (1) the variance is needed to allow: (i) a parenting youth in foster care to remain with
19.8 the child of the parenting youth; (ii) siblings to remain together; (iii) a child with an
19.9 established meaningful relationship with the family to remain with the family; or (iv) a
19.10 family with special training or skills to provide care to a child who has a severe disability;

19.11 (2) there is no risk of harm to a child currently in the home;

19.12 (3) the structural characteristics of the home, including sleeping space, accommodates
19.13 additional foster children;

19.14 (4) the home remains in compliance with applicable zoning, health, fire, and building
19.15 codes; and

19.16 (5) the statement of intended use specifies conditions for an exception to capacity limits
19.17 and specifies how the license holder will maintain a ratio of adults to children that ensures
19.18 the safety and appropriate supervision of all the children in the home.

19.19 (b) A variance granted to a family foster home under Minnesota Rules, part 2960.3030,
19.20 subpart 3, prior to October 1, 2019, remains in effect until January 1, 2020.

19.21 Sec. 23. Minnesota Statutes 2018, section 245C.02, is amended by adding a subdivision
19.22 to read:

19.23 **Subd. 6b. Children's residential facility.** "Children's residential facility" means a
19.24 children's residential facility licensed by the commissioner of corrections or the commissioner
19.25 of human services under Minnesota Rules, chapter 2960.

19.26 **EFFECTIVE DATE.** This section is effective July 1, 2019, for background studies
19.27 initiated on or after that date.

19.28 Sec. 24. Minnesota Statutes 2018, section 245C.05, subdivision 5, is amended to read:

19.29 **Subd. 5. Fingerprints and photograph.** (a) Notwithstanding paragraph (b), for
19.30 background studies conducted by the commissioner for child foster care, children's residential

20.1 facilities, adoptions, or a transfer of permanent legal and physical custody of a child, the
20.2 subject of the background study, who is 18 years of age or older, shall provide the
20.3 commissioner with a set of classifiable fingerprints obtained from an authorized agency for
20.4 a national criminal history record check.

20.5 (b) For background studies initiated on or after the implementation of NETStudy 2.0,
20.6 except as provided under subdivision 5a, every subject of a background study must provide
20.7 the commissioner with a set of the background study subject's classifiable fingerprints and
20.8 photograph. The photograph and fingerprints must be recorded at the same time by the
20.9 commissioner's authorized fingerprint collection vendor and sent to the commissioner
20.10 through the commissioner's secure data system described in section 245C.32, subdivision
20.11 1a, paragraph (b).

20.12 (c) The fingerprints shall be submitted by the commissioner to the Bureau of Criminal
20.13 Apprehension and, when specifically required by law, submitted to the Federal Bureau of
20.14 Investigation for a national criminal history record check.

20.15 (d) The fingerprints must not be retained by the Department of Public Safety, Bureau
20.16 of Criminal Apprehension, or the commissioner. The Federal Bureau of Investigation will
20.17 only retain fingerprints of subjects with a criminal history.

20.18 (e) The commissioner's authorized fingerprint collection vendor shall, for purposes of
20.19 verifying the identity of the background study subject, be able to view the identifying
20.20 information entered into NETStudy 2.0 by the entity that initiated the background study,
20.21 but shall not retain the subject's fingerprints, photograph, or information from NETStudy
20.22 2.0. The authorized fingerprint collection vendor shall retain no more than the name and
20.23 date and time the subject's fingerprints were recorded and sent, only as necessary for auditing
20.24 and billing activities.

20.25 (f) For any background study conducted under this chapter, the subject shall provide the
20.26 commissioner with a set of classifiable fingerprints when the commissioner has reasonable
20.27 cause to require a national criminal history record check as defined in section 245C.02,
20.28 subdivision 15a.

20.29 **EFFECTIVE DATE.** This section is effective July 1, 2019, for background studies
20.30 initiated on or after that date.

21.1 Sec. 25. Minnesota Statutes 2018, section 245C.08, subdivision 1, is amended to read:

21.2 **Subdivision 1. Background studies conducted by Department of Human Services.** (a)

21.3 For a background study conducted by the Department of Human Services, the commissioner
21.4 shall review:

21.5 (1) information related to names of substantiated perpetrators of maltreatment of
21.6 vulnerable adults that has been received by the commissioner as required under section
21.7 626.557, subdivision 9c, paragraph (j);

21.8 (2) the commissioner's records relating to the maltreatment of minors in licensed
21.9 programs, and from findings of maltreatment of minors as indicated through the social
21.10 service information system;

21.11 (3) information from juvenile courts as required in subdivision 4 for individuals listed
21.12 in section 245C.03, subdivision 1, paragraph (a), when there is reasonable cause;

21.13 (4) information from the Bureau of Criminal Apprehension, including information
21.14 regarding a background study subject's registration in Minnesota as a predatory offender
21.15 under section 243.166;

21.16 (5) except as provided in clause (6), information received as a result of submission of
21.17 fingerprints for a national criminal history record check, as defined in section 245C.02,
21.18 subdivision 13c, when the commissioner has reasonable cause for a national criminal history
21.19 record check as defined under section 245C.02, subdivision 15a, or as required under section
21.20 144.057, subdivision 1, clause (2);

21.21 (6) for a background study related to a child foster care application for licensure, children's
21.22 residential facilities, a transfer of permanent legal and physical custody of a child under
21.23 sections 260C.503 to 260C.515, or adoptions, and for a background study required for
21.24 family child care, certified license-exempt child care, child care centers, and legal nonlicensed
21.25 child care authorized under chapter 119B, the commissioner shall also review:

21.26 (i) information from the child abuse and neglect registry for any state in which the
21.27 background study subject has resided for the past five years; and

21.28 (ii) when the background study subject is 18 years of age or older, or a minor under
21.29 section 245C.05, subdivision 5a, paragraph (c), information received following submission
21.30 of fingerprints for a national criminal history record check; and

21.31 (7) for a background study required for family child care, certified license-exempt child
21.32 care centers, licensed child care centers, and legal nonlicensed child care authorized under

22.1 chapter 119B, the background study shall also include, to the extent practicable, a name
22.2 and date-of-birth search of the National Sex Offender Public website.

22.3 (b) Notwithstanding expungement by a court, the commissioner may consider information
22.4 obtained under paragraph (a), clauses (3) and (4), unless the commissioner received notice
22.5 of the petition for expungement and the court order for expungement is directed specifically
22.6 to the commissioner.

22.7 (c) The commissioner shall also review criminal case information received according
22.8 to section 245C.04, subdivision 4a, from the Minnesota court information system that relates
22.9 to individuals who have already been studied under this chapter and who remain affiliated
22.10 with the agency that initiated the background study.

22.11 (d) When the commissioner has reasonable cause to believe that the identity of a
22.12 background study subject is uncertain, the commissioner may require the subject to provide
22.13 a set of classifiable fingerprints for purposes of completing a fingerprint-based record check
22.14 with the Bureau of Criminal Apprehension. Fingerprints collected under this paragraph
22.15 shall not be saved by the commissioner after they have been used to verify the identity of
22.16 the background study subject against the particular criminal record in question.

22.17 (e) The commissioner may inform the entity that initiated a background study under
22.18 NETStudy 2.0 of the status of processing of the subject's fingerprints.

22.19 **EFFECTIVE DATE.** This section is effective July 1, 2019, for background studies
22.20 initiated on or after that date.

22.21 Sec. 26. Minnesota Statutes 2018, section 245C.10, is amended by adding a subdivision
22.22 to read:

22.23 Subd. 14. **Children's residential facilities.** The commissioner shall recover the cost of
22.24 background studies initiated by a licensed children's residential facility through a fee of no
22.25 more than \$51 per study. Fees collected under this subdivision are appropriated to the
22.26 commissioner for purposes of conducting background studies.

22.27 **EFFECTIVE DATE.** This section is effective July 1, 2019, for background studies
22.28 initiated on or after that date.

22.29 Sec. 27. Minnesota Statutes 2018, section 245C.24, is amended by adding a subdivision
22.30 to read:

22.31 Subd. 5. **Five-year bar to set aside disqualification; children's residential**
22.32 **facilities.** The commissioner shall not set aside the disqualification of an individual in

23.1 connection with a license for a children's residential facility who was convicted of a felony
23.2 within the past five years for: (1) physical assault or battery; or (2) a drug-related offense.

23.3 **EFFECTIVE DATE.** This section is effective for background studies initiated on or
23.4 after July 1, 2019.

23.5 Sec. 28. Minnesota Statutes 2018, section 245E.06, subdivision 3, is amended to read:

23.6 **Subd. 3. Appeal of department sanction action.** (a) If the department does not pursue
23.7 a criminal action against a provider, license holder, controlling individual, or recipient for
23.8 financial misconduct, but the department imposes an administrative sanction under section
23.9 245E.02, subdivision 4, paragraph (e), any individual or entity against whom the sanction
23.10 was imposed may appeal the department's administrative sanction under this section pursuant
23.11 to section 119B.16 or 256.045 with the additional requirements in clauses (1) to (4). An
23.12 appeal must specify:

23.13 (1) each disputed item, the reason for the dispute, and an estimate of the dollar amount
23.14 involved for each disputed item, if appropriate;

23.15 (2) the computation that is believed to be correct, if appropriate;

23.16 (3) the authority in the statute or rule relied upon for each disputed item; and

23.17 (4) the name, address, and phone number of the person at the provider's place of business
23.18 with whom contact may be made regarding the appeal.

23.19 (b) Notwithstanding section 245E.03, subdivision 4, an appeal is considered timely only
23.20 if postmarked or received by the department's Appeals Division within 30 days after receiving
23.21 a notice of department sanction.

23.22 (c) Before the appeal hearing, the department may deny or terminate authorizations or
23.23 payment to the entity or individual if the department determines that the action is necessary
23.24 to protect the public welfare or the interests of the child care assistance program.

23.25 A provider's rights related to the department's action taken under this chapter against a
23.26 provider are established in sections 119B.16 and 119B.161.

23.27 **EFFECTIVE DATE.** This section is effective February 26, 2021.

24.1 Sec. 29. Minnesota Statutes 2018, section 245H.07, is amended to read:

24.2 **245H.07 DECERTIFICATION.**

24.3 Subdivision 1. Generally. (a) The commissioner may decertify a center if a certification
24.4 holder:

24.5 (1) failed to comply with an applicable law or rule; or

24.6 (2) knowingly withheld relevant information from or gave false or misleading information
24.7 to the commissioner in connection with an application for certification, in connection with
24.8 the background study status of an individual, during an investigation, or regarding compliance
24.9 with applicable laws or rules; or

24.10 (3) has authorization to receive child care assistance payments revoked pursuant to
24.11 chapter 119B.

24.12 (b) When considering decertification, the commissioner shall consider the nature,
24.13 chronicity, or severity of the violation of law or rule.

24.14 (c) When a center is decertified, the center is ineligible to receive a child care assistance
24.15 payment under chapter 119B.

24.16 Subd. 2. Reconsideration. (a) The certification holder may request reconsideration of
24.17 the decertification by notifying the commissioner by certified mail or personal service. The
24.18 request must be made in writing. If sent by certified mail, the request must be postmarked
24.19 and sent to the commissioner within ten calendar days after the certification holder received
24.20 the order. If a request is made by personal service, it must be received by the commissioner
24.21 within ten calendar days after the certification holder received the order. The certification
24.22 holder may submit with the request for reconsideration written argument or evidence in
24.23 support of the request for reconsideration.

24.24 (b) If the commissioner decertifies a center pursuant to subdivision 1, paragraph (a),
24.25 clause (3), and if the center appeals the revocation of the center's authorization to receive
24.26 child care assistance payments, the final decertification determination is stayed until the
24.27 appeal of the center's authorization under chapter 119B is resolved. If the center also requests
24.28 reconsideration of the decertification, the center must do so according to paragraph (a). The
24.29 final decision on reconsideration is stayed until the appeal of the center's authorization under
24.30 chapter 119B is resolved.

24.31 (c) The commissioner's disposition of a request for reconsideration is final and not subject
24.32 to appeal under chapter 14.

25.1 **EFFECTIVE DATE.** This section is effective February 26, 2021.

25.2 Sec. 30. Minnesota Statutes 2018, section 256.01, subdivision 14b, is amended to read:

25.3 Subd. 14b. **American Indian child welfare projects.** (a) The commissioner of human
25.4 services may authorize projects to ~~test~~ initiate tribal delivery of child welfare services to
25.5 American Indian children and their parents and custodians living on the reservation. The
25.6 commissioner has authority to solicit and determine which tribes may participate in a project.
25.7 Grants may be issued to Minnesota Indian tribes to support the projects. The commissioner
25.8 may waive existing state rules as needed to accomplish the projects. The commissioner may
25.9 authorize projects to use alternative methods of (1) screening, investigating, and assessing
25.10 reports of child maltreatment, and (2) administrative reconsideration, administrative appeal,
25.11 and judicial appeal of maltreatment determinations, provided the alternative methods used
25.12 by the projects comply with the provisions of sections 256.045 and 626.556 ~~dealing that~~
25.13 deal with the rights of individuals who are the subjects of reports or investigations, including
25.14 notice and appeal rights and data practices requirements. The commissioner shall only
25.15 authorize alternative methods that comply with the public policy under section 626.556,
25.16 subdivision 1. The commissioner may seek any federal approvals necessary to carry out the
25.17 projects as well as seek and use any funds available to the commissioner, including use of
25.18 federal funds, foundation funds, existing grant funds, and other funds. The commissioner
25.19 is authorized to advance state funds as necessary to operate the projects. Federal
25.20 reimbursement applicable to the projects is appropriated to the commissioner for the purposes
25.21 of the projects. The projects must be required to address responsibility for safety, permanency,
25.22 and well-being of children.

25.23 (b) For the purposes of this section, "American Indian child" means a person under 21
25.24 years old and who is a tribal member or eligible for membership in one of the tribes chosen
25.25 for a project under this subdivision and who is residing on the reservation of that tribe.

25.26 (c) In order to qualify for an American Indian child welfare project, a tribe must:

25.27 (1) be one of the existing tribes with reservation land in Minnesota;

25.28 (2) have a tribal court with jurisdiction over child custody proceedings;

25.29 (3) have a substantial number of children for whom determinations of maltreatment have
25.30 occurred;

25.31 (4)(i) have capacity to respond to reports of abuse and neglect under section 626.556;

25.32 or (ii) have codified the tribe's screening, investigation, and assessment of reports of child

26.1 maltreatment procedures, if authorized to use an alternative method by the commissioner
26.2 under paragraph (a);

26.3 (5) provide a wide range of services to families in need of child welfare services; and

26.4 (6) have a tribal-state title IV-E agreement in effect.

26.5 (d) Grants awarded under this section may be used for the nonfederal costs of providing
26.6 child welfare services to American Indian children on the tribe's reservation, including costs
26.7 associated with:

26.8 (1) assessment and prevention of child abuse and neglect;

26.9 (2) family preservation;

26.10 (3) facilitative, supportive, and reunification services;

26.11 (4) out-of-home placement for children removed from the home for child protective
26.12 purposes; and

26.13 (5) other activities and services approved by the commissioner that further the goals of
26.14 providing safety, permanency, and well-being of American Indian children.

26.15 (e) When a tribe has initiated a project and has been approved by the commissioner to
26.16 assume child welfare responsibilities for American Indian children of that tribe under this
26.17 section, the affected county social service agency is relieved of responsibility for responding
26.18 to reports of abuse and neglect under section 626.556 for those children during the time
26.19 within which the tribal project is in effect and funded. The commissioner shall work with
26.20 tribes and affected counties to develop procedures for data collection, evaluation, and
26.21 clarification of ongoing role and financial responsibilities of the county and tribe for child
26.22 welfare services prior to initiation of the project. Children who have not been identified by
26.23 the tribe as participating in the project shall remain the responsibility of the county. Nothing
26.24 in this section shall alter responsibilities of the county for law enforcement or court services.

26.25 (f) Participating tribes may conduct children's mental health screenings under section
26.26 245.4874, subdivision 1, paragraph (a), clause (12), for children who are eligible for the
26.27 initiative and living on the reservation and who meet one of the following criteria:

26.28 (1) the child must be receiving child protective services;

26.29 (2) the child must be in foster care; or

26.30 (3) the child's parents must have had parental rights suspended or terminated.

27.1 Tribes may access reimbursement from available state funds for conducting the screenings.
27.2 Nothing in this section shall alter responsibilities of the county for providing services under
27.3 section 245.487.

27.4 (g) Participating tribes may establish a local child mortality review panel. In establishing
27.5 a local child mortality review panel, the tribe agrees to conduct local child mortality reviews
27.6 for child deaths or near-fatalities occurring on the reservation under subdivision 12. Tribes
27.7 with established child mortality review panels shall have access to nonpublic data and shall
27.8 protect nonpublic data under subdivision 12, paragraphs (c) to (e). The tribe shall provide
27.9 written notice to the commissioner and affected counties when a local child mortality review
27.10 panel has been established and shall provide data upon request of the commissioner for
27.11 purposes of sharing nonpublic data with members of the state child mortality review panel
27.12 in connection to an individual case.

27.13 (h) The commissioner shall collect information on outcomes relating to child safety,
27.14 permanency, and well-being of American Indian children who are served in the projects.
27.15 Participating tribes must provide information to the state in a format and completeness
27.16 deemed acceptable by the state to meet state and federal reporting requirements.

27.17 (i) In consultation with the White Earth Band, the commissioner shall develop and submit
27.18 to the chairs and ranking minority members of the legislative committees with jurisdiction
27.19 over health and human services a plan to transfer legal responsibility for providing child
27.20 protective services to White Earth Band member children residing in Hennepin County to
27.21 the White Earth Band. The plan shall include a financing proposal, definitions of key terms,
27.22 statutory amendments required, and other provisions required to implement the plan. The
27.23 commissioner shall submit the plan by January 15, 2012.

27.24 Sec. 31. Minnesota Statutes 2018, section 260C.007, subdivision 18, is amended to read:

27.25 Subd. 18. **Foster care.** (a) "Foster care" means ~~24 hour~~ 24-hour substitute care for
27.26 children placed away from their parents or guardian and a child for whom a responsible
27.27 social services agency has placement and care responsibility. "Foster care" includes, but is
27.28 not limited to, placement and:

27.29 (1) who is placed away from the child's parent or guardian in foster family homes, foster
27.30 homes of relatives, group homes, emergency shelters, residential facilities not excluded in
27.31 this subdivision, child care institutions, and preadoptive homes; or

27.32 (2) who is colocated with the child's parent or guardian in a licensed residential
27.33 family-based substance abuse disorder treatment program as defined in subdivision 22a; or

28.1 (3) who is returned to the care of the child's parent or guardian from whom the child
28.2 was removed under a trial home visit pursuant to section 260C.201, subdivision 1, paragraph
28.3 (a), clause (3).

28.4 (b) A child is in foster care under this definition regardless of whether the facility is
28.5 licensed and payments are made for the cost of care. Nothing in this definition creates any
28.6 authority to place a child in a home or facility that is required to be licensed which is not
28.7 licensed. "Foster care" does not include placement in any of the following facilities: hospitals,
28.8 inpatient chemical dependency treatment facilities where the child is the recipient of the
28.9 treatment, facilities that are primarily for delinquent children, any corrections facility or
28.10 program within a particular correction's facility not meeting requirements for title IV-E
28.11 facilities as determined by the commissioner, facilities to which a child is committed under
28.12 the provision of chapter 253B, forestry camps, or jails. Foster care is intended to provide
28.13 for a child's safety or to access treatment. Foster care must not be used as a punishment or
28.14 consequence for a child's behavior.

28.15 Sec. 32. Minnesota Statutes 2018, section 260C.007, is amended by adding a subdivision
28.16 to read:

28.17 Subd. 22a. Licensed residential family-based substance use disorder treatment
28.18 program. "Licensed residential family-based substance use disorder treatment program"
28.19 means a residential treatment facility that provides the parent or guardian with parenting
28.20 skills training, parent education, or individual and family counseling, under an organizational
28.21 structure and treatment framework that involves understanding, recognizing, and responding
28.22 to the effects of all types of trauma according to recognized principles of a trauma-informed
28.23 approach and trauma-specific interventions to address the consequences of trauma and
28.24 facilitate healing.

28.25 Sec. 33. Minnesota Statutes 2018, section 260C.178, subdivision 1, is amended to read:

28.26 **Subdivision 1. Hearing and release requirements.** (a) If a child was taken into custody
28.27 under section 260C.175, subdivision 1, clause (1) or (2), item (ii), the court shall hold a
28.28 hearing within 72 hours of the time the child was taken into custody, excluding Saturdays,
28.29 Sundays, and holidays, to determine whether the child should continue in custody.

28.30 (b) Unless there is reason to believe that the child would endanger self or others or not
28.31 return for a court hearing, or that the child's health or welfare would be immediately
28.32 endangered, the child shall be released to the custody of a parent, guardian, custodian, or
28.33 other suitable person, subject to reasonable conditions of release including, but not limited

29.1 to, a requirement that the child undergo a chemical use assessment as provided in section
29.2 260C.157, subdivision 1.

29.3 (c) If the court determines there is reason to believe that the child would endanger self
29.4 or others or not return for a court hearing, or that the child's health or welfare would be
29.5 immediately endangered if returned to the care of the parent or guardian who has custody
29.6 and from whom the child was removed, the court shall order the child into foster care as
29.7 defined in section 260C.007, subdivision 18, under the legal responsibility of the responsible
29.8 social services agency or responsible probation or corrections agency for the purposes of
29.9 protective care as that term is used in the juvenile court rules or into the home of a
29.10 noncustodial parent and order the noncustodial parent to comply with any conditions the
29.11 court determines to be appropriate to the safety and care of the child, including cooperating
29.12 with paternity establishment proceedings in the case of a man who has not been adjudicated
29.13 the child's father. The court shall not give the responsible social services legal custody and
29.14 order a trial home visit at any time prior to adjudication and disposition under section
29.15 260C.201, subdivision 1, paragraph (a), clause (3), but may order the child returned to the
29.16 care of the parent or guardian who has custody and from whom the child was removed and
29.17 order the parent or guardian to comply with any conditions the court determines to be
29.18 appropriate to meet the safety, health, and welfare of the child.

29.19 (d) In determining whether the child's health or welfare would be immediately
29.20 endangered, the court shall consider whether the child would reside with a perpetrator of
29.21 domestic child abuse.

29.22 (e) The court, before determining whether a child should be placed in or continue in
29.23 foster care under the protective care of the responsible agency, shall also make a
29.24 determination, consistent with section 260.012 as to whether reasonable efforts were made
29.25 to prevent placement or whether reasonable efforts to prevent placement are not required.
29.26 In the case of an Indian child, the court shall determine whether active efforts, according
29.27 to section 260.762 and the Indian Child Welfare Act of 1978, United States Code, title 25,
29.28 section 1912(d), were made to prevent placement. The court shall enter a finding that the
29.29 responsible social services agency has made reasonable efforts to prevent placement when
29.30 the agency establishes either:

29.31 (1) that it has actually provided services or made efforts in an attempt to prevent the
29.32 child's removal but that such services or efforts have not proven sufficient to permit the
29.33 child to safely remain in the home; or

30.1 (2) that there are no services or other efforts that could be made at the time of the hearing
30.2 that could safely permit the child to remain home or to return home. When reasonable efforts
30.3 to prevent placement are required and there are services or other efforts that could be ordered
30.4 which would permit the child to safely return home, the court shall order the child returned
30.5 to the care of the parent or guardian and the services or efforts put in place to ensure the
30.6 child's safety. When the court makes a *prima facie* determination that one of the
30.7 circumstances under paragraph (g) exists, the court shall determine that reasonable efforts
30.8 to prevent placement and to return the child to the care of the parent or guardian are not
30.9 required.

30.10 If the court finds the social services agency's preventive or reunification efforts have
30.11 not been reasonable but further preventive or reunification efforts could not permit the child
30.12 to safely remain at home, the court may nevertheless authorize or continue the removal of
30.13 the child.

30.14 (f) The court may not order or continue the foster care placement of the child unless the
30.15 court makes explicit, individualized findings that continued custody of the child by the
30.16 parent or guardian would be contrary to the welfare of the child and that placement is in the
30.17 best interest of the child.

30.18 (g) At the emergency removal hearing, or at any time during the course of the proceeding,
30.19 and upon notice and request of the county attorney, the court shall determine whether a
30.20 petition has been filed stating a *prima facie* case that:

30.21 (1) the parent has subjected a child to egregious harm as defined in section 260C.007,
30.22 subdivision 14;

30.23 (2) the parental rights of the parent to another child have been involuntarily terminated;

30.24 (3) the child is an abandoned infant under section 260C.301, subdivision 2, paragraph
30.25 (a), clause (2);

30.26 (4) the parents' custodial rights to another child have been involuntarily transferred to a
30.27 relative under Minnesota Statutes 2010, section 260C.201, subdivision 11, paragraph (e),
30.28 clause (1); section 260C.515, subdivision 4; or a similar law of another jurisdiction;

30.29 (5) the parent has committed sexual abuse as defined in section 626.556, subdivision 2,
30.30 against the child or another child of the parent;

30.31 (6) the parent has committed an offense that requires registration as a predatory offender
30.32 under section 243.166, subdivision 1b, paragraph (a) or (b); or

31.1 (7) the provision of services or further services for the purpose of reunification is futile
31.2 and therefore unreasonable.

31.3 (h) When a petition to terminate parental rights is required under section 260C.301,
31.4 subdivision 4, or 260C.503, subdivision 2, but the county attorney has determined not to
31.5 proceed with a termination of parental rights petition, and has instead filed a petition to
31.6 transfer permanent legal and physical custody to a relative under section 260C.507, the
31.7 court shall schedule a permanency hearing within 30 days of the filing of the petition.

31.8 (i) If the county attorney has filed a petition under section 260C.307, the court shall
31.9 schedule a trial under section 260C.163 within 90 days of the filing of the petition except
31.10 when the county attorney determines that the criminal case shall proceed to trial first under
31.11 section 260C.503, subdivision 2, paragraph (c).

31.12 (j) If the court determines the child should be ordered into foster care and the child's
31.13 parent refuses to give information to the responsible social services agency regarding the
31.14 child's father or relatives of the child, the court may order the parent to disclose the names,
31.15 addresses, telephone numbers, and other identifying information to the responsible social
31.16 services agency for the purpose of complying with sections 260C.151, 260C.212, 260C.215,
31.17 and 260C.221.

31.18 (k) If a child ordered into foster care has siblings, whether full, half, or step, who are
31.19 also ordered into foster care, the court shall inquire of the responsible social services agency
31.20 of the efforts to place the children together as required by section 260C.212, subdivision 2,
31.21 paragraph (d), if placement together is in each child's best interests, unless a child is in
31.22 placement for treatment or a child is placed with a previously noncustodial parent who is
31.23 not a parent to all siblings. If the children are not placed together at the time of the hearing,
31.24 the court shall inquire at each subsequent hearing of the agency's reasonable efforts to place
31.25 the siblings together, as required under section 260.012. If any sibling is not placed with
31.26 another sibling or siblings, the agency must develop a plan to facilitate visitation or ongoing
31.27 contact among the siblings as required under section 260C.212, subdivision 1, unless it is
31.28 contrary to the safety or well-being of any of the siblings to do so.

31.29 (l) When the court has ordered the child into foster care or into the home of a noncustodial
31.30 parent, the court may order a chemical dependency evaluation, mental health evaluation,
31.31 medical examination, and parenting assessment for the parent as necessary to support the
31.32 development of a plan for reunification required under subdivision 7 and section 260C.212,
31.33 subdivision 1, or the child protective services plan under section 626.556, subdivision 10,
31.34 and Minnesota Rules, part 9560.0228.

32.1 Sec. 34. **[260C.190] FAMILY-FOCUSED RESIDENTIAL PLACEMENT.**

32.2 Subdivision 1. Placement. (a) An agency with legal responsibility for a child under
32.3 section 260C.178, subdivision 1, paragraph (c), or legal custody of a child under section
32.4 260C.201, subdivision 1, paragraph (a), clause (3), may colocate a child with a parent who
32.5 is receiving services in a licensed residential family-based substance use disorder treatment
32.6 program for up to 12 months.

32.7 (b) During the child's placement under paragraph (a), the agency: (1) may visit the child
32.8 as the agency deems necessary and appropriate; (2) shall continue to have access to
32.9 information under section 260C.208; and (3) shall continue to provide appropriate services
32.10 to both the parent and the child.

32.11 (c) The agency may terminate the child's placement under paragraph (a) to protect the
32.12 child's health, safety, or welfare and may remove the child to foster care without a prior
32.13 court order or authorization.

32.14 Subd. 2. Case plans. (a) Before a child may be colocated with a parent in a licensed
32.15 residential family-based substance use disorder treatment program, a recommendation that
32.16 the child's placement with a parent is in the child's best interests must be documented in the
32.17 child's case plan. Each child must have a written case plan developed with the parent and
32.18 the treatment program staff that describes the safety plan for the child and the treatment
32.19 program's responsibilities if the parent leaves or is discharged without completing the
32.20 program. The treatment program must be provided with a copy of the case plan that includes
32.21 the recommendations and safety plan at the time the child is colocated with the parent.

32.22 (b) An out-of-home placement plan under section 260C.212, subdivision 1, must be
32.23 completed no later than 30 days from when a child is colocated with a parent in a licensed
32.24 residential family-based substance use disorder treatment program. The written plan
32.25 developed with parent and treatment program staff in paragraph (a) may be updated and
32.26 must be incorporated into the out-of-home placement plan. The treatment program must be
32.27 provided with a copy of the child's out-of-home placement plan.

32.28 Subd. 3. Required reviews and permanency proceedings. (a) For a child colocated
32.29 with a parent under subdivision 1, court reviews must occur according to section 260C.202.

32.30 (b) If a child has been in foster care for six months, a court review under section 260C.202
32.31 may be conducted in lieu of a permanency progress review hearing under section 260C.204
32.32 when the child is colocated with a parent consistent with section 260C.503, subdivision 3,
32.33 paragraph (c), in a licensed residential family-based substance use disorder treatment
32.34 program.

33.1 (c) If the child is colocated with a parent in a licensed residential family-based substance
33.2 use disorder treatment program 12 months after the child was placed in foster care, the
33.3 agency must file a report with the court regarding the parent's progress in the treatment
33.4 program and the agency's reasonable efforts to finalize the child's safe and permanent return
33.5 to the care and custody of the parent consistent with section 260C.503, subdivision 3,
33.6 paragraph (c), in lieu of filing a petition required under section 260C.505.

33.7 (d) The court shall make findings regarding the reasonable efforts of the agency to
33.8 finalize the child's return home as the permanency disposition order in the child's best
33.9 interests. The court may continue the child's foster care placement colocated with a parent
33.10 in a licensed residential family-based substance use disorder treatment program for up to
33.11 12 months. When a child has been in foster care placement for 12 months, but the duration
33.12 of the colocation with a parent in a licensed residential family-based substance use disorder
33.13 treatment program is less than 12 months, the court may continue the colocation with the
33.14 total time spent in foster care not exceeding 15 out of the most recent 22 months. If the
33.15 court finds that the agency fails to make reasonable efforts to finalize the child's return home
33.16 as the permanency disposition order in the child's best interests, the court may order additional
33.17 efforts to support the child remaining in the care of the parent.

33.18 (e) If a parent leaves or is discharged from a licensed residential family-based substance
33.19 use disorder treatment program without completing the program, the child's placement under
33.20 this section is terminated and the agency may remove the child to foster care without a prior
33.21 court order or authorization. Within three days of any termination of a child's placement,
33.22 the agency shall notify the court and each party.

33.23 (f) If a parent leaves or is discharged from a licensed residential family-based substance
33.24 use disorder treatment program without completing the program and the child has been in
33.25 foster care for less than six months, the court must hold a review hearing within ten days
33.26 of receiving notice of a termination of a child's placement and must order an alternative
33.27 disposition under section 260C.201.

33.28 (g) If a parent leaves or is discharged from a licensed residential family-based substance
33.29 use disorder treatment program without completing the program and the child is colocated
33.30 with a parent and the child has been in foster care for more than six months but less than
33.31 12 months, the court must conduct a permanency progress review hearing under section
33.32 260C.204 no later than 30 days after the day the parent leaves or is discharged.

33.33 (h) If a parent leaves or is discharged from a licensed residential family-based substance
33.34 use disorder treatment program without completing the program and the child is colocated

34.1 with a parent and the child has been in foster care for more than 12 months, the court shall
34.2 begin permanency proceedings under sections 260C.503 to 260C.521.

34.3 Sec. 35. Minnesota Statutes 2018, section 260C.201, subdivision 1, is amended to read:

34.4 **Subdivision 1. Dispositions.** (a) If the court finds that the child is in need of protection
34.5 or services or neglected and in foster care, it shall enter an order making any of the following
34.6 dispositions of the case:

34.7 (1) place the child under the protective supervision of the responsible social services
34.8 agency or child-placing agency in the home of a parent of the child under conditions
34.9 prescribed by the court directed to the correction of the child's need for protection or services:

34.10 (i) the court may order the child into the home of a parent who does not otherwise have
34.11 legal custody of the child, however, an order under this section does not confer legal custody
34.12 on that parent;

34.13 (ii) if the court orders the child into the home of a father who is not adjudicated, the
34.14 father must cooperate with paternity establishment proceedings regarding the child in the
34.15 appropriate jurisdiction as one of the conditions prescribed by the court for the child to
34.16 continue in the father's home; and

34.17 (iii) the court may order the child into the home of a noncustodial parent with conditions
34.18 and may also order both the noncustodial and the custodial parent to comply with the
34.19 requirements of a case plan under subdivision 2; or

34.20 (2) transfer legal custody to one of the following:

34.21 (i) a child-placing agency; or

34.22 (ii) the responsible social services agency. In making a foster care placement for a child
34.23 whose custody has been transferred under this subdivision, the agency shall make an
34.24 individualized determination of how the placement is in the child's best interests using the
34.25 consideration for relatives and, the best interest factors in section 260C.212, subdivision 2,
34.26 paragraph (b), and may include a child colocated with a parent in a licensed residential
34.27 family-based substance use disorder treatment program under section 260C.190; or

34.28 (3) order a trial home visit without modifying the transfer of legal custody to the
34.29 responsible social services agency under clause (2). Trial home visit means the child is
34.30 returned to the care of the parent or guardian from whom the child was removed for a period
34.31 not to exceed six months. During the period of the trial home visit, the responsible social
34.32 services agency:

35.1 (i) shall continue to have legal custody of the child, which means the agency may see
35.2 the child in the parent's home, at school, in a child care facility, or other setting as the agency
35.3 deems necessary and appropriate;

35.4 (ii) shall continue to have the ability to access information under section 260C.208;

35.5 (iii) shall continue to provide appropriate services to both the parent and the child during
35.6 the period of the trial home visit;

35.7 (iv) without previous court order or authorization, may terminate the trial home visit in
35.8 order to protect the child's health, safety, or welfare and may remove the child to foster care;

35.9 (v) shall advise the court and parties within three days of the termination of the trial
35.10 home visit when a visit is terminated by the responsible social services agency without a
35.11 court order; and

35.12 (vi) shall prepare a report for the court when the trial home visit is terminated whether
35.13 by the agency or court order which describes the child's circumstances during the trial home
35.14 visit and recommends appropriate orders, if any, for the court to enter to provide for the
35.15 child's safety and stability. In the event a trial home visit is terminated by the agency by
35.16 removing the child to foster care without prior court order or authorization, the court shall
35.17 conduct a hearing within ten days of receiving notice of the termination of the trial home
35.18 visit by the agency and shall order disposition under this subdivision or ~~conduct a permanency~~
35.19 ~~hearing under subdivision 11 or 11a commence permanency proceedings under sections~~
35.20 260C.503 to 260C.515. The time period for the hearing may be extended by the court for
35.21 good cause shown and if it is in the best interests of the child as long as the total time the
35.22 child spends in foster care without a permanency hearing does not exceed 12 months;

35.23 (4) if the child has been adjudicated as a child in need of protection or services because
35.24 the child is in need of special services or care to treat or ameliorate a physical or mental
35.25 disability or emotional disturbance as defined in section 245.4871, subdivision 15, the court
35.26 may order the child's parent, guardian, or custodian to provide it. The court may order the
35.27 child's health plan company to provide mental health services to the child. Section 62Q.535
35.28 applies to an order for mental health services directed to the child's health plan company.
35.29 If the health plan, parent, guardian, or custodian fails or is unable to provide this treatment
35.30 or care, the court may order it provided. Absent specific written findings by the court that
35.31 the child's disability is the result of abuse or neglect by the child's parent or guardian, the
35.32 court shall not transfer legal custody of the child for the purpose of obtaining special
35.33 treatment or care solely because the parent is unable to provide the treatment or care. If the
35.34 court's order for mental health treatment is based on a diagnosis made by a treatment

36.1 professional, the court may order that the diagnosing professional not provide the treatment
36.2 to the child if it finds that such an order is in the child's best interests; or

36.3 (5) if the court believes that the child has sufficient maturity and judgment and that it is
36.4 in the best interests of the child, the court may order a child 16 years old or older to be
36.5 allowed to live independently, either alone or with others as approved by the court under
36.6 supervision the court considers appropriate, if the county board, after consultation with the
36.7 court, has specifically authorized this dispositional alternative for a child.

36.8 (b) If the child was adjudicated in need of protection or services because the child is a
36.9 runaway or habitual truant, the court may order any of the following dispositions in addition
36.10 to or as alternatives to the dispositions authorized under paragraph (a):

36.11 (1) counsel the child or the child's parents, guardian, or custodian;

36.12 (2) place the child under the supervision of a probation officer or other suitable person
36.13 in the child's own home under conditions prescribed by the court, including reasonable rules
36.14 for the child's conduct and the conduct of the parents, guardian, or custodian, designed for
36.15 the physical, mental, and moral well-being and behavior of the child;

36.16 (3) subject to the court's supervision, transfer legal custody of the child to one of the
36.17 following:

36.18 (i) a reputable person of good moral character. No person may receive custody of two
36.19 or more unrelated children unless licensed to operate a residential program under sections
36.20 245A.01 to 245A.16; or

36.21 (ii) a county probation officer for placement in a group foster home established under
36.22 the direction of the juvenile court and licensed pursuant to section 241.021;

36.23 (4) require the child to pay a fine of up to \$100. The court shall order payment of the
36.24 fine in a manner that will not impose undue financial hardship upon the child;

36.25 (5) require the child to participate in a community service project;

36.26 (6) order the child to undergo a chemical dependency evaluation and, if warranted by
36.27 the evaluation, order participation by the child in a drug awareness program or an inpatient
36.28 or outpatient chemical dependency treatment program;

36.29 (7) if the court believes that it is in the best interests of the child or of public safety that
36.30 the child's driver's license or instruction permit be canceled, the court may order the
36.31 commissioner of public safety to cancel the child's license or permit for any period up to
36.32 the child's 18th birthday. If the child does not have a driver's license or permit, the court

37.1 may order a denial of driving privileges for any period up to the child's 18th birthday. The
37.2 court shall forward an order issued under this clause to the commissioner, who shall cancel
37.3 the license or permit or deny driving privileges without a hearing for the period specified
37.4 by the court. At any time before the expiration of the period of cancellation or denial, the
37.5 court may, for good cause, order the commissioner of public safety to allow the child to
37.6 apply for a license or permit, and the commissioner shall so authorize;

37.7 (8) order that the child's parent or legal guardian deliver the child to school at the
37.8 beginning of each school day for a period of time specified by the court; or

37.9 (9) require the child to perform any other activities or participate in any other treatment
37.10 programs deemed appropriate by the court.

37.11 To the extent practicable, the court shall enter a disposition order the same day it makes
37.12 a finding that a child is in need of protection or services or neglected and in foster care, but
37.13 in no event more than 15 days after the finding unless the court finds that the best interests
37.14 of the child will be served by granting a delay. If the child was under eight years of age at
37.15 the time the petition was filed, the disposition order must be entered within ten days of the
37.16 finding and the court may not grant a delay unless good cause is shown and the court finds
37.17 the best interests of the child will be served by the delay.

37.18 (c) If a child who is 14 years of age or older is adjudicated in need of protection or
37.19 services because the child is a habitual truant and truancy procedures involving the child
37.20 were previously dealt with by a school attendance review board or county attorney mediation
37.21 program under section 260A.06 or 260A.07, the court shall order a cancellation or denial
37.22 of driving privileges under paragraph (b), clause (7), for any period up to the child's 18th
37.23 birthday.

37.24 (d) In the case of a child adjudicated in need of protection or services because the child
37.25 has committed domestic abuse and been ordered excluded from the child's parent's home,
37.26 the court shall dismiss jurisdiction if the court, at any time, finds the parent is able or willing
37.27 to provide an alternative safe living arrangement for the child, as defined in Laws 1997,
37.28 chapter 239, article 10, section 2.

37.29 (e) When a parent has complied with a case plan ordered under subdivision 6 and the
37.30 child is in the care of the parent, the court may order the responsible social services agency
37.31 to monitor the parent's continued ability to maintain the child safely in the home under such
37.32 terms and conditions as the court determines appropriate under the circumstances.

38.1 Sec. 36. Minnesota Statutes 2018, section 260C.201, subdivision 2, is amended to read:

38.2 Subd. 2. **Written findings.** (a) Any order for a disposition authorized under this section
38.3 shall contain written findings of fact to support the disposition and case plan ordered and
38.4 shall also set forth in writing the following information:

38.5 (1) why the best interests and safety of the child are served by the disposition and case
38.6 plan ordered;

38.7 (2) what alternative dispositions or services under the case plan were considered by the
38.8 court and why such dispositions or services were not appropriate in the instant case;

38.9 (3) when legal custody of the child is transferred, the appropriateness of the particular
38.10 placement made or to be made by the placing agency using the factors in section 260C.212,
38.11 subdivision 2, paragraph (b), or the appropriateness of a child colocated with a parent in a
38.12 licensed residential family-based substance use disorder treatment program under section
38.13 260C.190;

38.14 (4) whether reasonable efforts to finalize the permanent plan for the child consistent
38.15 with section 260.012 were made including reasonable efforts:

38.16 (i) to prevent the child's placement and to reunify the child with the parent or guardian
38.17 from whom the child was removed at the earliest time consistent with the child's safety.
38.18 The court's findings must include a brief description of what preventive and reunification
38.19 efforts were made and why further efforts could not have prevented or eliminated the
38.20 necessity of removal or that reasonable efforts were not required under section 260.012 or
38.21 260C.178, subdivision 1;

38.22 (ii) to identify and locate any noncustodial or nonresident parent of the child and to
38.23 assess such parent's ability to provide day-to-day care of the child, and, where appropriate,
38.24 provide services necessary to enable the noncustodial or nonresident parent to safely provide
38.25 day-to-day care of the child as required under section 260C.219, unless such services are
38.26 not required under section 260.012 or 260C.178, subdivision 1;

38.27 (iii) to make the diligent search for relatives and provide the notices required under
38.28 section 260C.221; a finding made pursuant to a hearing under section 260C.202 that the
38.29 agency has made diligent efforts to conduct a relative search and has appropriately engaged
38.30 relatives who responded to the notice under section 260C.221 and other relatives, who came
38.31 to the attention of the agency after notice under section 260C.221 was sent, in placement
38.32 and case planning decisions fulfills the requirement of this item;

39.1 (iv) to identify and make a foster care placement in the home of an unlicensed relative,
39.2 according to the requirements of section 245A.035, a licensed relative, or other licensed
39.3 foster care provider who will commit to being the permanent legal parent or custodian for
39.4 the child in the event reunification cannot occur, but who will actively support the
39.5 reunification plan for the child; and

39.6 (v) to place siblings together in the same home or to ensure visitation is occurring when
39.7 siblings are separated in foster care placement and visitation is in the siblings' best interests
39.8 under section 260C.212, subdivision 2, paragraph (d); and

39.9 (5) if the child has been adjudicated as a child in need of protection or services because
39.10 the child is in need of special services or care to treat or ameliorate a mental disability or
39.11 emotional disturbance as defined in section 245.4871, subdivision 15, the written findings
39.12 shall also set forth:

39.13 (i) whether the child has mental health needs that must be addressed by the case plan;

39.14 (ii) what consideration was given to the diagnostic and functional assessments performed
39.15 by the child's mental health professional and to health and mental health care professionals'
39.16 treatment recommendations;

39.17 (iii) what consideration was given to the requests or preferences of the child's parent or
39.18 guardian with regard to the child's interventions, services, or treatment; and

39.19 (iv) what consideration was given to the cultural appropriateness of the child's treatment
39.20 or services.

39.21 (b) If the court finds that the social services agency's preventive or reunification efforts
39.22 have not been reasonable but that further preventive or reunification efforts could not permit
39.23 the child to safely remain at home, the court may nevertheless authorize or continue the
39.24 removal of the child.

39.25 (c) If the child has been identified by the responsible social services agency as the subject
39.26 of concurrent permanency planning, the court shall review the reasonable efforts of the
39.27 agency to develop a permanency plan for the child that includes a primary plan which is
39.28 for reunification with the child's parent or guardian and a secondary plan which is for an
39.29 alternative, legally permanent home for the child in the event reunification cannot be achieved
39.30 in a timely manner.

40.1 Sec. 37. Minnesota Statutes 2018, section 260C.201, subdivision 6, is amended to read:

40.2 Subd. 6. **Case plan.** (a) For each disposition ordered where the child is placed away
40.3 from a parent or guardian, the court shall order the responsible social services agency to
40.4 prepare a written out-of-home placement plan according to the requirements of section
40.5 260C.212, subdivision 1. When a foster child is colocated with a parent in a licensed
40.6 residential family-based substance use disorder treatment program under section 260C.190,
40.7 the case plan must specify the recommendation for the colocation before the child is colocated
40.8 with the parent.

40.9 (b) In cases where the child is not placed out of the home or is ordered into the home of
40.10 a noncustodial parent, the responsible social services agency shall prepare a plan for delivery
40.11 of social services to the child and custodial parent under section 626.556, subdivision 10,
40.12 or any other case plan required to meet the needs of the child. The plan shall be designed
40.13 to safely maintain the child in the home or to reunite the child with the custodial parent.

40.14 (c) The court may approve the case plan as presented or modify it after hearing from
40.15 the parties. Once the plan is approved, the court shall order all parties to comply with it. A
40.16 copy of the approved case plan shall be attached to the court's order and incorporated into
40.17 it by reference.

40.18 (d) A party has a right to request a court review of the reasonableness of the case plan
40.19 upon a showing of a substantial change of circumstances.

40.20 Sec. 38. Minnesota Statutes 2018, section 260C.212, subdivision 2, is amended to read:

40.21 Subd. 2. **Placement decisions based on best interests of the child.** (a) The policy of
40.22 the state of Minnesota is to ensure that the child's best interests are met by requiring an
40.23 individualized determination of the needs of the child and of how the selected placement
40.24 will serve the needs of the child being placed. The authorized child-placing agency shall
40.25 place a child, released by court order or by voluntary release by the parent or parents, in a
40.26 family foster home selected by considering placement with relatives and important friends
40.27 in the following order:

40.28 (1) with an individual who is related to the child by blood, marriage, or adoption; or
40.29 (2) with an individual who is an important friend with whom the child has resided or
40.30 had significant contact.

40.31 For an Indian child, the agency shall follow the order of placement preferences in the Indian
40.32 Child Welfare Act of 1978, United States Code, title 25, section 1915.

41.1 (b) Among the factors the agency shall consider in determining the needs of the child
41.2 are the following:

- 41.3 (1) the child's current functioning and behaviors;
- 41.4 (2) the medical needs of the child;
- 41.5 (3) the educational needs of the child;
- 41.6 (4) the developmental needs of the child;
- 41.7 (5) the child's history and past experience;
- 41.8 (6) the child's religious and cultural needs;
- 41.9 (7) the child's connection with a community, school, and faith community;
- 41.10 (8) the child's interests and talents;
- 41.11 (9) the child's relationship to current caretakers, parents, siblings, and relatives;
- 41.12 (10) the reasonable preference of the child, if the court, or the child-placing agency in
41.13 the case of a voluntary placement, deems the child to be of sufficient age to express
41.14 preferences; and
- 41.15 (11) for an Indian child, the best interests of an Indian child as defined in section 260.755,
41.16 subdivision 2a.

41.17 (c) Placement of a child cannot be delayed or denied based on race, color, or national
41.18 origin of the foster parent or the child.

41.19 (d) Siblings should be placed together for foster care and adoption at the earliest possible
41.20 time unless it is documented that a joint placement would be contrary to the safety or
41.21 well-being of any of the siblings or unless it is not possible after reasonable efforts by the
41.22 responsible social services agency. In cases where siblings cannot be placed together, the
41.23 agency is required to provide frequent visitation or other ongoing interaction between
41.24 siblings unless the agency documents that the interaction would be contrary to the safety
41.25 or well-being of any of the siblings.

41.26 (e) Except for emergency placement as provided for in section 245A.035, the following
41.27 requirements must be satisfied before the approval of a foster or adoptive placement in a
41.28 related or unrelated home: (1) a completed background study under section 245C.08; and
41.29 (2) a completed review of the written home study required under section 260C.215,
41.30 subdivision 4, clause (5), or 260C.611, to assess the capacity of the prospective foster or
41.31 adoptive parent to ensure the placement will meet the needs of the individual child.

42.1 (f) The agency must determine whether colocating with a parent who is receiving services
42.2 in a licensed residential family-based substance use disorder treatment program is in the
42.3 child's best interests according to paragraph (b) and include that determination in the child's
42.4 case plan. The agency may consider additional factors not identified in paragraph (b). The
42.5 agency's determination must be documented in the child's case plan before the child is
42.6 colocated with a parent.

42.7 **Sec. 39. [260C.228] VOLUNTARY FOSTER CARE; CHILD IS COLOCATED
42.8 WITH PARENT IN TREATMENT PROGRAM.**

42.9 Subdivision 1. Generally. When a parent requests assistance from an agency and both
42.10 the parent and agency agree that a child's placement in foster care and colocating with a
42.11 parent in a licensed residential family-based substance use treatment facility as defined by
42.12 section 260C.007, subdivision 22a, is in the child's best interests, the agency must specify
42.13 the recommendation for the placement in the child's case plan. After the child's case plan
42.14 includes the recommendation, the agency and the parent may enter into a written voluntary
42.15 placement agreement on a form approved by the commissioner.

42.16 Subd. 2. Judicial review. (a) A judicial review of a child's voluntary placement is
42.17 required within 165 days of the date the voluntary agreement was signed. The agency
42.18 responsible for the child's placement in foster care shall request the judicial review.

42.19 (b) The agency must forward a written report to the court at least five business days
42.20 prior to the judicial review in paragraph (a). The report must contain:

42.21 (i) a statement regarding whether the colocating of the child with a parent in a licensed
42.22 residential family-based substance use disorder treatment program meets the child's needs
42.23 and continues to be in the child's best interests;

42.24 (ii) the child's name, dates of birth, race, gender, and current address;

42.25 (iii) the names, race, dates of birth, residences, and post office addresses of the child's
42.26 parents or custodian;

42.27 (iv) a statement regarding the child's eligibility for membership or enrollment in an
42.28 Indian tribe and the agency's compliance with applicable provisions of sections 260.751 to
42.29 260.835;

42.30 (v) the name and address of the licensed residential family-based substance use disorder
42.31 treatment program where the child and parent or custodian are colocated;

43.1 (vi) a copy of the out-of-home placement plan under section 260C.212, subdivisions 1
43.2 and 3;

43.3 (vii) a written summary of the proceedings of any administrative review required under
43.4 section 260C.203; and

43.5 (viii) any other information the agency, parent or custodian, child, or licensed residential
43.6 family-based substance use disorder treatment program wants the court to consider.

43.7 (c) The agency must inform a child, if the child is 12 years of age or older; the child's
43.8 parent; and the licensed residential family-based substance use disorder treatment program
43.9 of the reporting and court review requirements of this section and of their rights to submit
43.10 information to the court as follows:

43.11 (1) if the child, the child's parent, or the licensed residential family-based substance use
43.12 disorder treatment program wants to send information to the court, the agency shall advise
43.13 those persons of the reporting date and the date by which the agency must receive the
43.14 information to submit to the court with the agency's report; and

43.15 (2) the agency must inform the child, the child's parent, and the licensed residential
43.16 family-based substance use disorder treatment program that they have the right to be heard
43.17 in person by the court. An in-person hearing must be held if requested by the child, parent
43.18 or legal guardian, or licensed residential family-based substance use disorder treatment
43.19 program.

43.20 (d) If, at the time required for the agency's report under this section, a child 12 years of
43.21 age or older disagrees about the placement colocating the child with the parent in a licensed
43.22 residential family-based substance use disorder treatment program or services provided
43.23 under the out-of-home placement plan under section 260C.212, subdivision 1, the agency
43.24 shall include information regarding the child's disagreement and to the extent possible the
43.25 basis for the child's disagreement in the report.

43.26 (e) Regardless of whether an in-person hearing is requested within ten days of receiving
43.27 the agency's report, the court has jurisdiction to and must determine:

43.28 (i) whether the voluntary foster care arrangement is in the child's best interests;

43.29 (ii) whether the parent and agency are appropriately planning for the child; and

43.30 (iii) if a child 12 years of age or older disagrees with the foster care placement colocating
43.31 the child with the parent in a licensed residential family-based substance use disorder
43.32 treatment program or services provided under the out-of-home placement plan, whether to
43.33 appoint counsel and a guardian ad litem for the child according to section 260C.163.

44.1 (f) Unless requested by the parent, representative of the licensed residential family-based
44.2 substance use disorder treatment program, or child, an in-person hearing is not required for
44.3 the court to make findings and issue an order.

44.4 (g) If the court finds the voluntary foster care arrangement is in the child's best interests
44.5 and that the agency and parent are appropriately planning for the child, the court shall issue
44.6 an order containing explicit individualized findings to support the court's determination.
44.7 The individual findings shall be based on the agency's written report and other materials
44.8 submitted to the court. The court may make this determination notwithstanding the child's
44.9 disagreement, if any, reported to the court under paragraph (d).

44.10 (h) The court shall send a copy of the order to the county attorney, the agency, the parent,
44.11 a child 12 years of age or older, and the licensed residential family-based substance use
44.12 disorder treatment program.

44.13 (i) If the court finds continuing the voluntary foster care arrangement is not in the child's
44.14 best interests or that the agency or the parent is not appropriately planning for the child, the
44.15 court shall notify the agency, the parent, the licensed residential family-based substance
44.16 use disorder treatment program, a child 12 years of age or older, and the county attorney of
44.17 the court's determination and the basis for the court's determination. The court shall set the
44.18 matter for hearing and appoint a guardian ad litem for the child under section 260C.163,
44.19 subdivision 5.

44.20 Subd. 3. **Termination.** The voluntary placement agreement terminates at the parent's
44.21 discharge from the licensed residential family-based substance use disorder treatment
44.22 program, or upon receipt of a written and dated request from the parent, unless the request
44.23 specifies a later date. If the child's voluntary foster care placement meets the calculated time
44.24 to require a permanency proceeding under section 260C.503, subdivision 3, paragraph (a),
44.25 and the child is not returned home, the agency must file a petition according to section
44.26 260C.141 or 260C.505.

44.27 Sec. 40. Minnesota Statutes 2018, section 260C.452, subdivision 4, is amended to read:

44.28 Subd. 4. **Administrative or court review of placements.** (a) When the child is 14 years
44.29 of age or older, the court, in consultation with the child, shall review the independent living
44.30 plan according to section 260C.203, paragraph (d).

44.31 (b) The responsible social services agency shall file a copy of the notification required
44.32 in subdivision 3 with the court. If the responsible social services agency does not file the

45.1 notice by the time the child is 17-1/2 years of age, the court shall require the responsible
45.2 social services agency to file the notice.

45.3 (c) The court shall ensure that the responsible social services agency assists the child in
45.4 obtaining the following documents before the child leaves foster care: a Social Security
45.5 card; an official or certified copy of the child's birth certificate; a state identification card
45.6 or driver's license, tribal enrollment identification card, green card, or school visa; health
45.7 insurance information; the child's school, medical, and dental records; a contact list of the
45.8 child's medical, dental, and mental health providers; and contact information for the child's
45.9 siblings, if the siblings are in foster care.

45.10 (d) For a child who will be discharged from foster care at 18 years of age or older, the
45.11 responsible social services agency must develop a personalized transition plan as directed
45.12 by the child during the 90-day period immediately prior to the expected date of discharge.
45.13 The transition plan must be as detailed as the child elects and include specific options,
45.14 including but not limited to:

- 45.15 (1) affordable housing with necessary supports that does not include a homeless shelter;
- 45.16 (2) health insurance, including eligibility for medical assistance as defined in section
45.17 256B.055, subdivision 17;
- 45.18 (3) education, including application to the Education and Training Voucher Program;
- 45.19 (4) local opportunities for mentors and continuing support services, including the Healthy
45.20 Transitions and Homeless Prevention program, if available;
- 45.21 (5) workforce supports and employment services;
- 45.22 (6) a copy of the child's consumer credit report as defined in section 13C.001 and
45.23 assistance in interpreting and resolving any inaccuracies in the report, at no cost to the child;
- 45.24 (7) information on executing a health care directive under chapter 145C and on the
45.25 importance of designating another individual to make health care decisions on behalf of the
45.26 child if the child becomes unable to participate in decisions; and
- 45.27 (8) appropriate contact information through 21 years of age if the child needs information
45.28 or help dealing with a crisis situation; and
- 45.29 (9) official documentation that the youth was previously in foster care.

46.1 Sec. 41. Minnesota Statutes 2018, section 260C.503, subdivision 1, is amended to read:

46.2 **Subdivision 1. Required permanency proceedings.** (a) Except for children in foster
46.3 care pursuant to chapter 260D, where the child is in foster care or in the care of a noncustodial
46.4 or nonresident parent, the court shall commence proceedings to determine the permanent
46.5 status of a child by holding the admit-denay hearing required under section 260C.507 not
46.6 later than 12 months after the child is placed in foster care or in the care of a noncustodial
46.7 or nonresident parent. Permanency proceedings for children in foster care pursuant to chapter
46.8 260D shall be according to section 260D.07.

46.9 (b) Permanency proceedings for a foster child who is colocated with a parent in a licensed
46.10 residential family-based substance use disorder treatment program shall be conducted
46.11 according to section 260C.190.

46.12 Sec. 42. Minnesota Statutes 2018, section 518A.32, subdivision 3, is amended to read:

46.13 **Subd. 3. Parent not considered voluntarily unemployed, underemployed, or employed**
46.14 **on a less than full-time basis.** A parent is not considered voluntarily unemployed,
46.15 underemployed, or employed on a less than full-time basis upon a showing by the parent
46.16 that:

46.17 (1) the unemployment, underemployment, or employment on a less than full-time basis
46.18 is temporary and will ultimately lead to an increase in income;

46.19 (2) the unemployment, underemployment, or employment on a less than full-time basis
46.20 represents a bona fide career change that outweighs the adverse effect of that parent's
46.21 diminished income on the child; or

46.22 (3) the unemployment, underemployment, or employment on a less than full-time basis
46.23 is because a parent is physically or mentally incapacitated or due to incarceration, ~~except~~
46.24 ~~where the reason for incarceration is the parent's nonpayment of support.~~

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

46.26 Sec. 43. **INSTRUCTION TO COMMISSIONER.**

46.27 All individuals in connection with a licensed children's residential facility required to
46.28 complete a background study under Minnesota Statutes, chapter 245C, must complete a
46.29 new background study consistent with the obligations and requirements of this article. The
46.30 commissioner of human services shall establish a schedule for (1) individuals in connection
46.31 with a licensed children's residential facility that serves children eligible to receive federal
46.32 Title IV-E funding to complete the new background study by March 1, 2020, and (2)

47.1 individuals in connection with a licensed children's residential facility that serves children
47.2 not eligible to receive federal Title IV-E funding to complete the new background study by
47.3 March 1, 2021.

47.4 **Sec. 44. CHILD WELFARE TRAINING ACADEMY.**

47.5 Subdivision 1. Establishment; purpose. The commissioner of human services shall
47.6 modify the Child Welfare Training System developed pursuant to Minnesota Statutes,
47.7 section 626.5591, subdivision 2, according to this section. The new training framework
47.8 shall be known as the Child Welfare Training Academy.

47.9 Subd. 2. Administration. (a) The Child Welfare Training Academy must be administered
47.10 through five regional hubs in northwest, northeast, southwest, southeast, and central
47.11 Minnesota. Each hub must deliver training targeted to the needs of the hub's particular
47.12 region, taking into account varying demographics, resources, and practice outcomes.

47.13 (b) The Child Welfare Training Academy must use training methods best suited to the
47.14 training content. National best practices in adult learning must be used to the greatest extent
47.15 possible, including online learning methodologies, coaching, mentoring, and simulated skill
47.16 application.

47.17 (c) Each child welfare worker and supervisor must complete a certification, including
47.18 a competency-based knowledge test and a skills demonstration, at the completion of the
47.19 worker's or supervisor's initial training and biennially thereafter. The commissioner shall
47.20 develop ongoing training requirements and a method for tracking certifications.

47.21 (d) Each regional hub must have a regional organizational effectiveness specialist trained
47.22 in continuous quality improvement strategies. The specialist shall provide organizational
47.23 change assistance to counties and tribes, with priority given to efforts intended to impact
47.24 child safety.

47.25 (e) The Child Welfare Training Academy must include training and resources that address
47.26 worker well-being and secondary traumatic stress.

47.27 (f) The Child Welfare Training Academy must serve the primary training audiences of
47.28 (1) county and tribal child welfare workers, (2) county and tribal child welfare supervisors,
47.29 and (3) staff at private agencies providing out-of-home placement services for children
47.30 involved in Minnesota's county and tribal child welfare system.

47.31 Subd. 3. Partnerships. (a) The commissioner of human services shall enter into a
47.32 partnership with the University of Minnesota to collaborate in the administration of workforce
47.33 training.

48.1 (b) The commissioner of human services shall enter into a partnership with one or more
48.2 agencies to provide consultation, subject matter expertise, and capacity building in
48.3 organizational resilience and child welfare workforce well-being.

48.4 Subd. 4. **Rulemaking.** The commissioner of human services may adopt rules by
48.5 December 31, 2020, as necessary to establish the Child Welfare Training Academy. If the
48.6 commissioner of human services does not adopt rules by July 1, 2023, rulemaking authority
48.7 under this section is repealed. Rulemaking authority under this section is not continuing
48.8 authority to amend or repeal rules. Any additional action on rules after adoption must be
48.9 under specific statutory authority to take the additional action.

48.10 Sec. 45. **CHILD WELFARE CASELOAD STUDY.**

48.11 (a) The commissioner of human services shall conduct a child welfare caseload study
48.12 to collect data on (1) the number of child welfare workers in Minnesota, and (2) the amount
48.13 of time that child welfare workers spend on different components of child welfare work.
48.14 The study must be completed by July 1, 2020.

48.15 (b) The commissioner shall report the results of the child welfare caseload study to the
48.16 governor and to the chairs and ranking minority members of the committees in the house
48.17 of representatives and senate with jurisdiction over human services by December 1, 2020.

48.18 (c) After the child welfare caseload study is complete, the commissioner shall work with
48.19 counties and other stakeholders to develop a process for ongoing monitoring of child welfare
48.20 workers' caseloads.

48.21 Sec. 46. **REPEALER.**

48.22 (a) Minnesota Statutes 2018, sections 119B.16, subdivision 2; and 245E.06, subdivisions
48.23 2, 4, and 5, are repealed effective the day following final enactment.

48.24 (b) Minnesota Rules, part 3400.0185, subpart 5, is repealed effective February 26, 2021.

48.25 (c) Minnesota Rules, part 2960.3030, subpart 3, is repealed.

ARTICLE 2

OPERATIONS

Section 1. Minnesota Statutes 2018, section 15C.02, is amended to read:

15C.02 LIABILITY FOR CERTAIN ACTS.

(a) A person who commits any act described in clauses (1) to (7) is liable to the state or the political subdivision for a civil penalty of ~~not less than \$5,500 and not more than \$11,000 per false or fraudulent claim~~ in the amounts set forth in the federal False Claims Act, United States Code, title 31, section 3729, and as modified by the federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015, plus three times the amount of damages that the state or the political subdivision sustains because of the act of that person, except as otherwise provided in paragraph (b):

(1) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;

(2) knowingly makes or uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim:

(3) knowingly conspires to commit a violation of clause (1), (2), (4), (5), (6), or (7);

(4) has possession, custody, or control of property or money used, or to be used, by the state or a political subdivision and knowingly delivers or causes to be delivered less than all of that money or property;

(5) is authorized to make or deliver a document certifying receipt for money or property used, or to be used, by the state or a political subdivision and, intending to defraud the state or a political subdivision, makes or delivers the receipt without completely knowing that the information on the receipt is true;

(6) knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the state or a political subdivision who lawfully may not sell or pledge the property; or

(7) knowingly makes or uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the state or a political subdivision, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the state or a political subdivision.

50.1 (b) Notwithstanding paragraph (a), the court may assess not less than two times the
50.2 amount of damages that the state or the political subdivision sustains because of the act of
50.3 the person if:

50.4 (1) the person committing a violation under paragraph (a) furnished an officer or
50.5 employee of the state or the political subdivision responsible for investigating the false or
50.6 fraudulent claim violation with all information known to the person about the violation
50.7 within 30 days after the date on which the person first obtained the information;

50.8 (2) the person fully cooperated with any investigation by the state or the political
50.9 subdivision of the violation; and

50.10 (3) at the time the person furnished the state or the political subdivision with information
50.11 about the violation, no criminal prosecution, civil action, or administrative action had been
50.12 commenced under this chapter with respect to the violation and the person did not have
50.13 actual knowledge of the existence of an investigation into the violation.

50.14 (c) A person violating this section is also liable to the state or the political subdivision
50.15 for the costs of a civil action brought to recover any penalty or damages.

50.16 (d) A person is not liable under this section for mere negligence, inadvertence, or mistake
50.17 with respect to activities involving a false or fraudulent claim.

50.18 Sec. 2. Minnesota Statutes 2018, section 245A.02, subdivision 18, is amended to read:

50.19 Subd. 18. **Supervision.** (a) For purposes of licensed child care centers, "supervision"
50.20 means when a program staff person:

50.21 (1) is ~~within sight and hearing of a child at all times so that the program staff accountable~~
50.22 for the child's care;

50.23 (2) can intervene to protect the health and safety of the child; and

50.24 (3) is within sight and hearing of the child at all times except as described in paragraphs
50.25 (b) to (d).

50.26 (b) When an infant is placed in a crib room to sleep, supervision occurs when a program
50.27 staff person is within sight or hearing of the infant. When supervision of a crib room is
50.28 provided by sight or hearing, the center must have a plan to address the other supervision
50.29 component components.

50.30 (c) When a single school-age child uses the restroom within the licensed space,
50.31 supervision occurs when a program staff person has knowledge of the child's activity and
50.32 location and checks on the child at least every five minutes. When a school-age child uses

51.1 the restroom outside the licensed space, including but not limited to field trips, supervision
51.2 occurs when staff accompany children to the restroom.

51.3 (d) When a school-age child leaves the classroom but remains within the licensed space
51.4 to deliver or retrieve items from the child's personal storage space, supervision occurs when
51.5 a program staff person has knowledge of the child's activity and location and checks on the
51.6 child at least every five minutes.

51.7 **EFFECTIVE DATE.** This section is effective September 30, 2019.

51.8 Sec. 3. Minnesota Statutes 2018, section 245A.14, subdivision 4, is amended to read:

51.9 Subd. 4. **Special family day care homes.** Nonresidential child care programs serving
51.10 14 or fewer children that are conducted at a location other than the license holder's own
51.11 residence shall be licensed under this section and the rules governing family day care or
51.12 group family day care if:

51.13 (a) the license holder is the primary provider of care and the nonresidential child care
51.14 program is conducted in a dwelling that is located on a residential lot;

51.15 (b) the license holder is an employer who may or may not be the primary provider of
51.16 care, and the purpose for the child care program is to provide child care services to children
51.17 of the license holder's employees;

51.18 (c) the license holder is a church or religious organization;

51.19 (d) the license holder is a community collaborative child care provider. For purposes of
51.20 this subdivision, a community collaborative child care provider is a provider participating
51.21 in a cooperative agreement with a community action agency as defined in section 256E.31;

51.22 (e) the license holder is a not-for-profit agency that provides child care in a dwelling
51.23 located on a residential lot and the license holder maintains two or more contracts with
51.24 community employers or other community organizations to provide child care services.
51.25 The county licensing agency may grant a capacity variance to a license holder licensed
51.26 under this paragraph to exceed the licensed capacity of 14 children by no more than five
51.27 children during transition periods related to the work schedules of parents, if the license
51.28 holder meets the following requirements:

51.29 (1) the program does not exceed a capacity of 14 children more than a cumulative total
51.30 of four hours per day;

51.31 (2) the program meets a one to seven staff-to-child ratio during the variance period;

52.1 (3) all employees receive at least an extra four hours of training per year than required
52.2 in the rules governing family child care each year;

52.3 (4) the facility has square footage required per child under Minnesota Rules, part
52.4 9502.0425;

52.5 (5) the program is in compliance with local zoning regulations;

52.6 (6) the program is in compliance with the applicable fire code as follows:

52.7 (i) if the program serves more than five children older than 2-1/2 years of age, but no
52.8 more than five children 2-1/2 years of age or less, the applicable fire code is educational
52.9 occupancy, as provided in Group E Occupancy under the Minnesota State Fire Code 2003
52.10 2015, Section 202; or

52.11 (ii) if the program serves more than five children 2-1/2 years of age or less, the applicable
52.12 fire code is Group I-4 Occupancies, as provided in the Minnesota State Fire Code 2003
52.13 2015, Section 202, unless the rooms in which the children are cared for are located on a
52.14 level of exit discharge and each of these child care rooms has an exit door directly to the
52.15 exterior, then the applicable fire code is Group E occupancies, as provided in the Minnesota
52.16 State Fire Code 2015, Section 202; and

52.17 (7) any age and capacity limitations required by the fire code inspection and square
52.18 footage determinations shall be printed on the license; or

52.19 (f) the license holder is the primary provider of care and has located the licensed child
52.20 care program in a commercial space, if the license holder meets the following requirements:

52.21 (1) the program is in compliance with local zoning regulations;

52.22 (2) the program is in compliance with the applicable fire code as follows:

52.23 (i) if the program serves more than five children older than 2-1/2 years of age, but no
52.24 more than five children 2-1/2 years of age or less, the applicable fire code is educational
52.25 occupancy, as provided in Group E Occupancy under the Minnesota State Fire Code 2003
52.26 2015, Section 202; or

52.27 (ii) if the program serves more than five children 2-1/2 years of age or less, the applicable
52.28 fire code is Group I-4 Occupancies, as provided under the Minnesota State Fire Code 2003
52.29 2015, Section 202;

52.30 (3) any age and capacity limitations required by the fire code inspection and square
52.31 footage determinations are printed on the license; and

53.1 (4) the license holder prominently displays the license issued by the commissioner which
53.2 contains the statement "This special family child care provider is not licensed as a child
53.3 care center."

53.4 (g) The commissioner may approve two or more licenses under paragraphs (a) to (f) to
53.5 be issued at the same location or under one contiguous roof, if each license holder is able
53.6 to demonstrate compliance with all applicable rules and laws. Each license holder must
53.7 operate the license holder's own respective licensed program as a distinct program and
53.8 within the capacity, age, and ratio distributions of each license.

53.9 (h) The commissioner may grant variances to this section to allow a primary provider
53.10 of care, a not-for-profit organization, a church or religious organization, an employer, or a
53.11 community collaborative to be licensed to provide child care under paragraphs (e) and (f)
53.12 if the license holder meets the other requirements of the statute.

53.13 **EFFECTIVE DATE.** This section is effective September 30, 2019.

53.14 Sec. 4. Minnesota Statutes 2018, section 245A.14, subdivision 8, is amended to read:

53.15 **Subd. 8. Experienced aides; child care centers.** (a) An individual employed as an aide
53.16 at a child care center may work with children without being directly supervised for an
53.17 amount of time that does not exceed 25 percent of the child care center's daily hours if:

53.18 (1) a teacher is in the facility;

53.19 ~~(2) the individual has received within the last three years first aid training that meets the~~
53.20 ~~requirements under section 245A.40, subdivision 3, and CPR training that meets the~~
53.21 ~~requirements under section 245A.40, subdivision 4;~~

53.22 ~~(3)~~(2) the individual is at least 20 years old; and

53.23 ~~(4)~~(3) the individual has at least 4,160 hours of child care experience as a staff member
53.24 in a licensed child care center or as the license holder of a family day care home, 120 days
53.25 of which must be in the employment of the current company.

53.26 (b) A child care center that uses experienced aides under this subdivision must notify
53.27 parents or guardians by posting the notification in each classroom that uses experienced
53.28 aides, identifying which staff member is the experienced aide. Records of experienced aide
53.29 usage must be kept on site and given to the commissioner upon request.

53.30 (c) A child care center may not use the experienced aide provision for one year following
53.31 two determined experienced aide violations within a one-year period.

54.1 (d) A child care center may use one experienced aide per every four full-time child care
54.2 classroom staff.

54.3 **EFFECTIVE DATE.** This section is effective September 30, 2019.

54.4 Sec. 5. Minnesota Statutes 2018, section 245A.14, is amended by adding a subdivision to
54.5 read:

54.6 **Subd. 16. Valid driver's license.** Notwithstanding any law to the contrary, when a
54.7 licensed child care center provides transportation for children or contracts to provide
54.8 transportation for children, a person who has a current, valid driver's license appropriate to
54.9 the vehicle driven may transport the child.

54.10 **EFFECTIVE DATE.** This section is effective September 30, 2019.

54.11 Sec. 6. Minnesota Statutes 2018, section 245A.14, is amended by adding a subdivision to
54.12 read:

54.13 **Subd. 17. Reusable water bottles or cups.** Notwithstanding any law to the contrary, a
54.14 child care center that meets the standards in Minnesota Rules, chapter 9503, may provide
54.15 drinking water to a child in a reusable water bottle or reusable cup if the center develops
54.16 and ensures implementation of a written policy that at a minimum includes the following
54.17 procedures:

54.18 (1) each day the water bottle or cup is used, the child care center cleans and sanitizes
54.19 the water bottle or cup using procedures that comply with the Food Code under Minnesota
54.20 Rules, chapter 4626;

54.21 (2) water bottle or cup is assigned to a specific child and labeled with the child's first
54.22 and last name;

54.23 (3) water bottles and cups are stored in a manner that reduces the risk of a child using
54.24 the wrong water bottle or cup; and

54.25 (4) a water bottle or cup is used only for water.

54.26 **EFFECTIVE DATE.** This section is effective September 30, 2019.

54.27 Sec. 7. Minnesota Statutes 2018, section 245A.151, is amended to read:

54.28 **245A.151 FIRE MARSHAL INSPECTION.**

54.29 When licensure under this chapter or certification under chapter 245H requires an
54.30 inspection by a fire marshal to determine compliance with the State Fire Code under section

55.1 299F.011, a local fire code inspector approved by the state fire marshal may conduct the
55.2 inspection. If a community does not have a local fire code inspector or if the local fire code
55.3 inspector does not perform the inspection, the state fire marshal must conduct the inspection.
55.4 A local fire code inspector or the state fire marshal may recover the cost of these inspections
55.5 through a fee of no more than \$50 per inspection charged to the applicant or license holder
55.6 or license-exempt child care center certification holder. The fees collected by the state fire
55.7 marshal under this section are appropriated to the commissioner of public safety for the
55.8 purpose of conducting the inspections.

55.9 **EFFECTIVE DATE.** This section is effective September 30, 2019.

55.10 Sec. 8. Minnesota Statutes 2018, section 245A.16, subdivision 1, is amended to read:

55.11 **Subdivision 1. Delegation of authority to agencies.** (a) County agencies and private
55.12 agencies that have been designated or licensed by the commissioner to perform licensing
55.13 functions and activities under section 245A.04 and background studies for family child care
55.14 under chapter 245C; to recommend denial of applicants under section 245A.05; to issue
55.15 correction orders, to issue variances, and recommend a conditional license under section
55.16 245A.06; or to recommend suspending or revoking a license or issuing a fine under section
55.17 245A.07, shall comply with rules and directives of the commissioner governing those
55.18 functions and with this section. The following variances are excluded from the delegation
55.19 of variance authority and may be issued only by the commissioner:

55.20 (1) dual licensure of family child care and child foster care, dual licensure of child and
55.21 adult foster care, and adult foster care and family child care;

55.22 (2) adult foster care maximum capacity;

55.23 (3) adult foster care minimum age requirement;

55.24 (4) child foster care maximum age requirement;

55.25 (5) variances regarding disqualified individuals except that, before the implementation
55.26 of NETStudy 2.0, county agencies may issue variances under section 245C.30 regarding
55.27 disqualified individuals when the county is responsible for conducting a consolidated
55.28 reconsideration according to sections 245C.25 and 245C.27, subdivision 2, clauses (a) and
55.29 (b), of a county maltreatment determination and a disqualification based on serious or
55.30 recurring maltreatment;

55.31 (6) the required presence of a caregiver in the adult foster care residence during normal
55.32 sleeping hours; **and**

56.1 (7) variances to requirements relating to chemical use problems of a license holder or a
56.2 household member of a license holder; and

56.3 (8) variances to section 245A.53 for a time-limited period. If the commissioner grants
56.4 a variance under this clause, the license holder must provide notice of the variance to all
56.5 parents and guardians of the children in care.

56.6 Except as provided in section 245A.14, subdivision 4, paragraph (e), a county agency must
56.7 not grant a license holder a variance to exceed the maximum allowable family child care
56.8 license capacity of 14 children.

56.9 (b) Before the implementation of NETStudy 2.0, county agencies must report information
56.10 about disqualification reconsiderations under sections 245C.25 and 245C.27, subdivision
56.11 2, paragraphs (a) and (b), and variances granted under paragraph (a), clause (5), to the
56.12 commissioner at least monthly in a format prescribed by the commissioner.

56.13 (c) For family child care programs, the commissioner shall require a county agency to
56.14 conduct one unannounced licensing review at least annually.

56.15 (d) For family adult day services programs, the commissioner may authorize licensing
56.16 reviews every two years after a licensee has had at least one annual review.

56.17 (e) A license issued under this section may be issued for up to two years.

56.18 (f) During implementation of chapter 245D, the commissioner shall consider:

56.19 (1) the role of counties in quality assurance;

56.20 (2) the duties of county licensing staff; and

56.21 (3) the possible use of joint powers agreements, according to section 471.59, with counties
56.22 through which some licensing duties under chapter 245D may be delegated by the
56.23 commissioner to the counties.

56.24 Any consideration related to this paragraph must meet all of the requirements of the corrective
56.25 action plan ordered by the federal Centers for Medicare and Medicaid Services.

56.26 (g) Licensing authority specific to section 245D.06, subdivisions 5, 6, 7, and 8, or
56.27 successor provisions; and section 245D.061 or successor provisions, for family child foster
56.28 care programs providing out-of-home respite, as identified in section 245D.03, subdivision
56.29 1, paragraph (b), clause (1), is excluded from the delegation of authority to county and
56.30 private agencies.

56.31 (h) A county agency shall report to the commissioner, in a manner prescribed by the
56.32 commissioner, the following information for a licensed family child care program:

57.1 (1) the results of each licensing review completed, including the date of the review, and
57.2 any licensing correction order issued; and

57.3 (2) any death, serious injury, or determination of substantiated maltreatment; and

57.4 (3) any fires that require the service of a fire department within 48 hours of the fire. The
57.5 information under this clause must also be reported to the State Fire Marshal within 48
57.6 hours of the fire.

57.7 EFFECTIVE DATE. This section is effective September 30, 2019.

57.8 Sec. 9. Minnesota Statutes 2018, section 245A.40, is amended to read:

57.9 **245A.40 CHILD CARE CENTER TRAINING REQUIREMENTS.**

57.10 Subdivision 1. **Orientation.** (a) The child care center license holder must ensure that
57.11 every the director, staff person and volunteer is persons, substitutes, and unsupervised
57.12 volunteers are given orientation training and successfully completes complete the training
57.13 before starting assigned duties. The orientation training in this subdivision applies to
57.14 volunteers who will have direct contact with or access to children and who are not under
57.15 the direct supervision of a staff person. Completion of the orientation must be documented
57.16 in the individual's personnel record. The orientation training must include information about:

57.17 (1) the center's philosophy, child care program, and procedures for maintaining health
57.18 and safety according to section 245A.41 and Minnesota Rules, part 9503.0140, and handling
57.19 emergencies and accidents according to Minnesota Rules, part 9503.0110;

57.20 (2) specific job responsibilities;

57.21 (3) the behavior guidance standards in Minnesota Rules, part 9503.0055; and

57.22 (4) the reporting responsibilities in section 626.556, and Minnesota Rules, part
57.23 9503.0130; and

57.24 (5) the center's drug and alcohol policy under section 245A.04, subdivision 1, paragraph
57.25 (c);

57.26 (6) the center's risk reduction plan as required under section 245A.66, subdivision 2;

57.27 (7) at least one-half hour of training on the standards under section 245A.1435 and on
57.28 reducing the risk of sudden unexpected infant death as required in subdivision 5, if applicable;

57.29 (8) at least one-half hour of training on the risk of abusive head trauma as required for
57.30 the director and staff under subdivision 5a, if applicable; and

58.1 (9) training required by a child's individual child care program plan as required under
58.2 Minnesota Rules, part 9503.0065, subpart 3, if applicable.

58.3 (b) In addition to paragraph (a), before having unsupervised direct contact with a child,
58.4 the director and staff persons within the first 90 days of employment, and substitutes and
58.5 unsupervised volunteers within 90 days after the first date of direct contact with a child,
58.6 must complete:

58.7 (1) pediatric first aid, in accordance with subdivision 3; and

58.8 (2) pediatric cardiopulmonary resuscitation, in accordance with subdivision 4.

58.9 (c) In addition to paragraph (b), the director and staff persons within the first 90 days
58.10 of employment, and substitutes and unsupervised volunteers within 90 days from the first
58.11 date of direct contact with a child, must complete training in child development, in accordance
58.12 with subdivision 2.

58.13 (d) The license holder must ensure that documentation, as required in subdivision 10,
58.14 identifies the number of hours completed for each topic with a minimum training time
58.15 identified, if applicable, and that all required content is included.

58.16 (e) Training in this subdivision must not be used to meet in-service training requirements
58.17 in subdivision 7.

58.18 (f) Training completed within the previous 12 months under paragraphs (a), clauses (7)
58.19 and (8), and (c) are transferable to another child care center.

58.20 Subd. 1a. **Definitions.** (a) For the purposes of this section, the following terms have the
58.21 meanings given.

58.22 (b) "Substitute" means an adult who is temporarily filling a position as a director, teacher,
58.23 assistant teacher, or aide in a licensed child care center for less than 240 hours total in a
58.24 calendar year due to the absence of a regularly employed staff person.

58.25 (c) "Staff person" means an employee of a child care center who provides direct contact
58.26 services to children.

58.27 (d) "Unsupervised volunteer" means an individual who:

58.28 (1) assists in the care of a child in care;

58.29 (2) is not under the continuous direct supervision of a staff person; and

58.30 (3) is not employed by the child care center.

59.1 **Subd. 2. Child development and learning training.** (a) ~~For purposes of child care~~
59.2 ~~centers, The director and all staff hired after July 1, 2006, persons, substitutes, and~~
59.3 ~~unsupervised volunteers shall complete and document at least two hours of child development~~
59.4 ~~and learning training within the first 90 days of employment. The director and staff persons,~~
59.5 ~~not including substitutes, must complete at least two hours of training on child development~~
59.6 ~~and learning. The training for substitutes and unsupervised volunteers is not required to be~~
59.7 ~~of a minimum length. For purposes of this subdivision, "child development and learning~~
59.8 ~~training" means any training in Knowledge and Competency Area I: Child Development~~
59.9 ~~and Learning, which is training in understanding how children develop physically,~~
59.10 ~~cognitively, emotionally, and socially and learn as part of the children's family, culture, and~~
59.11 ~~community. Training completed under this subdivision may be used to meet the in-service~~
59.12 ~~training requirements under subdivision 7.~~

59.13 (b) Notwithstanding paragraph (a), individuals are exempt from this requirement if they:

59.14 (1) have taken a three-credit college course on early childhood development within the
59.15 past five years;

59.16 (2) have received a baccalaureate or master's degree in early childhood education or
59.17 school-age child care within the past five years;

59.18 (3) are licensed in Minnesota as a prekindergarten teacher, an early childhood educator,
59.19 a kindergarten to sixth grade teacher with a prekindergarten specialty, an early childhood
59.20 special education teacher, or an elementary teacher with a kindergarten endorsement; or

59.21 (4) have received a baccalaureate degree with a Montessori certificate within the past
59.22 five years.

59.23 (c) The director and staff persons, not including substitutes, must complete at least two
59.24 hours of child development and learning training every second calendar year.

59.25 (d) Substitutes and unsupervised volunteers must complete child development and
59.26 learning training every second calendar year. There is no minimum number of training hours
59.27 required.

59.28 (e) Except for training required under paragraph (a), training completed under this
59.29 subdivision may be used to meet the in-service training requirements under subdivision 7.

59.30 **Subd. 3. First aid.** (a) ~~All teachers and assistant teachers in a child care center governed~~
59.31 ~~by Minnesota Rules, parts 9503.0005 to 9503.0170, and at least one staff person during~~
59.32 ~~field trips and when transporting children in care, must satisfactorily complete pediatric~~
59.33 ~~first aid training within 90 days of the start of work, unless the training has been completed~~

60.1 ~~within the previous two years.~~ Unless training has been completed within the previous two
60.2 years, the director, staff persons, substitutes, and unsupervised volunteers must satisfactorily
60.3 complete pediatric first aid training prior to having unsupervised direct contact with a child,
60.4 but not to exceed the first 90 days of employment.

60.5 (b) ~~Notwithstanding paragraph (a), which allows 90 days to complete training, at least~~
60.6 ~~one staff person who has satisfactorily completed pediatric first aid training must be present~~
60.7 ~~at all times in the center, during field trips, and when transporting children in care.~~ Pediatric
60.8 first aid training must be repeated at least every second calendar year. First aid training
60.9 under this subdivision must be provided by an individual approved as a first aid instructor
60.10 and must not be used to meet in-service training requirements under subdivision 7.

60.11 (c) ~~The pediatric first aid training must be repeated at least every two years, documented~~
60.12 ~~in the person's personnel record and indicated on the center's staffing chart, and provided~~
60.13 ~~by an individual approved as a first aid instructor. This training may be less than eight hours.~~

60.14 Subd. 4. **Cardiopulmonary resuscitation.** (a) ~~All teachers and assistant teachers in a~~
60.15 ~~child care center governed by Minnesota Rules, parts 9503.0005 to 9503.0170, and at least~~
60.16 ~~one staff person during field trips and when transporting children in care, must satisfactorily~~
60.17 ~~complete training in cardiopulmonary resuscitation (CPR) that includes CPR techniques~~
60.18 ~~for infants and children and in the treatment of obstructed airways. The CPR training must~~
60.19 ~~be completed within 90 days of the start of work, unless the training has been completed~~
60.20 ~~within the previous two years. The CPR training must have been provided by an individual~~
60.21 ~~approved to provide CPR instruction, must be repeated at least once every two years, and~~
60.22 ~~must be documented in the staff person's records.~~

60.23 (b) ~~Notwithstanding paragraph (a), which allows 90 days to complete training, at least~~
60.24 ~~one staff person who has satisfactorily completed cardiopulmonary resuscitation training~~
60.25 ~~must be present at all times in the center, during field trips, and when transporting children~~
60.26 ~~in care.~~

60.27 (c) ~~CPR training may be provided for less than four hours.~~

60.28 (d) ~~Persons providing CPR training must use CPR training that has been developed:~~

60.29 (1) ~~by the American Heart Association or the American Red Cross and incorporates~~
60.30 ~~psychomotor skills to support the instruction; or~~

60.31 (2) ~~using nationally recognized, evidence-based guidelines for CPR and incorporates~~
60.32 ~~psychomotor skills to support the instruction.~~

61.1 (a) Unless training has been completed within the previous two years, the director, staff
61.2 persons, substitutes, and unsupervised volunteers must satisfactorily complete pediatric
61.3 cardiopulmonary resuscitation (CPR) training that meets the requirements of this subdivision.
61.4 Pediatric CPR training must be completed prior to having unsupervised direct contact with
61.5 a child, but not to exceed the first 90 days of employment.

61.6 (b) Pediatric CPR training must be provided by an individual approved to provide
61.7 pediatric CPR instruction.

61.8 (c) The Pediatric CPR training must:

61.9 (1) cover CPR techniques for infants and children and the treatment of obstructed airways;
61.10 (2) include instruction, hands-on practice, and an in-person, observed skills assessment
61.11 under the direct supervision of a CPR instructor; and

61.12 (3) be developed by the American Heart Association, the American Red Cross, or another
61.13 organization that uses nationally recognized, evidence-based guidelines for CPR.

61.14 (d) Pediatric CPR training must be repeated at least once every second calendar year.

61.15 (e) Pediatric CPR training in this subdivision must not be used to meet in-service training
61.16 requirements under subdivision 7.

61.17 Subd. 5. **Sudden unexpected infant death and abusive head trauma training.** (a)

61.18 Before caring for infants, the director, staff persons, substitutes, and unsupervised volunteers
61.19 must receive training on the standards under section 245A.1435 and on reducing the risk
61.20 of sudden unexpected infant death during orientation and each calendar year thereafter.

61.21 (b) Sudden unexpected infant death reduction training required under this subdivision
61.22 must be at least one-half hour in length. At a minimum, the training must address the risk
61.23 factors related to sudden unexpected infant death, means of reducing the risk of sudden
61.24 unexpected infant death in child care, and license holder communication with parents
61.25 regarding reducing the risk of sudden unexpected infant death.

61.26 (c) Except if completed during orientation, training taken under this subdivision may
61.27 be used to meet the in-service training requirements under subdivision 7.

61.28 Subd. 5a. **Abusive head trauma training.** (a) License holders must document that
61.29 before staff persons and volunteers care for infants, they are instructed on the standards in
61.30 section 245A.1435 and receive training on reducing the risk of sudden unexpected infant
61.31 death. In addition, license holders must document that before staff persons care for infants
61.32 or children under school age, they receive training on the risk of abusive head trauma from

62.1 ~~shaking infants and young children. The training in this subdivision may be provided as~~
62.2 ~~orientation training under subdivision 1 and in-service training under subdivision 7.~~ (a)
62.3 Before caring for children under school age, the director, staff persons, substitutes, and
62.4 unsupervised volunteers must receive training on the risk of abusive head trauma during
62.5 orientation and each calendar year thereafter.

62.6 ~~(b) Sudden unexpected infant death reduction training required under this subdivision~~
62.7 ~~must be at least one half hour in length and must be completed at least once every year. At~~
62.8 ~~a minimum, the training must address the risk factors related to sudden unexpected infant~~
62.9 ~~death, means of reducing the risk of sudden unexpected infant death in child care, and license~~
62.10 ~~holder communication with parents regarding reducing the risk of sudden unexpected infant~~
62.11 ~~death.~~

62.12 ~~(e)~~ (b) Abusive head trauma training under this subdivision must be at least one-half
62.13 hour in length ~~and must be completed at least once every year.~~ At a minimum, the training
62.14 must address the risk factors related to shaking infants and young children, means to reduce
62.15 the risk of abusive head trauma in child care, and license holder communication with parents
62.16 regarding reducing the risk of abusive head trauma.

62.17 (c) Except if completed during orientation, training taken under this subdivision may
62.18 be used to meet the in-service training requirements under subdivision 7.

62.19 (d) The commissioner shall make available for viewing a video presentation on the
62.20 dangers associated with shaking infants and young children, which may be used in
62.21 conjunction with the annual training required under paragraph ~~(e)~~ (a).

62.22 Subd. 6. **Child passenger restraint systems; training requirement.** (a) A license
62.23 holder must comply with all seat belt and child passenger restraint system requirements
62.24 under section 169.685. (b) Child care centers that serve a child or children under nine years
62.25 of age must document training that fulfills the requirements in this subdivision.

62.26 (1) (a) Before a license holder transports a child or children under age ~~nine~~ eight in a
62.27 motor vehicle, the person placing the child or children in a passenger restraint must
62.28 satisfactorily complete training on the proper use and installation of child restraint systems
62.29 in motor vehicles. ~~Training completed under this subdivision may be used to meet orientation~~
62.30 ~~training under subdivision 1 and in-service training under subdivision 7.~~

62.31 (2) (b) Training required under this subdivision must be ~~at least one hour in length,~~
62.32 ~~completed at orientation, and repeated at least once every five years.~~ At a minimum, the
62.33 training must address the proper use of child restraint systems based on the child's size,

63.1 weight, and age, and the proper installation of a car seat or booster seat in the motor vehicle
63.2 used by the license holder to transport the child or children.

63.3 ~~(3)~~(c) Training required under this subdivision must be provided by individuals who
63.4 are certified and approved by the Department of Public Safety, Office of Traffic Safety.
63.5 License holders may obtain a list of certified and approved trainers through the Department
63.6 of Public Safety website or by contacting the agency.

63.7 ~~(4)~~(d) Child care providers that only transport school-age children as defined in section
63.8 245A.02, subdivision 16, in child care buses as defined in section 169.448, subdivision 1,
63.9 paragraph (e), are exempt from this subdivision.

63.10 (e) Training completed under this subdivision may be used to meet in-service training
63.11 requirements under subdivision 7. Training completed within the previous five years is
63.12 transferable upon a staff person's change in employment to another child care center.

63.13 Subd. 7. **In-service.** (a) A license holder must ensure that the center director and all staff
63.14 ~~who have direct contact with a child complete annual in-service training. In-service training~~
63.15 ~~requirements must be met by a staff person's participation in the following training areas:~~
63.16 ~~staff persons, substitutes, and unsupervised volunteers complete in-service training each~~
63.17 ~~calendar year.~~

63.18 (b) The center director and staff persons who work more than 20 hours per week must
63.19 complete 24 hours of in-service training each calendar year. Staff persons who work 20
63.20 hours or less per week must complete 12 hours of in-service training each calendar year.
63.21 Substitutes and unsupervised volunteers must complete the requirements of paragraphs (e)
63.22 to (h) and do not otherwise have a minimum number of hours of training to complete.

63.23 (c) The number of in-service training hours may be prorated for individuals not employed
63.24 for an entire year.

63.25 (d) Each year, in-service training must include:

63.26 (1) the center's procedures for maintaining health and safety according to section 245A.41
63.27 and Minnesota Rules, part 9503.0140, and handling emergencies and accidents according
63.28 to Minnesota Rules, part 9503.0110;

63.29 (2) the reporting responsibilities under section 626.556 and Minnesota Rules, part
63.30 9503.0130;

63.31 (3) at least one-half hour of training on the standards under section 245A.1435 and on
63.32 reducing the risk of sudden unexpected infant death as required under subdivision 5, if
63.33 applicable; and

- 64.1 (4) at least one-half hour of training on the risk of abusive head trauma from shaking
64.2 infants and young children as required under subdivision 5a, if applicable.
- 64.3 (e) Each year, or when a change is made, whichever is more frequent, in-service training
64.4 must be provided on: (1) the center's risk reduction plan under section 245A.66, subdivision
64.5 2; and (2) a child's individual child care program plan as required under Minnesota Rules,
64.6 part 9503.0065, subpart 3.
- 64.7 (f) At least once every two calendar years, the in-service training must include:
- 64.8 (1) child development and learning training under subdivision 2;
64.9 (2) pediatric first aid that meets the requirements of subdivision 3;
64.10 (3) pediatric cardiopulmonary resuscitation training that meets the requirements of
64.11 subdivision 4;
64.12 (4) cultural dynamics training to increase awareness of cultural differences; and
64.13 (5) disabilities training to increase awareness of differing abilities of children.
- 64.14 (g) At least once every five years, in-service training must include child passenger
64.15 restraint training that meets the requirements of subdivision 6, if applicable.
- 64.16 (h) The remaining hours of the in-service training requirement must be met by completing
64.17 training in the following content areas of the Minnesota Knowledge and Competency
64.18 Framework:
- 64.19 (1) Content area I: child development and learning;
64.20 (2) Content area II: developmentally appropriate learning experiences;
64.21 (3) Content area III: relationships with families;
64.22 (4) Content area IV: assessment, evaluation, and individualization;
64.23 (5) Content area V: historical and contemporary development of early childhood
64.24 education;
- 64.25 (6) Content area VI: professionalism; and
64.26 (7) Content area VII: health, safety, and nutrition; and
64.27 (8) Content area VIII: application through clinical experiences.
- 64.28 (b) (i) For purposes of this subdivision, the following terms have the meanings given
64.29 them.

65.1 (1) "Child development and learning training" ~~has the meaning given it in subdivision~~

65.2 2, paragraph (a), means training in understanding how children develop physically,

65.3 cognitively, emotionally, and socially and learn as part of the children's family, culture, and

65.4 community.

65.5 (2) "Developmentally appropriate learning experiences" means creating positive learning

65.6 experiences, promoting cognitive development, promoting social and emotional development,

65.7 promoting physical development, and promoting creative development.

65.8 (3) "Relationships with families" means training on building a positive, respectful

65.9 relationship with the child's family.

65.10 (4) "Assessment, evaluation, and individualization" means training in observing,

65.11 recording, and assessing development; assessing and using information to plan; and assessing

65.12 and using information to enhance and maintain program quality.

65.13 (5) "Historical and contemporary development of early childhood education" means

65.14 training in past and current practices in early childhood education and how current events

65.15 and issues affect children, families, and programs.

65.16 (6) "Professionalism" means training in knowledge, skills, and abilities that promote

65.17 ongoing professional development.

65.18 (7) "Health, safety, and nutrition" means training in establishing health practices, ensuring

65.19 safety, and providing healthy nutrition.

65.20 (8) "Application through clinical experiences" means clinical experiences in which a

65.21 person applies effective teaching practices using a range of educational programming models.

65.22 (e) ~~The director and all program staff persons must annually complete a number of hours~~

65.23 ~~of in-service training equal to at least two percent of the hours for which the director or~~

65.24 ~~program staff person is annually paid, unless one of the following is applicable.~~

65.25 (1) ~~A teacher at a child care center must complete one percent of working hours of~~

65.26 ~~in-service training annually if the teacher:~~

65.27 (i) ~~possesses a baccalaureate or master's degree in early childhood education or school-age~~

65.28 ~~care;~~

65.29 (ii) ~~is licensed in Minnesota as a prekindergarten teacher, an early childhood educator,~~

65.30 ~~a kindergarten to sixth grade teacher with a prekindergarten specialty, an early childhood~~

65.31 ~~special education teacher, or an elementary teacher with a kindergarten endorsement; or~~

65.32 (iii) ~~possesses a baccalaureate degree with a Montessori certificate.~~

66.1 (2) A teacher or assistant teacher at a child care center must complete one and one half

66.2 percent of working hours of in-service training annually if the individual is:

66.3 (i) a registered nurse or licensed practical nurse with experience working with infants;

66.4 (ii) possesses a Montessori certificate, a technical college certificate in early childhood
66.5 development, or a child development associate certificate; or

66.6 (iii) possesses an associate of arts degree in early childhood education, a baccalaureate
66.7 degree in child development, or a technical college diploma in early childhood development.

66.8 (d) The number of required training hours may be prorated for individuals not employed
66.9 full time or for an entire year.

66.10 (e) The annual in-service training must be completed within the calendar year for which
66.11 it was required. In-service training completed by staff persons is transferable upon a staff
66.12 person's change in employment to another child care program.

66.13 (f) (j) The license holder must ensure that, when a staff person completes in-service
66.14 training, the training is documented in the staff person's personnel record. The documentation
66.15 must include the date training was completed, the goal of the training and topics covered,
66.16 trainer's name and organizational affiliation, trainer's signed statement that training was
66.17 successfully completed, documentation, as required in subdivision 10, includes the number
66.18 of total training hours required to be completed, name of the training, the Minnesota
66.19 Knowledge and Competency Framework content area, number of hours completed, and the
66.20 director's approval of the training.

66.21 (k) In-service training completed by a staff person that is not specific to that child care
66.22 center is transferable upon a staff person's change in employment to another child care
66.23 program.

66.24 **Subd. 8. Cultural dynamics and disabilities training for child care providers.** (a)

66.25 The training required of licensed child care center staff must include training in the cultural
66.26 dynamics of early childhood development and child care. The cultural dynamics and
66.27 disabilities training and skills development of child care providers must be designed to
66.28 achieve outcomes for providers of child care that include, but are not limited to:

66.29 (1) an understanding and support of the importance of culture and differences in ability
66.30 in children's identity development;

66.31 (2) understanding the importance of awareness of cultural differences and similarities
66.32 in working with children and their families;

67.1 ~~(3) understanding and support of the needs of families and children with differences in~~

67.2 ~~ability;~~

67.3 ~~(4) developing skills to help children develop unbiased attitudes about cultural differences~~

67.4 ~~and differences in ability;~~

67.5 ~~(5) developing skills in culturally appropriate caregiving; and~~

67.6 ~~(6) developing skills in appropriate caregiving for children of different abilities.~~

67.7 ~~(b) Curriculum for cultural dynamics and disability training shall be approved by the~~

67.8 ~~commissioner.~~

67.9 ~~(c) The commissioner shall amend current rules relating to the training of the licensed~~

67.10 ~~child care center staff to require cultural dynamics training. Timelines established in the~~

67.11 ~~rule amendments for complying with the cultural dynamics training requirements must be~~

67.12 ~~based on the commissioner's determination that curriculum materials and trainers are available~~

67.13 ~~statewide.~~

67.14 ~~(d) For programs caring for children with special needs, the license holder shall ensure~~

67.15 ~~that any additional staff training required by the child's individual child care program plan~~

67.16 ~~required under Minnesota Rules, part 9503.0065, subpart 3, is provided.~~

67.17 ~~Subd. 9. Ongoing health and safety training. A staff person's orientation training on~~

67.18 ~~maintaining health and safety and handling emergencies and accidents, as required in~~

67.19 ~~subdivision 1, must be repeated at least once each calendar year by each staff person. The~~

67.20 ~~completion of the annual training must be documented in the staff person's personnel record.~~

67.21 Subd. 10. Documentation. All training must be documented and maintained on site in

67.22 each personnel record. In addition to any requirements for each training provided in this

67.23 section, documentation for each staff person must include the staff person's first date of

67.24 direct contact and first date of unsupervised contact with a child in care.

67.25 **EFFECTIVE DATE.** This section is effective September 30, 2019.

67.26 Sec. 10. Minnesota Statutes 2018, section 245A.41, is amended to read:

67.27 **245A.41 CHILD CARE CENTER HEALTH AND SAFETY REQUIREMENTS.**

67.28 **Subdivision 1. Allergy prevention and response.** (a) Before admitting a child for care,

67.29 the license holder must obtain documentation of any known allergy from the child's parent

67.30 or legal guardian or the child's source of medical care. If a child has a known allergy, the

67.31 license holder must maintain current information about the allergy in the child's record and

67.32 develop an individual child care program plan as specified in Minnesota Rules, part

68.1 9503.0065, subpart 3. The individual child care program plan must include but not be limited
68.2 to a description of the allergy, specific triggers, avoidance techniques, symptoms of an
68.3 allergic reaction, and procedures for responding to an allergic reaction, including medication,
68.4 dosages, and a doctor's contact information.

68.5 (b) The license holder must ensure that each staff person who is responsible for carrying
68.6 out the individual child care program plan review and follow the plan. Documentation of a
68.7 staff person's review must be kept on site.

68.8 (c) At least annually once each calendar year or following any changes made to
68.9 allergy-related information in the child's record, the license holder must update the child's
68.10 individual child care program plan and inform each staff person who is responsible for
68.11 carrying out the individual child care program plan of the change. The license holder must
68.12 keep on site documentation that a staff person was informed of a change.

68.13 (d) A child's allergy information must be available at all times including on site, when
68.14 on field trips, or during transportation. A child's food allergy information must be readily
68.15 available to a staff person in the area where food is prepared and served to the child.

68.16 (e) The license holder must contact the child's parent or legal guardian as soon as possible
68.17 in any instance of exposure or allergic reaction that requires medication or medical
68.18 intervention. The license holder must call emergency medical services when epinephrine
68.19 is administered to a child in the license holder's care.

68.20 Subd. 2. **Handling and disposal of bodily fluids.** The licensed child care center must
68.21 comply with the following procedures for safely handling and disposing of bodily fluids:

68.22 (1) surfaces that come in contact with potentially infectious bodily fluids, including
68.23 blood and vomit, must be cleaned and disinfected according to Minnesota Rules, part
68.24 9503.0005, subpart 11;

68.25 (2) blood-contaminated material must be disposed of in a plastic bag with a secure tie;

68.26 (3) sharp items used for a child with special care needs must be disposed of in a "sharps
68.27 container." The sharps container must be stored out of reach of a child;

68.28 (4) the license holder must have the following bodily fluid disposal supplies in the center:
68.29 disposable gloves, disposal bags, and eye protection; and

68.30 (5) the license holder must ensure that each staff person ~~is trained on follows~~ universal
68.31 precautions to reduce the risk of spreading infectious disease. ~~A staff person's completion~~
68.32 ~~of the training must be documented in the staff person's personnel record.~~

69.1 **Subd. 3. Emergency preparedness.** (a) ~~No later than September 30, 2017,~~ A licensed

69.2 child care center must have a written emergency plan for emergencies that require evacuation,
69.3 sheltering, or other protection of a child, such as fire, natural disaster, intruder, or other
69.4 threatening situation that may pose a health or safety hazard to a child. The plan must be
69.5 written on a form developed by the commissioner and must include:

69.6 (1) procedures for an evacuation, relocation, shelter-in-place, or lockdown;

69.7 (2) a designated relocation site and evacuation route;

69.8 (3) procedures for notifying a child's parent or legal guardian of the evacuation, relocation,
69.9 shelter-in-place, or lockdown, including procedures for reunification with families;

69.10 (4) accommodations for a child with a disability or a chronic medical condition;

69.11 (5) procedures for storing a child's medically necessary medicine that facilitates easy
69.12 removal during an evacuation or relocation;

69.13 (6) procedures for continuing operations in the period during and after a crisis; and

69.14 (7) procedures for communicating with local emergency management officials, law
69.15 enforcement officials, or other appropriate state or local authorities; and

69.16 (8) accommodations for infants and toddlers.

69.17 ~~(b) The license holder must train staff persons on the emergency plan at orientation,~~

69.18 ~~when changes are made to the plan, and at least once each calendar year. Training must be~~
69.19 ~~documented in each staff person's personnel file.~~

69.20 ~~(e)~~ (b) The license holder must conduct drills according to the requirements in Minnesota

69.21 Rules, part 9503.0110, subpart 3. The date and time of the drills must be documented.

69.22 ~~(d)~~ (c) The license holder must review and update the emergency plan annually at least

69.23 once each calendar year. Staff must be informed of any changes made to the emergency
69.24 plan. Documentation of the annual yearly emergency plan review and staff notification of
69.25 changes shall be maintained in the program's administrative records.

69.26 ~~(e)~~ (d) The license holder must include the emergency plan in the program's policies

69.27 and procedures as specified under section 245A.04, subdivision 14. ~~The license holder must~~
69.28 ~~provide a physical or electronic copy of the emergency plan to the child's parent or legal~~
69.29 ~~guardian upon enrollment.~~

69.30 ~~(f)~~ (e) The relocation site and evacuation route must be posted in a visible place as part

69.31 of the written procedures for emergencies and accidents in Minnesota Rules, part 9503.0140,
69.32 subpart 21.

70.1 Subd. 4. Child passenger restraint requirements. A license holder must comply with
70.2 all seat belt and child passenger restraint system requirements under section 169.685.

70.3 Subd. 5. Telephone requirement in licensed child care centers. (a) A working telephone
70.4 which is capable of making outgoing calls and receiving incoming calls must be located
70.5 within the licensed child care center at all times. Staff must have access to a working
70.6 telephone while providing care and supervision to children in care, even if the care occurs
70.7 outside of the child care facility. A license holder may use a cellular telephone to meet the
70.8 requirements of this subdivision.

70.9 (b) If a cellular telephone is used to satisfy the requirements of this subdivision, the
70.10 cellular telephone must be accessible to staff, be stored in a centrally located area when not
70.11 in use, and remain charged at all times.

70.12 **EFFECTIVE DATE.** This section is effective September 30, 2019.

70.13 Sec. 11. Minnesota Statutes 2018, section 245A.50, is amended to read:

70.14 **245A.50 FAMILY CHILD CARE TRAINING REQUIREMENTS.**

70.15 Subdivision 1. **Initial training.** (a) License holders, caregivers, and substitutes,
70.16 emergency substitutes, and helpers must comply with the training requirements in this
70.17 section.

70.18 (b) ~~Helpers who assist with care on a regular basis must complete six hours of training
70.19 within one year after the date of initial employment.~~

70.20 (b) The license holder, before initial licensure, and a caregiver, before caring for a child,
70.21 must complete:

70.22 (1) the six-hour Supervising for Safety for Family Child Care course developed by the
70.23 commissioner;

70.24 (2) a two-hour course in Knowledge and Competency Area I: Child Development and
70.25 Learning, as required by subdivision 2;

70.26 (3) a two-hour course in behavior guidance that may be fulfilled by completing any
70.27 course in Knowledge and Competency Area II-C: Promoting Social and Emotional
70.28 Development, as required by subdivision 2;

70.29 (4) pediatric first aid, as required by subdivision 3;

70.30 (5) pediatric cardiopulmonary resuscitation, as required by subdivision 4;

71.1 (6) if applicable, training in reducing the risk of sudden unexpected infant death and
71.2 abusive head trauma as required by subdivision 5; and

71.3 (7) if applicable, training in child passenger restraint as required by subdivision 6.

71.4 The license holder or caregiver may take one four-hour course that covers both clauses (2)
71.5 and (3) to meet the requirements of this subdivision.

71.6 (c) Before caring for a child, each substitute and emergency substitute must complete:

71.7 (1) the four-hour Basics of Licensed Family Child Care for Substitutes course developed
71.8 by the commissioner;

71.9 (2) pediatric first aid, as required by subdivision 3;

71.10 (3) pediatric cardiopulmonary resuscitation, as required by subdivision 4; and

71.11 (4) if applicable, training in reducing the risk of sudden unexpected infant death and
71.12 abusive head trauma as required by subdivision 5.

71.13 (d) Each helper must complete:

71.14 (1) if applicable, before assisting with the care of a child under school age, training in
71.15 reducing the risk of sudden unexpected infant death and abusive head trauma, as required
71.16 by subdivision 5; and

71.17 (2) within 90 days of the start of employment, the one-hour Child Development for
71.18 Helpers course developed by the commissioner.

71.19 (e) Before caring for a child or assisting in the care of a child, the license holder must
71.20 train each caregiver, substitute, and emergency substitute on:

71.21 (1) the emergency plan required under section 245A.51, subdivision 3, paragraph (b);

71.22 (2) allergy prevention and response required under section 245A.51, subdivision 1,
71.23 paragraph (b); and

71.24 (3) the drug and alcohol policy required under section 245A.04, subdivision 1, paragraph
71.25 (c).

71.26 (e)(f) Training requirements established under this section that must be completed prior
71.27 to initial licensure must be satisfied only by a newly licensed child care provider or by a
71.28 child care provider who has not held an active child care license in Minnesota in the previous
71.29 12 months. A child care provider who relocates within the state or who voluntarily cancels
71.30 a license or allows the license to lapse for a period of less than 12 months and who seeks
71.31 reinstatement of the lapsed or canceled license within 12 months of the lapse or cancellation

72.1 must satisfy the annual, ongoing training requirements, and is not required to satisfy the
72.2 training requirements that must be completed prior to initial licensure.

72.3 **Subd. 1a. Definitions.** (a) For the purposes of this section, the following terms have the
72.4 meanings given them.

72.5 (b) "Basics of Family Child Care for Substitutes" means a class developed by the
72.6 commissioner that includes the following topics: prevention and control of infectious
72.7 diseases; administering medication; preventing and responding to allergies; ensuring building
72.8 and physical premise safety; handling and storing biological contaminants; preventing and
72.9 reporting abuse and child maltreatment; emergency preparedness; and child development.

72.10 (c) "Caregiver" means an adult other than the license holder who supervises children
72.11 for a cumulative total of 300 or more hours in any calendar year.

72.12 (d) "Emergency substitute" means an adult who assumes the responsibility of a provider
72.13 for a cumulative total of not more than 50 hours in a calendar year.

72.14 (e) "Helper" means a minor, ages 13 through 17, who assists in the care of the children.

72.15 (f) "Substitute" means an adult who assumes the responsibility of a provider for a
72.16 cumulative total of not more than 300 hours in any calendar year.

72.17 **Subd. 2. Child development and learning and behavior guidance training.** (a) For
72.18 purposes of family and group family child care, The license holder and each adult caregiver
72.19 who provides care in the licensed setting for more than 30 days in any 12-month period
72.20 shall complete and document at least four hours of child growth and learning and behavior
72.21 guidance training prior to initial licensure, and before caring for children. For purposes of
72.22 this subdivision, "child development and learning training" means training in understanding
72.23 how children develop physically, cognitively, emotionally, and socially and learn as part
72.24 of the children's family, culture, and community. "Behavior guidance training" means
72.25 training in the understanding of the functions of child behavior and strategies for managing
72.26 challenging situations. At least two hours of child development and learning or behavior
72.27 guidance training must be repeated annually. Training curriculum shall be developed or
72.28 approved by the commissioner of human services.

72.29 (b) Notwithstanding paragraph (a), individuals are exempt from this requirement if they:

72.30 (1) have taken a three-credit course on early childhood development within the past five
72.31 years;

72.32 (2) have received a baccalaureate or master's degree in early childhood education or
72.33 school-age child care within the past five years;

73.1 (3) are licensed in Minnesota as a prekindergarten teacher, an early childhood educator,
73.2 a kindergarten to grade 6 teacher with a prekindergarten specialty, an early childhood special
73.3 education teacher, or an elementary teacher with a kindergarten endorsement; or

73.4 (4) have received a baccalaureate degree with a Montessori certificate within the past
73.5 five years.

73.6 (c) The license holder and each caregiver must complete at least two hours of child
73.7 development training annually that may be fulfilled by completing any course in Knowledge
73.8 and Competency Area I: Child Development and Learning; or behavior guidance training
73.9 that may be fulfilled by completing any course in Knowledge and Competency Area II-C:
73.10 Promoting Social and Emotional Development. The commissioner shall develop or approve
73.11 training curriculum.

73.12 Subd. 3. **First aid.** (a) When children are present in a family child care home governed
73.13 by Minnesota Rules, parts 9502.0315 to 9502.0445, at least one staff person must be present
73.14 in the home who has been trained in first aid. The license holder must complete pediatric
73.15 first aid training before licensure and each caregiver, substitute, and emergency substitute
73.16 must complete pediatric first aid training before caring for children. The first aid training
73.17 must have been provided by an individual approved to provide first aid instruction. First
73.18 aid training may be less than eight hours and persons qualified to provide first aid training
73.19 include individuals approved as first aid instructors. First aid training must be repeated
73.20 every two years.

73.21 (b) A family child care provider is exempt from the first aid training requirements under
73.22 this subdivision related to any substitute caregiver who provides less than 30 hours of care
73.23 during any 12-month period. The license holder, each caregiver, substitute, and emergency
73.24 substitute must complete additional pediatric first aid training every two years.

73.25 (c) Video training reviewed and approved by the county licensing agency satisfies the
73.26 training requirement of this subdivision.

73.27 Subd. 4. **Cardiopulmonary resuscitation.** (a) When children are present in a family
73.28 child care home governed by Minnesota Rules, parts 9502.0315 to 9502.0445, at least one
73.29 caregiver must be present in the home who has been trained in cardiopulmonary resuscitation
73.30 (CPR), including CPR techniques for infants and children, and in the treatment of obstructed
73.31 airways. The CPR training must have been provided by an individual approved to provide
73.32 CPR instruction, must be repeated at least once every two years, and must be documented
73.33 in the caregiver's records. The family child care license holder must complete pediatric
73.34 cardiopulmonary resuscitation (CPR) training prior to licensure. Caregivers, substitutes,

74.1 and emergency substitutes must complete pediatric CPR training prior to caring for children.
74.2 Training that has been completed in the previous two years fulfills this requirement.

74.3 (b) A family child care provider is exempt from the CPR training requirement in this
74.4 subdivision related to any substitute caregiver who provides less than 30 hours of care during
74.5 any 12-month period. The CPR training must be provided by an individual approved to
74.6 provide CPR instruction.

74.7 (c) Persons providing CPR training must use CPR training that has been developed. The
74.8 Pediatric CPR training must:

74.9 (1) by the American Heart Association or the American Red Cross and incorporates
74.10 psychomotor skills to support the instruction; or

74.11 (2) using nationally recognized, evidence-based guidelines for CPR training and
74.12 incorporates psychomotor skills to support the instruction.

74.13 (1) cover CPR techniques for infants and children and the treatment of obstructed airways;

74.14 (2) include instruction, hands-on practice, and an in-person observed skills assessment
74.15 under the direct supervision of a CPR instructor; and

74.16 (3) be developed by the American Heart Association, the American Red Cross, or another
74.17 organization that uses nationally recognized, evidence-based guidelines for CPR.

74.18 (d) License holders, caregivers, substitutes, and emergency substitutes must complete
74.19 pediatric CPR training at least once every two years.

74.20 **Subd. 5. Sudden unexpected infant death and abusive head trauma training.** (a)
74.21 The license holder must complete training on reducing the risk of sudden unexpected infant
74.22 death prior to caring for infants. License holders must document ensure that before staff
74.23 persons, caregivers, substitutes, emergency substitutes, and helpers assist in the care of
74.24 infants, they are instructed on the standards in section 245A.1435 and receive training on
74.25 reducing the risk of sudden unexpected infant death.

74.26 (b) The license holder must complete training on reducing the risk of abusive head
74.27 trauma, prior to caring for infants and children under school age. In addition, license holders
74.28 must document ensure that before staff persons, caregivers, substitutes, emergency substitutes,
74.29 and helpers assist in the care of infants and children under school age, they receive training
74.30 on reducing the risk of abusive head trauma from shaking infants and young children. The
74.31 training in this subdivision may be provided as initial training under subdivision 1 or ongoing
74.32 annual training under subdivision 7.

75.1 ~~(b)~~(c) Sudden unexpected infant death reduction training required under this subdivision
75.2 must, at a minimum, address the risk factors related to sudden unexpected infant death,
75.3 means of reducing the risk of sudden unexpected infant death in child care, and license
75.4 holder communication with parents regarding reducing the risk of sudden unexpected infant
75.5 death.

75.6 ~~(e)~~(d) Abusive head trauma training required under this subdivision must, at a minimum,
75.7 address the risk factors related to shaking infants and young children, means of reducing
75.8 the risk of abusive head trauma in child care, and license holder communication with parents
75.9 regarding reducing the risk of abusive head trauma.

75.10 ~~(d)~~(e) Training for family and group family child care providers must be developed by
75.11 the commissioner ~~in conjunction with the Minnesota Sudden Infant Death Center~~ and
75.12 approved by ~~the Minnesota Center for Professional Development~~ Achieve - The MN Center
75.13 for Professional Development. Sudden unexpected infant death reduction training and
75.14 abusive head trauma training may be provided in a single course of no more than two hours
75.15 in length.

75.16 ~~(e)~~(f) Sudden unexpected infant death reduction training and abusive head trauma
75.17 training required under this subdivision must be completed in person or as allowed under
75.18 subdivision 10, clause (1) or (2), at least once every two years. On the years when the license
75.19 holder ~~is, caregiver, substitute, and helper are~~ not receiving training in person or as allowed
75.20 under subdivision 10, clause (1) or (2), the license holder, ~~caregiver, substitute, and helper~~
75.21 must receive sudden unexpected infant death reduction training and abusive head trauma
75.22 training through a video of no more than one hour in length. The video must be developed
75.23 or approved by the commissioner.

75.24 ~~(f)~~(g) An individual who is related to the license holder as defined in section 245A.02,
75.25 subdivision 13, and who is involved only in the care of the license holder's own infant or
75.26 child under school age and who is not designated to be a caregiver, helper, or substitute, as
75.27 defined in Minnesota Rules, part 9502.0315, for the licensed program, is exempt from the
75.28 sudden unexpected infant death and abusive head trauma training.

75.29 **Subd. 6. Child passenger restraint systems; training requirement.** ~~(a) A license~~
75.30 ~~holder must comply with all seat belt and child passenger restraint system requirements~~
75.31 ~~under section 169.685.~~

75.32 ~~(b) Family and group family child care programs licensed by the Department of Human~~
75.33 ~~Services that serve a child or children under nine years of age must document training that~~
75.34 ~~fulfills the requirements in this subdivision.~~

76.1 (a)(1) Before a license holder, ~~staff person, caregiver, or helper~~ caregiver, substitute, or
76.2 ~~emergency substitute~~ transports a child or children under age ~~nine~~ eight in a motor vehicle,
76.3 the person placing the child or children in a passenger restraint must satisfactorily complete
76.4 training on the proper use and installation of child restraint systems in motor vehicles.
76.5 Training completed under this subdivision may be used to meet initial training under
76.6 subdivision 1 or ongoing training under subdivision 7.

76.7 (2) Training required under this subdivision must be ~~at least one hour in length, completed~~
76.8 ~~at initial training, and~~ repeated at least once every five years.

76.9 (3) At a minimum, the training must address the proper use of child restraint systems
76.10 based on the child's size, weight, and age, and the proper installation of a car seat or booster
76.11 seat in the motor vehicle used by the license holder to transport the child or children.

76.12 (3)(4) Training under this subdivision must be provided by individuals who are certified
76.13 and approved by the Department of Public Safety, Office of Traffic Safety. License holders
76.14 may obtain a list of certified and approved trainers through the Department of Public Safety
76.15 website or by contacting the agency.

76.16 (e)(b) Child care providers that only transport school-age children as defined in section
76.17 245A.02, subdivision 19, paragraph (f), in child care buses as defined in section 169.448,
76.18 subdivision 1, paragraph (e), are exempt from this subdivision.

76.19 Subd. 7. **Ongoing training requirements for family and group family child care**
76.20 **license holders and caregivers.** ~~For purposes of family and group family child care, (a)~~
76.21 The license holder and each primary caregiver must complete 16 hours of ongoing training
76.22 each year. ~~For purposes of this subdivision, a primary caregiver is an adult caregiver who~~
76.23 ~~provides services in the licensed setting for more than 30 days in any 12-month period.~~
76.24 ~~Repeat of topical training requirements in subdivisions 2 to 8 shall count toward the annual~~
76.25 ~~16-hour training requirement.~~

76.26 (b) The license holder and caregiver must annually complete ongoing training as follows:
76.27 (1) as required by subdivision 2, a two-hour course in: child development that may be
76.28 fulfilled by any course in Knowledge and Competency Area I: Child Development and
76.29 Learning; or behavior guidance that may be fulfilled by any course in Knowledge and
76.30 Competency Area II-C: Promoting Social and Emotional Development;

76.31 (2) a two-hour course in active supervision that may be fulfilled by any course in:
76.32 Knowledge and Competency Area VII-A: Establishing Healthy Practices; or Knowledge
76.33 and Competency Area VII-B: Ensuring Safety; and

77.1 (3) if applicable, ongoing training in reducing the risk of sudden unexpected infant death

77.2 and abusive head trauma, as required under subdivision 5.

77.3 (c) At least once every two years, the license holder and caregiver must complete ongoing

77.4 training as follows:

77.5 (1) training in pediatric first aid as required under subdivision 3;

77.6 (2) training in pediatric CPR as required under subdivision 4; and

77.7 (3) a two-hour course on accommodating children with disabilities or on cultural

77.8 dynamics that may be fulfilled by completing any course in Knowledge and Competency

77.9 Area III: Relationships with Families.

77.10 (d) At least once every five years, the license holder and caregiver must complete ongoing

77.11 training as follows:

77.12 (1) the two-hour courses Health and Safety I and Health and Safety II; and

77.13 (2) if applicable, ongoing training in child passenger restraint, as required under

77.14 subdivision 6.

77.15 (e) Additional ongoing training subjects to meet the annual 16-hour training requirement

77.16 must be selected from the following areas training in the following content areas of the

77.17 Minnesota Knowledge and Competency Framework:

77.18 (1) Content area I: child development and learning, including training under subdivision

77.19 2, paragraph (a) in understanding how children develop physically, cognitively, emotionally,

77.20 and socially; and learn as part of the childrens' family, culture, and community;

77.21 (2) Content area II: developmentally appropriate learning experiences, including training

77.22 in creating positive learning experiences, promoting cognitive development, promoting

77.23 social and emotional development, promoting physical development, promoting creative

77.24 development; and behavior guidance;

77.25 (3) Content area III: relationships with families, including training in building a positive,

77.26 respectful relationship with the child's family;

77.27 (4) Content area IV: assessment, evaluation, and individualization, including training

77.28 in observing, recording, and assessing development; assessing and using information to

77.29 plan; and assessing and using information to enhance and maintain program quality;

77.30 (5) Content area V: historical and contemporary development of early childhood

77.31 education, including training in past and current practices in early childhood education and

77.32 how current events and issues affect children, families, and programs;

78.1 (6) Content area VI: professionalism, including training in knowledge, skills, and abilities
78.2 that promote ongoing professional development; and

78.3 (7) Content area VII: health, safety, and nutrition, including training in establishing
78.4 healthy practices; ensuring safety; and providing healthy nutrition.

78.5 Subd. 8. **Other required training requirements** **Ongoing training requirements for**
78.6 **substitutes, emergency substitutes, and helpers.** (a) ~~The training required of family and~~
78.7 ~~group family child care providers and staff must include training in the cultural dynamics~~
78.8 ~~of early childhood development and child care. The cultural dynamics and disabilities~~
78.9 ~~training and skills development of child care providers must be designed to achieve outcomes~~
78.10 ~~for providers of child care that include, but are not limited to:~~

78.11 (1) ~~an understanding and support of the importance of culture and differences in ability~~
78.12 ~~in children's identity development;~~

78.13 (2) ~~understanding the importance of awareness of cultural differences and similarities~~
78.14 ~~in working with children and their families;~~

78.15 (3) ~~understanding and support of the needs of families and children with differences in~~
78.16 ~~ability;~~

78.17 (4) ~~developing skills to help children develop unbiased attitudes about cultural differences~~
78.18 ~~and differences in ability;~~

78.19 (5) ~~developing skills in culturally appropriate caregiving; and~~

78.20 (6) ~~developing skills in appropriate caregiving for children of different abilities.~~

78.21 The ~~commissioner shall approve the curriculum for cultural dynamics and disability~~
78.22 ~~training.~~

78.23 (b) ~~The provider must meet the training requirement in section 245A.14, subdivision~~
78.24 ~~11, paragraph (a), clause (4), to be eligible to allow a child cared for at the family child care~~
78.25 ~~or group family child care home to use the swimming pool located at the home.~~

78.26 (a) Each substitute and emergency substitute must complete ongoing training on the
78.27 following schedule:

78.28 (1) annually, if applicable, training in reducing the risk of sudden unexpected infant
78.29 death and abusive head trauma as required under subdivision 5;

78.30 (2) at least once every two years: (i) training in pediatric first aid as required under
78.31 subdivision 3; (ii) training in pediatric CPR as required under subdivision 4; and (iii) the
78.32 four-hour Basics of Licensed Family Child Care for Substitutes course; and

79.1 (3) at least once every five years, if applicable, training in child passenger restraints, as
79.2 required under subdivision 6.

79.3 (b) Each helper must complete training on the following schedule:

79.4 (1) annually, if applicable, training in reducing the risk of sudden unexpected infant
79.5 death and abusive head trauma as required under subdivision 5; and

79.6 (2) at least once every two years: (i) the one-hour course Basics of Child Development
79.7 for Helpers; or (ii) any course in Knowledge and Competency Area I: Child Development
79.8 and Learning.

79.9 ~~Subd. 9. Supervising for safety; training requirement. (a) Before initial licensure and~~
79.10 ~~before caring for a child, all family child care license holders and each adult caregiver who~~
79.11 ~~provides care in the licensed family child care home for more than 30 days in any 12-month~~
79.12 ~~period shall complete and document the completion of the six-hour Supervising for Safety~~
79.13 ~~for Family Child Care course developed by the commissioner.~~

79.14 ~~(b) The family child care license holder and each adult caregiver who provides care in~~
79.15 ~~the licensed family child care home for more than 30 days in any 12-month period shall~~
79.16 ~~complete and document:~~

79.17 ~~(1) the annual completion of a two-hour active supervision course developed by the~~
79.18 ~~commissioner; and~~

79.19 ~~(2) the completion at least once every five years of the two-hour courses Health and~~
79.20 ~~Safety I and Health and Safety II. A license holder's or adult caregiver's completion of either~~
79.21 ~~training in a given year meets the annual active supervision training requirement in clause~~
79.22 ~~(1).~~

79.23 Subd. 10. **Approved training.** County licensing staff must accept training approved by
79.24 ~~the Minnesota Center for Professional Development~~ Achieve - the MN Center for
79.25 Professional Development, including:

79.26 (1) face-to-face or classroom training;

79.27 (2) online training; and

79.28 (3) relationship-based professional development, such as mentoring, coaching, and
79.29 consulting.

79.30 Subd. 11. **Provider training.** New and increased training requirements under this section
79.31 must not be imposed on providers until the commissioner establishes statewide accessibility
79.32 to the required provider training.

80.1 Subd. 12. Documentation. The license holder must document the date of a completed
80.2 training required by this section for the license holder, each caregiver, substitute, emergency
80.3 substitute, and helper.

80.4 **EFFECTIVE DATE.** This section is effective September 30, 2019.

80.5 Sec. 12. Minnesota Statutes 2018, section 245A.51, subdivision 3, is amended to read:

80.6 Subd. 3. Emergency preparedness plan. (a) ~~No later than September 30, 2017,~~ A
80.7 licensed family child care provider must have a written emergency preparedness plan for
80.8 emergencies that require evacuation, sheltering, or other protection of children, such as fire,
80.9 natural disaster, intruder, or other threatening situation that may pose a health or safety
80.10 hazard to children. The plan must be written on a form developed by the commissioner and
80.11 updated at least annually. The plan must include:

- 80.12 (1) procedures for an evacuation, relocation, shelter-in-place, or lockdown;
- 80.13 (2) a designated relocation site and evacuation route;
- 80.14 (3) procedures for notifying a child's parent or legal guardian of the evacuation,
80.15 shelter-in-place, or lockdown, including procedures for reunification with families;
- 80.16 (4) accommodations for a child with a disability or a chronic medical condition;
- 80.17 (5) procedures for storing a child's medically necessary medicine that facilitate easy
80.18 removal during an evacuation or relocation;
- 80.19 (6) procedures for continuing operations in the period during and after a crisis; and
- 80.20 (7) procedures for communicating with local emergency management officials, law
80.21 enforcement officials, or other appropriate state or local authorities; and
- 80.22 (8) accommodations for infants and toddlers.

80.23 (b) The license holder must train caregivers before the caregiver provides care and at
80.24 least annually on the emergency preparedness plan and document completion of this training.

80.25 (c) The license holder must conduct drills according to the requirements in Minnesota
80.26 Rules, part 9502.0435, subpart 8. The date and time of the drills must be documented.

80.27 ~~(d) The license holder must have the emergency preparedness plan available for review
80.28 and posted in a prominent location. The license holder must provide a physical or electronic
80.29 copy of the plan to the child's parent or legal guardian upon enrollment.~~

80.30 **EFFECTIVE DATE.** This section is effective September 30, 2019.

81.1 Sec. 13. Minnesota Statutes 2018, section 245A.51, is amended by adding a subdivision
81.2 to read:

81.3 Subd. 4. **Transporting children.** A license holder must comply with all seat belt and
81.4 child passenger restraint system requirements under section 169.685.

81.5 **EFFECTIVE DATE.** This section is effective September 30, 2019.

81.6 Sec. 14. Minnesota Statutes 2018, section 245A.51, is amended by adding a subdivision
81.7 to read:

81.8 Subd. 5. **Telephone requirement.** Notwithstanding Minnesota Rules, part 9502.0435,
81.9 subpart 8, item B, a license holder is not required to post a list of emergency numbers. A
81.10 license holder may use a cellular telephone to meet the requirements of Minnesota Rules,
81.11 part 9502.0435, subpart 8, if the cellular telephone remains charged at all times.

81.12 **EFFECTIVE DATE.** This section is effective September 30, 2019.

81.13 Sec. 15. **[245A.52] FAMILY CHILD CARE PHYSICAL SPACE REQUIREMENTS.**

81.14 Subdivision 1. **Means of escape.** (a) (1) At least one emergency escape route separate
81.15 from the main exit from the space must be available in each room used for sleeping by
81.16 anyone receiving licensed care, and (2) a basement used for child care. One means of escape
81.17 must be a stairway or door leading to the floor of exit discharge. The other must be a door
81.18 or window leading directly outside. A window used as an emergency escape route must be
81.19 openable without special knowledge.

81.20 (b) In homes with construction that began before May 2, 2016, the interior of the window
81.21 leading directly outside must have a net clear opening area of not less than 4.5 square feet
81.22 or 648 square inches and have minimum clear opening dimensions of 20 inches wide and
81.23 20 inches high. The opening must be no higher than 48 inches from the floor. The height
81.24 to the window may be measured from a platform if a platform is located below the window.

81.25 (c) In homes with construction that began on or after May 2, 2016, the interior of the
81.26 window leading directly outside must have minimum clear opening dimensions of 20 inches
81.27 wide and 24 inches high. The net clear opening dimensions shall be the result of normal
81.28 operation of the opening. The opening must be no higher than 44 inches from the floor.

81.29 (d) The commissioner may establish additional requirements that are dependent on the
81.30 distance of the openings from the ground outside the window including: (1) windows or
81.31 other openings with a sill height not more than 44 inches above or below the finished ground
81.32 level adjacent to the opening (grade-floor emergency escape and rescue openings) must

82.1 have a minimum opening of five square feet; and (2) non-grade floor emergency escape
82.2 and rescue openings must have a minimum opening of 5.7 square feet.

82.3 **Subd. 2. Door to attached garage.** Notwithstanding Minnesota Rules, part 9502.0425,
82.4 subpart 5, day care residences with an attached garage are not required to have a self-closing
82.5 door to the residence. The door to the residence may be a steel insulated door if the door is
82.6 at least 1-3/8 inches thick.

82.7 **Subd. 3. Heating and venting systems.** Notwithstanding Minnesota Rules, part
82.8 9502.0425, subpart 7, items that can be ignited and support combustion, including but not
82.9 limited to plastic, fabric, and wood products must not be located within 18 inches of a gas
82.10 or fuel-oil heater or furnace. If a license holder produces manufacturer instructions listing
82.11 a smaller distance, then the manufacturer instructions control the distance combustible items
82.12 must be from gas, fuel-oil, or solid-fuel burning heaters or furnaces.

82.13 **Subd. 4. Fire extinguisher.** A portable, operational, multipurpose, dry chemical fire
82.14 extinguisher with a minimum 2 A 10 BC rating must be located in or near the kitchen and
82.15 cooking areas of the residence at all times. The fire extinguisher must be serviced annually
82.16 by a qualified inspector. All caregivers must know how to properly use the fire extinguisher.

82.17 **Subd. 5. Carbon monoxide and smoke alarms.** (a) All homes must have an approved
82.18 and operational carbon monoxide alarm installed within ten feet of each room used for
82.19 sleeping children in care.

82.20 (b) Smoke alarms that have been listed by the Underwriter Laboratory must be properly
82.21 installed and maintained on all levels including basements, but not including crawl spaces
82.22 and uninhabitable attics, and in hallways outside rooms used for sleeping children in care.

82.23 (c) In homes with construction that began on or after May 2, 2016, smoke alarms must
82.24 be installed and maintained in each room used for sleeping children in care.

82.25 **Subd. 6. Updates.** After readoption of the Minnesota State Fire Code, the fire marshal
82.26 must notify the commissioner of any changes that conflict with this section and Minnesota
82.27 Rules, chapter 9502. The state fire marshal must identify necessary statutory changes to
82.28 align statutes with the revised code. The commissioner must recommend updates to sections
82.29 of chapter 245A that are derived from the Minnesota State Fire Code in the legislative
82.30 session following readoption of the code.

82.31 **EFFECTIVE DATE.** This section is effective September 30, 2019.

83.1 **Sec. 16. [245A.53] SUPERVISION AND USE OF SUBSTITUTES.**

83.2 Notwithstanding Minnesota Rules, part 9502.0365, subpart 5, the use of a substitute
83.3 caregiver must be limited to a cumulative total of not more than 300 hours in a calendar
83.4 year and a provider may use an additional 50 hours of care provided by an emergency
83.5 substitute, as defined in section 245A.50, subdivision 1a, in the same calendar year.

83.6 **EFFECTIVE DATE.** This section is effective September 30, 2019.

83.7 Sec. 17. Minnesota Statutes 2018, section 245A.66, subdivision 2, is amended to read:

83.8 Subd. 2. **Child care centers; risk reduction plan.** (a) Child care centers licensed under
83.9 this chapter and Minnesota Rules, chapter 9503, must develop a risk reduction plan that
83.10 identifies the general risks to children served by the child care center. The license holder
83.11 must establish procedures to minimize identified risks, train staff on the procedures, and
83.12 annually review the procedures.

83.13 (b) The risk reduction plan must include an assessment of risk to children the center
83.14 serves or intends to serve and identify specific risks based on the outcome of the assessment.
83.15 The assessment of risk must be based on the following:

83.16 (1) an assessment of the risks presented by the physical plant where the licensed services
83.17 are provided, including an evaluation of the following factors: the condition and design of
83.18 the facility and its outdoor space, bathrooms, storage areas, and accessibility of medications
83.19 and cleaning products that are harmful to children when children are not supervised and the
83.20 existence of areas that are difficult to supervise; and

83.21 (2) an assessment of the risks presented by the environment for each facility and for
83.22 each site, including an evaluation of the following factors: the type of grounds and terrain
83.23 surrounding the building and the proximity to hazards, busy roads, and publicly accessed
83.24 businesses.

83.25 (c) The risk reduction plan must include a statement of measures that will be taken to
83.26 minimize the risk of harm presented to children for each risk identified in the assessment
83.27 required under paragraph (b) related to the physical plant and environment. At a minimum,
83.28 the stated measures must include the development and implementation of specific policies
83.29 and procedures or reference to existing policies and procedures that minimize the risks
83.30 identified.

83.31 (d) In addition to any program-specific risks identified in paragraph (b), the plan must
83.32 include development and implementation of specific policies and procedures or refer to

- 84.1 existing policies and procedures that minimize the risk of harm or injury to children,
84.2 including:
- 84.3 (1) closing children's fingers in doors, including cabinet doors;
- 84.4 (2) leaving children in the community without supervision;
- 84.5 (3) children leaving the facility without supervision;
- 84.6 (4) caregiver dislocation of children's elbows;
- 84.7 (5) burns from hot food or beverages, whether served to children or being consumed by
84.8 caregivers, and the devices used to warm food and beverages;
- 84.9 (6) injuries from equipment, such as scissors and glue guns;
- 84.10 (7) sunburn;
- 84.11 (8) feeding children foods to which they are allergic;
- 84.12 (9) children falling from changing tables; and
- 84.13 (10) children accessing dangerous items or chemicals or coming into contact with residue
84.14 from harmful cleaning products.
- 84.15 (e) The plan shall prohibit the accessibility of hazardous items to children.
- 84.16 (f) The plan must include specific policies and procedures to ensure adequate supervision
84.17 of children at all times as defined under section 245A.02, subdivision 18, with particular
84.18 emphasis on:
- 84.19 (1) times when children are transitioned from one area within the facility to another;
- 84.20 (2) nap-time supervision, including infant crib rooms as specified under section 245A.02,
84.21 subdivision 18, which requires that when an infant is placed in a crib to sleep, supervision
84.22 occurs when a staff person is within sight or hearing of the infant. When supervision of a
84.23 crib room is provided by sight or hearing, the center must have a plan to address the other
84.24 supervision components;
- 84.25 (3) child drop-off and pick-up times;
- 84.26 (4) supervision during outdoor play and on community activities, including but not
84.27 limited to field trips and neighborhood walks; and
- 84.28 (5) supervision of children in hallways; and
- 84.29 (6) supervision of school-age children when using the restroom and visiting the child's
84.30 personal storage space.

85.1 **EFFECTIVE DATE.** This section is effective September 30, 2019.

85.2 Sec. 18. Minnesota Statutes 2018, section 245A.66, subdivision 3, is amended to read:

85.3 Subd. 3. **Orientation to Yearly review of risk reduction plan and annual review of**
85.4 ~~plan. (a) The license holder shall ensure that all mandated reporters, as defined in section~~
85.5 ~~626.556, subdivision 3, who are under the control of the license holder, receive an orientation~~
85.6 ~~to the risk reduction plan prior to first providing unsupervised direct contact services, as~~
85.7 ~~defined in section 245C.02, subdivision 11, to children, not to exceed 14 days from the first~~
85.8 ~~supervised direct contact, and annually thereafter. The license holder must document the~~
85.9 ~~orientation to the risk reduction plan in the mandated reporter's personnel records.~~

85.10 (b) The license holder must review the risk reduction plan annually each calendar year
85.11 and document the annual review. When conducting the review, the license holder must
85.12 consider incidents that have occurred in the center since the last review, including:

- 85.13 (1) the assessment factors in the plan;
85.14 (2) the internal reviews conducted under this section, if any;
85.15 (3) substantiated maltreatment findings, if any; and
85.16 (4) incidents that caused injury or harm to a child, if any, that occurred since the last
85.17 review.

85.18 Following any change to the risk reduction plan, the license holder must inform ~~mandated~~
85.19 ~~reporters staff persons~~, under the control of the license holder, of the changes in the risk
85.20 reduction plan, and document that the ~~mandated reporters staff~~ were informed of the changes.

85.21 **EFFECTIVE DATE.** This section is effective September 30, 2019.

85.22 Sec. 19. Minnesota Statutes 2018, section 245C.02, is amended by adding a subdivision
85.23 to read:

85.24 Subd. 5a. **License-exempt child care center certification holder.** "License-exempt
85.25 child care center certification holder" has the meaning given for "certification holder" in
85.26 section 245H.01, subdivision 4.

85.27 Sec. 20. Minnesota Statutes 2018, section 245C.02, subdivision 6a, is amended to read:

85.28 Subd. 6a. **Child care background study subject.** (a) "Child care background study
85.29 subject" means an individual who is affiliated with a licensed child care center, certified

86.1 license exempt child care center, licensed family child care program, or legal nonlicensed
86.2 child care provider authorized under chapter 119B, and who is:

- 86.3 (1) who is employed by a child care provider for compensation;
86.4 (2) whose activities involve assisting in the supervision care of a child for a child care
86.5 provider; or
86.6 (3) who is required to have a background study under section 245C.03, subdivision 1.
86.7 (3) a person applying for licensure, certification, or enrollment;
86.8 (4) a controlling individual as defined in section 245A.02, subdivision 5a;
86.9 (5) an individual 13 years of age or older who lives in the household where the licensed
86.10 program will be provided and who is not receiving licensed services from the program;
86.11 (6) an individual ten to 12 years of age who lives in the household where the licensed
86.12 services will be provided when the commissioner has reasonable cause as defined in section
86.13 245C.02, subdivision 15;
86.14 (7) an individual who, without providing direct contact services at a licensed program,
86.15 certified program, or program authorized under chapter 119B, may have unsupervised access
86.16 to a child receiving services from a program when the commissioner has reasonable cause
86.17 as defined in section 245C.02, subdivision 15; or
86.18 (8) a volunteer, contractor, prospective employee, or other individual who has
86.19 unsupervised physical access to a child served by a program and who is not under direct,
86.20 continuous supervision by an individual listed in clause (1) or (5), regardless of whether
86.21 the individual provides program services.

86.22 (b) Notwithstanding paragraph (a), an individual who is providing services that are not
86.23 part of the child care program is not required to have a background study if:

- 86.24 (1) the child receiving services is signed out of the child care program for the duration
86.25 that the services are provided;
86.26 (2) the licensed program, certified program, or program authorized under chapter 119B
86.27 has obtained advanced written permission from the parent authorizing the child to receive
86.28 the services, which is maintained in the child's record;
86.29 (3) the license holder maintains documentation on-site that identifies the individual
86.30 service provider and the services being provided; and

87.1 (4) the license holder ensures that the service provider does not have unsupervised access
87.2 to a child not receiving the provider's services.

87.3 Sec. 21. Minnesota Statutes 2018, section 245C.03, subdivision 1, is amended to read:

87.4 **Subdivision 1. Licensed programs.** (a) The commissioner shall conduct a background
87.5 study on:

87.6 (1) the person or persons applying for a license;

87.7 (2) an individual age 13 and over living in the household where the licensed program
87.8 will be provided who is not receiving licensed services from the program;

87.9 (3) current or prospective employees or contractors of the applicant who will have direct
87.10 contact with persons served by the facility, agency, or program;

87.11 (4) volunteers or student volunteers who will have direct contact with persons served
87.12 by the program to provide program services if the contact is not under the continuous, direct
87.13 supervision by an individual listed in clause (1) or (3);

87.14 (5) an individual age ten to 12 living in the household where the licensed services will
87.15 be provided when the commissioner has reasonable cause as defined in section 245C.02,
87.16 subdivision 15;

87.17 (6) an individual who, without providing direct contact services at a licensed program,
87.18 may have unsupervised access to children or vulnerable adults receiving services from a
87.19 program, when the commissioner has reasonable cause as defined in section 245C.02,
87.20 subdivision 15;

87.21 (7) all controlling individuals as defined in section 245A.02, subdivision 5a; and

87.22 (8) notwithstanding the other requirements in this subdivision, child care background
87.23 study subjects as defined in section 245C.02, subdivision 6a.

87.24 ~~(b) Paragraph (a), clauses (2), (5), and (6), apply to legal nonlicensed child care and
87.25 certified license-exempt child care programs.~~

87.26 ~~(e)~~ (b) For child foster care when the license holder resides in the home where foster
87.27 care services are provided, a short-term substitute caregiver providing direct contact services
87.28 for a child for less than 72 hours of continuous care is not required to receive a background
87.29 study under this chapter.

88.1 Sec. 22. Minnesota Statutes 2018, section 245C.05, subdivision 5a, is amended to read:

88.2 Subd. 5a. **Background study requirements for minors.** (a) A background study
88.3 completed under this chapter on a subject who is required to be studied under section
88.4 245C.03, subdivision 1, and is 17 years of age or younger shall be completed by the
88.5 commissioner for:

88.6 (1) a legal nonlicensed child care provider authorized under chapter 119B;

88.7 (2) a licensed family child care program; or

88.8 (3) a licensed foster care home.

88.9 (b) The subject shall submit to the commissioner only the information under subdivision
88.10 1, paragraph (a).

88.11 (c) A subject who is 17 years of age or younger is required to submit fingerprints and a
88.12 photograph, and the commissioner shall conduct a national criminal history record check,
88.13 if:

88.14 (1) the commissioner has reasonable cause to require a national criminal history record
88.15 check defined in section 245C.02, subdivision 15a; or

88.16 (2) under paragraph (a), clauses (1) and (2), the subject is employed by the provider or
88.17 supervises children served by the program.

88.18 (d) A subject who is 17 years of age or younger is required to submit
88.19 non-fingerprint-based data according to section 245C.08, subdivision 1, paragraph (a),
88.20 clause (6), item (iii), and the commissioner shall conduct the check if:

88.21 (1) the commissioner has reasonable cause to require a national criminal history record
88.22 check defined in section 245C.02, subdivision 15a; or

88.23 (2) the subject is employed by the provider or supervises children served by the program
88.24 under paragraph (a), clauses (1) and (2).

88.25 Sec. 23. Minnesota Statutes 2018, section 245C.08, subdivision 1, is amended to read:

88.26 Subdivision 1. **Background studies conducted by Department of Human Services.** (a)
88.27 For a background study conducted by the Department of Human Services, the commissioner
88.28 shall review:

88.29 (1) information related to names of substantiated perpetrators of maltreatment of
88.30 vulnerable adults that has been received by the commissioner as required under section
88.31 626.557, subdivision 9c, paragraph (j);

89.1 (2) the commissioner's records relating to the maltreatment of minors in licensed
89.2 programs, and from findings of maltreatment of minors as indicated through the social
89.3 service information system;

89.4 (3) information from juvenile courts as required in subdivision 4 for individuals listed
89.5 in section 245C.03, subdivision 1, paragraph (a), when there is reasonable cause;

89.6 (4) information from the Bureau of Criminal Apprehension, including information
89.7 regarding a background study subject's registration in Minnesota as a predatory offender
89.8 under section 243.166;

89.9 (5) except as provided in clause (6), information received as a result of submission of
89.10 fingerprints for a national criminal history record check, as defined in section 245C.02,
89.11 subdivision 13c, when the commissioner has reasonable cause for a national criminal history
89.12 record check as defined under section 245C.02, subdivision 15a, or as required under section
89.13 144.057, subdivision 1, clause (2);

89.14 (6) for a background study related to a child foster care application for licensure, a
89.15 transfer of permanent legal and physical custody of a child under sections 260C.503 to
89.16 260C.515, or adoptions, and for a background study required for family child care, certified
89.17 license-exempt child care, child care centers, and legal nonlicensed child care authorized
89.18 under chapter 119B, the commissioner shall also review:

89.19 (i) information from the child abuse and neglect registry for any state in which the
89.20 background study subject has resided for the past five years; and

89.21 (ii) when the background study subject is 18 years of age or older, or a minor under
89.22 section 245C.05, subdivision 5a, paragraph (c), information received following submission
89.23 of fingerprints for a national criminal history record check; and

89.24 (iii) when the background study subject is 18 years of age or older or a minor under
89.25 section 245C.05, subdivision 5a, paragraph (d), for licensed family child care, certified
89.26 license-exempt child care, licensed child care centers, and legal nonlicensed child care
89.27 authorized under chapter 119B, information obtained using non-fingerprint-based data
89.28 including information from the criminal and sex offender registries for any state in which
89.29 the background study subject resided for the past five years and information from the national
89.30 crime information database and the national sex offender registry; and

89.31 (7) for a background study required for family child care, certified license-exempt child
89.32 care centers, licensed child care centers, and legal nonlicensed child care authorized under

90.1 chapter 119B, the background study shall also include, to the extent practicable, a name
90.2 and date-of-birth search of the National Sex Offender Public website.

90.3 (b) Notwithstanding expungement by a court, the commissioner may consider information
90.4 obtained under paragraph (a), clauses (3) and (4), unless the commissioner received notice
90.5 of the petition for expungement and the court order for expungement is directed specifically
90.6 to the commissioner.

90.7 (c) The commissioner shall also review criminal case information received according
90.8 to section 245C.04, subdivision 4a, from the Minnesota court information system that relates
90.9 to individuals who have already been studied under this chapter and who remain affiliated
90.10 with the agency that initiated the background study.

90.11 (d) When the commissioner has reasonable cause to believe that the identity of a
90.12 background study subject is uncertain, the commissioner may require the subject to provide
90.13 a set of classifiable fingerprints for purposes of completing a fingerprint-based record check
90.14 with the Bureau of Criminal Apprehension. Fingerprints collected under this paragraph
90.15 shall not be saved by the commissioner after they have been used to verify the identity of
90.16 the background study subject against the particular criminal record in question.

90.17 (e) The commissioner may inform the entity that initiated a background study under
90.18 NETStudy 2.0 of the status of processing of the subject's fingerprints.

90.19 Sec. 24. Minnesota Statutes 2018, section 245C.08, subdivision 3, is amended to read:

90.20 Subd. 3. **Arrest and investigative information.** (a) For any background study completed
90.21 under this section, if the commissioner has reasonable cause to believe the information is
90.22 pertinent to the disqualification of an individual, the commissioner also may review arrest
90.23 and investigative information from:

90.24 (1) the Bureau of Criminal Apprehension;

90.25 (2) the ~~commissioner~~ commissioners of health and human services;

90.26 (3) a county attorney;

90.27 (4) a county sheriff;

90.28 (5) a county agency;

90.29 (6) a local chief of police;

90.30 (7) other states;

90.31 (8) the courts;

91.1 (9) the Federal Bureau of Investigation;

91.2 (10) the National Criminal Records Repository; and

91.3 (11) criminal records from other states.

91.4 (b) Except as required by law, the commissioner is not required to conduct more than
91.5 one review of a subject's records from the Federal Bureau of Investigation if a review of
91.6 the subject's criminal history with the Federal Bureau of Investigation has already been
91.7 completed by the commissioner and there has been no break in the subject's affiliation with
91.8 the ~~license holder who~~ entity that initiated the background study.

91.9 (c) If the commissioner conducts a national criminal history record check when required
91.10 by law and uses the relevant information under paragraph (a), clauses (9) and (10), to make
91.11 a disqualification determination: (1) the data is private and cannot be shared with county
91.12 agencies, private agencies, or prospective employers of the study subject; and (2) the license
91.13 holder or other entity that submitted the study is not required to obtain a copy of the study
91.14 subject's notice of disqualification under section 245C.17, subdivision 3.

91.15 **EFFECTIVE DATE.** This section is effective September 30, 2019.

91.16 Sec. 25. Minnesota Statutes 2018, section 245C.30, subdivision 1, is amended to read:

91.17 **Subdivision 1. License holder and license-exempt child care center certification**

91.18 **holder variance.** (a) Except for any disqualification under section 245C.15, subdivision 1,
91.19 when the commissioner has not set aside a background study subject's disqualification, and
91.20 there are conditions under which the disqualified individual may provide direct contact
91.21 services or have access to people receiving services that minimize the risk of harm to people
91.22 receiving services, the commissioner may grant a time-limited variance to a license holder
91.23 or license-exempt child care center certification holder.

91.24 (b) The variance shall state the reason for the disqualification, the services that may be
91.25 provided by the disqualified individual, and the conditions with which the license holder,
91.26 license-exempt child care center certification holder, or applicant must comply for the
91.27 variance to remain in effect.

91.28 (c) Except for programs licensed to provide family child care, foster care for children
91.29 in the provider's own home, or foster care or day care services for adults in the provider's
91.30 own home, the variance must be requested by the license holder or license-exempt child
91.31 care center certification holder.

91.32 **EFFECTIVE DATE.** This section is effective September 30, 2019.

92.1 Sec. 26. Minnesota Statutes 2018, section 245C.30, subdivision 2, is amended to read:

92.2 **Subd. 2. Disclosure of reason for disqualification.** (a) The commissioner may not grant
92.3 a variance for a disqualified individual unless the applicant, license-exempt child care center
92.4 certification holder, or license holder requests the variance and the disqualified individual
92.5 provides written consent for the commissioner to disclose to the applicant, license-exempt
92.6 child care center certification holder, or license holder the reason for the disqualification.

92.7 (b) This subdivision does not apply to programs licensed to provide family child care
92.8 for children, foster care for children in the provider's own home, or foster care or day care
92.9 services for adults in the provider's own home. When the commissioner grants a variance
92.10 for a disqualified individual in connection with a license to provide the services specified
92.11 in this paragraph, the disqualified individual's consent is not required to disclose the reason
92.12 for the disqualification to the license holder in the variance issued under subdivision 1,
92.13 provided that the commissioner may not disclose the reason for the disqualification if the
92.14 disqualification is based on a felony-level conviction for a drug-related offense within the
92.15 past five years.

92.16 **EFFECTIVE DATE.** This section is effective September 30, 2019.

92.17 Sec. 27. Minnesota Statutes 2018, section 245C.30, subdivision 3, is amended to read:

92.18 **Subd. 3. Consequences for failing to comply with conditions of variance.** When a
92.19 license holder or license-exempt child care center certification holder permits a disqualified
92.20 individual to provide any services for which the subject is disqualified without complying
92.21 with the conditions of the variance, the commissioner may terminate the variance effective
92.22 immediately and subject the license holder to a licensing action under sections 245A.06
92.23 and 245A.07 or a license-exempt child care center certification holder to an action under
92.24 sections 245H.06 and 245H.07.

92.25 **EFFECTIVE DATE.** This section is effective September 30, 2019.

92.26 Sec. 28. Minnesota Statutes 2018, section 245H.01, is amended by adding a subdivision
92.27 to read:

92.28 **Subd. 7. Substitute.** "Substitute" means an adult who is temporarily filling a position
92.29 as a staff person for less than 240 hours total in a calendar year due to the absence of a
92.30 regularly employed staff person who provides direct contact services to a child.

92.31 **EFFECTIVE DATE.** This section is effective September 30, 2019.

93.1 Sec. 29. Minnesota Statutes 2018, section 245H.01, is amended by adding a subdivision
93.2 to read:

93.3 Subd. 8. **Staff person.** "Staff person" means an employee of a certified center who
93.4 provides direct contact services to children.

93.5 **EFFECTIVE DATE.** This section is effective September 30, 2019.

93.6 Sec. 30. Minnesota Statutes 2018, section 245H.01, is amended by adding a subdivision
93.7 to read:

93.8 Subd. 9. **Unsupervised volunteer.** "Unsupervised volunteer" means an individual who:
93.9 (1) assists in the care of a child in care; (2) is not under the continuous direct supervision
93.10 of a staff person; and (3) is not employed by the certified center.

93.11 **EFFECTIVE DATE.** This section is effective September 30, 2019.

93.12 Sec. 31. Minnesota Statutes 2018, section 245H.03, is amended by adding a subdivision
93.13 to read:

93.14 Subd. 4. **Reconsideration of certification denial.** (a) The applicant may request
93.15 reconsideration of the denial by notifying the commissioner by certified mail or personal
93.16 service. The request must be made in writing. If sent by certified mail, the request must be
93.17 postmarked and sent to the commissioner within ten calendar days after the applicant received
93.18 the order. If a request is made by personal service, it must be received by the commissioner
93.19 within ten calendar days after the applicant received the order. The applicant may submit
93.20 with the request for reconsideration a written argument or evidence in support of the request
93.21 for reconsideration.

93.22 (b) The commissioner's disposition of a request for reconsideration is final and not
93.23 subject to appeal under chapter 14.

93.24 **EFFECTIVE DATE.** This section is effective September 30, 2019.

93.25 Sec. 32. Minnesota Statutes 2018, section 245H.07, is amended to read:

93.26 **245H.07 DECERTIFICATION.**

93.27 Subdivision 1. **Generally.** (a) The commissioner may decertify a center if a certification
93.28 holder:

93.29 (1) failed to comply with an applicable law or rule; or

94.1 (2) knowingly withheld relevant information from or gave false or misleading information
94.2 to the commissioner in connection with an application for certification, in connection with
94.3 the background study status of an individual, during an investigation, or regarding compliance
94.4 with applicable laws or rules.

94.5 (b) When considering decertification, the commissioner shall consider the nature,
94.6 chronicity, or severity of the violation of law or rule.

94.7 (c) When a center is decertified, the center is ineligible to receive a child care assistance
94.8 payment.

94.9 Subd. 2. Reconsideration of decertification. (a) The certification holder may request
94.10 reconsideration of the decertification by notifying the commissioner by certified mail or
94.11 personal service. The request must be made in writing. If sent by certified mail, the request
94.12 must be postmarked and sent to the commissioner within ten calendar days after the
94.13 certification holder received the order. If a request is made by personal service, it must be
94.14 received by the commissioner within ten calendar days after the certification holder received
94.15 the order. With the request for reconsideration, the certification holder may submit a written
94.16 argument or evidence in support of the request for reconsideration.

94.17 (b) If the commissioner decertifies a center pursuant to subdivision 1, paragraph (a),
94.18 clause (1), based on a determination that the center was responsible for maltreatment, and
94.19 if the center requests reconsideration of the decertification according to this subdivision
94.20 and appeals the maltreatment determination under section 626.556, subdivision 10i, the
94.21 final decertification determination is stayed until the commissioner issues a final decision
94.22 regarding the maltreatment appeal.

94.23 (c) The commissioner's disposition of a request for reconsideration is final and not subject
94.24 to appeal under chapter 14.

94.25 **EFFECTIVE DATE.** This section is effective September 30, 2019.

94.26 Sec. 33. Minnesota Statutes 2018, section 245H.10, subdivision 1, is amended to read:

94.27 Subdivision 1. **Documentation.** (a) The applicant or certification holder must submit
94.28 and maintain documentation of a completed background study for:

94.29 (1) each person applying for the certification;
94.30 (2) each person identified as a center operator or program operator as defined in section
94.31 245H.01, subdivision 3;

95.1 (3) each current or prospective staff person or contractor of the certified center who will
95.2 have direct contact with a child served by the center;

95.3 (4) each volunteer who has direct contact with a child served by the center if the contact
95.4 is not under the continuous, direct supervision by an individual listed in clause (1), (2), or
95.5 (3); and

95.6 (5) each managerial staff person of the certification holder with oversight and supervision
95.7 of the certified center.

95.8 (b) To be accepted for certification, a background study on every individual in paragraph
95.9 (a), clause (1), must be completed under chapter 245C and result in a not disqualified
95.10 determination under section 245C.14 or a disqualification that was set aside under section
95.11 245C.22 or was issued a variance under section 245C.30.

95.12 **EFFECTIVE DATE.** This section is effective September 30, 2019.

95.13 Sec. 34. Minnesota Statutes 2018, section 245H.11, is amended to read:

95.14 **245H.11 REPORTING.**

95.15 (a) The certification holder must comply and must have written policies for staff to
95.16 comply with the reporting requirements for abuse and neglect specified in section 626.556.
95.17 A person mandated to report physical or sexual child abuse or neglect occurring within a
95.18 certified center shall report the information to the commissioner.

95.19 (b) The certification holder must inform the commissioner within 24 hours of:

95.20 (1) the death of a child in the program; and

95.21 (2) any injury to a child in the program that required treatment by a physician.

95.22 **EFFECTIVE DATE.** This section is effective September 30, 2019.

95.23 Sec. 35. Minnesota Statutes 2018, section 245H.12, is amended to read:

95.24 **245H.12 FEES.**

95.25 The commissioner shall consult with stakeholders to develop an administrative fee to
95.26 implement this chapter. By February 15, 2019, the commissioner shall provide
95.27 recommendations on the amount of an administrative fee to the legislative committees with
95.28 jurisdiction over health and human services policy and finance. A certified center must pay
95.29 an initial application fee of \$200 and an annual nonrefundable renewal fee of \$100.

96.1 **EFFECTIVE DATE.** This section is effective for any center that applies for certification
96.2 or certified center that renews the center's certification to provide services on January 1,
96.3 2020, and thereafter.

96.4 Sec. 36. Minnesota Statutes 2018, section 245H.13, subdivision 5, is amended to read:

96.5 Subd. 5. Building and physical premises; free of hazards. (a) ~~The certified center must document compliance with the State Fire Code by providing To be accepted for certification, the applicant must demonstrate compliance with the State Fire Code, section 299F.011, by either:~~

96.9 (1) 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; or

96.12 (2) complying with the fire marshal inspection requirements according to section 245A.151.

96.14 (b) The certified center must designate a primary indoor and outdoor space used for child care on a facility site floor plan.

96.16 (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.

96.19 (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.

96.22 (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.

96.26 **EFFECTIVE DATE.** This section is effective September 30, 2019.

96.27 Sec. 37. Minnesota Statutes 2018, section 245H.13, is amended by adding a subdivision to read:

96.29 Subd. 7. Risk reduction plan. (a) The certified center must develop a risk reduction plan that identifies risks to children served by the child care center. The assessment of risk must include risks presented by (1) the physical plant where the certified services are

97.1 provided, including electrical hazards; and (2) the environment, including the proximity to
97.2 busy roads and bodies of water.

97.3 (b) The certification holder must establish policies and procedures to minimize identified
97.4 risks. After any change to the risk reduction plan, the certification holder must inform staff
97.5 of the change in the risk reduction plan and document that staff were informed of the change.

97.6 **EFFECTIVE DATE.** This section is effective September 30, 2019.

97.7 Sec. 38. Minnesota Statutes 2018, section 245H.13, is amended by adding a subdivision
97.8 to read:

97.9 Subd. 8. **Required policies.** A certified center must have written policies for health and
97.10 safety items in subdivisions 1 to 6.

97.11 **EFFECTIVE DATE.** This section is effective September 30, 2019.

97.12 Sec. 39. Minnesota Statutes 2018, section 245H.13, is amended by adding a subdivision
97.13 to read:

97.14 Subd. 9. **Behavior guidance.** The certified center must ensure that staff and volunteers
97.15 use positive behavior guidance and do not subject children to:

97.16 (1) corporal punishment, including but not limited to rough handling, shoving, hair
97.17 pulling, ear pulling, shaking, slapping, kicking, biting, pinching, hitting, and spanking;

97.18 (2) humiliation;

97.19 (3) abusive language;

97.20 (4) the use of mechanical restraints, including tying;

97.21 (5) the use of physical restraints other than to physically hold a child when containment
97.22 is necessary to protect a child or others from harm; or

97.23 (6) the withholding or forcing of food and other basic needs.

97.24 **EFFECTIVE DATE.** This section is effective September 30, 2019.

97.25 Sec. 40. Minnesota Statutes 2018, section 245H.13, is amended by adding a subdivision
97.26 to read:

97.27 Subd. 10. **Supervision.** Staff must supervise each child at all times. Staff are responsible
97.28 for the ongoing activity of each child, appropriate visual or auditory awareness, physical
97.29 proximity, and knowledge of activity requirements and each child's needs. Staff must

98.1 intervene when necessary to ensure a child's safety. In determining the appropriate level of
98.2 supervision of a child, staff must consider: (1) the age of a child; (2) individual differences
98.3 and abilities; (3) indoor and outdoor layout of the child care program; and (4) environmental
98.4 circumstances, hazards, and risks.

98.5 **EFFECTIVE DATE.** This section is effective September 30, 2019.

98.6 Sec. 41. Minnesota Statutes 2018, section 245H.14, subdivision 1, is amended to read:

98.7 Subdivision 1. **First aid and cardiopulmonary resuscitation.** ~~At least one designated~~
98.8 ~~staff person who completed pediatric first aid training and pediatric cardiopulmonary~~
98.9 ~~resuscitation (CPR) training must be present at all times at the program, during field trips,~~
98.10 ~~and when transporting a child. The designated staff person must repeat pediatric first aid~~
98.11 ~~training and pediatric CPR training at least once every two years.~~

98.12 (a) Before having unsupervised direct contact with a child, but within the first 90 days
98.13 of employment, the director and all staff persons, including substitutes and unsupervised
98.14 volunteers who have direct contact with a child, must successfully complete pediatric first
98.15 aid and pediatric cardiopulmonary resuscitation (CPR) training, unless the training has been
98.16 completed within the previous two calendar years. Staff must complete the pediatric first
98.17 aid and pediatric CPR training at least every other calendar year and the center must
98.18 document the training in the staff person's personnel record.

98.19 (b) Training completed under this subdivision may be used to meet the in-service training
98.20 requirements under subdivision 6.

98.21 **EFFECTIVE DATE.** This section is effective September 30, 2019.

98.22 Sec. 42. Minnesota Statutes 2018, section 245H.14, subdivision 3, is amended to read:

98.23 Subd. 3. **Abusive head trauma.** A certified center that cares for a child ~~through four~~
98.24 ~~years of age under school age~~ must ensure that ~~the director and all staff persons and~~
98.25 ~~volunteers, including substitutes and unsupervised volunteers,~~ receive training on abusive
98.26 head trauma ~~from shaking infants and young children~~ before assisting in the care of a child
98.27 ~~through four years of age under school age.~~

98.28 **EFFECTIVE DATE.** This section is effective September 30, 2019.

98.29 Sec. 43. Minnesota Statutes 2018, section 245H.14, subdivision 4, is amended to read:

98.30 Subd. 4. **Child development.** The certified center must ensure ~~each staff person completes~~
98.31 ~~at least two hours of~~ that the director and all staff persons, including substitutes and

99.1 ~~unsupervised volunteers, complete child development and learning training within 14~~ 90
99.2 days of employment and ~~annually~~ every second calendar year thereafter. The director and
99.3 staff persons not including substitutes must complete at least two hours of training on child
99.4 development. The training for substitutes and unsupervised volunteers is not required to be
99.5 of a minimum length. For purposes of this subdivision, "child development and learning
99.6 training" means how a child develops physically, cognitively, emotionally, and socially and
99.7 learns as part of the child's family, culture, and community.

99.8 **EFFECTIVE DATE.** This section is effective September 30, 2019.

99.9 Sec. 44. Minnesota Statutes 2018, section 245H.14, subdivision 5, is amended to read:

99.10 Subd. 5. **Orientation.** The certified center must ensure ~~each staff person is the director~~
99.11 and all staff persons, substitutes, and unsupervised volunteers are trained at orientation on
99.12 health and safety requirements in sections 245H.11, 245H.13, 245H.14, and 245H.15. The
99.13 certified center must provide ~~staff with an~~ the orientation within 14 days of employment or
99.14 first date of direct contact with a child, whichever is earlier. Before the completion of
99.15 orientation, ~~a staff person~~ these individuals must be supervised while providing direct care
99.16 to a child.

99.17 **EFFECTIVE DATE.** This section is effective September 30, 2019.

99.18 Sec. 45. Minnesota Statutes 2018, section 245H.14, subdivision 6, is amended to read:

99.19 Subd. 6. **In service.** (a) The certified center must ensure ~~each that the director and all~~
99.20 staff person is persons, including substitutes and unsupervised volunteers, are trained at
99.21 least annually once each calendar year on health and safety requirements in sections 245H.11,
99.22 245H.13, 245H.14, and 245H.15.

99.23 (b) The director and each staff person, not including substitutes, must annually complete
99.24 at least six hours of training each calendar year. Training required under paragraph (a) may
99.25 be used toward the hourly training requirements of this subdivision.

99.26 **EFFECTIVE DATE.** This section is effective September 30, 2019.

99.27 Sec. 46. Minnesota Statutes 2018, section 245H.15, subdivision 1, is amended to read:

99.28 Subdivision 1. **Written emergency plan.** (a) A certified center must have a written
99.29 emergency plan for emergencies that require evacuation, sheltering, or other protection of
99.30 children, such as fire, natural disaster, intruder, or other threatening situation that may pose
99.31 a health or safety hazard to children. The plan must be written on a form developed by the

100.1 commissioner and reviewed and updated at least once each calendar year. The annual review
100.2 of the emergency plan must be documented.

100.3 (b) The plan must include:

100.4 (1) procedures for an evacuation, relocation, shelter-in-place, or lockdown;

100.5 (2) a designated relocation site and evacuation route;

100.6 (3) procedures for notifying a child's parent or legal guardian of the relocation and
100.7 reunification with families;

100.8 (4) accommodations for a child with a disability or a chronic medical condition;

100.9 (5) procedures for storing a child's medically necessary medicine that facilitates easy
100.10 removal during an evacuation or relocation;

100.11 (6) procedures for continuing operations in the period during and after a crisis; and

100.12 (7) procedures for communicating with local emergency management officials, law
100.13 enforcement officials, or other appropriate state or local authorities; and

100.14 (8) accommodations for infants and toddlers.

100.15 (e) ~~The certification holder must have an emergency plan available for review upon~~
100.16 ~~request by the child's parent or legal guardian.~~

100.17 **EFFECTIVE DATE.** This section is effective September 30, 2019.

100.18 Sec. 47. **REPEALER.**

100.19 Minnesota Rules, parts 9502.0425, subparts 4, 16, and 17; and 9503.0155, subpart 8,
100.20 are repealed.

100.21 **EFFECTIVE DATE.** This section is effective September 30, 2019.

100.22 **ARTICLE 3**

100.23 **DIRECT CARE AND TREATMENT**

100.24 Section 1. Minnesota Statutes 2018, section 246B.10, is amended to read:

100.25 **246B.10 LIABILITY OF COUNTY; REIMBURSEMENT.**

100.26 (a) The civilly committed sex offender's county shall pay to the state a portion of the
100.27 cost of care provided in the Minnesota sex offender program to a civilly committed sex
100.28 offender who has legally settled in that county.

101.1 (b) A county's payment must be made from the county's own sources of revenue and
101.2 payments must:

101.3 (1) equal ten percent of the cost of care, as determined by the commissioner, for each
101.4 day or portion of a day that the civilly committed sex offender spends at the facility for
101.5 individuals admitted to the Minnesota sex offender program before August 1, 2011; or

101.6 (2) equal 25 percent of the cost of care, as determined by the commissioner, for each
101.7 day or portion of a day, that the civilly committed sex offender:

101.8 (i) spends at the facility, for individuals admitted to the Minnesota sex offender program
101.9 on or after August 1, 2011; or

101.10 (ii) receives services within a program operated by the Minnesota sex offender program
101.11 while on provisional discharge.

101.12 (c) The county is responsible for paying the state the remaining amount if payments
101.13 received by the state under this chapter exceed:

101.14 (1) 90 percent of the cost of care for individuals admitted to the Minnesota sex offender
101.15 program before August 1, 2011; or

101.16 (2) 75 percent of the cost of care, the county is responsible for paying the state the
101.17 remaining amount for individuals:

101.18 (i) admitted to the Minnesota sex offender program on or after August 1, 2011; or

101.19 (ii) receiving services within a program operated by the Minnesota sex offender program
101.20 while on provisional discharge.

101.21 (d) The county is not entitled to reimbursement from the civilly committed sex offender,
101.22 the civilly committed sex offender's estate, or from the civilly committed sex offender's
101.23 relatives, except as provided in section 246B.07.

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

101.25 Sec. 2. **REPEALER.**

101.26 (a) Minnesota Statutes 2018, section 246.18, subdivisions 8 and 9, are repealed.

101.27 (b) Laws 2010, First Special Session chapter 1, article 25, section 3, subdivision 10, is
101.28 repealed.

ARTICLE 4**CONTINUING CARE FOR OLDER ADULTS**

102.3 Section 1. Minnesota Statutes 2018, section 144.0724, subdivision 4, is amended to read:

102.4 **Subd. 4. Resident assessment schedule.** (a) A facility must conduct and electronically
102.5 submit to the commissioner of health MDS assessments that conform with the assessment
102.6 schedule defined by Code of Federal Regulations, title 42, section 483.20, and published
102.7 by the United States Department of Health and Human Services, Centers for Medicare and
102.8 Medicaid Services, in the Long Term Care Assessment Instrument User's Manual, version
102.9 3.0, and subsequent updates when issued by the Centers for Medicare and Medicaid Services.
102.10 The commissioner of health may substitute successor manuals or question and answer
102.11 documents published by the United States Department of Health and Human Services,
102.12 Centers for Medicare and Medicaid Services, to replace or supplement the current version
102.13 of the manual or document.

102.14 (b) The assessments used to determine a case mix classification for reimbursement
102.15 include the following:

102.16 (1) a new admission assessment;

102.17 (2) an annual assessment which must have an assessment reference date (ARD) within
102.18 92 days of the previous assessment and the previous comprehensive assessment;

102.19 (3) a significant change in status assessment must be completed within 14 days of the
102.20 identification of a significant change, whether improvement or decline, and regardless of
102.21 the amount of time since the last significant change in status assessment; Effective for
102.22 rehabilitation therapy completed on or after January 1, 2020, a facility must complete a
102.23 significant change in status assessment if for any reason all speech, occupational, and
102.24 physical therapies have ended. The ARD of the significant change in status assessment must
102.25 be the eighth day after all speech, occupational, and physical therapies have ended. The last
102.26 day on which rehabilitation therapy was furnished is considered day zero when determining
102.27 the ARD for the significant change in status assessment;

102.28 (4) all quarterly assessments must have an assessment reference date (ARD) within 92
102.29 days of the ARD of the previous assessment;

102.30 (5) any significant correction to a prior comprehensive assessment, if the assessment
102.31 being corrected is the current one being used for RUG classification; and

102.32 (6) any significant correction to a prior quarterly assessment, if the assessment being
102.33 corrected is the current one being used for RUG classification; and

103.1 (7) modifications to the most recent assessment in clauses (1) to (6).

103.2 (c) In addition to the assessments listed in paragraph (b), the assessments used to
103.3 determine nursing facility level of care include the following:

103.4 (1) preadmission screening completed under section 256.975, subdivisions 7a to 7c, by
103.5 the Senior LinkAge Line or other organization under contract with the Minnesota Board on
103.6 Aging; and

103.7 (2) a nursing facility level of care determination as provided for under section 256B.0911,
103.8 subdivision 4e, as part of a face-to-face long-term care consultation assessment completed
103.9 under section 256B.0911, by a county, tribe, or managed care organization under contract
103.10 with the Department of Human Services.

103.11 Sec. 2. Minnesota Statutes 2018, section 144.0724, subdivision 5, is amended to read:

103.12 Subd. 5. **Short stays.** (a) A facility must submit to the commissioner of health an
103.13 admission assessment for all residents who stay in the facility 14 days or less.

103.14 (b) Notwithstanding the admission assessment requirements of paragraph (a), a facility
103.15 may elect to accept a short stay rate with a case mix index of 1.0 for all facility residents
103.16 who stay 14 days or less in lieu of submitting an admission assessment. Facilities shall make
103.17 this election annually.

103.18 (c) Nursing facilities must elect one of the options described in paragraphs (a) and (b)
103.19 by reporting to the commissioner of health, as prescribed by the commissioner. The election
103.20 is effective on July 1 each year.

103.21 (d) An admission assessment is not required regardless of the facility's election status
103.22 when a resident is admitted to and discharged from the facility on the same day.

103.23 **EFFECTIVE DATE.** This section is effective for admissions on or after July 1, 2019.

103.24 Sec. 3. Minnesota Statutes 2018, section 144.0724, subdivision 8, is amended to read:

103.25 Subd. 8. **Request for reconsideration of resident classifications.** (a) The resident, or
103.26 resident's representative, or the nursing facility or boarding care home may request that the
103.27 commissioner of health reconsider the assigned reimbursement classification including any
103.28 items changed during the audit process. The request for reconsideration must be submitted
103.29 in writing to the commissioner within 30 days of the day the resident or the resident's
103.30 representative receives the resident classification notice. The request for reconsideration
103.31 must include the name of the resident, the name and address of the facility in which the

104.1 resident resides, the reasons for the reconsideration, and documentation supporting the
104.2 request. The documentation accompanying the reconsideration request is limited to ~~a copy~~
104.3 ~~of the MDS that determined the classification and other~~ documents that would support or
104.4 change the MDS findings.

104.5 (b) Upon request, the nursing facility must give the resident or the resident's representative
104.6 a copy of the assessment form and the other documentation that was given to the
104.7 commissioner of health to support the assessment findings. The nursing facility shall also
104.8 provide access to and a copy of other information from the resident's record that has been
104.9 requested by or on behalf of the resident to support a resident's reconsideration request. A
104.10 copy of any requested material must be provided within three working days of receipt of a
104.11 written request for the information. Notwithstanding any law to the contrary, the facility
104.12 may not charge a fee for providing copies of the requested documentation. If a facility fails
104.13 to provide the material within this time, it is subject to the issuance of a correction order
104.14 and penalty assessment under sections 144.653 and 144A.10. Notwithstanding those sections,
104.15 any correction order issued under this subdivision must require that the nursing facility
104.16 immediately comply with the request for information and that as of the date of the issuance
104.17 of the correction order, the facility shall forfeit to the state a \$100 fine for the first day of
104.18 noncompliance, and an increase in the \$100 fine by \$50 increments for each day the
104.19 noncompliance continues.

104.20 (c) In addition to the information required under paragraphs (a) and (b), a reconsideration
104.21 request from a nursing facility must contain the following information: (i) the date the
104.22 reimbursement classification notices were received by the facility; (ii) the date the
104.23 classification notices were distributed to the resident or the resident's representative; and
104.24 (iii) a copy of a notice sent to the resident or to the resident's representative. This notice
104.25 must inform the resident or the resident's representative that a reconsideration of the resident's
104.26 classification is being requested, the reason for the request, that the resident's rate will change
104.27 if the request is approved by the commissioner, the extent of the change, that copies of the
104.28 facility's request and supporting documentation are available for review, and that the resident
104.29 also has the right to request a reconsideration. If the facility fails to provide the required
104.30 information listed in item (iii) with the reconsideration request, the commissioner may
104.31 request that the facility provide the information within 14 calendar days. The reconsideration
104.32 request must be denied if the information is then not provided, and the facility may not
104.33 make further reconsideration requests on that specific reimbursement classification.

104.34 (d) Reconsideration by the commissioner must be made by individuals not involved in
104.35 reviewing the assessment, audit, or reconsideration that established the disputed classification.

105.1 The reconsideration must be based upon the assessment that determined the classification
105.2 and upon the information provided to the commissioner under paragraphs (a) and (b). If
105.3 necessary for evaluating the reconsideration request, the commissioner may conduct on-site
105.4 reviews. Within 15 working days of receiving the request for reconsideration, the
105.5 commissioner shall affirm or modify the original resident classification. The original
105.6 classification must be modified if the commissioner determines that the assessment resulting
105.7 in the classification did not accurately reflect characteristics of the resident at the time of
105.8 the assessment. The resident and the nursing facility or boarding care home shall be notified
105.9 within five working days after the decision is made. A decision by the commissioner under
105.10 this subdivision is the final administrative decision of the agency for the party requesting
105.11 reconsideration.

105.12 (e) The resident classification established by the commissioner shall be the classification
105.13 that applies to the resident while the request for reconsideration is pending. If a request for
105.14 reconsideration applies to an assessment used to determine nursing facility level of care
105.15 under subdivision 4, paragraph (c), the resident shall continue to be eligible for nursing
105.16 facility level of care while the request for reconsideration is pending.

105.17 (f) The commissioner may request additional documentation regarding a reconsideration
105.18 necessary to make an accurate reconsideration determination.

105.19 Sec. 4. Minnesota Statutes 2018, section 144A.071, subdivision 1a, is amended to read:

105.20 Subd. 1a. **Definitions.** For purposes of sections 144A.071 to 144A.073, the following
105.21 terms have the meanings given them:

105.22 (a) "Attached fixtures" has the meaning given in Minnesota Rules, part 9549.0020,
105.23 subpart 6.

105.24 (b) "Buildings" "Building" has the meaning given in Minnesota Rules, part 9549.0020,
105.25 subpart 7 section 256R.261, subdivision 4.

105.26 (c) "Capital assets" has the meaning given in section ~~256B.421~~, subdivision 16 ~~256R.02~~,
105.27 subdivision 8.

105.28 (d) "Commenced construction" means that all of the following conditions were met: the
105.29 final working drawings and specifications were approved by the commissioner of health;
105.30 the construction contracts were let; a timely construction schedule was developed, stipulating
105.31 dates for beginning, achieving various stages, and completing construction; and all zoning
105.32 and building permits were applied for.

106.1 (e) "Completion date" means the date on which clearance for the construction project
106.2 is issued, or if a clearance for the construction project is not required, the date on which the
106.3 construction project assets are available for facility use.

106.4 (f) "Construction" means any erection, building, alteration, reconstruction, modernization,
106.5 or improvement necessary to comply with the nursing home licensure rules.

106.6 (g) "Construction project" means:

106.7 (1) a capital asset addition to, or replacement of a nursing home or certified boarding
106.8 care home that results in new space or the remodeling of or renovations to existing facility
106.9 space; and

106.10 (2) the remodeling or renovation of existing facility space the use of which is modified
106.11 as a result of the project described in clause (1). This existing space and the project described
106.12 in clause (1) must be used for the functions as designated on the construction plans on
106.13 completion of the project described in clause (1) for a period of not less than 24 months.

106.14 (h) "Depreciation guidelines" means the most recent publication of "The Estimated
106.15 Useful Lives of Depreciable Hospital Assets," issued by the American Hospital Association,
106.16 840 North Lake Shore Drive, Chicago, Illinois, 60611 has the meaning given in section
106.17 256R.261, subdivision 9.

106.18 (i) "New licensed" or "new certified beds" means:

106.19 (1) newly constructed beds in a facility or the construction of a new facility that would
106.20 increase the total number of licensed nursing home beds or certified boarding care or nursing
106.21 home beds in the state; or

106.22 (2) newly licensed nursing home beds or newly certified boarding care or nursing home
106.23 beds that result from remodeling of the facility that involves relocation of beds but does not
106.24 result in an increase in the total number of beds, except when the project involves the upgrade
106.25 of boarding care beds to nursing home beds, as defined in section 144A.073, subdivision
106.26 1. "Remodeling" includes any of the type of conversion, renovation, replacement, or
106.27 upgrading projects as defined in section 144A.073, subdivision 1.

106.28 (j) "Project construction costs" means the cost of the following items that have a
106.29 completion date within 12 months before or after the completion date of the project described
106.30 in item (g), clause (1):

106.31 (1) facility capital asset additions;

106.32 (2) replacements;

107.1 (3) ~~renovations;~~

107.2 (4) ~~remodeling projects;~~

107.3 (5) ~~construction site preparation costs;~~

107.4 (6) ~~related soft costs;~~ and

107.5 (7) the cost of new technology implemented as part of the construction project and
107.6 depreciable equipment directly identified to the project, if the construction costs for clauses
107.7 (1) to (6) exceed the threshold for additions and replacements stated in section 256B.431,
107.8 subdivision 16. Technology and depreciable equipment shall be included in the project
107.9 construction costs unless a written election is made by the facility, to not include it in the
107.10 facility's appraised value for purposes of Minnesota Rules, part 9549.0020, subpart 5. Debt
107.11 incurred for purchase of technology and depreciable equipment shall be included as allowable
107.12 debt for purposes of Minnesota Rules, part 9549.0060, subpart 5, items A and C, unless the
107.13 written election is to not include it. Any new technology and depreciable equipment included
107.14 in the project construction costs that the facility elects not to include in its appraised value
107.15 and allowable debt shall be treated as provided in section 256B.431, subdivision 17,
107.16 paragraph (b). Written election under this paragraph must be included in the facility's request
107.17 for the rate change related to the project, and this election may not be changed.

107.18 (k) "Technology" means information systems or devices that make documentation,
107.19 charting, and staff time more efficient or encourage and allow for care through alternative
107.20 settings including, but not limited to, touch screens, monitors, hand holds, swipe cards,
107.21 motion detectors, pagers, telemedicine, medication dispensers, and equipment to monitor
107.22 vital signs and self-injections, and to observe skin and other conditions.

107.23 EFFECTIVE DATE. This section is effective January 1, 2020.

107.24 Sec. 5. Minnesota Statutes 2018, section 144A.071, subdivision 2, is amended to read:

107.25 Subd. 2. **Moratorium.** The commissioner of health, in coordination with the
107.26 commissioner of human services, shall deny each request for new licensed or certified
107.27 nursing home or certified boarding care beds except as provided in subdivision 3 or 4a, or
107.28 section 144A.073. "Certified bed" means a nursing home bed or a boarding care bed certified
107.29 by the commissioner of health for the purposes of the medical assistance program, under
107.30 United States Code, title 42, sections 1396 et seq. Certified beds in facilities which do not
107.31 allow medical assistance intake shall be deemed to be decertified for purposes of this section
107.32 only.

108.1 The commissioner of human services, in coordination with the commissioner of health,
108.2 shall deny any request to issue a license under section 252.28 and chapter 245A to a nursing
108.3 home or boarding care home, if that license would result in an increase in the medical
108.4 assistance reimbursement amount.

108.5 In addition, the commissioner of health must not approve any construction project whose
108.6 cost exceeds ~~\$1,000,000~~ \$1,500,000, unless:

108.7 (a) any construction costs exceeding ~~\$1,000,000~~ \$1,500,000 are not added to the facility's
108.8 appraised value and are not included in the facility's payment rate for reimbursement under
108.9 the medical assistance program; or

108.10 (b) the project:

108.11 (1) has been approved through the process described in section 144A.073;

108.12 (2) meets an exception in subdivision 3 or 4a;

108.13 (3) is necessary to correct violations of state or federal law issued by the commissioner
108.14 of health;

108.15 (4) is necessary to repair or replace a portion of the facility that was damaged by fire,
108.16 lightning, ground shifts, or other such hazards, including environmental hazards, provided
108.17 that the provisions of subdivision 4a, clause (a), are met;

108.18 (5) as of May 1, 1992, the facility has submitted to the commissioner of health written
108.19 documentation evidencing that the facility meets the "commenced construction" definition
108.20 as specified in subdivision 1a, paragraph (d), or that substantial steps have been taken prior
108.21 to April 1, 1992, relating to the construction project. "Substantial steps" require that the
108.22 facility has made arrangements with outside parties relating to the construction project and
108.23 include the hiring of an architect or construction firm, submission of preliminary plans to
108.24 the Department of Health or documentation from a financial institution that financing
108.25 arrangements for the construction project have been made; or

108.26 (6) is being proposed by a licensed nursing facility that is not certified to participate in
108.27 the medical assistance program and will not result in new licensed or certified beds.

108.28 Prior to the final plan approval of any construction project, the ~~commissioner~~
108.29 commissioners of health and human services shall be provided with an itemized cost estimate
108.30 for the project construction costs. If a construction project is anticipated to be completed in
108.31 phases, the total estimated cost of all phases of the project shall be submitted to the
108.32 ~~commissioner~~ commissioners and shall be considered as one construction project. Once the
108.33 construction project is completed and prior to the final clearance by the ~~commissioner~~

109.1 commissioners, the total project construction costs for the construction project shall be
109.2 submitted to the ~~e~~commissioner commissioners. If the final project construction cost exceeds
109.3 the dollar threshold in this subdivision, the commissioner of human services shall not
109.4 recognize any of the project construction costs or the related financing costs in excess of
109.5 this threshold in establishing the facility's property-related payment rate.

109.6 The dollar thresholds for construction projects are as follows: for construction projects
109.7 other than those authorized in clauses (1) to (6), the dollar threshold is \$1,000,000. For
109.8 projects authorized after July 1, 1993, under clause (1), the dollar threshold is the cost
109.9 estimate submitted with a proposal for an exception under section 144A.073, plus inflation
109.10 as calculated according to section 256B.431, subdivision 3f, paragraph (a). For projects
109.11 authorized under clauses (2) to (4), the dollar threshold is the itemized estimate project
109.12 construction costs submitted to the commissioner of health at the time of final plan approval,
109.13 plus inflation as calculated according to section 256B.431, subdivision 3f, paragraph (a).

109.14 The commissioner of health shall adopt rules to implement this section or to amend the
109.15 emergency rules for granting exceptions to the moratorium on nursing homes under section
109.16 144A.073.

109.17 Sec. 6. Minnesota Statutes 2018, section 144A.071, subdivision 3, is amended to read:

109.18 **Subd. 3. Exceptions authorizing increase in beds; hardship areas.** (a) The
109.19 commissioner of health, in coordination with the commissioner of human services, may
109.20 approve the addition of new licensed and Medicare and Medicaid certified nursing home
109.21 beds, using the criteria and process set forth in this subdivision.

109.22 (b) The commissioner, in cooperation with the commissioner of human services, shall
109.23 consider the following criteria when determining that an area of the state is a hardship area
109.24 with regard to access to nursing facility services:

109.25 (1) a low number of beds per thousand in a specified area using as a standard the beds
109.26 per thousand people age 65 and older, in five year age groups, using data from the most
109.27 recent census and population projections, weighted by each group's most recent nursing
109.28 home utilization, of the county at the 20th percentile, as determined by the commissioner
109.29 of human services;

109.30 (2) a high level of out-migration for nursing facility services associated with a described
109.31 area from the county or counties of residence to other Minnesota counties, as determined
109.32 by the commissioner of human services, using as a standard an amount greater than the
109.33 out-migration of the county ranked at the 50th percentile;

110.1 (3) an adequate level of availability of noninstitutional long-term care services measured
110.2 as public spending for home and community-based long-term care services per individual
110.3 age 65 and older, in five year age groups, using data from the most recent census and
110.4 population projections, weighted by each group's most recent nursing home utilization, as
110.5 determined by the commissioner of human services using as a standard an amount greater
110.6 than the 50th percentile of counties;

110.7 (4) there must be a declaration of hardship resulting from insufficient access to nursing
110.8 home beds by local county agencies and area agencies on aging; and

110.9 (5) other factors that may demonstrate the need to add new nursing facility beds.

110.10 (c) On August 15 of odd-numbered years, the commissioner, in cooperation with the
110.11 commissioner of human services, may publish in the State Register a request for information
110.12 in which interested parties, using the data provided under section 144A.351, along with any
110.13 other relevant data, demonstrate that a specified area is a hardship area with regard to access
110.14 to nursing facility services. For a response to be considered, the commissioner must receive
110.15 it by November 15. The commissioner shall make responses to the request for information
110.16 available to the public and shall allow 30 days for comment. The commissioner shall review
110.17 responses and comments and determine if any areas of the state are to be declared hardship
110.18 areas.

110.19 (d) For each designated hardship area determined in paragraph (c), the commissioner
110.20 shall publish a request for proposals in accordance with section 144A.073 and Minnesota
110.21 Rules, parts 4655.1070 to 4655.1098. The request for proposals must be published in the
110.22 State Register by March 15 following receipt of responses to the request for information.
110.23 The request for proposals must specify the number of new beds which may be added in the
110.24 designated hardship area, which must not exceed the number which, if added to the existing
110.25 number of beds in the area, including beds in layaway status, would have prevented it from
110.26 being determined to be a hardship area under paragraph (b), clause (1). Beginning July 1,
110.27 2011, the number of new beds approved must not exceed 200 beds statewide per biennium.
110.28 After June 30, 2019, the number of new beds that may be approved in a biennium must not
110.29 exceed 300 statewide. For a proposal to be considered, the commissioner must receive it
110.30 within six months of the publication of the request for proposals. The commissioner shall
110.31 review responses to the request for proposals and shall approve or disapprove each proposal
110.32 by the following July 15, in accordance with section 144A.073 and Minnesota Rules, parts
110.33 4655.1070 to 4655.1098. The commissioner shall base approvals or disapprovals on a
110.34 comparison and ranking of proposals using only the criteria in subdivision 4a. Approval of
110.35 a proposal expires after 18 months unless the facility has added the new beds using existing

111.1 space, subject to approval by the commissioner, or has commenced construction as defined
111.2 in subdivision 1a, paragraph (d). If, after the approved beds have been added, fewer than
111.3 50 percent of the beds in a facility are newly licensed, the operating payment rates previously
111.4 in effect shall remain. If, after the approved beds have been added, 50 percent or more of
111.5 the beds in a facility are newly licensed, operating and external fixed payment rates shall
111.6 be determined according to ~~Minnesota Rules, part 9549.0057, using the limits under sections~~
111.7 ~~256R.23, subdivision 5, and 256R.24, subdivision 3. External fixed costs payment rates~~
111.8 ~~must be determined according to section 256R.25 section 256R.21, subdivision 5. Property~~
111.9 payment rates for facilities with beds added under this subdivision must be determined ~~in~~
111.10 ~~the same manner as rate determinations resulting from projects approved and completed~~
111.11 ~~under section 144A.073 under section 256R.26.~~

111.12 (e) The commissioner may:

111.13 (1) certify or license new beds in a new facility that is to be operated by the commissioner
111.14 of veterans affairs or when the costs of constructing and operating the new beds are to be
111.15 reimbursed by the commissioner of veterans affairs or the United States Veterans
111.16 Administration; and

111.17 (2) license or certify beds in a facility that has been involuntarily delicensed or decertified
111.18 for participation in the medical assistance program, provided that an application for
111.19 licensure or recertification is submitted to the commissioner by an organization that is
111.20 not a related organization as defined in section 256R.02, subdivision 43, to the prior licensee
111.21 within 120 days after delicensure or decertification.

111.22 **EFFECTIVE DATE.** This section is effective January 1, 2020.

111.23 Sec. 7. Minnesota Statutes 2018, section 144A.071, subdivision 4a, is amended to read:

111.24 Subd. 4a. **Exceptions for replacement beds.** It is in the best interest of the state to
111.25 ensure that nursing homes and boarding care homes continue to meet the physical plant
111.26 licensing and certification requirements by permitting certain construction projects. Facilities
111.27 should be maintained in condition to satisfy the physical and emotional needs of residents
111.28 while allowing the state to maintain control over nursing home expenditure growth.

111.29 The commissioner of health in coordination with the commissioner of human services,
111.30 may approve the renovation, replacement, upgrading, or relocation of a nursing home or
111.31 boarding care home, under the following conditions:

112.1 (a) to license or certify beds in a new facility constructed to replace a facility or to make
112.2 repairs in an existing facility that was destroyed or damaged after June 30, 1987, by fire,
112.3 lightning, or other hazard provided:

112.4 (i) destruction was not caused by the intentional act of or at the direction of a controlling
112.5 person of the facility;

112.6 (ii) at the time the facility was destroyed or damaged the controlling persons of the
112.7 facility maintained insurance coverage for the type of hazard that occurred in an amount
112.8 that a reasonable person would conclude was adequate;

112.9 (iii) the net proceeds from an insurance settlement for the damages caused by the hazard
112.10 are applied to the cost of the new facility or repairs;

112.11 (iv) the number of licensed and certified beds in the new facility does not exceed the
112.12 number of licensed and certified beds in the destroyed facility; and

112.13 (v) the commissioner determines that the replacement beds are needed to prevent an
112.14 inadequate supply of beds.

112.15 Project construction costs incurred for repairs authorized under this clause shall not be
112.16 considered in the dollar threshold amount defined in subdivision 2;

112.17 (b) to license or certify beds that are moved from one location to another within a nursing
112.18 home facility, provided the total costs of remodeling performed in conjunction with the
112.19 relocation of beds does not exceed \$1,000,000;

112.20 (c) to license or certify beds in a project recommended for approval under section
112.21 144A.073;

112.22 (d) to license or certify beds that are moved from an existing state nursing home to a
112.23 different state facility, provided there is no net increase in the number of state nursing home
112.24 beds;

112.25 (e) to certify and license as nursing home beds boarding care beds in a certified boarding
112.26 care facility if the beds meet the standards for nursing home licensure, or in a facility that
112.27 was granted an exception to the moratorium under section 144A.073, and if the cost of any
112.28 remodeling of the facility does not exceed \$1,000,000. If boarding care beds are licensed
112.29 as nursing home beds, the number of boarding care beds in the facility must not increase
112.30 beyond the number remaining at the time of the upgrade in licensure. The provisions
112.31 contained in section 144A.073 regarding the upgrading of the facilities do not apply to
112.32 facilities that satisfy these requirements;

113.1 (f) to license and certify up to 40 beds transferred from an existing facility owned and
113.2 operated by the Amherst H. Wilder Foundation in the city of St. Paul to a new unit at the
113.3 same location as the existing facility that will serve persons with Alzheimer's disease and
113.4 other related disorders. The transfer of beds may occur gradually or in stages, provided the
113.5 total number of beds transferred does not exceed 40. At the time of licensure and certification
113.6 of a bed or beds in the new unit, the commissioner of health shall delicense and decertify
113.7 the same number of beds in the existing facility. As a condition of receiving a license or
113.8 certification under this clause, the facility must make a written commitment to the
113.9 commissioner of human services that it will not seek to receive an increase in its
113.10 property-related payment rate as a result of the transfers allowed under this paragraph;

113.11 (g) to license and certify nursing home beds to replace currently licensed and certified
113.12 boarding care beds which may be located either in a remodeled or renovated boarding care
113.13 or nursing home facility or in a remodeled, renovated, newly constructed, or replacement
113.14 nursing home facility within the identifiable complex of health care facilities in which the
113.15 currently licensed boarding care beds are presently located, provided that the number of
113.16 boarding care beds in the facility or complex are decreased by the number to be licensed as
113.17 nursing home beds and further provided that, if the total costs of new construction,
113.18 replacement, remodeling, or renovation exceed ten percent of the appraised value of the
113.19 facility or \$200,000, whichever is less, the facility makes a written commitment to the
113.20 commissioner of human services that it will not seek to receive an increase in its
113.21 property-related payment rate by reason of the new construction, replacement, remodeling,
113.22 or renovation. The provisions contained in section 144A.073 regarding the upgrading of
113.23 facilities do not apply to facilities that satisfy these requirements;

113.24 (h) to license as a nursing home and certify as a nursing facility a facility that is licensed
113.25 as a boarding care facility but not certified under the medical assistance program, but only
113.26 if the commissioner of human services certifies to the commissioner of health that licensing
113.27 the facility as a nursing home and certifying the facility as a nursing facility will result in
113.28 a net annual savings to the state general fund of \$200,000 or more;

113.29 (i) to certify, after September 30, 1992, and prior to July 1, 1993, existing nursing home
113.30 beds in a facility that was licensed and in operation prior to January 1, 1992;

113.31 (j) to license and certify new nursing home beds to replace beds in a facility acquired
113.32 by the Minneapolis Community Development Agency as part of redevelopment activities
113.33 in a city of the first class, provided the new facility is located within three miles of the site
113.34 of the old facility. Operating and property costs for the new facility must be determined and
113.35 allowed under section 256B.431 or 256B.434 or chapter 256R;

114.1 (k) to license and certify up to 20 new nursing home beds in a community-operated
114.2 hospital and attached convalescent and nursing care facility with 40 beds on April 21, 1991,
114.3 that suspended operation of the hospital in April 1986. The commissioner of human services
114.4 shall provide the facility with the same per diem property-related payment rate for each
114.5 additional licensed and certified bed as it will receive for its existing 40 beds;

114.6 (l) to license or certify beds in renovation, replacement, or upgrading projects as defined
114.7 in section 144A.073, subdivision 1, so long as the cumulative total costs of the facility's
114.8 remodeling projects do not exceed \$1,000,000;

114.9 (m) to license and certify beds that are moved from one location to another for the
114.10 purposes of converting up to five four-bed wards to single or double occupancy rooms in
114.11 a nursing home that, as of January 1, 1993, was county-owned and had a licensed capacity
114.12 of 115 beds;

114.13 (n) to allow a facility that on April 16, 1993, was a 106-bed licensed and certified nursing
114.14 facility located in Minneapolis to layaway all of its licensed and certified nursing home
114.15 beds. These beds may be relicensed and recertified in a newly constructed teaching nursing
114.16 home facility affiliated with a teaching hospital upon approval by the legislature. The
114.17 proposal must be developed in consultation with the interagency committee on long-term
114.18 care planning. The beds on layaway status shall have the same status as voluntarily delicensed
114.19 and decertified beds, except that beds on layaway status remain subject to the surcharge in
114.20 section 256.9657. This layaway provision expires July 1, 1998;

114.21 (o) to allow a project which will be completed in conjunction with an approved
114.22 moratorium exception project for a nursing home in southern Cass County and which is
114.23 directly related to that portion of the facility that must be repaired, renovated, or replaced,
114.24 to correct an emergency plumbing problem for which a state correction order has been
114.25 issued and which must be corrected by August 31, 1993;

114.26 (p) to allow a facility that on April 16, 1993, was a 368-bed licensed and certified nursing
114.27 facility located in Minneapolis to layaway, upon 30 days prior written notice to the
114.28 commissioner, up to 30 of the facility's licensed and certified beds by converting three-bed
114.29 wards to single or double occupancy. Beds on layaway status shall have the same status as
114.30 voluntarily delicensed and decertified beds except that beds on layaway status remain subject
114.31 to the surcharge in section 256.9657, remain subject to the license application and renewal
114.32 fees under section 144A.07 and shall be subject to a \$100 per bed reactivation fee. In
114.33 addition, at any time within three years of the effective date of the layaway, the beds on
114.34 layaway status may be:

115.1 (1) relicensed and recertified upon relocation and reactivation of some or all of the beds
115.2 to an existing licensed and certified facility or facilities located in Pine River, Brainerd, or
115.3 International Falls; provided that the total project construction costs related to the relocation
115.4 of beds from layaway status for any facility receiving relocated beds may not exceed the
115.5 dollar threshold provided in subdivision 2 unless the construction project has been approved
115.6 through the moratorium exception process under section 144A.073;

115.7 (2) relicensed and recertified, upon reactivation of some or all of the beds within the
115.8 facility which placed the beds in layaway status, if the commissioner has determined a need
115.9 for the reactivation of the beds on layaway status.

115.10 The property-related payment rate of a facility placing beds on layaway status must be
115.11 adjusted by the incremental change in its rental per diem after recalculating the rental per
115.12 diem as provided in section 256B.431, subdivision 3a, paragraph (c). The property-related
115.13 payment rate for a facility relicensing and recertifying beds from layaway status must be
115.14 adjusted by the incremental change in its rental per diem after recalculating its rental per
115.15 diem using the number of beds after the relicensing to establish the facility's capacity day
115.16 divisor, which shall be effective the first day of the month following the month in which
115.17 the relicensing and recertification became effective. Any beds remaining on layaway status
115.18 more than three years after the date the layaway status became effective must be removed
115.19 from layaway status and immediately delicensed and decertified;

115.20 (q) to license and certify beds in a renovation and remodeling project to convert 12
115.21 four-bed wards into 24 two-bed rooms, expand space, and add improvements in a nursing
115.22 home that, as of January 1, 1994, met the following conditions: the nursing home was located
115.23 in Ramsey County; had a licensed capacity of 154 beds; and had been ranked among the
115.24 top 15 applicants by the 1993 moratorium exceptions advisory review panel. The total
115.25 project construction cost estimate for this project must not exceed the cost estimate submitted
115.26 in connection with the 1993 moratorium exception process;

115.27 (r) to license and certify up to 117 beds that are relocated from a licensed and certified
115.28 138-bed nursing facility located in St. Paul to a hospital with 130 licensed hospital beds
115.29 located in South St. Paul, provided that the nursing facility and hospital are owned by the
115.30 same or a related organization and that prior to the date the relocation is completed the
115.31 hospital ceases operation of its inpatient hospital services at that hospital. After relocation,
115.32 the nursing facility's status shall be the same as it was prior to relocation. The nursing
115.33 facility's property-related payment rate resulting from the project authorized in this paragraph
115.34 shall become effective no earlier than April 1, 1996. For purposes of calculating the
115.35 incremental change in the facility's rental per diem resulting from this project, the allowable

116.1 appraised value of the nursing facility portion of the existing health care facility physical
116.2 plant prior to the renovation and relocation may not exceed \$2,490,000;

116.3 (s) to license and certify two beds in a facility to replace beds that were voluntarily
116.4 delicensed and decertified on June 28, 1991;

116.5 (t) to allow 16 licensed and certified beds located on July 1, 1994, in a 142-bed nursing
116.6 home and 21-bed boarding care home facility in Minneapolis, notwithstanding the licensure
116.7 and certification after July 1, 1995, of the Minneapolis facility as a 147-bed nursing home
116.8 facility after completion of a construction project approved in 1993 under section 144A.073,
116.9 to be laid away upon 30 days' prior written notice to the commissioner. Beds on layaway
116.10 status shall have the same status as voluntarily delicensed or decertified beds except that
116.11 they shall remain subject to the surcharge in section 256.9657. The 16 beds on layaway
116.12 status may be relicensed as nursing home beds and recertified at any time within five years
116.13 of the effective date of the layaway upon relocation of some or all of the beds to a licensed
116.14 and certified facility located in Watertown, provided that the total project construction costs
116.15 related to the relocation of beds from layaway status for the Watertown facility may not
116.16 exceed the dollar threshold provided in subdivision 2 unless the construction project has
116.17 been approved through the moratorium exception process under section 144A.073.

116.18 The property-related payment rate of the facility placing beds on layaway status must
116.19 be adjusted by the incremental change in its rental per diem after recalculating the rental
116.20 per diem as provided in section 256B.431, subdivision 3a, paragraph (c). The property-related
116.21 payment rate for the facility relicensing and recertifying beds from layaway status must be
116.22 adjusted by the incremental change in its rental per diem after recalculating its rental per
116.23 diem using the number of beds after the relicensing to establish the facility's capacity day
116.24 divisor, which shall be effective the first day of the month following the month in which
116.25 the relicensing and recertification became effective. Any beds remaining on layaway status
116.26 more than five years after the date the layaway status became effective must be removed
116.27 from layaway status and immediately delicensed and decertified;

116.28 (u) to license and certify beds that are moved within an existing area of a facility or to
116.29 a newly constructed addition which is built for the purpose of eliminating three- and four-bed
116.30 rooms and adding space for dining, lounge areas, bathing rooms, and ancillary service areas
116.31 in a nursing home that, as of January 1, 1995, was located in Fridley and had a licensed
116.32 capacity of 129 beds;

117.1 (v) to relocate 36 beds in Crow Wing County and four beds from Hennepin County to
117.2 a 160-bed facility in Crow Wing County, provided all the affected beds are under common
117.3 ownership;

117.4 (w) to license and certify a total replacement project of up to 49 beds located in Norman
117.5 County that are relocated from a nursing home destroyed by flood and whose residents were
117.6 relocated to other nursing homes. The operating cost payment rates for the new nursing
117.7 facility shall be determined based on the interim and settle-up payment provisions of
117.8 Minnesota Rules, part 9549.0057, section 256R.27 and the reimbursement provisions of
117.9 chapter 256R. Property-related reimbursement rates shall be determined under section
117.10 256R.26, taking into account any federal or state flood-related loans or grants provided to
117.11 the facility;

117.12 (x) to license and certify to the licensee of a nursing home in Polk County that was
117.13 destroyed by flood in 1997 replacement projects with a total of up to 129 beds, with at least
117.14 25 beds to be located in Polk County and up to 104 beds distributed among up to three other
117.15 counties. These beds may only be distributed to counties with fewer than the median number
117.16 of age intensity adjusted beds per thousand, as most recently published by the commissioner
117.17 of human services. If the licensee chooses to distribute beds outside of Polk County under
117.18 this paragraph, prior to distributing the beds, the commissioner of health must approve the
117.19 location in which the licensee plans to distribute the beds. The commissioner of health shall
117.20 consult with the commissioner of human services prior to approving the location of the
117.21 proposed beds. The licensee may combine these beds with beds relocated from other nursing
117.22 facilities as provided in section 144A.073, subdivision 3c. The operating payment rates for
117.23 the new nursing facilities shall be determined based on the interim and settle-up payment
117.24 provisions of Minnesota Rules, parts 9549.0010 to 9549.0080. Property-related
117.25 reimbursement rates shall be determined under section 256R.26. If the replacement beds
117.26 permitted under this paragraph are combined with beds from other nursing facilities, the
117.27 rates shall be calculated as the weighted average of rates determined as provided in this
117.28 paragraph and section 256R.50;

117.29 (y) to license and certify beds in a renovation and remodeling project to convert 13
117.30 three-bed wards into 13 two-bed rooms and 13 single-bed rooms, expand space, and add
117.31 improvements in a nursing home that, as of January 1, 1994, met the following conditions:
117.32 the nursing home was located in Ramsey County, was not owned by a hospital corporation,
117.33 had a licensed capacity of 64 beds, and had been ranked among the top 15 applicants by
117.34 the 1993 moratorium exceptions advisory review panel. The total project construction cost

118.1 estimate for this project must not exceed the cost estimate submitted in connection with the
118.2 1993 moratorium exception process;

118.3 (z) to license and certify up to 150 nursing home beds to replace an existing 285 bed
118.4 nursing facility located in St. Paul. The replacement project shall include both the renovation
118.5 of existing buildings and the construction of new facilities at the existing site. The reduction
118.6 in the licensed capacity of the existing facility shall occur during the construction project
118.7 as beds are taken out of service due to the construction process. Prior to the start of the
118.8 construction process, the facility shall provide written information to the commissioner of
118.9 health describing the process for bed reduction, plans for the relocation of residents, and
118.10 the estimated construction schedule. The relocation of residents shall be in accordance with
118.11 the provisions of law and rule;

118.12 (aa) to allow the commissioner of human services to license an additional 36 beds to
118.13 provide residential services for the physically disabled under Minnesota Rules, parts
118.14 9570.2000 to 9570.3400, in a 198-bed nursing home located in Red Wing, provided that
118.15 the total number of licensed and certified beds at the facility does not increase;

118.16 (bb) to license and certify a new facility in St. Louis County with 44 beds constructed
118.17 to replace an existing facility in St. Louis County with 31 beds, which has resident rooms
118.18 on two separate floors and an antiquated elevator that creates safety concerns for residents
118.19 and prevents nonambulatory residents from residing on the second floor. The project shall
118.20 include the elimination of three- and four-bed rooms;

118.21 (cc) to license and certify four beds in a 16-bed certified boarding care home in
118.22 Minneapolis to replace beds that were voluntarily delicensed and decertified on or before
118.23 March 31, 1992. The licensure and certification is conditional upon the facility periodically
118.24 assessing and adjusting its resident mix and other factors which may contribute to a potential
118.25 institution for mental disease declaration. The commissioner of human services shall retain
118.26 the authority to audit the facility at any time and shall require the facility to comply with
118.27 any requirements necessary to prevent an institution for mental disease declaration, including
118.28 delicensure and decertification of beds, if necessary;

118.29 (dd) to license and certify 72 beds in an existing facility in Mille Lacs County with 80
118.30 beds as part of a renovation project. The renovation must include construction of an addition
118.31 to accommodate ten residents with beginning and midstage dementia in a self-contained
118.32 living unit; creation of three resident households where dining, activities, and support spaces
118.33 are located near resident living quarters; designation of four beds for rehabilitation in a
118.34 self-contained area; designation of 30 private rooms; and other improvements;

119.1 (ee) to license and certify beds in a facility that has undergone replacement or remodeling
119.2 as part of a planned closure under section 256R.40;

119.3 (ff) to license and certify a total replacement project of up to 124 beds located in Wilkin
119.4 County that are in need of relocation from a nursing home significantly damaged by flood.
119.5 The operating cost payment rates for the new nursing facility shall be determined based on
119.6 the interim and settle-up payment provisions of ~~Minnesota Rules, part 9549.0057, section~~
119.7 256R.27 and the reimbursement provisions of chapter 256R. Property-related reimbursement
119.8 rates shall be determined under section 256R.26, taking into account any federal or state
119.9 flood-related loans or grants provided to the facility;

119.10 (gg) to allow the commissioner of human services to license an additional nine beds to
119.11 provide residential services for the physically disabled under Minnesota Rules, parts
119.12 9570.2000 to 9570.3400, in a 240-bed nursing home located in Duluth, provided that the
119.13 total number of licensed and certified beds at the facility does not increase;

119.14 (hh) to license and certify up to 120 new nursing facility beds to replace beds in a facility
119.15 in Anoka County, which was licensed for 98 beds as of July 1, 2000, provided the new
119.16 facility is located within four miles of the existing facility and is in Anoka County. Operating
119.17 and property rates shall be determined and allowed under chapter 256R and Minnesota
119.18 Rules, parts 9549.0010 to 9549.0080; or

119.19 (ii) to transfer up to 98 beds of a 129-licensed bed facility located in Anoka County that,
119.20 as of March 25, 2001, is in the active process of closing, to a 122-licensed bed nonprofit
119.21 nursing facility located in the city of Columbia Heights or its affiliate. The transfer is effective
119.22 when the receiving facility notifies the commissioner in writing of the number of beds
119.23 accepted. The commissioner shall place all transferred beds on layaway status held in the
119.24 name of the receiving facility. The layaway adjustment provisions of section 256B.431,
119.25 subdivision 30, do not apply to this layaway. The receiving facility may only remove the
119.26 beds from layaway for recertification and relicensure at the receiving facility's current site,
119.27 or at a newly constructed facility located in Anoka County. The receiving facility must
119.28 receive statutory authorization before removing these beds from layaway status, or may
119.29 remove these beds from layaway status if removal from layaway status is part of a
119.30 moratorium exception project approved by the commissioner under section 144A.073.

119.31 Sec. 8. Minnesota Statutes 2018, section 144A.071, subdivision 4c, is amended to read:

119.32 Subd. 4c. **Exceptions for replacement beds after June 30, 2003.** (a) The commissioner
119.33 of health, in coordination with the commissioner of human services, may approve the

120.1 renovation, replacement, upgrading, or relocation of a nursing home or boarding care home,
120.2 under the following conditions:

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

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

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

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

120.25 (4) to license and certify up to 80 beds transferred from an existing state-owned nursing
120.26 facility in Cass County to a new facility located on the grounds of the Ah-Gwah-Ching
120.27 campus. The operating cost payment rates for the new facility shall be determined based
120.28 on the interim and settle-up payment provisions of Minnesota Rules, part 9549.0057, section
120.29 256R.27 and the reimbursement provisions of chapter 256R. The property payment rate for
120.30 the first three years of operation shall be \$35 per day. For subsequent years, the property
120.31 payment rate of \$35 per day shall be adjusted for inflation as provided in section 256B.434,
120.32 subdivision 4, paragraph (c), as long as the facility has a contract under section 256B.434;

120.33 (5) to initiate a pilot program to license and certify up to 80 beds transferred from an
120.34 existing county-owned nursing facility in Steele County relocated to the site of a new acute

121.1 care facility as part of the county's Communities for a Lifetime comprehensive plan to create
121.2 innovative responses to the aging of its population. Upon relocation to the new site, the
121.3 nursing facility shall delicense 28 beds. The payment rate for external fixed costs for the
121.4 new facility shall be increased by an amount as calculated according to items (i) to (v):

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

121.8 (ii) compute the annual savings to the medical assistance program from the delicensure
121.9 of 28 beds by multiplying the anticipated decrease in medical assistance residents, determined
121.10 in item (i), by the existing facility's weighted average payment rate multiplied by 365;

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

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

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

121.19 (6) to consolidate and relocate nursing facility beds to a new site in Goodhue County
121.20 and to integrate these services with other community-based programs and services under a
121.21 communities for a lifetime pilot program and comprehensive plan to create innovative
121.22 responses to the aging of its population. Two nursing facilities, one for 84 beds and one for
121.23 65 beds, in the city of Red Wing licensed on July 1, 2015, shall be consolidated into a newly
121.24 renovated 64-bed nursing facility resulting in the delicensure of 85 beds. Notwithstanding
121.25 the carryforward of the approval authority in section 144A.073, subdivision 11, the funding
121.26 approved in April 2009 by the commissioner of health for a project in Goodhue County
121.27 shall not carry forward. The closure of the 85 beds shall not be eligible for a planned closure
121.28 rate adjustment under section 256R.40. The construction project permitted in this clause
121.29 shall not be eligible for a threshold project rate adjustment under section 256B.434,
121.30 subdivision 4f. The payment rate for external fixed costs for the new facility shall be
121.31 increased by an amount as calculated according to items (i) to (vi):

121.32 (i) compute the estimated decrease in medical assistance residents served by both nursing
121.33 facilities by multiplying the difference between the occupied beds of the two nursing facilities

122.1 for the reporting year ending September 30, 2009, and the projected occupancy of the facility
122.2 at 95 percent occupancy by the historical percentage of medical assistance resident days;

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

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

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

122.12 (v) multiply the amount in item (iv) by 57.2 percent; and

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

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

122.19 Sec. 9. Minnesota Statutes 2018, section 144A.071, subdivision 5a, is amended to read:

122.20 Subd. 5a. **Cost estimate of a moratorium exception project.** (a) For the purposes of
122.21 this section and section 144A.073, the cost estimate of a moratorium exception project shall
122.22 include the effects of the proposed project on the costs of the state subsidy for
122.23 community-based services, nursing services, and housing in institutional and noninstitutional
122.24 settings. The commissioner of health, in cooperation with the commissioner of human
122.25 services, shall define the method for estimating these costs in the permanent rule
122.26 implementing section 144A.073. The commissioner of human services shall prepare an
122.27 estimate of the property-related payment rate to be established upon completion of the
122.28 project and total state annual long-term costs of each moratorium exception proposal. The
122.29 property-related payment rate estimate shall be made using the actual cost of the project
122.30 but the final property rate must be based on the appraisal and subject to the limitations in
122.31 section 256R.26, subdivision 6.

122.32 (b) ~~The interest rate to be used for estimating the cost of each moratorium exception~~
122.33 ~~project proposal shall be the lesser of either the prime rate plus two percentage points, or~~

123.1 ~~the posted yield for standard conventional fixed rate mortgages of the Federal Home Loan
123.2 Mortgage Corporation plus two percentage points as published in the Wall Street Journal
123.3 and in effect 56 days prior to the application deadline. If the applicant's proposal uses this
123.4 interest rate, the commissioner of human services, in determining the facility's actual
123.5 property related payment rate to be established upon completion of the project must use the
123.6 actual interest rate obtained by the facility for the project's permanent financing up to the
123.7 maximum permitted under Minnesota Rules, part 9549.0060, subpart 6.~~

123.8 ~~The applicant may choose an alternate interest rate for estimating the project's cost. If
123.9 the applicant makes this election, the commissioner of human services, in determining the
123.10 facility's actual property related payment rate to be established upon completion of the
123.11 project, must use the lesser of the actual interest rate obtained for the project's permanent
123.12 financing or the interest rate which was used to estimate the proposal's project cost. For
123.13 succeeding rate years, the applicant is at risk for financing costs in excess of the interest
123.14 rate selected.~~

123.15 **EFFECTIVE DATE.** This section is effective January 1, 2020.

123.16 Sec. 10. Minnesota Statutes 2018, section 144A.073, subdivision 3c, is amended to read:

123.17 Subd. 3c. **Cost neutral Relocation projects.** (a) Notwithstanding subdivision 3, the
123.18 commissioner may at any time accept proposals, or amendments to proposals previously
123.19 approved under this section, for relocations ~~that are cost neutral with respect to state costs~~
123.20 ~~as defined in section 144A.071, subdivision 5a.~~ The commissioner, in consultation with the
123.21 commissioner of human services, shall evaluate proposals according to subdivision 4a,
123.22 clauses (1), (4), (5), (6), and (8), and other criteria established in rule or law. ~~The~~
123.23 ~~commissioner of human services shall determine the allowable payment rates of the facility~~
123.24 ~~receiving the beds in accordance with section 256R.50.~~ The commissioner shall approve or
123.25 disapprove a project within 90 days.

123.26 (b) For the purposes of paragraph (a), cost neutrality shall be measured over the first
123.27 three 12-month periods of operation after completion of the project.

123.28 **EFFECTIVE DATE.** This section is effective January 1, 2020.

123.29 Sec. 11. Minnesota Statutes 2018, section 256R.02, subdivision 8, is amended to read:

123.30 Subd. 8. **Capital assets.** "Capital assets" means a nursing facility's buildings, ~~attached~~
123.31 ~~fixtures~~ fixed equipment, land improvements, leasehold improvements, and all additions to
123.32 or replacements of those assets used directly for resident care.

124.1 Sec. 12. Minnesota Statutes 2018, section 256R.02, subdivision 19, is amended to read:

124.2 Subd. 19. **External fixed costs.** "External fixed costs" means costs related to the nursing
124.3 home surcharge under section 256.9657, subdivision 1; licensure fees under section 144.122;
124.4 family advisory council fee under section 144A.33; scholarships under section 256R.37;
124.5 ~~planned closure rate adjustments under section 256R.40; consolidation rate adjustments~~
124.6 ~~under section 144A.071, subdivisions 4c, paragraph (a), clauses (5) and (6), and 4d;~~
124.7 ~~single bed room incentives under section 256R.41; property taxes, special assessments, and~~
124.8 payments in lieu of taxes; employer health insurance costs; quality improvement incentive
124.9 payment rate adjustments under section 256R.39; performance-based incentive payments
124.10 under section 256R.38; special dietary needs under section 256R.51; rate adjustments for
124.11 compensation-related costs for minimum wage changes under section 256R.49 provided
124.12 on or after January 1, 2018; and Public Employees Retirement Association employer costs.

124.13 **EFFECTIVE DATE.** This section is effective January 1, 2020.

124.14 Sec. 13. Minnesota Statutes 2018, section 256R.16, subdivision 1, is amended to read:

124.15 Subdivision 1. **Calculation of a quality score.** (a) The commissioner shall determine
124.16 a quality score for each nursing facility using quality measures established in section
124.17 256B.439, according to methods determined by the commissioner in consultation with
124.18 stakeholders and experts, and using the most recently available data as provided in the
124.19 Minnesota Nursing Home Report Card. These methods shall be exempt from the rulemaking
124.20 requirements under chapter 14.

124.21 (b) For each quality measure, a score shall be determined with the number of points
124.22 assigned as determined by the commissioner using the methodology established according
124.23 to this subdivision. The determination of the quality measures to be used and the methods
124.24 of calculating scores may be revised annually by the commissioner.

124.25 (c) The quality score shall include up to 50 points related to the Minnesota quality
124.26 indicators score derived from the minimum data set, up to 40 points related to the resident
124.27 quality of life score derived from the consumer survey conducted under section 256B.439,
124.28 subdivision 3, and up to ten points related to the state inspection results score.

124.29 (d) The commissioner, in cooperation with the commissioner of health, may adjust the
124.30 formula in paragraph (c), or the methodology for computing the total quality score, ~~effective~~
124.31 ~~July 1 of any year~~, with five months advance public notice. In changing the formula, the
124.32 commissioner shall consider quality measure priorities registered by report card users, advice
124.33 of stakeholders, and available research.

125.1 Sec. 14. Minnesota Statutes 2018, section 256R.21, is amended by adding a subdivision
125.2 to read:

125.3 **Subd. 5. Total payment rate for new facilities.** For a new nursing facility created under
125.4 section 144A.073, subdivision 3c, the total payment rate must be determined according to
125.5 this section, except:

125.6 (1) the direct care payment rate used in subdivision 2, clause (1), must be determined
125.7 according to section 256R.27;

125.8 (2) the other care-related payment rate used in subdivision 2, clause (2), must be
125.9 determined according to section 256R.27;

125.10 (3) the external fixed costs payment rate used in subdivision 4, clause (2), must be
125.11 determined according to section 256R.27; and

125.12 (4) the property payment rate used in subdivision 4, clause (3), must be determined
125.13 according to section 256R.26.

125.14 **EFFECTIVE DATE.** This section is effective January 1, 2020.

125.15 Sec. 15. Minnesota Statutes 2018, section 256R.23, subdivision 5, is amended to read:

125.16 **Subd. 5. Determination of total care-related payment rate limits.** The commissioner
125.17 must determine each facility's total care-related payment rate limit by:

125.18 (1) multiplying the facility's quality score, as determined under section 256R.16,
125.19 subdivision 1, paragraph (d), by 0.5625 2.0;

125.20 (2) adding 89.375 to subtracting 40.0 from the amount determined in clause (1), and
125.21 dividing the total by 100; and

125.22 (3) multiplying the amount determined in clause (2) by the median total care-related
125.23 cost per day; and

125.24 (4) multiplying the amount determined in clause (3) by the most-recent available
125.25 Core-Based Statistical Area wage indices established by the Centers for Medicare and
125.26 Medicaid Services for the Skilled Nursing Facility Prospective Payment System.

125.27 **EFFECTIVE DATE.** This section is effective January 1, 2020.

125.28 Sec. 16. Minnesota Statutes 2018, section 256R.24, subdivision 3, is amended to read:

125.29 **Subd. 3. Determination of the other operating payment rate.** A facility's other
125.30 operating payment rate equals the lesser of (1) 105 percent of the median other operating

126.1 cost per day as determined by subdivisions 1 and 2, or (2) the prior year operating payment
126.2 rate adjusted by a forecasting market basket and forecasting index. The adjustment factor
126.3 shall come from the Information Handling Services Healthcare Cost Review, the Skilled
126.4 Nursing Facility Total Market Basket Index, and the four-quarter moving average percentage
126.5 change line or a comparable index if this index ceases to be published. The commissioner
126.6 shall use the fourth quarter index of the upcoming calendar year from the forecast published
126.7 for the third quarter of the calendar year immediately prior to the rate year for which the
126.8 rate is being determined.

126.9 Sec. 17. Minnesota Statutes 2018, section 256R.25, is amended to read:

126.10 **256R.25 EXTERNAL FIXED COSTS PAYMENT RATE.**

126.11 (a) The payment rate for external fixed costs is the sum of the amounts in paragraphs
126.12 (b) to ~~(n)~~ (k).

126.13 (b) For a facility licensed as a nursing home, the portion related to the provider surcharge
126.14 under section 256.9657 is equal to \$8.86 per resident day. For a facility licensed as both a
126.15 nursing home and a boarding care home, the portion related to the provider surcharge under
126.16 section 256.9657 is equal to \$8.86 per resident day multiplied by the result of its number
126.17 of nursing home beds divided by its total number of licensed beds.

126.18 (c) The portion related to the licensure fee under section 144.122, paragraph (d), is the
126.19 amount of the fee divided by the sum of the facility's resident days.

126.20 (d) The portion related to development and education of resident and family advisory
126.21 councils under section 144A.33 is \$5 per resident day divided by 365.

126.22 (e) The portion related to scholarships is determined under section 256R.37.

126.23 ~~(f) The portion related to planned closure rate adjustments is as determined under section~~
126.24 ~~256R.40, subdivision 5, and Minnesota Statutes 2010, section 256B.436.~~

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

126.27 ~~(h) The portion related to single bed room incentives is as determined under section~~
126.28 ~~256R.41.~~

126.29 ~~(i) (f) The portions related to real estate taxes, special assessments, and payments made~~
126.30 ~~in lieu of real estate taxes directly identified or allocated to the nursing facility are the actual~~
126.31 ~~allowable amounts divided by the sum of the facility's resident days. Allowable costs under~~
126.32 ~~this paragraph for payments made by a nonprofit nursing facility that are in lieu of real~~

127.1 estate taxes shall not exceed the amount which the nursing facility would have paid to a
127.2 city or township and county for fire, police, sanitation services, and road maintenance costs
127.3 had real estate taxes been levied on that property for those purposes.

127.4 ~~(f)~~ (g) The portion related to employer health insurance costs is the allowable costs
127.5 divided by the sum of the facility's resident days.

127.6 ~~(k)~~ (h) The portion related to the Public Employees Retirement Association is ~~actual~~
127.7 allowable costs divided by the sum of the facility's resident days.

127.8 ~~(f)~~ (i) The portion related to quality improvement incentive payment rate adjustments
127.9 is the amount determined under section 256R.39.

127.10 ~~(m)~~ (j) The portion related to performance-based incentive payments is the amount
127.11 determined under section 256R.38.

127.12 ~~(n)~~ (k) The portion related to special dietary needs is the amount determined under
127.13 section 256R.51.

127.14 **EFFECTIVE DATE.** This section is effective January, 1, 2020.

127.15 Sec. 18. Minnesota Statutes 2018, section 256R.26, is amended to read:

127.16 **256R.26 PROPERTY PAYMENT RATE.**

127.17 Subdivision 1. Generally. The property payment rate for a nursing facility is the property
127.18 rate established for the facility under sections 256B.431 and 256B.434. (a) For rate years
127.19 beginning on or after January 1, 2020, the commissioner shall reimburse nursing facilities
127.20 participating in the medical assistance program for the rental use of real estate and depreciable
127.21 assets according to this section and sections 256R.261 to 256R.27. The property payment
127.22 rate made under this methodology is the only payment for costs related to capital assets,
127.23 including depreciation, interest and lease expenses for all depreciable assets, also including
127.24 movable equipment, land improvements, and land.

127.25 (b) The commercial valuation system selected by the commissioner must be utilized in
127.26 all appraisals. The appraisal is not intended to exactly reflect market value, and no
127.27 adjustments or substitutions are permitted for any alternative analysis of properties than the
127.28 selected commercial valuation system.

127.29 (c) Based on the valuation of a building and fixed equipment, the property appraisal
127.30 firm selected by the commissioner must produce a report detailing both the depreciated
127.31 replacement cost (DRC) and undepreciated replacement cost (URC) of the nursing facility.
127.32 The valuation excludes movable equipment, land, or land improvements. The valuation

128.1 must be adjusted for any shared area included in the DRC and URC not used for nursing
128.2 facility purposes. Physical plant for central office operations is not included in the appraisal.

128.3 (d) The appraisal initially may include the full value of all shared areas. The DRC, URC,
128.4 and square footage are established by an appraisal and must be adjusted to reflect only the
128.5 nursing facility usage of shared areas in the final nursing facility values. The adjustment
128.6 must be based on a Medicare-approved allocation basis for the type of service provided by
128.7 each area. Shared areas outside the appraised space must be added to the DRC, URC, and
128.8 related square footage using the average of each value from the space in the appraisal.

128.9 Subd. 2. **Appraised value.** For rate years beginning on or after January 1, 2020, the
128.10 DRC and URC are based on the appraisals of a building and attached fixtures as determined
128.11 by the contracted property appraisal firm using a commercial valuation system selected by
128.12 the commissioner.

128.13 Subd. 3. **Initial rate year.** The property payment rate calculated under section 256R.265
128.14 for the initial rate year effective January 1, 2020, must be a per diem amount based on the
128.15 DRC and URC of a nursing facility's building and attached fixtures, as estimated by a
128.16 commercial property appraisal firm in 2016. The initial values for both the DRC and URC,
128.17 adjusted for nonnursing facility space, must be increased by six percent.

128.18 Subd. 4. **Subsequent rate years.** (a) Beginning in calendar year 2020, the commissioner
128.19 shall contract with a property appraisal firm to appraise the building and attached fixtures
128.20 for nursing facilities using the commercial valuation system. Approximately one-third of
128.21 the nursing facilities must be appraised each year.

128.22 (b) If a nursing facility wishes to appeal findings of fact in the appraisal report, the
128.23 nursing facility must request a revision within 20 calendar days after receipt of the appraisal
128.24 report.

128.25 (c) The property payment rate for rate year beginning January 1, 2021, for the one-third
128.26 of nursing facilities that are newly appraised in 2020 must be based upon new DRCs and
128.27 URCs for buildings and attached fixtures as determined by the contracted property appraisal
128.28 firm.

128.29 (d) The property payment rate for rate years beginning January 1, 2021, and January 1,
128.30 2022, for the remainder of the nursing facilities that were not previously appraised, must
128.31 use the net DRC and URC used in the January 1, 2020, property payment rates adjusted for
128.32 inflation before any formula limitations are applied. The index for the inflation adjustment
128.33 must be based on the change in the United States All-Items Consumer Price Index (CPI-U)
128.34 forecasted by the Reports and Forecasts Division of the Department of Human Services in

129.1 the third quarter of the calendar year preceding the rate year. The inflation adjustment must
129.2 be based on the 12-month period from the midpoint of the previous rate year to the midpoint
129.3 of the rate year for which the rate is being determined. Nursing facilities under this paragraph
129.4 must have the property payment rates beginning January 1, 2022, and January 1, 2023,
129.5 based on new replacement costs and depreciated values as determined in appraisals based
129.6 on the three-year cycle.

129.7 (e) For the nursing facility's new physical appraisal after the nursing facility's 2016
129.8 appraisal, the most recent DRC and URC must be updated through the commercial valuation
129.9 system. These valuations are updates only and not subject to revisions of any of the original
129.10 valuations or appeal by the nursing facility.

129.11 Subd. 5. Special reappraisals. (a) A nursing facility that completes an addition to or
129.12 replacement of a building or attached fixtures as approved in section 144A.073 after January
129.13 1, 2020, may request a property rate adjustment effective the first of January, April, July,
129.14 or October after project completion. The nursing facility must submit all cost data related
129.15 to the project to the commissioner within 90 days of project completion. The commissioner
129.16 must add the nursing facility to the next group of scheduled appraisals. The nursing facility's
129.17 updated appraisal must be used to calculate a revised property rate effective the first of
129.18 January, April, July, or October after project completion. If an updated appraisal cannot be
129.19 scheduled within 90 days of the effective date of the revised property, the commissioner
129.20 must establish an interim valuation which must be adjusted retroactively when the updated
129.21 appraisal is available. For a nursing facility with projects approved under section 144A.073
129.22 prior to January 1, 2020, moratorium project construction adjustments must be calculated
129.23 under Minnesota Statutes 2018, section 256B.434, subdivision 4f, and the adjustment added
129.24 to the nursing facility's hold harmless rate effective the first of January, April, July, or
129.25 October after project completion. This adjustment is in addition to the updated appraisal
129.26 described in this paragraph.

129.27 (b) A nursing facility that completes a threshold construction project after January 1,
129.28 2020, may submit a project rate adjustment request to the commissioner if the building
129.29 improvement or addition costs exceed \$300,000 and the threshold construction project is
129.30 not reflected in an appraisal used for rate setting. The cost must be incurred by the nursing
129.31 facility, or if the nursing facility is leased and the cost is incurred by the lease holder, the
129.32 provider's lease has been increased for the project. Threshold project costs exceeding a total
129.33 of \$1,500,000 within a three-year period, or a prorated amount if the appraisals are less than
129.34 three years apart, must not be recognized. The property payment rate must be updated to
129.35 reflect the new DRC and URC values effective the first of January or July after project

130.1 completion. In subsequent property payment rate calculations, an addition to the DRC and
130.2 URC must be eliminated once a full appraisal is complete for the nursing facility after project
130.3 completion. At the option of the commissioner the appraisal schedule may be adjusted for
130.4 nursing facilities completing threshold projects. Threshold project costs are not considered
130.5 if the costs were incurred prior to the date of the last appraisal.

130.6 (c) Effective January 1, 2020, a nursing facility new to the medical assistance program
130.7 must have the building and fixed equipment appraised by the property appraisal firm upon
130.8 completion of construction of the nursing facility, or, if not newly constructed, upon entering
130.9 the medical assistance program. If an appraisal cannot be scheduled within 90 days of the
130.10 certification date, the commissioner must establish an interim valuation to be adjusted
130.11 retroactively when the appraisal is available.

130.12 Subd. 6. **Limitation on appraisal valuations.** Effective for appraisals conducted on or
130.13 after January 1, 2020, the increase in the URC is limited to \$500,000 per year since the last
130.14 completed appraisal plus any completed project costs approved under section 144A.073.
130.15 Any limitation to the URC must be applied in the same proportion to the DRC.

130.16 Subd. 7. **Total hold harmless rate.** (a) Total hold harmless rate includes closure
130.17 adjustments under Minnesota Statutes 2018, section 256R.40, subdivision 5; consolidation
130.18 adjustments under section 144A.071, subdivisions 4c, paragraph (a), clauses (5) and (6),
130.19 and 4d; equity incentives under sections 256B.431, subdivision 16, and Minnesota Statutes
130.20 2018, 256B.434, subdivision 4f; single-bed incentives under Minnesota Statutes 2018,
130.21 section 256R.41; project construction costs under Minnesota Statutes 2018, section 144A.071,
130.22 subdivision 1a, paragraph (j); and all components of the property payment rate under section
130.23 256R.26 in effect on December 31, 2019.

130.24 (b) For moratorium projects as defined under sections 144A.071 and 144A.073 that are
130.25 eligible for rate adjustments approved prior to January 1, 2020, but not reflected in the rate
130.26 on December 31, 2019, the moratorium rate adjustments determined under Minnesota
130.27 Statutes 2018, sections 256B.431, subdivisions 3f, 17, 17a, 17c, 17d, 17e, 21, 30, and 45,
130.28 and 256B.434, subdivisions 4f and 4j, must be added to the total hold harmless rate in effect
130.29 on the first of January, April, July, or October after project completion.

130.30 (c) Effective January 1, 2020, rate adjustments under Minnesota Statutes 2018, section
130.31 256R.25, paragraphs (f) to (h) from previous rate years shall be included in the total hold
130.32 harmless rate.

130.33 Subd. 8. **Phase out of hold harmless rate.** (a) For a nursing facility that has a higher
130.34 total hold harmless rate than the rate calculated in section 256R.265, the nursing facility

131.1 must receive 100 percent of the total hold harmless rate for the rate year beginning January
131.2 1, 2020.

131.3 (b) For rate years beginning January 1, 2021, to January 1, 2024, the property payment
131.4 rate is a blending of the total hold harmless rate and the property rate determined in section
131.5 256R.265, plus any adjustments issued for construction projects between appraisals, if a
131.6 higher rate results. If not, the property payment rate is determined according to section
131.7 256R.265.

131.8 (c) For the rate year beginning January 1, 2021, for eligible nursing facilities, the property
131.9 payment rate is 80 percent of the total hold harmless rate and 20 percent of the property
131.10 payment rate calculated in section 256R.265.

131.11 (d) For the rate year beginning January 1, 2022, for eligible nursing facilities, the property
131.12 payment rate is 60 percent of the total hold harmless rate and 40 percent of the property
131.13 payment rate calculated in section 256R.265.

131.14 (e) For the rate year beginning January 1, 2023, for eligible nursing facilities, the property
131.15 payment rate is 40 percent of the total hold harmless rate and 60 percent of the property
131.16 payment rate calculated in section 256R.265.

131.17 (f) For the rate year beginning January 1, 2024, for eligible nursing facilities, the property
131.18 payment rate is 20 percent of the total hold harmless rate and 80 percent of the property
131.19 payment rate calculated in section 256R.265.

131.20 (g) For rate years beginning January 1, 2025, and thereafter, the property payment rate
131.21 is as calculated under section 256R.265.

131.22 Sec. 19. **[256R.261] NURSING FACILITY PROPERTY RATE DEFINITIONS.**

131.23 Subdivision 1. **Definitions.** For purposes of sections 256R.26 to 256R.27, the following
131.24 terms have the meanings given them.

131.25 Subd. 2. **Addition.** "Addition" means an extension, enlargement, or expansion of the
131.26 nursing facility for the purpose of increasing the number of licensed beds or improving
131.27 resident care.

131.28 Subd. 3. **Appraisal.** "Appraisal" means an evaluation of the nursing facility's physical
131.29 real estate conducted by a property appraisal firm selected by the commissioner to establish
131.30 the valuation of a building and fixed equipment.

132.1 Subd. 4. **Building.** "Building" means the physical plant and fixed equipment used directly
132.2 for resident care and licensed under chapter 144A or sections 144.50 to 144.56. Building
132.3 excludes buildings or portions of buildings used by central, affiliated, or corporate offices.

132.4 Subd. 5. **Commercial valuation system.** "Commercial valuation system" means a
132.5 commercially available building valuation system selected by the commissioner that may
132.6 include the Marshall and Swift Valuation System.

132.7 Subd. 6. **Depreciable movable equipment.** "Depreciable movable equipment" means
132.8 the standard movable care equipment and support service equipment generally used in
132.9 nursing facilities. Depreciable movable equipment includes equipment specified in the major
132.10 movable equipment table of the depreciation guidelines. The general characteristics of this
132.11 equipment are: (1) a relatively fixed location in the building; (2) capable of being moved
132.12 as distinguished from building equipment; (3) a unit cost sufficient to justify ledger control;
132.13 and (4) sufficient size and identity to make control feasible by means of identification tags.

132.14 Subd. 7. **Depreciated replacement cost or DRC.** "Depreciated replacement cost" or
132.15 "DRC" means the depreciated replacement cost determined by an appraisal using the
132.16 commercial valuation system. DRC excludes costs related to parking structures.

132.17 Subd. 8. **Depreciation expense.** "Depreciation expense" means the portion of a capital
132.18 asset deemed to be consumed or expired over the life of the asset.

132.19 Subd. 9. **Depreciation guidelines.** "Depreciation guidelines" means the most recent
132.20 publication of "Estimated Useful Lives of Depreciable Hospital Assets" issued by the
132.21 American Hospital Association.

132.22 Subd. 10. **Equipment allowance.** "Equipment allowance" means the component of the
132.23 property-related payment rate which is a payment for the use of depreciable movable
132.24 equipment.

132.25 Subd. 11. **Fair rental value system.** "Fair rental value system" means a system that
132.26 establishes a price for the use of a space based on an appraised value of the property. The
132.27 price is established without consideration of the actual accounting cost to construct or
132.28 remodel the property. The price is the nursing facility value, subject to limits, multiplied
132.29 by an established rental rate.

132.30 Subd. 12. **Fixed equipment.** "Fixed equipment" means equipment affixed to the building
132.31 and not subject to transfer, including but not limited to wiring, electrical fixtures, plumbing,
132.32 elevators, and heating and air conditioning systems.

133.1 Subd. 13. **Land improvement.** "Land improvement" means improvement to the land
133.2 surrounding the nursing facility directly used for nursing facility operations as specified in
133.3 the land improvements table of the depreciation guidelines. Land improvement includes
133.4 construction of auxiliary buildings including sheds, garages, storage buildings, and parking
133.5 structures.

133.6 Subd. 14. **Rental rate.** "Rental rate" means the percentage applied to the allowable value
133.7 of the building and attached fixtures per year in the property payment calculation as
133.8 determined by the commissioner.

133.9 Subd. 15. **Shared area.** "Shared area" means square footage that a nursing facility shares
133.10 with a non-nursing facility operation to provide a support service.

133.11 Subd. 16. **Threshold project.** "Threshold project" means additions to a building or fixed
133.12 equipment that exceed the costs specified in section 256R.26, subdivision 5, paragraph (b).
133.13 Threshold projects exclude land, land improvements, and movable equipment purchases.

133.14 Subd. 17. **Undepreciated replacement cost or URC.** "Undepreciated replacement cost"
133.15 or "URC" means the undepreciated replacement cost determined by the appraisal for building
133.16 and attached fixtures using a commercial valuation system. URC excludes costs related to
133.17 parking structures.

133.18 Subd. 18. **Undepreciated replacement cost (URC) per bed limit.** "Undepreciated
133.19 replacement cost (URC) per bed limit" means the maximum allowed URC per nursing
133.20 facility bed as established by the commissioner based on values across the industry and
133.21 compared to an industry standard for reasonableness.

133.22 **Sec. 20. [256R.265] PROPERTY RATE CALCULATION UNDER FAIR RENTAL
133.23 VALUE SYSTEM.**

133.24 Subdivision 1. **Square feet per bed limit.** The square feet per bed limit is calculated as
133.25 follows:

133.26 (1) the URC of the nursing facility from the appraisal is divided by the allowable nursing
133.27 facility square feet;

133.28 (2) the allowable total square feet is calculated by dividing the actual square feet from
133.29 the appraisal, after adjustment for non-nursing facility area, by the number of licensed beds
133.30 three months prior to the beginning of the rate year limited to the following maximum. The
133.31 allowable square feet maximum is 800 square feet per bed plus 25 percent of the square
133.32 feet over 800 up to 1,200 square feet per bed. Square feet over 1,200 square feet per bed is
133.33 not recognized; and

134.1 (3) the allowable total square feet in clause (2) is multiplied by the amount in clause (1)
134.2 and by the number of licensed beds three months prior to the beginning of the rate year to
134.3 determine the square feet per bed limit.

134.4 **Subd. 2. Total URC limit.** The total URC limit is calculated as follows:

134.5 (1) the allowable square feet per bed limit as determined in subdivision 1 is divided by
134.6 the number of licensed beds three months prior to the beginning of the rate year to determine
134.7 allowable URC per bed limit for each nursing facility, adjusted for square feet limitation;

134.8 (2) the allowable URC per bed limit, adjusted for square feet limitation, for all nursing
134.9 facilities is placed in an array annually to determine the value at the 75th percentile. This
134.10 is the limit for URC per bed limit for non-single beds;

134.11 (3) the value determined in clause (2) is multiplied by 115 percent to determine the limit
134.12 for URC per bed limit for single beds;

134.13 (4) the number of non-single-licensed beds three months prior to the beginning of the
134.14 rate year is multiplied by the amount in clause (2);

134.15 (5) the number of single-licensed beds three months prior to the beginning of the rate
134.16 year is multiplied by the amount in clause (3); and

134.17 (6) the amounts in clauses (4) and (5) are summed to determine the total URC limit;

134.18 **Subd. 3. Calculation of total property rate.** The total property rate is calculated as
134.19 follows:

134.20 (1) the lower of the allowable URC based on square feet per bed limit as determined
134.21 under subdivision 1 or the total URC limit in subdivision 2 is the final allowed URC;

134.22 (2) the final allowed URC determined in clause (1) is divided by the URC from the
134.23 appraisal to determine the allowed percentage. The allowed percentage is multiplied by the
134.24 depreciated replacement value from the appraisal, adjusted for non-nursing facility area, to
134.25 determine the final allowed depreciated replacement value;

134.26 (3) the number of licensed beds three months prior to the beginning of the rate year is
134.27 multiplied by \$5,305 to determine reimbursement for land and land improvements. There
134.28 is no separate addition to the property rate for parking structures;

134.29 (4) the values in clauses (2) and (3) are summed and then multiplied by the rental rate
134.30 of 5.5 percent to determine allowable property reimbursement;

134.31 (5) the allowable property reimbursement determined in clause (4) is divided by 90
134.32 percent of capacity days to determine the building property rate. Capacity days are determined

135.1 by multiplying the number of licensed beds three months prior to the beginning of the report
135.2 year by 365;

135.3 (6) for the rate year beginning January 1, 2020, the equipment allowance is \$2.77 per
135.4 resident day. For the rate year beginning January 1, 2021, the equipment allowance must
135.5 be adjusted annually for inflation. The index for the inflation adjustment must be based on
135.6 the change in the United States All Items Consumer Price Index (CPI-U) forecasted by the
135.7 Reports and Forecasts Division of the Department of Human Services in the third quarter
135.8 of the calendar year preceding the rate year. The inflation adjustment must be based on the
135.9 12-month period from the midpoint of the previous rate year to the midpoint of the rate year
135.10 for which the rate is being determined; and

135.11 (7) the sum of the building property rate and the equipment allowance is the total property
135.12 rate.

135.13 Sec. 21. **[256R.27] INTERIM AND SETTLE UP TOTAL OPERATING AND**
135.14 **EXTERNAL FIXED COST PAYMENT RATES.**

135.15 Subdivision 1. **Generally.** (a) A newly constructed nursing facility, or a nursing facility
135.16 with a capacity increase of 50 percent or more, must receive an interim total operating rate
135.17 payment and settle up total operating cost payment according to this section.

135.18 (b) The nursing facility shall submit a written application to the commissioner to receive
135.19 an interim total operating payment rate. In its application, the nursing facility shall state
135.20 any reasons for noncompliance with this chapter.

135.21 (c) The effective date of the interim total operating payment rate is the earlier of either
135.22 the first day a resident is admitted to the newly constructed nursing facility or the date the
135.23 nursing facility bed is certified for the medical assistance program. The interim total operating
135.24 payment rate must not be in effect more than 17 months.

135.25 (d) The nursing facility must continue to receive the interim total operating payment
135.26 rate until the settle up total operating cost payment is determined under subdivision 3.

135.27 (e) The settle up total operating cost payment rate is effective retroactively to the
135.28 beginning of the interim cost report period, and is effective until the end of the interim rate
135.29 period.

135.30 (f) For the 15-month period following the settle up reporting period, the total operating
135.31 rate payment and external fixed cost payment rate must be determined according to
135.32 subdivision 3, paragraph (b).

136.1 (g) The total operating rate payment and external fixed cost payment rate for the rate
136.2 year beginning January 1 following the 15-month period in paragraph (f) must be determined
136.3 under this chapter.

136.4 (h) The commissioner shall determine interim total operating cost payment rates and
136.5 settle up total operating cost payment rates for a newly constructed nursing facility, or a
136.6 nursing facility with an increase in licensed capacity of 50 percent or more, according to
136.7 subdivisions 2 and 3.

136.8 **Subd. 2. Determination of interim operating and external fixed cost payment rate.** (a)
136.9 The nursing facility shall submit an interim cost report in a format similar to the Minnesota
136.10 Statistical and Cost Report and other supporting information as required by this chapter for
136.11 the reporting year in which the nursing facility plans to begin operation at least 60 days
136.12 before the first day a resident is admitted to the newly constructed nursing facility bed. The
136.13 interim cost report must include the nursing facility's anticipated interim costs and anticipated
136.14 interim resident days for each resident class in the interim cost report. The anticipated interim
136.15 resident days for each resident class is multiplied by the weight for that resident class to
136.16 determine the anticipated interim standardized days as defined in section 256R.02,
136.17 subdivision 50, and resident days as defined in section 256R.02, subdivision 45, for the
136.18 reporting period.

136.19 (b) The interim total operating cost payment rate is determined according to this section,
136.20 except that:

136.21 (1) the anticipated interim costs and anticipated interim resident days reported on the
136.22 interim cost report and the anticipated interim standardized days as defined by section
136.23 256R.02, subdivision 50, must be used for the interim;

136.24 (2) the commissioner shall use anticipated interim costs and anticipated interim
136.25 standardized days in determining the allowable historical direct care cost per standardized
136.26 day as determined under section 256R.23, subdivision 2;

136.27 (3) the commissioner shall use anticipated interim costs and anticipated interim resident
136.28 days in determining the allowable historical other care-related cost per resident day as
136.29 determined under section 256R.23, subdivision 3;

136.30 (4) the commissioner shall use anticipated interim costs and anticipated interim resident
136.31 days to determine the allowable historical external fixed cost per day under section 256R.25,
136.32 paragraphs (b) to (k);

137.1 (5) the total care-related payment rate limits established in section 256R.23, subdivision

137.2 5, and in effect at the beginning of the interim period, must be increased by ten percent; and

137.3 (6) the other operating payment rate as determined under section 256R.24 in effect for

137.4 the rate year must be used for the other operating cost per day.

137.5 **Subd. 3. Determination of settle up operating and external fixed cost payment**

137.6 rate. (a) When the interim payment rate begins between May 1 and September 30, the

137.7 nursing facility shall file settle up cost reports for the period from the beginning of the

137.8 interim payment rate through September 30 of the following year.

137.9 (b) When the interim payment rate begins between October 1 and April 30, the nursing

137.10 facility shall file settle up cost reports for the period from the beginning of the interim

137.11 payment rate to the first September 30 following the beginning of the interim payment rate.

137.12 (c) The settle up total operating cost payment rate is determined according to this section,

137.13 except that:

137.14 (1) the allowable costs and resident days reported on the settle up cost report and the

137.15 standardized days as defined by section 256R.02, subdivision 50, must be used for the

137.16 interim and settle-up period;

137.17 (2) the commissioner shall use the allowable costs and standardized days in clause (1)

137.18 to determine the allowable historical direct care cost per standardized day as determined

137.19 under section 256R.23, subdivision 2;

137.20 (3) the commissioner shall use the allowable costs and the allowable resident days to

137.21 determine both the allowable historical other care-related cost per resident day as determined

137.22 under section 256R.23, subdivision 3;

137.23 (4) the commissioner shall use the allowable costs and the allowable resident days to

137.24 determine the allowable historical external fixed cost per day under section 256R.25,

137.25 paragraphs (b) to (k);

137.26 (5) the total care-related payment limits established in section 256R.23, subdivision 5,

137.27 are the limits for the settle up reporting periods. If the interim period includes more than

137.28 one July 1 date, the commissioner shall use the total care-related payment limit established

137.29 in section 256R.23, subdivision 5, increased by ten percent for the second July 1 date; and

137.30 (6) the other operating payment rate as determined under section 256R.24 in effect for

137.31 the rate year must be used for the other operating cost per day.

138.1 Sec. 22. Minnesota Statutes 2018, section 256R.44, is amended to read:

138.2 **256R.44 RATE ADJUSTMENT FOR PRIVATE ROOMS FOR MEDICAL
138.3 NECESSITY.**

138.4 The amount paid for a private room is ~~111.5~~ 110 percent of the established total payment
138.5 rate for a resident if the resident is a medical assistance recipient and the private room is
138.6 considered a medical necessity for the resident or others who are affected by the resident's
138.7 condition, ~~except as provided in Minnesota Rules, part 9549.0060, subpart 11, item C.~~
138.8 Conditions requiring a private room must be determined by the resident's attending physician
138.9 and submitted to the commissioner for approval or denial by the commissioner on the basis
138.10 of medical necessity.

138.11 **EFFECTIVE DATE.** This section is effective January 1, 2020.

138.12 Sec. 23. Minnesota Statutes 2018, section 256R.47, is amended to read:

138.13 **256R.47 RATE ADJUSTMENT FOR CRITICAL ACCESS NURSING
138.14 FACILITIES.**

138.15 (a) The commissioner, in consultation with the commissioner of health, may designate
138.16 certain nursing facilities as critical access nursing facilities. The designation shall be granted
138.17 on a competitive basis, within the limits of funds appropriated for this purpose.

138.18 (b) The commissioner shall request proposals from nursing facilities every two years.
138.19 Proposals must be submitted in the form and according to the timelines established by the
138.20 commissioner. In selecting applicants to designate, the commissioner, in consultation with
138.21 the commissioner of health, and with input from stakeholders, shall develop criteria designed
138.22 to preserve access to nursing facility services in isolated areas, rebalance long-term care,
138.23 and improve quality. To the extent practicable, the commissioner shall ensure an even
138.24 distribution of designations across the state.

138.25 (c) The commissioner shall allow the benefits in clauses (1) to (5) for nursing facilities
138.26 designated as critical access nursing facilities:

138.27 (1) partial rebasing, with the commissioner allowing a designated facility operating
138.28 payment rates being the sum of up to 60 percent of the operating payment rate determined
138.29 in accordance with section 256R.21, subdivision 3, and at least 40 percent, with the sum of
138.30 the two portions being equal to 100 percent, of the operating payment rate that would have
138.31 been allowed had the facility not been designated. The commissioner may adjust these
138.32 percentages by up to 20 percent and may approve a request for less than the amount allowed;

139.1 (2) enhanced payments for leave days. Notwithstanding section 256R.43, upon
139.2 designation as a critical access nursing facility, the commissioner shall limit payment for
139.3 leave days to 60 percent of that nursing facility's total payment rate for the involved resident,
139.4 and shall allow this payment only when the occupancy of the nursing facility, inclusive of
139.5 bed hold days, is equal to or greater than 90 percent;

139.6 (3) two designated critical access nursing facilities, with up to 100 beds in active service,
139.7 may jointly apply to the commissioner of health for a waiver of Minnesota Rules, part
139.8 4658.0500, subpart 2, in order to jointly employ a director of nursing. The commissioner
139.9 of health shall consider each waiver request independently based on the criteria under
139.10 Minnesota Rules, part 4658.0040;

139.11 (4) the minimum threshold under section 256B.431, subdivision 15, paragraph (e), shall
139.12 be 40 percent of the amount that would otherwise apply; and

139.13 (5) the quality-based rate limits under section 256R.23, subdivisions 5 to 7, apply to
139.14 designated critical access nursing facilities.

139.15 (d) Designation of a critical access nursing facility is for a period of two years, after
139.16 which the benefits allowed under paragraph (c) shall be removed. Designated facilities may
139.17 apply for continued designation.

139.18 (e) This section is suspended and no state or federal funding shall be appropriated or
139.19 allocated for the purposes of this section from January 1, 2016, ~~to December 31, 2019,~~
139.20 through December 31, 2023.

139.21 Sec. 24. Minnesota Statutes 2018, section 256R.50, subdivision 6, is amended to read:

139.22 **Subd. 6. Determination of rate adjustment.** (a) If the amount determined in subdivision
139.23 5 is less than or equal to the amount determined in subdivision 4, the commissioner shall
139.24 allow a total payment rate equal to the amount used in subdivision 5, clause (3).

139.25 (b) If the amount determined in subdivision 5 is greater than the amount determined in
139.26 subdivision 4, the commissioner shall allow a rate with a case mix index of 1.0 that when
139.27 used in subdivision 5, clause (3), results in the amount determined in subdivision 5 being
139.28 equal to the amount determined in subdivision 4.

139.29 (c) If the commissioner relies upon provider estimates in subdivision 5, clause (1) or
139.30 (2), then annually, for three years after the rates determined in this section take effect, the
139.31 commissioner shall determine the accuracy of the alternative factors of medical assistance
139.32 case load and the facility average case mix index used in this section and shall reduce the
139.33 total payment rate if the factors used result in medical assistance costs exceeding the amount

140.1 in subdivision 4. If the actual medical assistance costs exceed the estimates by more than
140.2 five percent, the commissioner shall also recover the difference between the estimated costs
140.3 in subdivision 5 and the actual costs according to section 256B.0641. The commissioner
140.4 may require submission of data from the receiving facility needed to implement this
140.5 paragraph.

140.6 (d) When beds approved for relocation are put into active service at the destination
140.7 facility, rates determined in this section must be adjusted by any adjustment amounts that
140.8 were implemented after the date of the letter of approval.

140.9 (e) Rate adjustments determined under this subdivision expire after three full rate years
140.10 following the effective date of the rate adjustment. This subdivision expires when the final
140.11 rate adjustment determined under this subdivision expires.

140.12 Sec. 25. DIRECTION TO COMMISSIONER; MORATORIUM EXCEPTION

FUNDING.

140.14 In fiscal year 2019, the commissioner of human services may approve moratorium
140.15 exception projects under Minnesota Statutes, section 144A.073, for which the full annualized
140.16 state share of medical assistance costs does not exceed \$1,500,000 plus any carryover of
140.17 previous appropriations for this purpose.

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

140.19 Sec. 26. REPEALER.

140.20 (a) Minnesota Statutes 2018, sections 144A.071, subdivision 4d; 256R.40; and 256R.41,
140.21 are repealed effective July 1, 2019.

140.22 (b) Minnesota Statutes 2018, sections 256B.431, subdivisions 3a, 3f, 3g, 3i, 13, 15, 17,
140.23 17a, 17c, 17d, 17e, 18, 21, 22, 30, and 45; 256B.434, subdivisions 4, 4f, 4i, and 4j; and
140.24 256R.36, and Minnesota Rules, parts 9549.0057; and 9549.0060, subparts 4, 5, 6, 7, 10, 11,
140.25 and 14, are repealed effective January 1, 2020.

ARTICLE 5

DISABILITY SERVICES

140.28 Section 1. Minnesota Statutes 2018, section 237.50, subdivision 4a, is amended to read:

140.29 Subd. 4a. **Deaf.** "Deaf" means a hearing loss of such severity that the individual person
140.30 must depend primarily upon visual communication such as writing, lip reading, sign language,
140.31 and gestures.

141.1 **EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented
141.2 by October 1, 2019.

141.3 Sec. 2. Minnesota Statutes 2018, section 237.50, is amended by adding a subdivision to
141.4 read:

141.5 Subd. 4c. **Discounted telecommunications services.** "Discounted telecommunications
141.6 services" means private, nonprofit, and public programs intended to subsidize or reduce the
141.7 monthly costs of telecommunications services for a person who meets a program's eligibility
141.8 requirements.

141.9 **EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented
141.10 by October 1, 2019.

141.11 Sec. 3. Minnesota Statutes 2018, section 237.50, subdivision 6a, is amended to read:

141.12 Subd. 6a. **Hard-of-hearing.** "Hard-of-hearing" means a hearing loss resulting in a
141.13 functional limitation, but not to the extent that the individual person must depend primarily
141.14 upon visual communication in all interactions.

141.15 **EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented
141.16 by October 1, 2019.

141.17 Sec. 4. Minnesota Statutes 2018, section 237.50, is amended by adding a subdivision to
141.18 read:

141.19 Subd. 6b. **Interconnectivity product.** "Interconnectivity product" means any product
141.20 including an accessory, application, or device that a person with a communication disability
141.21 needs to use in conjunction with a telecommunications device to have functionally equivalent
141.22 access to telecommunications services as a person without a communication disability.
141.23 Interconnectivity product may include a hearing aid streamer, Bluetooth-enabled device,
141.24 advanced communications application for a smartphone, or any other product the
141.25 commissioner of human services deems appropriate.

141.26 **EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented
141.27 by October 1, 2019.

142.1 Sec. 5. Minnesota Statutes 2018, section 237.50, is amended by adding a subdivision to
142.2 read:

142.3 **Subd. 6c. Multifunctional safety device.** "Multifunctional safety device" means an
142.4 alerting device that has two or more functions. Multifunctional safety device may include
142.5 a telephone ring signaler that also alerts a person with a communication disability to the
142.6 doorbell, smoke alarm, carbon monoxide alarm, noises in another room, or other
142.7 environmental sounds.

142.8 **EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented
142.9 by October 1, 2019.

142.10 Sec. 6. Minnesota Statutes 2018, section 237.50, subdivision 10a, is amended to read:

142.11 **Subd. 10a. Telecommunications device.** "Telecommunications device" means a device
142.12 that (1) allows a person with a communication disability to have access to
142.13 telecommunications services as defined in subdivision 13, and (2) is specifically selected
142.14 by the Department of Human Services for its capacity to allow persons with communication
142.15 disabilities to use telecommunications services in a manner that is functionally equivalent
142.16 to the ability of ~~an individual~~ a person who does not have a communication disability. A
142.17 telecommunications device may include a ring signaler, an amplified telephone, a hands-free
142.18 telephone, a text telephone, a captioned telephone, a wireless device, a device that produces
142.19 Braille output for use with a telephone, and any other device the Department of Human
142.20 Services deems appropriate.

142.21 **EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented
142.22 by October 1, 2019.

142.23 Sec. 7. Minnesota Statutes 2018, section 237.50, subdivision 11, is amended to read:

142.24 **Subd. 11. Telecommunications Relay Services.** "Telecommunications Relay Services"
142.25 or "TRS" means the telecommunications transmission services required under Federal
142.26 Communications Commission regulations at Code of Federal Regulations, title 47, sections
142.27 64.604 to 64.606. TRS allows ~~an individual~~ a person who has a communication disability
142.28 to use telecommunications services in a manner that is functionally equivalent to the ability
142.29 of ~~an individual~~ a person who does not have a communication disability.

142.30 **EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented
142.31 by October 1, 2019.

143.1 Sec. 8. Minnesota Statutes 2018, section 237.51, subdivision 1, is amended to read:

143.2 Subdivision 1. **Creation.** (a) The commissioner of commerce shall:

143.3 (1) administer through interagency agreement with the commissioner of human services

143.4 a program to distribute telecommunications devices, interconnectivity products, and

143.5 multifunctional safety devices to eligible persons who have communication disabilities;

143.6 and

143.7 (2) contract with one or more qualified vendors that serve persons who have

143.8 communication disabilities to provide telecommunications relay services.

143.9 (b) For purposes of sections 237.51 to 237.56, the Department of Commerce and any

143.10 organization with which it contracts pursuant to this section or section 237.54, subdivision

143.11 2, are not telephone companies or telecommunications carriers as defined in section 237.01.

143.12 **EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented

143.13 by October 1, 2019.

143.14 Sec. 9. Minnesota Statutes 2018, section 237.51, subdivision 5a, is amended to read:

143.15 Subd. 5a. **Commissioner of human services duties.** (a) In addition to any duties specified

143.16 elsewhere in sections 237.51 to 237.56, the commissioner of human services shall:

143.17 (1) define economic hardship, special needs, and household criteria so as to determine

143.18 the priority of eligible applicants for initial distribution of devices and products and to

143.19 determine circumstances necessitating provision of more than one telecommunications

143.20 device per household;

143.21 (2) establish a method to verify eligibility requirements;

143.22 (3) establish specifications for telecommunications devices, interconnectivity products,

143.23 and multifunctional safety devices to be provided under section 237.53, subdivision 3;

143.24 (4) inform the public and specifically persons who have communication disabilities of

143.25 the program; and

143.26 (5) provide devices and products based on the assessed need of eligible applicants.; and

143.27 (6) assist a person with completing an application for discounted telecommunications

143.28 services.

143.29 (b) The commissioner may establish an advisory board to advise the department in

143.30 carrying out the duties specified in this section and to advise the commissioner of commerce

144.1 in carrying out duties under section 237.54. If so established, the advisory board must
144.2 include, at a minimum, the following persons:

144.3 (1) at least one member who is deaf;

144.4 (2) at least one member who has a speech disability;

144.5 (3) at least one member who has a physical disability that makes it difficult or impossible
144.6 for the person to access telecommunications services; and

144.7 (4) at least one member who is hard-of-hearing.

144.8 (c) The membership terms, compensation, and removal of members and the filling of
144.9 membership vacancies are governed by section 15.059. Advisory board meetings shall be
144.10 held at the discretion of the commissioner.

144.11 **EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented
144.12 by October 1, 2019.

144.13 Sec. 10. Minnesota Statutes 2018, section 237.52, subdivision 5, is amended to read:

144.14 Subd. 5. **Expenditures.** (a) Money in the fund may only be used for:

144.15 (1) expenses of the Department of Commerce, including personnel cost, public relations,
144.16 advisory board members' expenses, preparation of reports, and other reasonable expenses
144.17 not to exceed ten percent of total program expenditures;

144.18 (2) reimbursing the commissioner of human services for purchases made or services
144.19 provided pursuant to section 237.53; and

144.20 (3) contracting for the provision of TRS required by section 237.54.

144.21 (b) All costs directly associated with the establishment of the program, the purchase and
144.22 distribution of telecommunications devices, interconnectivity products, and multifunctional
144.23 safety devices and the provision of TRS are either reimbursable or directly payable from
144.24 the fund after authorization by the commissioner of commerce. The commissioner of
144.25 commerce shall contract with one or more TRS providers to indemnify the
144.26 telecommunications service providers for any fines imposed by the Federal Communications
144.27 Commission related to the failure of the relay service to comply with federal service
144.28 standards. Notwithstanding section 16A.41, the commissioner may advance money to the
144.29 TRS providers if the providers establish to the commissioner's satisfaction that the advance
144.30 payment is necessary for the provision of the service. The advance payment may be used
144.31 only for working capital reserve for the operation of the service. The advance payment must

145.1 be offset or repaid by the end of the contract fiscal year together with interest accrued from
145.2 the date of payment.

145.3 **EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented
145.4 by October 1, 2019.

145.5 Sec. 11. Minnesota Statutes 2018, section 237.53, is amended to read:

145.6 **237.53 TELECOMMUNICATIONS DEVICE, INTERCONNECTIVITY**
145.7 **PRODUCTS, AND MULTIFUNCTIONAL SAFETY DEVICES.**

145.8 Subdivision 1. **Application.** A person applying for a telecommunications device,
145.9 interconnectivity product, or multifunctional safety device under this section must apply to
145.10 the program administrator on a form prescribed by the Department of Human Services.

145.11 Subd. 2. **Eligibility.** To be eligible to obtain a telecommunications device,
145.12 interconnectivity product, or multifunctional safety device under this section, a person must:

145.13 (1) be able to benefit from and use the equipment for its intended purpose;

145.14 (2) have a communication disability;

145.15 (3) be a resident of the state;

145.16 (4) be a resident in a household that has a median income at or below the applicable
145.17 median household income in the state, except a person who is deafblind applying for a
145.18 Braille device may reside in a household that has a median income no more than 150 percent
145.19 of the applicable median household income in the state; and

145.20 (5) be a resident in a household that has telecommunications service or that has made
145.21 application for service and has been assigned a telephone number; or a resident in a residential
145.22 care facility, such as a nursing home or group home where telecommunications service is
145.23 not included as part of overall service provision.

145.24 Subd. 2a. **Assessment of needs.** After a person is determined to be eligible for the
145.25 program, the commissioner of human services shall assess the person's telecommunications
145.26 needs to determine: (1) the type of telecommunications devices that provide the person with
145.27 functionally equivalent access to telecommunications services; (2) appropriate
145.28 interconnectivity products for the person; and (3) multifunctional safety devices to alert the
145.29 person to noises in the person's home.

145.30 Subd. 3. **Distribution.** The commissioner of human services shall (1) purchase and
145.31 distribute a sufficient number of telecommunications devices, interconnectivity products,
145.32 and multifunctional safety devices so that each eligible household receives appropriate

146.1 devices and products as determined under section 237.51, subdivision 5a. ~~The commissioner~~
146.2 ~~of human services shall, and~~ (2) distribute the devices and products to eligible households
146.3 free of charge.

146.4 Subd. 4. **Training; information; maintenance.** The commissioner of human services
146.5 shall maintain the telecommunications devices, interconnectivity products, and
146.6 multifunctional safety devices until the warranty period expires, and provide training, without
146.7 charge, to first-time users of the devices. and products. The commissioner shall provide
146.8 information about assistive communications devices and products that may benefit a program
146.9 participant and about where a person may obtain or purchase assistive communications
146.10 devices and products. Assistive communications devices and products include a pocket
146.11 talker for a person who is hard-of-hearing, a communication board for a person with a speech
146.12 disability, a one-to-one video communication application for a person who is deaf, and other
146.13 devices and products designed to facilitate effective communication for a person with a
146.14 communication disability.

146.15 Subd. 6. **Ownership.** Telecommunications devices, interconnectivity products, and
146.16 multifunctional safety devices purchased pursuant to subdivision 3, clause (1), are the
146.17 property of the state of Minnesota. Policies and procedures for the return of distributed
146.18 devices from individuals who withdraw from the program or whose eligibility status changes
146.19 and products shall be determined by the commissioner of human services.

146.20 Subd. 7. **Standards.** The telecommunications devices distributed under this section must
146.21 comply with the electronic industries alliance standards and be approved by the Federal
146.22 Communications Commission. The commissioner of human services must provide each
146.23 eligible person a choice of several models of devices, the retail value of which may not
146.24 exceed \$600 for a text telephone, and a retail value of \$7,000 for a Braille device, or an
146.25 amount authorized by the Department of Human Services for all other telecommunications
146.26 devices and auxiliary equipment, interconnectivity products, and multifunctional safety
146.27 devices it deems cost-effective and appropriate to distribute according to sections 237.51
146.28 to 237.56.

146.29 Subd. 9. **Discounted telecommunications services assistance.** The commissioner of
146.30 human services shall assist a person who is applying for telecommunication devices and
146.31 products in applying for discounted telecommunications services.

146.32 **EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented
146.33 by October 1, 2019.

147.1 Sec. 12. Minnesota Statutes 2018, section 245C.03, is amended by adding a subdivision
147.2 to read:

147.3 **Subd. 13. Early intensive developmental and behavioral intervention providers.** The
147.4 commissioner shall conduct background studies according to this chapter when initiated by
147.5 an early intensive developmental and behavioral intervention provider under section
147.6 256B.0949.

147.7 Sec. 13. Minnesota Statutes 2018, section 245C.10, is amended by adding a subdivision
147.8 to read:

147.9 **Subd. 14. Early intensive developmental and behavioral intervention providers.** The
147.10 commissioner shall recover the cost of background studies required under section 245C.03,
147.11 subdivision 13, for the purposes of early intensive developmental and behavioral intervention
147.12 under section 256B.0949, through a fee of no more than \$32 per study charged to the enrolled
147.13 agency. Fees collected under this subdivision are appropriated to the commissioner for the
147.14 purpose of conducting background studies.

147.15 Sec. 14. Minnesota Statutes 2018, section 245D.03, subdivision 1, is amended to read:

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

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

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

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

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

148.6 (4) 24-hour emergency assistance, personal emergency response as defined under the
148.7 community access for disability inclusion and developmental disability waiver plans;

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

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

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

148.14 (8) individualized home supports services as defined under the brain injury, community
148.15 alternative care, and community access for disability inclusion, and developmental disability
148.16 waiver plans.

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

148.20 (1) intervention services, including:

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

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

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

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

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

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

- 149.1 (iii) semi-independent living services; and
- 149.2 (iv) ~~individualized home supports services as defined under the brain injury, community alternative care, and community access for disability inclusion waiver plans;~~
- 149.3 (iv) individualized home support with training services as defined under the brain injury, community alternative care, community access for disability inclusion, and developmental disability waiver plans; and
- 149.4 (v) individualized home support with family training services as defined under the brain injury, community alternative care, community access for disability inclusion, and developmental disability waiver plans;
- 149.5 (3) residential supports and services, including:
- 149.6 (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;
- 149.7 (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
- 149.8 (iii) community residential services as defined under the brain injury, community alternative care, community access for disability inclusion, and developmental disability waiver plans provided in a corporate child foster care residence, a community residential setting, or a supervised living facility;
- 149.9 (iv) family residential services as defined in the brain injury, community alternative care, community access for disability inclusion, and developmental disability waiver plans provided in a family child foster care residence or a family adult foster care residence; and
- 149.10 (v) residential services provided to more than four persons with developmental disabilities in a supervised living facility, including ICFs/DD;
- 149.11 (4) day services, including:
- 149.12 (i) structured day services as defined under the brain injury waiver plan;
- 149.13 (ii) day services under sections 252.41 to 252.46, and as defined under the brain injury, community alternative care, community access for disability inclusion, and developmental disability waiver plans;

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

150.3 ~~(iii)~~ (iv) prevocational services as defined under the brain injury and, community
150.4 alternative care, community access for disability inclusion, and developmental disability
150.5 waiver plans; and

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

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

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

150.15 (8) integrated community support as defined under the brain injury and community
150.16 access for disability inclusion waiver plans beginning January 1, 2021, and community
150.17 alternative care and developmental disability waiver plans beginning January 1, 2023.

150.18 **EFFECTIVE DATE.** This section is effective January 1, 2021, or upon federal approval,
150.19 whichever is later. The commissioner of human services shall notify the revisor of statutes
150.20 when federal approval is obtained.

150.21 Sec. 15. Minnesota Statutes 2018, section 245D.071, subdivision 1, is amended to read:

150.22 **Subdivision 1. Requirements for intensive support services.** Except for services
150.23 identified in section 245D.03, subdivision 1, paragraph (c), clauses (1) and (2), item (ii), a
150.24 license holder providing intensive support services identified in section 245D.03, subdivision
150.25 1, paragraph (c), must comply with the requirements in this section and section 245D.07,
150.26 subdivisions 1, 1a, and 3. Services identified in section 245D.03, subdivision 1, paragraph
150.27 (c), clauses (1) and (2), item (ii), must comply with the requirements in section 245D.07,
150.28 subdivision 2.

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

151.1 Sec. 16. [245D.12] INTEGRATED COMMUNITY SUPPORTS; SETTING

151.2 CAPACITY REPORT.

151.3 (a) The license holder providing integrated community support, as defined in section
151.4 245D.03, subdivision 1, paragraph (c), clause (8), must submit a setting capacity report to
151.5 the commissioner to ensure the identified location of service delivery meets the criteria of
151.6 the home and community-based service requirements as specified in section 256B.492.

151.7 (b) The license holder shall provide the setting capacity report on the forms and in the
151.8 manner prescribed by the commissioner. The report must include:

151.9 (1) the address of the multifamily housing building where the license holder delivers
151.10 integrated community supports and owns, leases, or has a direct or indirect financial
151.11 relationship with the property owner;

151.12 (2) the total number of living units in the multifamily housing building described in
151.13 clause (1) where integrated community supports are delivered;

151.14 (3) the total number of living units in the multifamily housing building described in
151.15 clause (1), including the living units identified in clause (2); and

151.16 (4) the percentage of living units that are controlled by the license holder in the
151.17 multifamily housing building by dividing clause (2) by clause (3).

151.18 (c) Only one license holder may deliver integrated community supports at the address
151.19 of the multifamily housing building.

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

151.23 Sec. 17. Minnesota Statutes 2018, section 252.275, subdivision 3, is amended to read:

151.24 Subd. 3. **Reimbursement.** Counties shall be reimbursed for all expenditures made
151.25 pursuant to subdivision 1 at a rate of 70 85 percent, up to the allocation determined pursuant
151.26 to subdivisions 4 and 4b. However, the commissioner shall not reimburse costs of services
151.27 for any person if the costs exceed the state share of the average medical assistance costs for
151.28 services provided by intermediate care facilities for a person with a developmental disability
151.29 for the same fiscal year, and shall not reimburse costs of a onetime living allowance for any
151.30 person if the costs exceed \$1,500 in a state fiscal year. The commissioner may make
151.31 payments to each county in quarterly installments. The commissioner may certify an advance

152.1 of up to 25 percent of the allocation. Subsequent payments shall be made on a reimbursement
152.2 basis for reported expenditures and may be adjusted for anticipated spending patterns.

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

152.4 Sec. 18. Minnesota Statutes 2018, section 252.41, subdivision 3, is amended to read:

152.5 **Subd. 3. Day training and habilitation services for adults with developmental**
152.6 **disabilities.** (a) "Day training and habilitation services for adults with developmental

152.7 disabilities" means services that:

152.8 (1) include supervision, training, assistance, support, center-based facility-based
152.9 work-related activities, or other community-integrated activities designed and implemented
152.10 in accordance with the individual service and individual habilitation plans coordinated
152.11 service and support plan and coordinated service and support plan addendum required under
152.12 sections 245D.02, subdivision 4, paragraphs (a) and (b), and 256B.092, subdivision 1b, and
152.13 Minnesota Rules, parts part 9525.0004, to 9525.0036 subpart 12, to help an adult reach and
152.14 maintain the highest possible level of independence, productivity, and integration into the
152.15 community; and

152.16 (2) include day support services, prevocational services, day training and habilitation
152.17 services, structured day services, and adult day services as defined in Minnesota's federally
152.18 approved disability waiver plans; and

152.19 (3) are provided by a vendor licensed under sections 245A.01 to 245A.16 and, 245D.27
152.20 to 245D.31, 252.28, subdivision 2, and 252.41 to 252.46, and Minnesota Rules, parts
152.21 9525.1200 to 9525.1330, to provide day training and habilitation services.

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

152.27 (c) Day training and habilitation services do not include employment exploration,
152.28 employment development, or employment support services as defined in the home and
152.29 community-based services waivers for people with disabilities authorized under sections
152.30 256B.092 and 256B.49.

152.31 **EFFECTIVE DATE.** This section is effective January 1, 2021, or upon federal approval,
152.32 whichever is later. The commissioner of human services shall notify the revisor of statutes
152.33 when federal approval is obtained.

153.1 Sec. 19. Minnesota Statutes 2018, section 252.41, subdivision 4, is amended to read:

153.2 Subd. 4. **Independence.** "Independence" means the extent to which persons with
153.3 ~~developmental~~ disabilities exert control and choice over their own lives.

153.4 **EFFECTIVE DATE.** This section is effective January 1, 2021.

153.5 Sec. 20. Minnesota Statutes 2018, section 252.41, subdivision 5, is amended to read:

153.6 Subd. 5. **Integration.** "Integration" means that persons with ~~developmental~~ disabilities:

153.7 (1) use the same community resources that are used by and available to individuals who
153.8 are not disabled;

153.9 (2) participate in the same community activities in which nondisabled individuals
153.10 participate; and

153.11 (3) regularly interact and have contact with nondisabled individuals.

153.12 **EFFECTIVE DATE.** This section is effective January 1, 2021.

153.13 Sec. 21. Minnesota Statutes 2018, section 252.41, subdivision 6, is amended to read:

153.14 Subd. 6. **Productivity.** "Productivity" means that persons with ~~developmental~~ disabilities:

153.15 (1) engage in income-producing work designed to improve their income level,
153.16 employment status, or job advancement; or

153.17 (2) engage in activities that contribute to a business, household, or community.

153.18 **EFFECTIVE DATE.** This section is effective January 1, 2021.

153.19 Sec. 22. Minnesota Statutes 2018, section 252.41, subdivision 7, is amended to read:

153.20 Subd. 7. **Regional center.** "Regional center" means any state-operated facility under
153.21 the direct administrative authority of the commissioner that serves persons with
153.22 ~~developmental~~ disabilities.

153.23 **EFFECTIVE DATE.** This section is effective January 1, 2021.

153.24 Sec. 23. Minnesota Statutes 2018, section 252.41, subdivision 9, is amended to read:

153.25 Subd. 9. **Vendor.** "Vendor" means a ~~nonprofit~~ legal entity that:

153.26 (1) is licensed under sections 245A.01 to 245A.16 and, 245D.27 to 245D.31, 252.28,
153.27 subdivision 2, and 252.41 to 252.46, and Minnesota Rules, parts 9525.1200 to 9525.1330,

154.1 to provide day ~~training and habilitation~~ services to adults with ~~developmental~~ disabilities;
154.2 and

154.3 (2) does not have a financial interest in the legal entity that provides residential services
154.4 to the same person or persons to whom it provides day ~~training and habilitation~~ services.

154.5 This clause does not apply to regional treatment centers, state-operated, community-based
154.6 programs operating according to section 252.50 until July 1, 2000, or vendors licensed prior
154.7 to April 15, 1983.

154.8 **EFFECTIVE DATE.** This section is effective January 1, 2021.

154.9 Sec. 24. Minnesota Statutes 2018, section 252.42, is amended to read:

154.10 **252.42 SERVICE PRINCIPLES.**

154.11 The design and delivery of services eligible for reimbursement should reflect the
154.12 following principles:

154.13 (1) services must suit a person's chronological age and be provided in the least restrictive
154.14 environment possible, consistent with the needs identified in the person's ~~individual service~~
154.15 ~~and individual habilitation plans under coordinated service and support plan and coordinated~~
154.16 ~~service and support plan addendum required under sections 256B.092, subdivision 1b, and~~
154.17 ~~245D.02, subdivision 4, paragraphs (a) and (b), and Minnesota Rules, parts 9525.0004 to~~
154.18 ~~9525.0036, subpart 12;~~

154.19 (2) a person with a ~~developmental~~ disability whose individual ~~service and individual~~
154.20 ~~habilitation plans coordinated service and support plans and coordinated service and support~~
154.21 ~~plan addendums~~ authorize employment or employment-related activities shall be given the
154.22 opportunity to participate in employment and employment-related activities in which
154.23 nondisabled persons participate;

154.24 (3) a person with a ~~developmental~~ disability participating in work shall be paid wages
154.25 commensurate with the rate for comparable work and productivity except as regional centers
154.26 are governed by section 246.151;

154.27 (4) a person with a ~~developmental~~ disability shall receive services which include services
154.28 offered in settings used by the general public and designed to increase the person's active
154.29 participation in ordinary community activities;

154.30 (5) a person with a ~~developmental~~ disability shall participate in the patterns, conditions,
154.31 and rhythms of everyday living and working that are consistent with the norms of the
154.32 mainstream of society.

155.1 **EFFECTIVE DATE.** This section is effective January 1, 2021.

155.2 Sec. 25. Minnesota Statutes 2018, section 252.43, is amended to read:

155.3 **252.43 COMMISSIONER'S DUTIES.**

155.4 The commissioner shall supervise county boards' lead agencies' provision of day ~~training and habilitation~~ services to adults with developmental disabilities. The commissioner shall:

155.6 (1) determine the need for day ~~training and habilitation~~ services under section ~~252.28~~

155.7 256B.4914;

155.8 (2) establish payment rates as provided under section 256B.4914;

155.9 (3) add transportation costs to the day services payment rate;

155.10 (4) adopt rules for the administration and provision of day training and habilitation

155.11 services under sections 252.41 to 252.46 and sections 245A.01 to 245A.16 and, 252.28,

155.12 subdivision 2, and 252.41 to 252.46, and Minnesota Rules, parts 9525.1200 to 9525.1330;

155.13 (4)(5) enter into interagency agreements necessary to ensure effective coordination and
155.14 provision of day training and habilitation services;

155.15 (5)(6) monitor and evaluate the costs and effectiveness of day training and habilitation
155.16 services; and

155.17 (6)(7) provide information and technical help to county boards lead agencies and vendors
155.18 in their administration and provision of day training and habilitation services.

155.19 **EFFECTIVE DATE.** This section is effective January 1, 2021.

155.20 Sec. 26. Minnesota Statutes 2018, section 252.44, is amended to read:

155.21 **252.44 COUNTY LEAD AGENCY BOARD RESPONSIBILITIES.**

155.22 When the need for day ~~training and habilitation~~ services in a county or tribe has been
155.23 determined under section 252.28, the board of commissioners for that county lead agency
155.24 shall:

155.25 (1) authorize the delivery of services according to the individual service and habilitation
155.26 plans coordinated service and support plans and coordinated service and support plan
155.27 addendums required as part of the county's lead agency's provision of case management
155.28 services under sections 256B.0913, subdivision 8; 256B.0915, subdivision 6; 256B.092,
155.29 subdivision 1b; and 256B.49, subdivision 15, and Minnesota Rules, parts 9525.0004 to
155.30 9525.0036. For calendar years for which section 252.46, subdivisions 2 to 10, apply, the

156.1 ~~county board shall not authorize a change in service days from the number of days authorized~~
156.2 ~~for the previous calendar year unless there is documentation for the change in the individual~~
156.3 ~~service plan. An increase in service days must also be supported by documentation that the~~
156.4 ~~goals and objectives assigned to the vendor cannot be met more economically and effectively~~
156.5 ~~by other available community services and that without the additional days of service the~~
156.6 ~~individual service plan could not be implemented in a manner consistent with the service~~
156.7 ~~principles in section 252.42;~~

156.8 (2) ensure that transportation is provided or arranged by the vendor in the most efficient
156.9 and reasonable way possible; and

156.10 (3) monitor and evaluate the cost and effectiveness of the services.

156.11 **EFFECTIVE DATE.** This section is effective January 1, 2021.

156.12 Sec. 27. Minnesota Statutes 2018, section 252.45, is amended to read:

156.13 **252.45 VENDOR'S DUTIES.**

156.14 A day service vendor enrolled with the commissioner is responsible for items under
156.15 clauses (1), (2), and (3), and extends only to the provision of services that are reimbursable
156.16 under state and federal law. A vendor providing day ~~training and habilitation~~ services shall:

156.17 (1) provide the amount and type of services authorized in the individual service plan
156.18 under ~~coordinated service and support plan and coordinated service and support plan~~
156.19 ~~addendum required under sections 245D.02, subdivision 4, paragraphs (a) and (b), and~~
156.20 ~~256B.092, subdivision 1b, and Minnesota Rules, parts part 9525.0004 to 9525.0036, subpart~~
156.21 12;

156.22 (2) design the services to achieve the outcomes assigned to the vendor in the ~~individual~~
156.23 ~~service plan~~ ~~coordinated service and support plan and coordinated service and support plan~~
156.24 ~~addendum required under sections 245D.02, subdivision 4, paragraphs (a) and (b), and~~
156.25 256B.092, subdivision 1b, and Minnesota Rules, part 9525.0004, subpart 12;

156.26 (3) provide or arrange for transportation of persons receiving services to and from service
156.27 sites;

156.28 (4) enter into agreements with community-based intermediate care facilities for persons
156.29 with developmental disabilities to ensure compliance with applicable federal regulations;
156.30 and

156.31 (5) comply with state and federal law.

156.32 **EFFECTIVE DATE.** This section is effective January 1, 2021.

157.1 Sec. 28. Minnesota Statutes 2018, section 256.9365, is amended to read:

157.2 **256.9365 PURCHASE OF CONTINUATION HEALTH CARE COVERAGE FOR**
AIDS PATIENTS PEOPLE LIVING WITH HIV.

157.4 Subdivision 1. **Program established.** The commissioner of human services shall establish
157.5 a program to pay ~~private~~ the cost of health plan premiums and cost sharing for prescriptions,
157.6 including co-payments, deductibles, and coinsurance for persons who have contracted human
157.7 immunodeficiency virus (HIV) to enable them to continue coverage under or enroll in a
157.8 group or individual health plan. If a person is determined to be eligible under subdivision
157.9 2, the commissioner shall pay the ~~portion of the group plan premium for which the individual~~
157.10 ~~is responsible, if the individual is responsible for at least 50 percent of the cost of the~~
157.11 ~~premium, or pay the individual plan premium~~ health insurance premiums and prescription
157.12 cost sharing, including co-payments and deductibles required under section 256B.0631.
157.13 The commissioner shall not pay for that portion of a premium that is attributable to other
157.14 family members or dependents or is paid by the individual's employer.

157.15 Subd. 2. **Eligibility requirements.** To be eligible for the program, an applicant must
157.16 ~~satisfy the following requirements:~~ meet all eligibility requirements for and enroll in Part
157.17 B of the Ryan White HIV/AIDS Treatment Extension Act of 2009, Public Law 111-87.

157.18 ~~(1) the applicant must provide a physician's, advanced practice registered nurse's, or~~
157.19 ~~physician assistant's statement verifying that the applicant is infected with HIV and is, or~~
157.20 ~~within three months is likely to become, too ill to work in the applicant's current employment~~
157.21 ~~because of HIV-related disease;~~

157.22 ~~(2) the applicant's monthly gross family income must not exceed 300 percent of the~~
157.23 ~~federal poverty guidelines, after deducting medical expenses and insurance premiums;~~

157.24 ~~(3) the applicant must not own assets with a combined value of more than \$25,000; and~~
157.25 ~~(4) if applying for payment of group plan premiums, the applicant must be covered by~~
157.26 ~~an employer's or former employer's group insurance plan.~~

157.27 Subd. 3. **Cost-effective coverage.** Requirements for the payment of individual plan
157.28 premiums under subdivision 2, ~~clause (5)~~, must be designed to ensure that the state cost of
157.29 paying an individual plan premium does not exceed the estimated state cost that would
157.30 otherwise be incurred in the medical assistance program. The commissioner shall purchase
157.31 the most cost-effective coverage available for eligible individuals.

158.1 Sec. 29. Minnesota Statutes 2018, section 256B.0915, subdivision 3a, is amended to read:

158.2 Subd. 3a. **Elderly waiver cost limits.** (a) Effective on the first day of the state fiscal
158.3 year in which the resident assessment system as described in section 256R.17 for nursing
158.4 home rate determination is implemented and the first day of each subsequent state fiscal
158.5 year, the monthly limit for the cost of waivered services to an individual elderly waiver
158.6 client shall be the monthly limit of the case mix resident class to which the waiver client
158.7 would be assigned under Minnesota Rules, parts 9549.0051 to 9549.0059, in effect on the
158.8 last day of the previous state fiscal year, adjusted by any legislatively adopted home and
158.9 community-based services percentage rate adjustment. If a legislatively authorized increase
158.10 is service-specific, the monthly cost limit shall be adjusted based on the overall average
158.11 increase to the elderly waiver program.

158.12 (b) The monthly limit for the cost of waivered services under paragraph (a) to an
158.13 individual elderly waiver client assigned to a case mix classification A with:

158.14 (1) no dependencies in activities of daily living; or

158.15 (2) up to two dependencies in bathing, dressing, grooming, walking, and eating when
158.16 the dependency score in eating is three or greater as determined by an assessment performed
158.17 under section 256B.0911 shall be \$1,750 per month effective on July 1, 2011, for all new
158.18 participants enrolled in the program on or after July 1, 2011. This monthly limit shall be
158.19 applied to all other participants who meet this criteria at reassessment. This monthly limit
158.20 shall be increased annually as described in paragraphs (a) and (e).

158.21 (c) If extended medical supplies and equipment or environmental modifications are or
158.22 will be purchased for an elderly waiver client, the costs may be prorated for up to 12
158.23 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's
158.24 waivered services exceeds the monthly limit established in paragraph (a), (b), (d), or (e),
158.25 the annual cost of all waivered services shall be determined. In this event, the annual cost
158.26 of all waivered services shall not exceed 12 times the monthly limit of waivered services
158.27 as described in paragraph (a), (b), (d), or (e).

158.28 (d) Effective July 1, 2013, the monthly cost limit of waiver services, including any
158.29 necessary home care services described in section 256B.0651, subdivision 2, for individuals
158.30 who meet the criteria as ventilator-dependent given in section 256B.0651, subdivision 1,
158.31 paragraph (g), shall be the average of the monthly medical assistance amount established
158.32 for home care services as described in section 256B.0652, subdivision 7, and the annual
158.33 average contracted amount established by the commissioner for nursing facility services

159.1 for ventilator-dependent individuals. This monthly limit shall be increased annually as
159.2 described in paragraphs (a) and (e).

159.3 (e) Effective January 1, 2018, and each January 1 thereafter, the monthly cost limits for
159.4 elderly waiver services in effect on the previous December 31 shall be increased by the
159.5 difference between any legislatively adopted home and community-based provider rate
159.6 increases effective on January 1 or since the previous January 1 and the average statewide
159.7 percentage increase in nursing facility operating payment rates under chapter 256R, effective
159.8 the previous January 1. This paragraph shall only apply if the average statewide percentage
159.9 increase in nursing facility operating payment rates is greater than any legislatively adopted
159.10 home and community-based provider rate increases effective on January 1, or occurring
159.11 since the previous January 1.

159.12 (f) The commissioner shall approve an exception to the monthly case mix budget cap
159.13 in paragraph (a) to pay for an enhanced rate for personal care services as described in section
159.14 256B.0659. The exception shall not exceed 107.5 percent of the budget otherwise available
159.15 to the individual. The exception must be reapproved on an annual basis at the time of a
159.16 participant's annual reassessment.

159.17 **EFFECTIVE DATE.** This section is effective July 1, 2019, or upon federal approval,
159.18 whichever is later. The commissioner of human services shall notify the revisor of statutes
159.19 when federal approval is obtained.

159.20 Sec. 30. Minnesota Statutes 2018, section 256B.0949, is amended by adding a subdivision
159.21 to read:

159.22 Subd. 16a. **Background studies.** The requirements for background studies under this
159.23 section shall be met by an early intensive developmental and behavioral intervention services
159.24 agency through the commissioner's NETStudy system as provided under sections 245C.03,
159.25 subdivision 13, and 245C.10, subdivision 14.

159.26 Sec. 31. Minnesota Statutes 2018, section 256B.4914, subdivision 2, is amended to read:

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

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

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

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

160.4 (e) "Direct care staff" means employees providing direct services to an individual
160.5 receiving services under this section. Direct care staff excludes executive, managerial, or
160.6 administrative staff.

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

160.10 (g) "Individual staffing" means the time spent as a one-to-one interaction specific to
160.11 an individual recipient by staff to provide direct support and assistance with activities of
160.12 daily living, instrumental activities of daily living, and training to participants, and is based
160.13 on the requirements in each individual's coordinated service and support plan under section
160.14 245D.02, subdivision 4b; any coordinated service and support plan addendum under section
160.15 245D.02, subdivision 4c; and an assessment tool. Provider observation of an individual's
160.16 needs must also be considered.

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

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

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

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

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

160.28 (m) "Shared staffing" means time spent by employees, not defined under paragraph
160.29 (f), providing or available to provide more than one individual with direct support and
160.30 assistance with activities of daily living as defined under section 256B.0659, subdivision
160.31 1, paragraph (b); instrumental activities of daily living as defined under section 256B.0659,
160.32 subdivision 1, paragraph (i); ancillary activities needed to support individual services; and
160.33 training to participants, and is based on the requirements in each individual's coordinated

161.1 service and support plan under section 245D.02, subdivision 4b; any coordinated service
161.2 and support plan addendum under section 245D.02, subdivision 4c; an assessment tool; and
161.3 provider observation of an individual's service need. Total shared staffing hours are divided
161.4 proportionally by the number of individuals who receive the shared service provisions.

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

161.9 ~~(n)~~ (o) "Unit of service" means the following:

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

161.13 (2) for day services under subdivision 7:

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

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

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

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

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

161.23 (iii) for day support services, a unit of service is 15 minutes; and

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

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

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

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

162.1 (4) for unit-based services without programming under subdivision 9, a unit of service
162.2 is 15 minutes.

162.3 Sec. 32. Minnesota Statutes 2018, section 256B.4914, subdivision 3, is amended to read:

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

- 162.8 (1) 24-hour customized living;
- 162.9 (2) adult day care services;
- 162.10 (3) adult day care services bath;
- 162.11 (4) behavioral programming;
- 162.12 (5) (4) companion services;
- 162.13 (5) community residential services;
- 162.14 (6) customized living;
- 162.15 (7) day support services;
- 162.16 (8) day training and habilitation;
- 162.17 (9) employment exploration services;
- 162.18 (10) employment development services;
- 162.19 (11) employment support services;
- 162.20 (12) family residential services;
- 162.21 (8) (13) housing access coordination;
- 162.22 (9) (14) independent living skills;
- 162.23 (15) individualized home supports;
- 162.24 (16) individualized home supports with training;
- 162.25 (17) individualized home supports with family training;
- 162.26 (10) (18) in-home family support;
- 162.27 (19) integrated community supports;
- 162.28 (11) (20) night supervision;

163.1 ~~(12)~~ (21) personal support;

163.2 (22) positive support services;

163.3 ~~(13)~~ (23) prevocational services;

163.4 ~~(14)~~ ~~residential care services~~;

163.5 ~~(15)~~ (24) residential support services;

163.6 ~~(16)~~ (25) respite services;

163.7 ~~(17)~~ (26) structured day services;

163.8 ~~(18)~~ ~~supported employment services~~;

163.9 ~~(19)~~ (27) supported living services;

163.10 ~~(20)~~ (28) transportation services; and

163.11 ~~(21)~~ ~~individualized home supports~~;

163.12 ~~(22)~~ ~~independent living skills specialist services~~;

163.13 ~~(23)~~ ~~employment exploration services~~;

163.14 ~~(24)~~ ~~employment development services~~;

163.15 ~~(25)~~ ~~employment support services~~; and

163.16 ~~(26)~~ (29) other services as approved by the federal government in the state home and

163.17 community-based services plan.

163.18 **EFFECTIVE DATE.** This section is effective January 1, 2021, or upon federal approval,
163.19 whichever is later, except the amendment striking clause (18) related to supported
163.20 employment services is effective September 1, 2019. The commissioner of human services
163.21 shall notify the revisor of statutes when federal approval is obtained.

163.22 Sec. 33. Minnesota Statutes 2018, section 256B.4914, subdivision 5, is amended to read:

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

- 164.1 (1) for residential direct care staff, the sum of:
- 164.2 (i) 15 percent of the subtotal of 50 percent of the median wage for personal and home
164.3 health aide (SOC code 39-9021); 30 percent of the median wage for nursing assistant (SOC
164.4 code 31-1014); and 20 percent of the median wage for social and human services aide (SOC
164.5 code 21-1093); and
- 164.6 (ii) 85 percent of the subtotal of 20 percent of the median wage for home health aide
164.7 (SOC code 31-1011); 20 percent of the median wage for personal and home health aide
164.8 (SOC code 39-9021); 20 percent of the median wage for nursing assistant (SOC code
164.9 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053);
164.10 and 20 percent of the median wage for social and human services aide (SOC code 21-1093);
- 164.11 (2) for adult day services, 70 percent of the median wage for nursing assistant (SOC
164.12 code 31-1014); and 30 percent of the median wage for personal care aide (SOC code
164.13 39-9021);
- 164.14 (3) for day services, day support services, and prevocational services, 20 percent of the
164.15 median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for
164.16 psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social
164.17 and human services aide (SOC code 21-1093);
- 164.18 (~~3~~)⁽⁴⁾ for residential asleep-overnight staff, the wage is the minimum wage in Minnesota
164.19 for large employers, except in a family foster care setting, the wage is 36 percent of the
164.20 minimum wage in Minnesota for large employers;
- 164.21 (~~4~~)⁽⁵⁾ for behavior program positive supports analyst staff, 100 percent of the median
164.22 wage for mental health counselors (SOC code 21-1014);
- 164.23 (~~5~~)⁽⁶⁾ for behavior program positive supports professional staff, 100 percent of the
164.24 median wage for clinical counseling and school psychologist (SOC code 19-3031);
- 164.25 (~~6~~)⁽⁷⁾ for behavior program positive supports specialist staff, 100 percent of the median
164.26 wage for psychiatric technicians (SOC code 29-2053);
- 164.27 (~~7~~)⁽⁸⁾ for supportive living services staff, 20 percent of the median wage for nursing
164.28 assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician
164.29 (SOC code 29-2053); and 60 percent of the median wage for social and human services
164.30 aide (SOC code 21-1093);
- 164.31 (~~8~~)⁽⁹⁾ for housing access coordination staff, 100 percent of the median wage for
164.32 community and social services specialist (SOC code 21-1099);

165.1 ~~(9)~~(10) for in-home family support and individualized home supports with family
165.2 training staff, 20 percent of the median wage for nursing aide (SOC code 31-1012); 30
165.3 percent of the median wage for community social service specialist (SOC code 21-1099);
165.4 40 percent of the median wage for social and human services aide (SOC code 21-1093);
165.5 and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

165.6 ~~(10)~~(11) for individualized home supports with training services staff, 40 percent of the
165.7 median wage for community social service specialist (SOC code 21-1099); 50 percent of
165.8 the median wage for social and human services aide (SOC code 21-1093); and ten percent
165.9 of the median wage for psychiatric technician (SOC code 29-2053);

165.10 ~~(11)~~(12) for independent living skills staff, 40 percent of the median wage for community
165.11 social service specialist (SOC code 21-1099); 50 percent of the median wage for social and
165.12 human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric
165.13 technician (SOC code 29-2053);

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

165.16 ~~(13)~~ for supported employment staff, 20 percent of the median wage for nursing assistant
165.17 (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code
165.18 29-2053); and 60 percent of the median wage for social and human services aide (SOC code
165.19 21-1093);

165.20 ~~(14)~~(13) for employment support services staff, 50 percent of the median wage for
165.21 rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for
165.22 community and social services specialist (SOC code 21-1099);

165.23 ~~(15)~~(14) for employment exploration services staff, 50 percent of the median wage for
165.24 rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for
165.25 community and social services specialist (SOC code 21-1099);

165.26 ~~(16)~~(15) for employment development services staff, 50 percent of the median wage
165.27 for education, guidance, school, and vocational counselors (SOC code 21-1012); and 50
165.28 percent of the median wage for community and social services specialist (SOC code
165.29 21-1099);

165.30 ~~(17)~~(16) for adult companion staff, 50 percent of the median wage for personal and
165.31 home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant
165.32 (SOC code 31-1014);

166.1 (17) for individualized home supports staff, 50 percent of the median wage for personal
166.2 and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing
166.3 assistant (SOC code 31-1014);

166.4 (18) for night supervision staff, 20 percent of the median wage for home health aide
166.5 (SOC code 31-1011); 20 percent of the median wage for personal and home health aide
166.6 (SOC code 39-9021); 20 percent of the median wage for nursing assistant (SOC code
166.7 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053);
166.8 and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

166.9 (19) for respite staff, 50 percent of the median wage for personal and home care aide
166.10 (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code
166.11 31-1014);

166.12 (20) for personal support staff, 50 percent of the median wage for personal and home
166.13 care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant
166.14 (SOC code 31-1014);

166.15 (21) for supervisory staff, 100 percent of the median wage for community and social
166.16 services specialist (SOC code 21-1099), with the exception of the supervisor of behavior
166.17 positive supports professional, behavior positive supports analyst, and behavior positive
166.18 supports specialists, which is 100 percent of the median wage for clinical counseling and
166.19 school psychologist (SOC code 19-3031);

166.20 (22) for registered nurse staff, 100 percent of the median wage for registered nurses
166.21 (SOC code 29-1141); and

166.22 (23) for licensed practical nurse staff, 100 percent of the median wage for licensed
166.23 practical nurses (SOC code 29-2061).

166.24 (b) The commissioner shall adjust the base wage index in paragraph (k) with a competitive
166.25 workforce factor of 4.7 percent to provide increased compensation to direct care staff. A
166.26 provider shall use the additional revenue from the competitive workforce factor to increase
166.27 wages for direct care staff or to improve benefits provided to direct care staff as defined in
166.28 subdivision 2, paragraph (e).

166.29 (c) Beginning February 1, 2021, and every two years thereafter, the commissioner shall
166.30 report to the chairs and ranking minority members of the legislative committees and divisions
166.31 with jurisdiction over health and human services policy and finance an analysis of the
166.32 competitive workforce factor. The report shall include recommendations to improve the
166.33 competitive workforce factor using (1) the most recently available wage data by SOC code

167.1 of the weighted average wage for direct-care staff for residential services and direct-care
167.2 staff for day services; (2) the most recently available wage data by SOC code of the weighted
167.3 average wage of comparable occupations; and (3) labor market data as required under
167.4 subdivision 10a, paragraph (g). The commissioner shall not recommend an increase or
167.5 decrease of the competitive workforce factor from the current value by more than two
167.6 percentage points. If, after a biennial analysis for the next report, the competitive workforce
167.7 factor is less than or equal to zero, the commissioner shall recommend a competitive
167.8 workforce factor of zero.

167.9 ~~(b)~~ (d) Component values for ~~residential~~ corporate foster care services, corporate
167.10 supportive living services daily, community residential services, and integrated community
167.11 support services are:

- 167.12 (1) supervisory span of control ratio: 11 percent;
- 167.13 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
- 167.14 (3) employee-related cost ratio: 23.6 percent;
- 167.15 (4) general administrative support ratio: 13.25 percent;
- 167.16 (5) program-related expense ratio: 1.3 percent; and
- 167.17 (6) absence and utilization factor ratio: 3.9 percent.

167.18 ~~(e)~~ (e) Component values for family foster care are:

- 167.19 (1) supervisory span of control ratio: 11 percent;
- 167.20 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
- 167.21 (3) employee-related cost ratio: 23.6 percent;
- 167.22 (4) general administrative support ratio: 3.3 percent;
- 167.23 (5) program-related expense ratio: 1.3 percent; and
- 167.24 (6) absence factor: 1.7 percent.

167.25 ~~(d)~~ (f) Component values for day ~~training and habilitation, day support services, and~~
167.26 ~~prevocational services for all servicees~~ are:

- 167.27 (1) supervisory span of control ratio: 11 percent;
- 167.28 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
- 167.29 (3) employee-related cost ratio: 23.6 percent;
- 167.30 (4) program plan support ratio: 5.6 percent;

168.1 (5) client programming and support ratio: ten percent;
168.2 (6) general administrative support ratio: 13.25 percent;
168.3 (7) program-related expense ratio: 1.8 percent; and
168.4 (8) absence and utilization factor ratio: ~~9.4~~ 4.5 percent.

168.5 (g) Component values for adult day services:

168.6 (1) supervisory span of control ratio: 11 percent;
168.7 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;

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

168.9 (4) program plan support ratio: 5.6 percent;

168.10 (5) client programming and support ratio: 7.4 percent;

168.11 (6) general administrative support ratio: 13.25 percent;

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

168.13 (8) absence and utilization factor ratio: 4.5 percent.

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

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

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

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

168.18 (4) program plan supports ratio: 15.5 percent;

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

168.20 (6) general administrative support ratio: 13.25 percent;

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

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

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

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

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

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

- 169.1 (4) program plan support ratio: 7.0 percent;
- 169.2 (5) client programming and support ratio: 2.3 percent;
- 169.3 (6) general administrative support ratio: 13.25 percent;
- 169.4 (7) program-related expense ratio: 2.9 percent; and
- 169.5 (8) absence and utilization factor ratio: 3.9 percent.
- 169.6 ~~(g)~~ (j) Component values for unit-based services without programming for respite are:
- 169.7 (1) supervisory span of control ratio: 11 percent;
- 169.8 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
- 169.9 (3) employee-related cost ratio: 23.6 percent;
- 169.10 (4) general administrative support ratio: 13.25 percent;
- 169.11 (5) program-related expense ratio: 2.9 percent; and
- 169.12 (6) absence and utilization factor ratio: 3.9 percent.
- 169.13 ~~(h) On July 1, 2017, the commissioner shall update the base wage index in paragraph~~
- 169.14 ~~(a) based on the wage data by standard occupational code (SOC) from the Bureau of Labor~~
- 169.15 ~~Statistics available on December 31, 2016. The commissioner shall publish these updated~~
- 169.16 ~~values and load them into the rate management system.~~ (k) On July 1, 2022, and every ~~five~~
- 169.17 ~~two~~ years thereafter, the commissioner shall update the base wage index in paragraph (a)
- 169.18 based on ~~the most recently available~~ wage data by SOC from the Bureau of Labor Statistics
- 169.19 ~~available 18 months and one day prior.~~ The commissioner shall publish these updated values
- 169.20 and load them into the rate management system.
- 169.21 ~~(i) On July 1, 2017, the commissioner shall update the framework components in~~
- 169.22 ~~paragraph (d), clause (5); paragraph (e), clause (5); and paragraph (f), clause (5); subdivision~~
- 169.23 ~~6, clauses (8) and (9); and subdivision 7, clauses (10), (16), and (17), for changes in the~~
- 169.24 ~~Consumer Price Index. The commissioner will adjust these values higher or lower by the~~
- 169.25 ~~percentage change in the Consumer Price Index-All Items, United States city average~~
- 169.26 ~~(CPI-U) from January 1, 2014, to January 1, 2017. The commissioner shall publish these~~
- 169.27 ~~updated values and load them into the rate management system.~~ (l) On July 1, 2022, and
- 169.28 every ~~five~~ two years thereafter, the commissioner shall update the framework components
- 169.29 in paragraph ~~(d)~~ (f), clause (5); paragraph ~~(e)~~ (h), clause (5); and paragraph ~~(f)~~ (i), clause
- 169.30 ~~(5); paragraph (g), clause (5); subdivision 6, paragraphs (b), clauses (8) and (9);, and (d),~~
- 169.31 ~~clause (9); and subdivision 7, clauses (10), (16), and (17), for changes in the Consumer~~
- 169.32 Price Index. The commissioner shall adjust these values higher or lower by the percentage

170.1 change in the CPI-U from the date of the previous update to the ~~date of the data most recently~~
170.2 available on December 31 two years prior to the scheduled update. The commissioner shall
170.3 publish these updated values and load them into the rate management system.

170.4 (m) Upon the implementation of automatic inflation adjustments under paragraphs (k)
170.5 and (l), rate adjustments authorized under section 256B.439, subdivision 7; Laws 2013,
170.6 chapter 108, article 7, section 60; and Laws 2014, chapter 312, article 27, section 75, shall
170.7 be removed from service rates calculated under this section.

170.8 (n) Any rate adjustments applied to the service rates calculated under this section outside
170.9 of the cost components and rate methodology specified in this section shall be removed
170.10 from rate calculations upon implementation of automatic inflation adjustments under
170.11 paragraphs (k) and (l).

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

170.15 (p) In this subdivision, if the Bureau of Labor Statistics occupational codes used to
170.16 calculate the base wage index in paragraph (a) are revised, the commissioner shall use the
170.17 most recently available data prior to the scheduled update.

170.18 **EFFECTIVE DATE.** This section is effective January 1, 2021, or upon federal approval,
170.19 whichever is later, except the new paragraph (b) is effective January 1, 2020, or upon federal
170.20 approval, whichever is later; and the amendment striking paragraph (a), clause (13), related
170.21 to supported employment staff, is effective September 1, 2019. The commissioner of human
170.22 services shall notify the revisor of statutes when federal approval is obtained.

170.23 Sec. 34. Minnesota Statutes 2018, section 256B.4914, subdivision 6, is amended to read:

170.24 **Subd. 6. Payments for residential support services.** (a) For purposes of this subdivision,
170.25 residential support services include 24-hour customized living services, community residential
170.26 services, customized living services, family residential services, foster care services,
170.27 integrated community supports, and supportive living services daily.

170.28 (b) Payments for residential support services, as defined in sections 256B.092, subdivision
170.29 11, and 256B.49, subdivision 22, in which the person providing services does not live in
170.30 the setting where the service is provided, including community residential services, corporate
170.31 foster care services, and corporate supportive living services daily must be calculated as
170.32 follows:

- 171.1 (1) determine the number of shared staffing and individual direct staff hours to meet a
171.2 recipient's needs provided on site or through monitoring technology;
- 171.3 (2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics
171.4 Minnesota-specific rates or rates derived by the commissioner as provided in subdivision
171.5 5. This is defined as the direct-care rate;
- 171.6 (3) for a recipient requiring customization for deaf and hard-of-hearing language
171.7 accessibility under subdivision 12, add the customization rate provided in subdivision 12
171.8 to the result of clause (2). This is defined as the customized direct-care rate;
- 171.9 (4) multiply the number of shared and individual direct staff hours provided on site or
171.10 through monitoring technology and nursing hours by the appropriate staff wages in
171.11 subdivision 5, paragraph (a), or the customized direct-care rate;
- 171.12 (5) multiply the number of shared and individual direct staff hours provided on site or
171.13 through monitoring technology and nursing hours by the product of the supervision span
171.14 of control ratio in subdivision 5, paragraph (b), clause (1), and the appropriate supervision
171.15 wage in subdivision 5, paragraph (a), clause (21);
- 171.16 (6) combine the results of clauses (4) and (5), excluding any shared and individual direct
171.17 staff hours provided through monitoring technology, and multiply the result by one plus
171.18 the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (b),
171.19 clause (2). This is defined as the direct staffing cost;
- 171.20 (7) for employee-related expenses, multiply the direct staffing cost, excluding any shared
171.21 and individual direct staff hours provided through monitoring technology, by one plus the
171.22 employee-related cost ratio in subdivision 5, paragraph (b), clause (3);
- 171.23 (8) for client programming and supports, the commissioner shall add \$2,179; and
- 171.24 (9) for transportation, if provided, the commissioner shall add \$1,680, or \$3,000 if
171.25 customized for adapted transport, based on the resident with the highest assessed need.
- 171.26 **(b)** The total rate must be calculated using the following steps:
- 171.27 (1) subtotal paragraph (a), clauses (7) to (9), and the direct staffing cost of any shared
171.28 and individual direct staff hours provided through monitoring technology that was excluded
171.29 in clause (7);
- 171.30 (2) sum the standard general and administrative rate, the program-related expense ratio,
171.31 and the absence and utilization ratio;

172.1 (3) divide the result of clause (1) by one minus the result of clause (2). This is the total

172.2 payment amount; and

172.3 (4) adjust the result of clause (3) by a factor to be determined by the commissioner to

172.4 adjust for regional differences in the cost of providing services.

172.5 ~~(e)~~ (d) Payments for integrated community support services must be calculated as follows:

172.6 ~~(1) the base shared staffing shall be eight hours divided by the number of people receiving~~

172.7 ~~support in the integrated community support setting;~~

172.8 ~~(2) the individual staffing hours shall be the average number of direct support hours~~

172.9 ~~provided directly to the service recipient;~~

172.10 ~~(3) the personnel hourly wage rate must be based on the most recent Bureau of Labor~~

172.11 ~~Statistics Minnesota-specific rates or rates derived by the commissioner as provided in~~

172.12 ~~subdivision 5. This is defined as the direct-care rate;~~

172.13 ~~(4) for a recipient requiring customization for deaf and hard-of-hearing language~~

172.14 ~~accessibility under subdivision 12, add the customization rate provided in subdivision 12~~

172.15 ~~to the result of clause (2). This is defined as the customized direct-care rate;~~

172.16 ~~(5) multiply the number of shared and individual direct staff hours in clauses (1) and~~

172.17 ~~(2) by the appropriate staff wages in subdivision 5, paragraph (a), or the customized~~

172.18 ~~direct-care rate;~~

172.19 ~~(6) multiply the number of shared and individual direct staff hours in clauses (1) and~~

172.20 ~~(2) by the product of the supervision span of control ratio in subdivision 5, paragraph (b),~~

172.21 ~~clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause~~

172.22 ~~(21);~~

172.23 ~~(7) combine the results of clauses (4) and (5) and multiply the result by one plus the~~

172.24 ~~employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (b), clause~~

172.25 ~~(2). This is defined as the direct staffing cost;~~

172.26 ~~(8) for employee-related expenses, multiply the direct staffing cost by one plus the~~

172.27 ~~employee-related cost ratio in subdivision 5, paragraph (b), clause (3); and~~

172.28 ~~(9) for client programming and supports, the commissioner shall add \$2,260.21 divided~~

172.29 ~~by 365.~~

172.30 ~~(e) The total rate must be calculated using the following steps:~~

172.31 ~~(1) subtotal of paragraph (d), clauses (6) to (8);~~

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

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

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

173.7 (f) The payment methodology for customized living, and 24-hour customized living,
173.8 and residential care services must be the customized living tool. Revisions to the customized
173.9 living tool must be made to reflect the services and activities unique to disability-related
173.10 recipient needs and adjusted by a factor to be determined by the commissioner to adjust for
173.11 regional differences in the cost of providing services.

173.12 ~~(d) For individuals enrolled prior to January 1, 2014, the days of service authorized must~~
173.13 ~~meet or exceed the days of service used to convert service agreements in effect on December~~
173.14 ~~1, 2013, and must not result in a reduction in spending or service utilization due to conversion~~
173.15 ~~during the implementation period under section 256B.4913, subdivision 4a. If during the~~
173.16 ~~implementation period, an individual's historical rate, including adjustments required under~~
173.17 ~~section 256B.4913, subdivision 4a, paragraph (e), is equal to or greater than the rate~~
173.18 ~~determined in this subdivision, the number of days authorized for the individual is 365.~~

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

173.21 **EFFECTIVE DATE.** This section is effective January 1, 2021, or upon federal approval,
173.22 whichever is later. The commissioner of human services shall notify the revisor of statutes
173.23 when federal approval is obtained.

173.24 Sec. 35. Minnesota Statutes 2018, section 256B.4914, subdivision 7, is amended to read:

173.25 Subd. 7. **Payments for day programs.** Payments for services with day programs
173.26 including adult day ~~care~~ services, day treatment and habilitation, day support services,
173.27 prevocational services, and structured day services must be calculated as follows:

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

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

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

- 174.1 (2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics
174.2 Minnesota-specific rates or rates derived by the commissioner as provided in subdivision
174.3 5;
- 174.4 (3) for a recipient requiring customization for deaf and hard-of-hearing language
174.5 accessibility under subdivision 12, add the customization rate provided in subdivision 12
174.6 to the result of clause (2). This is defined as the customized direct-care rate;
- 174.7 (4) multiply the number of day program direct staff hours and nursing hours by the
174.8 appropriate staff wage in subdivision 5, paragraph (a), or the customized direct-care rate;
- 174.9 (5) multiply the number of day direct staff hours by the product of the supervision span
174.10 of control ratio in subdivision 5, paragraph (d), clause (1), and the appropriate supervision
174.11 wage in subdivision 5, paragraph (a), clause (21);
- 174.12 (6) combine the results of clauses (4) and (5), and multiply the result by one plus the
174.13 employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (d), clause
174.14 (2). This is defined as the direct staffing rate;
- 174.15 (7) for program plan support, multiply the result of clause (6) by one plus the program
174.16 plan support ratio in subdivision 5, paragraph (d), clause (4);
- 174.17 (8) for employee-related expenses, multiply the result of clause (7) by one plus the
174.18 employee-related cost ratio in subdivision 5, paragraph (d), clause (3);
- 174.19 (9) for client programming and supports, multiply the result of clause (8) by one plus
174.20 the client programming and support ratio in subdivision 5, paragraph (d), clause (5);
- 174.21 (10) for program facility costs, add \$19.30 per week with consideration of staffing ratios
174.22 to meet individual needs;
- 174.23 (11) for adult day bath services, add \$7.01 per 15 minute unit;
- 174.24 (12) this is the subtotal rate;
- 174.25 (13) sum the standard general and administrative rate, the program-related expense ratio,
174.26 and the absence and utilization factor ratio;
- 174.27 (14) divide the result of clause (12) by one minus the result of clause (13). This is the
174.28 total payment amount;
- 174.29 (15) adjust the result of clause (14) by a factor to be determined by the commissioner
174.30 to adjust for regional differences in the cost of providing services;

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

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

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

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

175.12 (iv) \$33.50 for a trip of 51 miles or more for a nonshared ride in a vehicle without a lift,
175.13 \$16.50 for a shared ride in a vehicle without a lift, and \$20.75 for a shared ride in a vehicle
175.14 with a lift;

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

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

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

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

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

175.25 **EFFECTIVE DATE.** This section is effective January 1, 2021, or upon federal approval,
175.26 whichever is later. The commissioner of human services shall notify the revisor of statutes
175.27 when federal approval is obtained.

175.28 Sec. 36. Minnesota Statutes 2018, section 256B.4914, subdivision 8, is amended to read:

175.29 **Subd. 8. Payments for unit-based services with programming.** Payments for unit-based
175.30 services with programming, including ~~behavior programming employment exploration~~
175.31 ~~services, employment development services, housing access coordination, individualized~~
175.32 ~~home supports with family training, individualized home supports with training, in-home~~

176.1 family support, independent living skills training, ~~independent living skills specialist services, individualized home supports, and hourly supported living services, employment exploration services, employment development services, supported employment, and 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:

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

176.8 (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;

176.11 (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;

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

176.16 (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 (21);

176.19 (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;

176.22 (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);

176.24 (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);

176.26 (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);

176.28 (10) this is the subtotal rate;

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

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

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

177.8 (13) for employment exploration services provided in a shared manner, divide the total
177.9 payment amount in clause (12) by the number of service recipients, not to exceed five. For
177.10 employment support services provided in a shared manner, divide the total payment amount
177.11 in clause (12) by the number of service recipients, not to exceed six. For independent living
177.12 skills training, individualized home supports with training, and individualized home supports
177.13 with family training provided in a shared manner, divide the total payment amount in clause
177.14 (12) by the number of service recipients, not to exceed two; and

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

177.17 **EFFECTIVE DATE.** This section is effective January 1, 2021, or upon federal approval,
177.18 whichever is later, except the amendments striking "supported employment," in paragraph
177.19 (a) and striking clause (13) related to supported employment are effective September 1,
177.20 2019. The commissioner of human services shall notify the revisor of statutes when federal
177.21 approval is obtained.

177.22 Sec. 37. Minnesota Statutes 2018, section 256B.4914, subdivision 9, is amended to read:

177.23 Subd. 9. **Payments for unit-based services without programming.** Payments for
177.24 unit-based services without programming, including individualized home supports, night
177.25 supervision, personal support, respite, and companion care provided to an individual outside
177.26 of any day or residential service plan must be calculated as follows unless the services are
177.27 authorized separately under subdivision 6 or 7:

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

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

- 178.1 (3) for a recipient requiring customization for deaf and hard-of-hearing language
178.2 accessibility under subdivision 12, add the customization rate provided in subdivision 12
178.3 to the result of clause (2). This is defined as the customized direct care rate;
- 178.4 (4) multiply the number of direct staff hours by the appropriate staff wage in subdivision
178.5 5 or the customized direct care rate;
- 178.6 (5) multiply the number of direct staff hours by the product of the supervision span of
178.7 control ratio in subdivision 5, paragraph (f), clause (1), and the appropriate supervision
178.8 wage in subdivision 5, paragraph (a), clause (21);
- 178.9 (6) combine the results of clauses (4) and (5), and multiply the result by one plus the
178.10 employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (f), clause
178.11 (2). This is defined as the direct staffing rate;
- 178.12 (7) for program plan support, multiply the result of clause (6) by one plus the program
178.13 plan support ratio in subdivision 5, paragraph (f), clause (4);
- 178.14 (8) for employee-related expenses, multiply the result of clause (7) by one plus the
178.15 employee-related cost ratio in subdivision 5, paragraph (f), clause (3);
- 178.16 (9) for client programming and supports, multiply the result of clause (8) by one plus
178.17 the client programming and support ratio in subdivision 5, paragraph (f), clause (5);
- 178.18 (10) this is the subtotal rate;
- 178.19 (11) sum the standard general and administrative rate, the program-related expense ratio,
178.20 and the absence and utilization factor ratio;
- 178.21 (12) divide the result of clause (10) by one minus the result of clause (11). This is the
178.22 total payment amount;
- 178.23 (13) for respite services, determine the number of day units of service to meet an
178.24 individual's needs;
- 178.25 (14) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics
178.26 Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;
- 178.27 (15) for a recipient requiring deaf and hard-of-hearing customization under subdivision
178.28 12, add the customization rate provided in subdivision 12 to the result of clause (14). This
178.29 is defined as the customized direct care rate;
- 178.30 (16) multiply the number of direct staff hours by the appropriate staff wage in subdivision
178.31 5, paragraph (a);

179.1 (17) multiply the number of direct staff hours by the product of the supervisory span of
179.2 control ratio in subdivision 5, paragraph (g), clause (1), and the appropriate supervision
179.3 wage in subdivision 5, paragraph (a), clause (21);

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

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

179.9 (20) this is the subtotal rate;

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

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

179.14 (23) for individualized home supports provided in a shared manner, divide the total
179.15 payment amount in clause (12) by the number of service recipients, not to exceed two. For
179.16 respite care services provided in a shared manner, divide the total payment amount in clause
179.17 (22) by the number of service recipients, not to exceed three; and

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

179.20 **EFFECTIVE DATE.** This section is effective January 1, 2021, or upon federal approval,
179.21 whichever is later. The commissioner of human services shall notify the revisor of statutes
179.22 when federal approval is obtained.

179.23 Sec. 38. Minnesota Statutes 2018, section 256B.4914, subdivision 10, is amended to read:

179.24 **Subd. 10. Updating payment values and additional information.** (a) From January
179.25 1, 2014, through December 31, 2017, the commissioner shall develop and implement uniform
179.26 procedures to refine terms and adjust values used to calculate payment rates in this section.

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

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

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

180.4 (3) the distinct underlying costs for services provided by a license holder under sections
180.5 245D.05, 245D.06, 245D.07, 245D.071, 245D.081, and 245D.09, and for services provided
180.6 by a license holder certified under section 245D.33.

180.7 ~~(e) 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.~~

180.15 ~~(d)~~ (b) 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:

180.18 (1) values for transportation rates;

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

180.20 (3) values for indirect services;

180.21 (4) values for nursing;

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

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

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

180.26 (8) direct care workforce labor market measures;

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

180.29 ~~(9)~~ (10) outcome measures, determined by the commissioner, for home and

180.30 community-based services rates determined under this section.; ~~and~~

181.1 (11) different competitive workforce factors by service, as determined under subdivision
181.2 5, paragraph (k).

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

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

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

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

181.11 ~~(4) January 15, 2020 2021, with another full report, and a full report once every four~~
181.12 years thereafter.

181.13 ~~(f) The commissioner shall implement a regional adjustment factor to all rate calculations~~
181.14 ~~in subdivisions 6 to 9, effective no later than January 1, 2015.~~ (d) Beginning July 1, 2017
181.15 January 1, 2022, the commissioner shall renew analysis and implement changes to the
181.16 regional adjustment factors ~~when adjustments required under subdivision 5, paragraph (h),~~
181.17 ~~occur~~ once every six years. Prior to implementation, the commissioner shall consult with
181.18 stakeholders on the methodology to calculate the adjustment.

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

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

181.24 (2) service utilization;

181.25 (3) county and tribal allocation changes; and

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

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

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

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

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

182.7 ~~(f)~~ (g) Beginning July 1, 2017, the commissioner shall collect transportation and trip
182.8 information for all day services through the rates management system.

182.9 (h) The commissioner shall develop a new rate methodology for residential services in
182.10 which the service provider lives in the setting where the service is provided based on levels
182.11 of support needs. The commissioner shall submit recommendations to the legislative
182.12 committees with jurisdiction over human services of the new rate methodology to replace
182.13 subdivision 6, paragraph (d), by January 1, 2020.

182.14 (i) The commissioner shall study value-based payment strategies for fee-for-service
182.15 home and community-based services and submit a report to the legislative committees with
182.16 jurisdiction over human services by October 1, 2020, with recommended strategies to
182.17 improve the quality, efficiency, and effectiveness of services.

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

182.19 Sec. 39. Minnesota Statutes 2018, section 256B.4914, subdivision 10a, is amended to
182.20 read:

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

182.28 (1) worker wage costs;

182.29 (2) benefits paid;

182.30 (3) supervisor wage costs;

182.31 (4) executive wage costs;

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

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

183.2 (7) administrative costs paid;

183.3 (8) program costs paid;

183.4 (9) transportation costs paid;

183.5 (10) vacancy rates; and

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

183.8 (b) At least once in any five-year period, a provider must submit cost data for a fiscal
183.9 year that ended not more than 18 months prior to the submission date. The commissioner
183.10 shall provide each provider a 90-day notice prior to its submission due date. If a provider
183.11 fails to submit required reporting data, the commissioner shall provide notice to providers
183.12 that have not provided required data 30 days after the required submission date, and a second
183.13 notice for providers who have not provided required data 60 days after the required
183.14 submission date. The commissioner shall temporarily suspend payments to the provider if
183.15 cost data is not received 90 days after the required submission date. Withheld payments
183.16 shall be made once data is received by the commissioner.

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

183.20 (d) The commissioner shall analyze cost documentation in paragraph (a) and, in
183.21 consultation with stakeholders identified in section 256B.4913, subdivision 5, may submit
183.22 recommendations on component values and inflationary factor adjustments to the chairs
183.23 and ranking minority members of the legislative committees with jurisdiction over human
183.24 services every four years beginning January 1, 2020 2021. The commissioner shall make
183.25 recommendations in conjunction with reports submitted to the legislature according to
183.26 subdivision 10, paragraph ~~(e)~~(c). The commissioner shall release cost data in an aggregate
183.27 form, and cost data from individual providers shall not be released except as provided for
183.28 in current law.

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

184.1 (f) By December 31, 2020, providers paid with rates calculated under subdivision 5,
184.2 paragraph (b), shall identify additional revenues from the competitive workforce factor and
184.3 prepare a written distribution plan for the revenues. A provider shall make the provider's
184.4 distribution plan available and accessible to all direct care staff for a minimum of one
184.5 calendar year. Upon request, a provider shall submit the written distribution plan to the
184.6 commissioner.

184.7 (g) Providers enrolled to provide services with rates determined under section 256B.4914,
184.8 subdivision 3, shall submit labor market data to the commissioner annually on or before
184.9 November 1, including but not limited to:

- 184.10 (1) number of direct care staff;
- 184.11 (2) wages of direct care staff;
- 184.12 (3) overtime wages of direct care staff;
- 184.13 (4) hours worked by direct care staff;
- 184.14 (5) overtime hours worked by direct care staff;
- 184.15 (6) benefits provided to direct care staff;
- 184.16 (7) direct care staff job vacancies; and
- 184.17 (8) direct care staff retention rates.

184.18 (h) The commissioner shall publish annual reports on provider and state-level labor
184.19 market data, including but not limited to the data obtained under paragraph (g).

184.20 (i) The commissioner shall temporarily suspend payments to the provider if data requested
184.21 under paragraph (g) is not received 90 days after the required submission date. Withheld
184.22 payments shall be made once data is received by the commissioner.

184.23 **EFFECTIVE DATE.** This section is effective the day following final enactment except
184.24 paragraph (g) is effective November 1, 2019, and paragraph (h) is effective February 1,
184.25 2020.

184.26 Sec. 40. Minnesota Statutes 2018, section 256B.85, subdivision 3, is amended to read:

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

- 184.28 (1) is an enrollee of medical assistance as determined under section 256B.055, 256B.056,
184.29 or 256B.057, subdivisions 5 and 9;
- 184.30 (2) is a participant in the alternative care program under section 256B.0913;

185.1 (3) is a waiver participant as defined under section 256B.0915, 256B.092, 256B.093, or
185.2 256B.49; or

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

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

185.7 (1) require assistance and be determined dependent in one activity of daily living or
185.8 Level I behavior based on assessment under section 256B.0911; and

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

185.10 (c) A pregnant woman eligible for medical assistance under section 256B.055, subdivision
185.11 6, is eligible for CFSS without federal financial participation if the woman: (1) is eligible
185.12 for CFSS under paragraphs (a) and (b); and (2) does not meet institutional level of care, as
185.13 determined under section 256B.0911.

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

185.15 Sec. 41. Laws 2017, First Special Session chapter 6, article 3, section 49, is amended to
185.16 read:

185.17 **Sec. 49. ELECTRONIC SERVICE DELIVERY DOCUMENTATION SYSTEM**

185.18 **VISIT VERIFICATION.**

185.19 Subdivision 1. **Documentation; establishment.** The commissioner of human services
185.20 shall establish implementation requirements and standards for ~~an electronic service delivery~~
185.21 ~~documentation system~~ visit verification to comply with the 21st Century Cures Act, Public
185.22 Law 114-255. Within available appropriations, the commissioner shall take steps to comply
185.23 with the electronic visit verification requirements in the 21st Century Cures Act, Public
185.24 Law 114-255.

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

185.27 (b) "Electronic service delivery documentation visit verification" means the electronic
185.28 documentation of the:

185.29 (1) type of service performed;

185.30 (2) individual receiving the service;

- 186.1 (3) date of the service;
- 186.2 (4) location of the service delivery;
- 186.3 (5) individual providing the service; and
- 186.4 (6) time the service begins and ends.
- 186.5 (c) "Electronic service delivery documentation visit verification system" means a system
186.6 that provides electronic service delivery documentation verification of services that complies
186.7 with the 21st Century Cures Act, Public Law 114-255, and the requirements of subdivision
186.8 3.
- 186.9 (d) "Service" means one of the following:
- 186.10 (1) personal care assistance services as defined in Minnesota Statutes, section 256B.0625,
186.11 subdivision 19a, and provided according to Minnesota Statutes, section 256B.0659; or
- 186.12 (2) community first services and supports under Minnesota Statutes, section 256B.85;
- 186.13 (3) home health services under Minnesota Statutes, section 256B.0625, subdivision 6a;
- 186.14 or
- 186.15 (4) other medical supplies and equipment or home and community-based services that
186.16 are required to be electronically verified by the 21st Century Cures Act, Public Law 114-255.
- 186.17 **Subd. 3. Requirements.** (a) In developing implementation requirements for an electronic
186.18 service delivery documentation system visit verification, the commissioner shall consider
186.19 electronic visit verification systems and other electronic service delivery documentation
186.20 methods. The commissioner shall convene stakeholders that will be impacted by an electronic
186.21 service delivery system, including service providers and their representatives, service
186.22 recipients and their representatives, and, as appropriate, those with expertise in the
186.23 development and operation of an electronic service delivery documentation system, to ensure
186.24 that the requirements:
- 186.25 (1) are minimally administratively and financially burdensome to a provider;
- 186.26 (2) are minimally burdensome to the service recipient and the least disruptive to the
186.27 service recipient in receiving and maintaining allowed services;
- 186.28 (3) consider existing best practices and use of electronic service delivery documentation
186.29 visit verification;
- 186.30 (4) are conducted according to all state and federal laws;

187.1 (5) are effective methods for preventing fraud when balanced against the requirements
187.2 of clauses (1) and (2); and

187.3 (6) are consistent with the Department of Human Services' policies related to covered
187.4 services, flexibility of service use, and quality assurance.

187.5 (b) The commissioner shall make training available to providers on the electronic ~~service~~
187.6 ~~delivery documentation visit verification~~ system requirements.

187.7 (c) The commissioner shall establish baseline measurements related to preventing fraud
187.8 and establish measures to determine the effect of electronic ~~service delivery documentation~~
187.9 ~~visit verification~~ requirements on program integrity.

187.10 (d) The commissioner shall make a state-selected electronic visit verification system
187.11 available to providers of services.

187.12 Subd. 3a. Provider requirements. (a) A provider of services may select any electronic
187.13 visit verification system that meets the requirements established by the commissioner.

187.14 (b) All electronic visit verification systems used by providers to comply with the
187.15 requirements established by the commissioner must provide data to the commissioner in a
187.16 format and at a frequency to be established by the commissioner.

187.17 (c) Providers must implement the electronic visit verification systems required under
187.18 this section by a date established by the commissioner to be set after the state-selected
187.19 electronic visit verification systems for personal care services and home health services are
187.20 in production. For purposes of this paragraph, "personal care services" and "home health
187.21 services" have the meanings given in United States Code, title 42, section 1396b(l)(5).

187.22 Subd. 4. Legislative report. (a) The commissioner shall submit a report by January 15,
187.23 2018, to the chairs and ranking minority members of the legislative committees with
187.24 jurisdiction over human services with recommendations, based on the requirements of
187.25 subdivision 3, to establish electronic service delivery documentation system requirements
187.26 and standards. The report shall identify:

187.27 (1) the essential elements necessary to operationalize a base level electronic service
187.28 delivery documentation system to be implemented by January 1, 2019; and

187.29 (2) enhancements to the base level electronic service delivery documentation system to
187.30 be implemented by January 1, 2019, or after, with projected operational costs and the costs
187.31 and benefits for system enhancements.

188.1 (b) The report must also identify current regulations on service providers that are either
188.2 inefficient, minimally effective, or will be unnecessary with the implementation of an
188.3 electronic service delivery documentation system.

188.4 Sec. 42. DIRECTION TO COMMISSIONER; SKILLED NURSE VISIT RATES.

188.5 The commissioner of human services shall ensure that skilled nurse visits reimbursed
188.6 under Minnesota Statutes, section 256B.0653, are coded, specific to the category of the
188.7 nurse performing the visit, using code sets compliant with the Health Insurance Portability
188.8 and Accountability Act, Public Law 104-191. "Skilled nurse visit" has the meaning given
188.9 in Minnesota Statutes, section 256B.0653, subdivision 2, paragraph (j).

188.10 Sec. 43. DIRECTION TO COMMISSIONER; INTERAGENCY AGREEMENTS.

188.11 By October 1, 2019, the Department of Commerce, Public Utilities Commission, and
188.12 Department of Human Services must amend all interagency agreements necessary to
188.13 implement sections 1 to 11.

188.14 Sec. 44. DIRECTION TO COMMISSIONER; FEDERAL AUTHORITY FOR
188.15 RECONFIGURED WAIVER SERVICES.

188.16 The commissioner of human services shall seek necessary federal authority to implement
188.17 new and reconfigured waiver services under section 45. The commissioner of human services
188.18 shall notify the revisor of statutes when federal approval is obtained and when new services
188.19 are fully implemented.

188.20 Sec. 45. DISABILITY WAIVER RECONFIGURATION.

188.21 Subdivision 1. Intent. It is the intent of the legislature to reform the medical assistance
188.22 waiver programs for people with disabilities to simplify administration of the programs,
188.23 encourage person-centered supports, enhance each person's personal authority over the
188.24 person's service choice, align benefits across waivers, encourage equity across programs
188.25 and populations, and promote long-term sustainability of needed services.

188.26 Subd. 2. Report. By January 15, 2021, the commissioner of human services shall submit
188.27 a report to the members of the legislative committees with jurisdiction over human services
188.28 on any necessary waivers, state plan amendments, requests for new funding or realignment
188.29 of existing funds, any changes to state statute or rule, and any other federal authority
188.30 necessary to implement this section.

189.1 Subd. 3. **Proposal.** By January 15, 2021, the commissioner shall develop a proposal to
189.2 reconfigure the medical assistance waivers provided in sections 256B.092 and 256B.49.
189.3 The proposal shall include all necessary plans for implementing two home and
189.4 community-based services waiver programs, as authorized under section 1915(c) of the
189.5 Social Security Act that serve persons who are determined to require the levels of care
189.6 provided in a nursing home, a hospital, a neurobehavioral hospital, or an intermediate care
189.7 facility for persons with developmental disabilities.

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

189.9 Sec. 46. **INDIVIDUAL PROVIDERS OF DIRECT SUPPORT SERVICES.**

189.10 The labor agreement between the state of Minnesota and the Service Employees
189.11 International Union Healthcare Minnesota, submitted to the Legislative Coordinating
189.12 Commission on, is ratified.

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

189.14 Sec. 47. **RATE INCREASE FOR DIRECT SUPPORT SERVICES PROVIDERS**
189.15 **WORKFORCE NEGOTIATIONS.**

189.16 (a) If the labor agreement between the state of Minnesota and the Service Employees
189.17 International Union Healthcare Minnesota under Minnesota Statutes, section 179A.54, is
189.18 approved pursuant to Minnesota Statutes, section 3.855, the commissioner of human services
189.19 shall increase reimbursement rates, individual budgets, grants, or allocations by 2.37 percent
189.20 for services provided on or after July 1, 2019, to implement the minimum hourly wage,
189.21 holiday, enhanced rate, and paid time off provisions of that agreement.

189.22 (b) The rate changes described in this section apply to direct support services provided
189.23 through a covered program, as defined in Minnesota Statutes, section 256B.0711, subdivision
189.24 1.

189.25 Sec. 48. **REPEALER.**

189.26 (a) Minnesota Statutes 2018, section 256B.0705, is repealed.

189.27 (b) Minnesota Statutes 2018, sections 252.431; and 252.451, are repealed.

189.28 (c) Minnesota Statutes 2018, section 252.41, subdivision 8, is repealed.

189.29 **EFFECTIVE DATE.** Paragraph (a) is effective the day following final enactment.

189.30 Paragraph (b) is effective September 1, 2019. Paragraph (c) is effective January 1, 2020.

ARTICLE 6**CHEMICAL AND MENTAL HEALTH**

190.3 Section 1. Minnesota Statutes 2018, section 245.4889, subdivision 1, is amended to read:

190.4 **Subdivision 1. Establishment and authority.** (a) The commissioner is authorized to
190.5 make grants from available appropriations to assist:

190.6 (1) counties;

190.7 (2) Indian tribes;

190.8 (3) children's collaboratives under section 124D.23 or 245.493; or

190.9 (4) mental health service providers.

190.10 (b) The following services are eligible for grants under this section:

190.11 (1) services to children with emotional disturbances as defined in section 245.4871,
190.12 subdivision 15, and their families;

190.13 (2) transition services under section 245.4875, subdivision 8, for young adults under
190.14 age 21 and their families;

190.15 (3) respite care services for children with severe emotional disturbances who are at risk
190.16 of out-of-home placement;

190.17 (4) children's mental health crisis services;

190.18 (5) mental health services for people from cultural and ethnic minorities;

190.19 (6) children's mental health screening and follow-up diagnostic assessment and treatment;

190.20 (7) services to promote and develop the capacity of providers to use evidence-based
190.21 practices in providing children's mental health services;

190.22 (8) school-linked mental health services, ~~including transportation for children receiving~~
190.23 ~~school-linked mental health services when school is not in session~~ under section 245.4901;

190.24 (9) building evidence-based mental health intervention capacity for children birth to age
190.25 five;

190.26 (10) suicide prevention and counseling services that use text messaging statewide;

190.27 (11) mental health first aid training;

190.28 (12) training for parents, collaborative partners, and mental health providers on the
190.29 impact of adverse childhood experiences and trauma and development of an interactive
190.30 website to share information and strategies to promote resilience and prevent trauma;

191.1 (13) transition age services to develop or expand mental health treatment and supports
191.2 for adolescents and young adults 26 years of age or younger;

191.3 (14) early childhood mental health consultation;

191.4 (15) evidence-based interventions for youth at risk of developing or experiencing a first
191.5 episode of psychosis, and a public awareness campaign on the signs and symptoms of
191.6 psychosis;

191.7 (16) psychiatric consultation for primary care practitioners; and

191.8 (17) providers to begin operations and meet program requirements when establishing a
191.9 new children's mental health program. These may be start-up grants.

191.10 (c) Services under paragraph (b) must be designed to help each child to function and
191.11 remain with the child's family in the community and delivered consistent with the child's
191.12 treatment plan. Transition services to eligible young adults under this paragraph must be
191.13 designed to foster independent living in the community.

191.14 (d) As a condition of receiving grant funds, a grantee shall obtain all available third-party
191.15 reimbursement sources, if applicable.

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

191.17 Sec. 2. **[245.4901] SCHOOL-LINKED MENTAL HEALTH GRANTS.**

191.18 Subdivision 1. **Establishment.** The commissioner of human services shall establish a
191.19 school-linked mental health grant program to provide early identification and intervention
191.20 for students with mental health needs and to build the capacity of schools to support students
191.21 with mental health needs in the classroom.

191.22 Subd. 2. **Eligible applicants.** An eligible applicant for school-linked mental health grants

191.23 is an entity that is:

191.24 (1) certified under Minnesota Rules, parts 9520.0750 to 9520.0870;

191.25 (2) a community mental health center under section 256B.0625, subdivision 5;

191.26 (3) an Indian health service facility or a facility owned and operated by a tribe or tribal
191.27 organization operating under United States Code, title 25, section 5321;

191.28 (4) a provider of children's therapeutic services and supports as defined in section
191.29 256B.0943; or

191.30 (5) enrolled in medical assistance as a mental health or substance use disorder provider
191.31 agency and employs at least two full-time equivalent mental health professionals as defined

192.1 in section 245.4871, subdivision 27, clauses (1) to (6), or two alcohol and drug counselors
192.2 licensed or exempt from licensure under chapter 148F who are qualified to provide clinical
192.3 services to children and families.

192.4 **Subd. 3. Allowable grant activities and related expenses.** (a) Allowable grant activities
192.5 and related expenses may include but are not limited to:

192.6 (1) identifying and diagnosing mental health conditions of students;
192.7 (2) delivering mental health treatment and services to students and their families,
192.8 including via telemedicine consistent with section 256B.0625, subdivision 3b;
192.9 (3) supporting families in meeting their child's needs, including navigating health care,
192.10 social service, and juvenile justice systems;

192.11 (4) providing transportation for students receiving school-linked mental health services
192.12 when school is not in session;

192.13 (5) building the capacity of schools to meet the needs of students with mental health
192.14 concerns, including school staff development activities for licensed and nonlicensed staff;
192.15 and

192.16 (6) purchasing equipment, connection charges, on-site coordination, set-up fees, and
192.17 site fees in order to deliver school-linked mental health services via telemedicine.

192.18 (b) Grantees shall obtain all available third-party reimbursement sources as a condition
192.19 of receiving a grant. For purposes of this grant program, a third-party reimbursement source
192.20 excludes a public school as defined in section 120A.20, subdivision 1. Grantees shall serve
192.21 students regardless of health coverage status or ability to pay.

192.22 **Subd. 4. Data collection and outcome measurement.** Grantees shall provide data to
192.23 the commissioner for the purpose of evaluating the effectiveness of the school-linked mental
192.24 health grant program.

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

192.26 Sec. 3. Minnesota Statutes 2018, section 245.735, subdivision 3, is amended to read:

192.27 **Subd. 3. Certified community behavioral health clinics.** (a) The commissioner shall
192.28 establish a state certification process for certified community behavioral health clinics
192.29 ~~(CCBHCs) to be eligible for the prospective payment system in paragraph (f).~~ Entities that
192.30 choose to be CCBHCs must:

- 193.1 (1) comply with the CCBHC criteria published by the United States Department of
193.2 Health and Human Services;
- 193.3 (2) employ or contract for clinic staff who have backgrounds in diverse disciplines,
193.4 including licensed mental health professionals and licensed alcohol and drug counselors,
193.5 and staff who are culturally and linguistically trained to serve meet the needs of the clinic's
193.6 patient population the clinic serves;
- 193.7 (3) ensure that clinic services are available and accessible to patients individuals and
193.8 families of all ages and genders and that crisis management services are available 24 hours
193.9 per day;
- 193.10 (4) establish fees for clinic services for nonmedical assistance patients individuals who
193.11 are not enrolled in medical assistance using a sliding fee scale that ensures that services to
193.12 patients are not denied or limited due to a patient's an individual's inability to pay for services;
- 193.13 (5) comply with quality assurance reporting requirements and other reporting
193.14 requirements, including any required reporting of encounter data, clinical outcomes data,
193.15 and quality data;
- 193.16 (6) provide crisis mental health and substance use services, withdrawal management
193.17 services, emergency crisis intervention services, and stabilization services; screening,
193.18 assessment, and diagnosis services, including risk assessments and level of care
193.19 determinations; patient-centered person- and family-centered treatment planning; outpatient
193.20 mental health and substance use services; targeted case management; psychiatric
193.21 rehabilitation services; peer support and counselor services and family support services;
193.22 and intensive community-based mental health services, including mental health services
193.23 for members of the armed forces and veterans;
- 193.24 (7) provide coordination of care across settings and providers to ensure seamless
193.25 transitions for patients individuals being served across the full spectrum of health services,
193.26 including acute, chronic, and behavioral needs. Care coordination may be accomplished
193.27 through partnerships or formal contracts with:
- 193.28 (i) counties, health plans, pharmacists, pharmacies, rural health clinics, federally qualified
193.29 health centers, inpatient psychiatric facilities, substance use and detoxification facilities, or
193.30 community-based mental health providers; and
- 193.31 (ii) other community services, supports, and providers, including schools, child welfare
193.32 agencies, juvenile and criminal justice agencies, Indian health services clinics, tribally
193.33 licensed health care and mental health facilities, urban Indian health clinics, Department of

- 194.1 Veterans Affairs medical centers, outpatient clinics, drop-in centers, acute care hospitals,
194.2 and hospital outpatient clinics;
- 194.3 (8) be certified as mental health clinics under section 245.69, subdivision 2;
- 194.4 (9) be certified to provide integrated treatment for co-occurring mental illness and
194.5 substance use disorders in adults or children under Minnesota Rules, chapter 9533, effective
194.6 July 1, 2017;
- 194.7 (10) comply with standards relating to mental health services in Minnesota Rules,
194.8 parts 9505.0370 to 9505.0372;
- 194.9 (11) be licensed to provide ~~chemical dependency~~ substance use disorder treatment
194.10 under chapter 245G;
- 194.11 (12) be certified to provide children's therapeutic services and supports under section
194.12 256B.0943;
- 194.13 (13) be certified to provide adult rehabilitative mental health services under section
194.14 256B.0623;
- 194.15 (14) be enrolled to provide mental health crisis response services under section
194.16 256B.0624;
- 194.17 (15) be enrolled to provide mental health targeted case management under section
194.18 256B.0625, subdivision 20;
- 194.19 (16) comply with standards relating to mental health case management in Minnesota
194.20 Rules, parts 9520.0900 to 9520.0926; and
- 194.21 (17) provide services that comply with the evidence-based practices described in
194.22 paragraph (e); and
- 194.23 (18) comply with standards relating to peer services under sections 256B.0615,
194.24 256B.0616, and 245G.07, subdivision 1, paragraph (a), clause (5), if peer services are
194.25 provided.
- 194.26 (b) If an entity is unable to provide one or more of the services listed in paragraph (a),
194.27 clauses (6) to (17), the commissioner may certify the entity as a CCBHC, if the entity has
194.28 a current contract with another entity that has the required authority to provide that service
194.29 and that meets federal CCBHC criteria as a designated collaborating organization, or, to
194.30 the extent allowed by the federal CCBHC criteria, the commissioner may approve a referral
194.31 arrangement. The CCBHC must meet federal requirements regarding the type and scope of
194.32 services to be provided directly by the CCBHC.

195.1 (c) Notwithstanding any other law that requires a county contract or other form of county
195.2 approval for certain services listed in paragraph (a), clause (6), a clinic that otherwise meets
195.3 CCBHC requirements may receive the prospective payment under paragraph (f) section
195.4 256B.0625, subdivision 5m, for those services without a county contract or county approval.

195.5 There is no county share when medical assistance pays the CCBHC prospective payment.
195.6 As part of the certification process in paragraph (a), the commissioner shall require a letter
195.7 of support from the CCBHC's host county confirming that the CCBHC and the county or
195.8 counties it serves have an ongoing relationship to facilitate access and continuity of care,
195.9 especially for individuals who are uninsured or who may go on and off medical assistance.

195.10 (d) When the standards listed in paragraph (a) or other applicable standards conflict or
195.11 address similar issues in duplicative or incompatible ways, the commissioner may grant
195.12 variances to state requirements if the variances do not conflict with federal requirements.

195.13 If standards overlap, the commissioner may substitute all or a part of a licensure or
195.14 certification that is substantially the same as another licensure or certification. The
195.15 commissioner shall consult with stakeholders, as described in subdivision 4, before granting
195.16 variances under this provision. For the CCBHC that is certified but not approved for
195.17 prospective payment under section 256B.0625, subdivision 5m, the commissioner may
195.18 grant a variance under this paragraph if the variance does not increase the state share of
195.19 costs.

195.20 (e) The commissioner shall issue a list of required evidence-based practices to be
195.21 delivered by CCBHCs, and may also provide a list of recommended evidence-based practices.

195.22 The commissioner may update the list to reflect advances in outcomes research and medical
195.23 services for persons living with mental illnesses or substance use disorders. The commissioner
195.24 shall take into consideration the adequacy of evidence to support the efficacy of the practice,
195.25 the quality of workforce available, and the current availability of the practice in the state.
195.26 At least 30 days before issuing the initial list and any revisions, the commissioner shall
195.27 provide stakeholders with an opportunity to comment.

195.28 (f) ~~The commissioner shall establish standards and methodologies for a prospective~~
195.29 ~~payment system for medical assistance payments for services delivered by certified~~
195.30 ~~community behavioral health clinics, in accordance with guidance issued by the Centers~~
195.31 ~~for Medicare and Medicaid Services. During the operation of the demonstration project,~~
195.32 ~~payments shall comply with federal requirements for an enhanced federal medical assistance~~
195.33 ~~percentage. The commissioner may include quality bonus payment in the prospective~~
195.34 ~~payment system based on federal criteria and on a clinic's provision of the evidence-based~~
195.35 ~~practices in paragraph (e). The prospective payment system does not apply to MinnesotaCare.~~

196.1 ~~Implementation of the prospective payment system is effective July 1, 2017, or upon federal~~
196.2 ~~approval, whichever is later.~~

196.3 ~~(g) The commissioner shall seek federal approval to continue federal financial~~
196.4 ~~participation in payment for CCBHC services after the federal demonstration period ends~~
196.5 ~~for clinics that were certified as CCBHCs during the demonstration period and that continue~~
196.6 ~~to meet the CCBHC certification standards in paragraph (a). Payment for CCBHC services~~
196.7 ~~shall cease effective July 1, 2019, if continued federal financial participation for the payment~~
196.8 ~~of CCBHC services cannot be obtained.~~

196.9 ~~(h) The commissioner may certify at least one CCBHC located in an urban area and at~~
196.10 ~~least one CCBHC located in a rural area, as defined by federal criteria. To the extent allowed~~
196.11 ~~by federal law, the commissioner may limit the number of certified clinics so that the~~
196.12 ~~projected claims for certified clinics will not exceed the funds budgeted for this purpose.~~
196.13 ~~The commissioner shall give preference to clinics that:~~

196.14 ~~(1) provide a comprehensive range of services and evidence-based practices for all age~~
196.15 ~~groups, with services being fully coordinated and integrated; and~~

196.16 ~~(2) enhance the state's ability to meet the federal priorities to be selected as a CCBHC~~
196.17 ~~demonstration state.~~

196.18 ~~(f) The commissioner shall recertify CCBHCs at least every three years. The~~
196.19 ~~commissioner shall establish a process for decertification and shall require corrective action,~~
196.20 ~~medical assistance repayment, or decertification of a CCBHC that no longer meets the~~
196.21 ~~requirements in this section or that fails to meet the standards provided by the commissioner~~
196.22 ~~in the application and certification process.~~

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

196.24 Sec. 4. Minnesota Statutes 2018, section 254B.02, subdivision 1, is amended to read:

196.25 Subdivision 1. **Chemical dependency treatment allocation.** The chemical dependency
196.26 treatment appropriation shall be placed in a special revenue account. ~~The commissioner~~
196.27 ~~shall annually transfer funds from the chemical dependency fund to pay for operation of~~
196.28 ~~the drug and alcohol abuse normative evaluation system and to pay for all costs incurred~~
196.29 ~~by adding two positions for licensing of chemical dependency treatment and rehabilitation~~
196.30 ~~programs located in hospitals for which funds are not otherwise appropriated. The remainder~~
196.31 ~~of the money in the special revenue account must be used according to the requirements in~~
196.32 ~~this chapter.~~

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

197.1 Sec. 5. Minnesota Statutes 2018, section 254B.03, subdivision 2, is amended to read:

197.2 **Subd. 2. Chemical dependency fund payment.** (a) Payment from the chemical
197.3 dependency fund is limited to payments for services other than detoxification licensed under
197.4 Minnesota Rules, parts 9530.6510 to 9530.6590, that, if located outside of federally
197.5 recognized tribal lands, would be required to be licensed by the commissioner as a chemical
197.6 dependency treatment or rehabilitation program under sections 245A.01 to 245A.16, and
197.7 services other than detoxification provided in another state that would be required to be
197.8 licensed as a chemical dependency program if the program were in the state. Out of state
197.9 vendors must also provide the commissioner with assurances that the program complies
197.10 substantially with state licensing requirements and possesses all licenses and certifications
197.11 required by the host state to provide chemical dependency treatment. Vendors receiving
197.12 payments from the chemical dependency fund must not require co-payment from a recipient
197.13 of benefits for services provided under this subdivision. The vendor is prohibited from using
197.14 the client's public benefits to offset the cost of services paid under this section. The vendor
197.15 shall not require the client to use public benefits for room or board costs. This includes but
197.16 is not limited to cash assistance benefits under chapters 119B, 256D, and 256J, or SNAP
197.17 benefits. Retention of SNAP benefits is a right of a client receiving services through the
197.18 consolidated chemical dependency treatment fund or through state contracted managed care
197.19 entities. Payment from the chemical dependency fund shall be made for necessary room
197.20 and board costs provided by vendors ~~certified according to meeting the criteria under section~~
197.21 254B.05, subdivision 1a, or in a community hospital licensed by the commissioner of health
197.22 according to sections 144.50 to 144.56 to a client who is:

197.23 (1) determined to meet the criteria for placement in a residential chemical dependency
197.24 treatment program according to rules adopted under section 254A.03, subdivision 3; and

197.25 (2) concurrently receiving a chemical dependency treatment service in a program licensed
197.26 by the commissioner and reimbursed by the chemical dependency fund.

197.27 (b) A county may, from its own resources, provide chemical dependency services for
197.28 which state payments are not made. A county may elect to use the same invoice procedures
197.29 and obtain the same state payment services as are used for chemical dependency services
197.30 for which state payments are made under this section if county payments are made to the
197.31 state in advance of state payments to vendors. When a county uses the state system for
197.32 payment, the commissioner shall make monthly billings to the county using the most recent
197.33 available information to determine the anticipated services for which payments will be made
197.34 in the coming month. Adjustment of any overestimate or underestimate based on actual

198.1 expenditures shall be made by the state agency by adjusting the estimate for any succeeding
198.2 month.

198.3 (c) The commissioner shall coordinate chemical dependency services and determine
198.4 whether there is a need for any proposed expansion of chemical dependency treatment
198.5 services. The commissioner shall deny vendor certification to any provider that has not
198.6 received prior approval from the commissioner for the creation of new programs or the
198.7 expansion of existing program capacity. The commissioner shall consider the provider's
198.8 capacity to obtain clients from outside the state based on plans, agreements, and previous
198.9 utilization history, when determining the need for new treatment services.

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

198.11 Sec. 6. Minnesota Statutes 2018, section 254B.03, subdivision 4, is amended to read:

198.12 Subd. 4. **Division of costs.** (a) Except for services provided by a county under section
198.13 254B.09, subdivision 1, or services provided under section 256B.69, the county shall, out
198.14 of local money, pay the state for 22.95 percent of the cost of chemical dependency services,
198.15 ~~including except for those services provided to persons eligible for enrolled in medical~~
198.16 ~~assistance under chapter 256B and room and board services under section 254B.05,~~
198.17 ~~subdivision 5, paragraph (b), clause (12).~~ Counties may use the indigent hospitalization
198.18 levy for treatment and hospital payments made under this section.

198.19 (b) 22.95 percent of any state collections from private or third-party pay, less 15 percent
198.20 for the cost of payment and collections, must be distributed to the county that paid for a
198.21 portion of the treatment under this section.

198.22 (e) ~~For fiscal year 2017 only, the 22.95 percentages under paragraphs (a) and (b) are~~
198.23 ~~equal to 20.2 percent.~~

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

198.25 Sec. 7. Minnesota Statutes 2018, section 254B.04, subdivision 1, is amended to read:

198.26 Subdivision 1. **Eligibility.** (a) Persons eligible for benefits under Code of Federal
198.27 Regulations, title 25, part 20, ~~and persons eligible for medical assistance benefits under~~
198.28 ~~sections 256B.055, 256B.056, and 256B.057, subdivisions 1, 5, and 6, or who meet the~~
198.29 income standards of section 256B.056, subdivision 4, ~~and are not enrolled in medical~~
198.30 ~~assistance,~~ are entitled to chemical dependency fund services. State money appropriated
198.31 for this paragraph must be placed in a separate account established for this purpose.

199.1 (b) Persons with dependent children who are determined to be in need of chemical
199.2 dependency treatment pursuant to an assessment under section 626.556, subdivision 10, or
199.3 a case plan under section 260C.201, subdivision 6, or 260C.212, shall be assisted by the
199.4 local agency to access needed treatment services. Treatment services must be appropriate
199.5 for the individual or family, which may include long-term care treatment or treatment in a
199.6 facility that allows the dependent children to stay in the treatment facility. The county shall
199.7 pay for out-of-home placement costs, if applicable.

199.8 (c) Notwithstanding paragraph (a), persons enrolled in medical assistance are eligible
199.9 for room and board services under section 254B.05, subdivision 5, paragraph (b), clause
199.10 (12).

199.11 **EFFECTIVE DATE.** This section is effective September 1, 2019.

199.12 Sec. 8. Minnesota Statutes 2018, section 254B.05, subdivision 1a, is amended to read:

199.13 **Subd. 1a. Room and board provider requirements.** (a) Effective January 1, 2000,
199.14 vendors of room and board are eligible for chemical dependency fund payment if the vendor:

199.15 (1) has rules prohibiting residents bringing chemicals into the facility or using chemicals
199.16 while residing in the facility and provide consequences for infractions of those rules;

199.17 (2) is determined to meet applicable health and safety requirements;

199.18 (3) is not a jail or prison;

199.19 (4) is not concurrently receiving funds under chapter 256I for the recipient;

199.20 (5) admits individuals who are 18 years of age or older;

199.21 (6) is registered as a board and lodging or lodging establishment according to section
199.22 157.17;

199.23 (7) has awake staff on site 24 hours per day;

199.24 (8) has staff who are at least 18 years of age and meet the requirements of section
199.25 245G.11, subdivision 1, paragraph (b);

199.26 (9) has emergency behavioral procedures that meet the requirements of section 245G.16;

199.27 (10) meets the requirements of section 245G.08, subdivision 5, if administering
199.28 medications to clients;

199.29 (11) meets the abuse prevention requirements of section 245A.65, including a policy on
199.30 fraternization and the mandatory reporting requirements of section 626.557;

200.1 (12) documents coordination with the treatment provider to ensure compliance with
200.2 section 254B.03, subdivision 2;

200.3 (13) protects client funds and ensures freedom from exploitation by meeting the
200.4 provisions of section 245A.04, subdivision 13;

200.5 (14) has a grievance procedure that meets the requirements of section 245G.15,
200.6 subdivision 2; and

200.7 (15) has sleeping and bathroom facilities for men and women separated by a door that
200.8 is locked, has an alarm, or is supervised by awake staff.

200.9 (b) Programs licensed according to Minnesota Rules, chapter 2960, are exempt from
200.10 paragraph (a), clauses (5) to (15).

200.11 (c) Licensed programs providing intensive residential treatment services or residential
200.12 crisis services pursuant to section 256B.0622 are eligible vendors of room and board and
200.13 are exempt from paragraph (a), clauses (6) to (15).

200.14 **EFFECTIVE DATE.** This section is effective September 1, 2019.

200.15 Sec. 9. Minnesota Statutes 2018, section 254B.06, subdivision 1, is amended to read:

200.16 Subdivision 1. **State collections.** The commissioner is responsible for all collections
200.17 from persons determined to be partially responsible for the cost of care of an eligible person
200.18 receiving services under Laws 1986, chapter 394, sections 8 to 20. The commissioner may
200.19 initiate, or request the attorney general to initiate, necessary civil action to recover the unpaid
200.20 cost of care. The commissioner may collect all third-party payments for chemical dependency
200.21 services provided under Laws 1986, chapter 394, sections 8 to 20, including private insurance
200.22 and federal Medicaid and Medicare financial participation. ~~The commissioner shall deposit~~
200.23 ~~in a dedicated account a percentage of collections to pay for the cost of operating the chemical~~
200.24 ~~dependency consolidated treatment fund invoice processing and vendor payment system,~~
200.25 ~~billing, and collections.~~ The remaining receipts must be deposited in the chemical dependency
200.26 fund.

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

200.28 Sec. 10. Minnesota Statutes 2018, section 254B.06, subdivision 2, is amended to read:

200.29 Subd. 2. **Allocation of collections.** ~~(a) The commissioner shall allocate all federal~~
200.30 ~~financial participation collections to a special revenue account.~~ The commissioner shall

201.1 allocate 77.05 percent of patient payments and third-party payments to the special revenue
201.2 account and 22.95 percent to the county financially responsible for the patient.

201.3 ~~(b) For fiscal year 2017 only, the commissioner's allocation to the special revenue account~~
201.4 ~~shall be increased from 77.05 percent to 79.8 percent and the county financial responsibility~~
201.5 ~~shall be reduced from 22.95 percent to 20.2 percent.~~

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

201.7 Sec. 11. Minnesota Statutes 2018, section 256.478, is amended to read:

201.8 **256.478 HOME AND COMMUNITY-BASED SERVICES TRANSITIONS**
201.9 **GRANTS TRANSITION TO COMMUNITY INITIATIVE.**

201.10 Subdivision 1. Eligibility. (a) An individual is eligible for the transition to community
201.11 initiative if the individual meets the following criteria:

201.12 (1) without the additional resources available through the transitions to community
201.13 initiative the individual would otherwise remain at the Anoka-Metro Regional Treatment
201.14 Center, a state-operated community behavioral health hospital, or the Minnesota Security
201.15 Hospital;

201.16 (2) the individual's discharge would be significantly delayed without the additional
201.17 resources available through the transitions to community initiative; and

201.18 (3) the individual met treatment objectives and no longer needs hospital-level care or a
201.19 secure treatment setting.

201.20 (b) An individual who is in a community hospital and on the waiting list for the
201.21 Anoka-Metro Regional Treatment Center, but for whom alternative community placement
201.22 would be appropriate is eligible for the transition to community initiative upon the
201.23 commissioner's approval.

201.24 Subd. 2. Transition grants. The commissioner shall make available ~~home and~~
201.25 ~~community-based services~~ transition to community grants to serve assist individuals who
201.26 ~~do not meet eligibility criteria for the medical assistance program under section 256B.056~~
201.27 ~~or 256B.057, but who otherwise meet the criteria under section 256B.092, subdivision 13,~~
201.28 ~~or 256B.49, subdivision 24 who met the criteria under subdivision 1.~~

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

202.1 Sec. 12. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision
202.2 to read:

202.3 Subd. 5m. Certified community behavioral health clinic services. (a) Medical
202.4 assistance covers certified community behavioral health clinic (CCBHC) services that meet
202.5 the requirements of section 245.735, subdivision 3.

202.6 (b) The commissioner shall establish standards and methodologies for a prospective
202.7 payment system for medical assistance payments for services delivered by a CCBHC, in
202.8 accordance with guidance issued by the Centers for Medicare and Medicaid Services. The
202.9 commissioner may include a quality bonus payment in the prospective payment system
202.10 based on federal criteria and on a CCBHC's provision of the evidence-based practices in
202.11 section 245.735, subdivision 3, paragraph (e). The prospective payment system does not
202.12 apply to MinnesotaCare.

202.13 (c) To the extent allowed by federal law, the commissioner may limit the number of
202.14 CCBHCs for the prospective payment system in paragraph (b) to ensure that the projected
202.15 claims do not exceed the money appropriated for this purpose. The commissioner shall
202.16 apply the following priorities, in the order listed, to give preference to clinics that:

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

202.19 (2) are certified as CCBHCs during the federal CCBHC demonstration period;

202.20 (3) receive CCBHC grants from the United States Department of Health and Human
202.21 Services; or

202.22 (4) focus on serving individuals in tribal areas and other underserved communities.

202.23 (d) Unless otherwise indicated in applicable federal requirements, the prospective payment
202.24 system must continue to be based on the federal instructions issued for the federal CCBHC
202.25 demonstration, except:

202.26 (1) the commissioner shall rebase CCBHC rates at least every two years; and

202.27 (2) the prospective payment rate under this section does not apply for services rendered
202.28 by CCBHCs to individuals who are dually eligible for Medicare and medical assistance
202.29 when Medicare is the primary payer for the service.

202.30 **EFFECTIVE DATE.** Contingent upon federal approval, this section is effective July
202.31 1, 2019. The commissioner of human services shall notify the revisor of statutes when
202.32 federal approval is obtained or denied.

203.1 Sec. 13. Minnesota Statutes 2018, section 256B.0625, subdivision 24, is amended to read:

203.2 Subd. 24. **Other medical or remedial care.** Medical assistance covers any other medical
203.3 or remedial care licensed and recognized under state law unless otherwise prohibited by
203.4 law, ~~except licensed chemical dependency treatment programs or primary treatment or~~
203.5 ~~extended care treatment units in hospitals that are covered under chapter 254B.~~ The
203.6 ~~commissioner shall include chemical dependency services in the state medical assistance~~
203.7 ~~plan for federal reporting purposes, but payment must be made under chapter 254B.~~ The
203.8 commissioner shall publish in the State Register a list of elective surgeries that require a
203.9 second medical opinion before medical assistance reimbursement, and the criteria and
203.10 standards for deciding whether an elective surgery should require a second medical opinion.
203.11 The list and criteria and standards are not subject to the requirements of sections 14.01 to
203.12 14.69.

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

203.14 Sec. 14. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision
203.15 to read:

203.16 Subd. 24a. **Substance use disorder services.** Medical assistance covers substance use
203.17 disorder treatment services according to section 254B.05, subdivision 5, except for room
203.18 and board.

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

203.20 Sec. 15. Minnesota Statutes 2018, section 256B.0625, subdivision 45a, is amended to
203.21 read:

203.22 Subd. 45a. **Psychiatric residential treatment facility services for persons younger**
203.23 **than 21 years of age.** (a) Medical assistance covers psychiatric residential treatment facility
203.24 services, according to section 256B.0941, for persons younger than 21 years of age.
203.25 Individuals who reach age 21 at the time they are receiving services are eligible to continue
203.26 receiving services until they no longer require services or until they reach age 22, whichever
203.27 occurs first.

203.28 (b) For purposes of this subdivision, "psychiatric residential treatment facility" means
203.29 a facility other than a hospital that provides psychiatric services, as described in Code of
203.30 Federal Regulations, title 42, sections 441.151 to 441.182, to individuals under age 21 in
203.31 an inpatient setting.

204.1 (c) The commissioner shall enroll up to ~~150~~ 300 certified psychiatric residential treatment
204.2 facility services beds ~~at up to six sites~~. The commissioner shall select psychiatric residential
204.3 treatment facility services providers through a request for proposals process. Providers of
204.4 state-operated services may respond to the request for proposals. The commissioner shall
204.5 prioritize programs that demonstrate the capacity to serve children and youth with aggressive
204.6 and risky behaviors toward themselves or others, multiple diagnoses, neurodevelopmental
204.7 disorders, or complex trauma related issues.

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

204.9 Sec. 16. Minnesota Statutes 2018, section 256B.0625, subdivision 57, is amended to read:

204.10 Subd. 57. **Payment for Part B Medicare crossover claims.** (a) Effective for services
204.11 provided on or after January 1, 2012, medical assistance payment for an enrollee's
204.12 cost-sharing associated with Medicare Part B is limited to an amount up to the medical
204.13 assistance total allowed, when the medical assistance rate exceeds the amount paid by
204.14 Medicare.

204.15 (b) Excluded from this limitation are payments for mental health services and payments
204.16 for dialysis services provided to end-stage renal disease patients. The exclusion for mental
204.17 health services does not apply to payments for physician services provided by psychiatrists
204.18 and advanced practice nurses with a specialty in mental health.

204.19 (c) Excluded from this limitation are payments to federally qualified health centers ~~and~~,
204.20 rural health clinics, and CCBHCs subject to the prospective payment system under
204.21 subdivision 5m.

204.22 **EFFECTIVE DATE.** Contingent upon federal approval, this section is effective July
204.23 1, 2019. The commissioner of human services shall notify the revisor of statutes when
204.24 federal approval is obtained or denied.

204.25 Sec. 17. Minnesota Statutes 2018, section 256B.0915, subdivision 3b, is amended to read:

204.26 Subd. 3b. **Cost limits for elderly waiver applicants who reside in a nursing facility**
204.27 or another eligible facility. (a) For a person who is a nursing facility resident at the time
204.28 of requesting a determination of eligibility for elderly waivered services, a monthly
204.29 conversion budget limit for the cost of elderly waivered services may be requested. The
204.30 monthly conversion budget limit for the cost of elderly waiver services shall be ~~the resident~~
204.31 ~~class assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, for that resident in~~
204.32 ~~the nursing facility where the resident currently resides until July 1 of the state fiscal year~~

205.1 ~~in which the resident assessment system as described in section 256B.438 for nursing home~~
205.2 ~~rate determination is implemented. Effective on July 1 of the state fiscal year in which the~~
205.3 ~~resident assessment system as described in section 256B.438 for nursing home rate~~
205.4 ~~determination is implemented, the monthly conversion budget limit for the cost of elderly~~
205.5 ~~waiver services shall be based on the per diem nursing facility rate as determined by the~~
205.6 ~~resident assessment system as described in section 256B.438 256R.17 for residents in the~~
205.7 ~~nursing facility where the elderly waiver applicant currently resides. The monthly conversion~~
205.8 ~~budget limit shall be calculated by multiplying the per diem by 365, divided by 12, and~~
205.9 ~~reduced by the recipient's maintenance needs allowance as described in subdivision 1d. The~~
205.10 ~~initially approved monthly conversion budget limit shall be adjusted annually as described~~
205.11 ~~in subdivision 3a, paragraph (a). The limit under this subdivision paragraph only applies to~~
205.12 ~~persons discharged from a nursing facility after a minimum 30-day stay and found eligible~~
205.13 ~~for waivered services on or after July 1, 1997. For conversions from the nursing home to~~
205.14 ~~the elderly waiver with consumer directed community support services, the nursing facility~~
205.15 ~~per diem used to calculate the monthly conversion budget limit must be reduced by a~~
205.16 ~~percentage equal to the percentage difference between the consumer directed services budget~~
205.17 ~~limit that would be assigned according to the federally approved waiver plan and the~~
205.18 ~~corresponding community case mix cap, but not to exceed 50 percent.~~

205.19 (b) A person who meets elderly waiver eligibility criteria and the eligibility criteria under
205.20 section 256.478, subdivision 1, is eligible for a special monthly budget limit for the cost of
205.21 elderly waivered services up to \$21,610 per month. The special monthly budget limit must
205.22 be adjusted annually as described in subdivision 3a, paragraphs (a) and (e). For a person
205.23 using a special monthly budget limit under the elderly waiver with consumer-directed
205.24 community support services, the special monthly budget limit must be reduced as described
205.25 in paragraph (a).

205.26 (c) The commissioner may provide an additional payment for documented costs between
205.27 a threshold determined by the commissioner and the special monthly budget limit to a
205.28 managed care plan for elderly waiver services provided to a person who is: (1) eligible for
205.29 a special monthly budget limit under paragraph (b); and (2) enrolled in a managed care plan
205.30 that provides elderly waiver services under section 256B.69.

205.31 (d) For monthly conversion budget limits under paragraph (a) and special monthly budget
205.32 limits under paragraph (b), the service rate limits for adult foster care under subdivision 3d
205.33 and for customized living under subdivision 3e may be exceeded if necessary for the provider
205.34 to meet identified needs and provide services as approved in the coordinated service and
205.35 support plan, if the total cost of all services does not exceed the monthly conversion or

206.1 special monthly budget limit. Service rates must be established using tools provided by the
206.2 commissioner.

206.3 (e) The following costs must be included in determining the total monthly costs for the
206.4 waiver client:

206.5 (1) cost of all waivered services, including specialized supplies and equipment and
206.6 environmental accessibility adaptations; and

206.7 (2) cost of skilled nursing, home health aide, and personal care services reimbursable
206.8 by medical assistance.

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

206.11 Sec. 18. Minnesota Statutes 2018, section 256B.092, subdivision 13, is amended to read:

206.12 **Subd. 13. Waiver allocations for transition populations.** (a) The commissioner shall
206.13 make available additional waiver allocations and additional necessary resources ~~to assure~~
206.14 ~~timely discharges from the Anoka Metro Regional Treatment Center and the Minnesota~~
206.15 ~~Security Hospital in St. Peter~~ for individuals who meet the following eligibility criteria:
206.16 established under section 256.478, subdivision 1.

206.17 (1) ~~are otherwise eligible for the developmental disabilities waiver under this section;~~

206.18 (2) ~~who would otherwise remain at the Anoka Metro Regional Treatment Center or the~~
206.19 ~~Minnesota Security Hospital;~~

206.20 (3) ~~whose discharge would be significantly delayed without the available waiver~~
206.21 ~~allocation; and~~

206.22 (4) ~~who have met treatment objectives and no longer meet hospital level of care.~~

206.23 (b) Additional waiver allocations under this subdivision must meet cost-effectiveness
206.24 requirements of the federal approved waiver plan.

206.25 (c) Any corporate foster care home developed under this subdivision must be considered
206.26 an exception under section 245A.03, subdivision 7, paragraph (a).

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

206.28 Sec. 19. Minnesota Statutes 2018, section 256B.49, subdivision 24, is amended to read:

206.29 **Subd. 24. Waiver allocations for transition populations.** (a) The commissioner shall
206.30 make available additional waiver allocations and additional necessary resources ~~to assure~~

207.1 ~~timely discharges from the Anoka-Metro Regional Treatment Center and the Minnesota~~
207.2 ~~Security Hospital in St. Peter~~ for individuals who meet the following eligibility criteria:
207.3 established under section 256.478, subdivision 1.

207.4 ~~(1) are otherwise eligible for the brain injury, community access for disability inclusion,~~
207.5 ~~or community alternative care waivers under this section;~~

207.6 ~~(2) who would otherwise remain at the Anoka-Metro Regional Treatment Center or the~~
207.7 ~~Minnesota Security Hospital;~~

207.8 ~~(3) whose discharge would be significantly delayed without the available waiver~~
207.9 ~~allocation; and~~

207.10 ~~(4) who have met treatment objectives and no longer meet hospital level of care.~~

207.11 (b) Additional waiver allocations under this subdivision must meet cost-effectiveness
207.12 requirements of the federal approved waiver plan.

207.13 (c) Any corporate foster care home developed under this subdivision must be considered
207.14 an exception under section 245A.03, subdivision 7, paragraph (a).

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

207.16 Sec. 20. Minnesota Statutes 2018, section 256I.04, subdivision 1, is amended to read:

207.17 **Subdivision 1. Individual eligibility requirements.** An individual is eligible for and
207.18 entitled to a housing support payment to be made on the individual's behalf if the agency
207.19 has approved the setting where the individual will receive housing support and the individual
207.20 meets the requirements in paragraph (a), (b), or (c).

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

207.30 (b) The individual meets a category of eligibility under section 256D.05, subdivision 1,
207.31 paragraph (a), clauses (1), (3), (4) to (8), and (13), and paragraph (b), if applicable, and the
207.32 individual's resources are less than the standards specified by section 256P.02, and the

208.1 individual's countable income as determined under section 256P.06, less the medical
208.2 assistance personal needs allowance under section 256B.35 is less than the monthly rate
208.3 specified in the agency's agreement with the provider of housing support in which the
208.4 individual resides.

208.5 (c) The individual ~~receives licensed residential crisis stabilization services under section~~
208.6 ~~256B.0624, subdivision 7, and is receiving medical assistance. The individual may receive~~
208.7 ~~concurrent housing support payments if receiving licensed residential crisis stabilization~~
208.8 ~~services under section 256B.0624, subdivision 7, lacks a fixed, adequate, nighttime residence~~
208.9 ~~upon discharge from a residential behavioral health treatment program, as determined by~~
208.10 ~~treatment staff from the residential behavioral health treatment program. An individual is~~
208.11 ~~eligible under this paragraph for up to three months, including a full or partial month from~~
208.12 ~~the individual's move-in date at a setting approved for housing support following discharge~~
208.13 ~~from treatment, plus two full months.~~

208.14 **EFFECTIVE DATE.** This section is effective September 1, 2019.

208.15 Sec. 21. Minnesota Statutes 2018, section 256I.04, subdivision 2f, is amended to read:

208.16 Subd. 2f. **Required services.** (a) In licensed and registered settings under subdivision
208.17 2a, providers shall ensure that participants have at a minimum:

208.18 (1) food preparation and service for three nutritional meals a day on site;
208.19 (2) a bed, clothing storage, linen, bedding, laundering, and laundry supplies or service;
208.20 (3) housekeeping, including cleaning and lavatory supplies or service; and
208.21 (4) maintenance and operation of the building and grounds, including heat, water, garbage
208.22 removal, electricity, telephone for the site, cooling, supplies, and parts and tools to repair
208.23 and maintain equipment and facilities.

208.24 (b) In addition, when providers serve participants described in subdivision 1, paragraph
208.25 (c), the providers are required to assist the participants in applying for continuing housing
208.26 support payments before the end of the eligibility period.

208.27 **EFFECTIVE DATE.** This section is effective September 1, 2019.

208.28 Sec. 22. Minnesota Statutes 2018, section 256I.06, subdivision 8, is amended to read:

208.29 Subd. 8. **Amount of housing support payment.** (a) The amount of a room and board
208.30 payment to be made on behalf of an eligible individual is determined by subtracting the
208.31 individual's countable income under section 256I.04, subdivision 1, for a whole calendar

209.1 month from the room and board rate for that same month. The housing support payment is
209.2 determined by multiplying the housing support rate times the period of time the individual
209.3 was a resident or temporarily absent under section 256I.05, subdivision 1c, paragraph (d).

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

209.9 (c) For an individual who receives ~~licensed residential crisis stabilization services under~~
209.10 ~~section 256B.0624, subdivision 7, housing support payments under section 256I.04,~~
209.11 ~~subdivision 1, paragraph (c),~~ the amount of ~~the~~ housing support payment is determined by
209.12 multiplying the housing support rate times the period of time the individual was a resident.

209.13 **EFFECTIVE DATE.** This section is effective September 1, 2019.

209.14 Sec. 23. Laws 2017, First Special Session chapter 6, article 8, section 71, the effective
209.15 date, is amended to read:

209.16 **EFFECTIVE DATE.** This section is effective for services provided on July 1, 2017,
209.17 ~~through April 30, 2019, and expires May 1, 2019 and thereafter.~~

209.18 **EFFECTIVE DATE.** This section is effective April 30, 2019.

209.19 Sec. 24. Laws 2017, First Special Session chapter 6, article 8, section 72, the effective
209.20 date, is amended to read:

209.21 **EFFECTIVE DATE.** This section is effective for services provided on July 1, 2017,
209.22 ~~through April 30, 2019, and expires May 1, 2019 and thereafter.~~

209.23 **EFFECTIVE DATE.** This section is effective April 30, 2019.

209.24 Sec. 25. **DIRECTION TO COMMISSIONER; IMPROVING SCHOOL-LINKED**
209.25 **MENTAL HEALTH GRANT PROGRAM.**

209.26 (a) The commissioner of human services, in collaboration with the commissioner of
209.27 education, representatives from the education community, mental health providers, and
209.28 advocates, shall assess the school-linked mental health grant program under Minnesota
209.29 Statutes, section 245.4901, and develop recommendations for improvements. The assessment
209.30 must include but is not limited to the following:

209.31 (1) promoting stability among current grantees and school partners;

210.1 (2) assessing the minimum number of full-time equivalents needed per school site to
210.2 effectively carry out the program;

210.3 (3) developing a funding formula that promotes sustainability and consistency across
210.4 grant cycles;

210.5 (4) reviewing current data collection and evaluation; and

210.6 (5) analyzing the impact on outcomes when a school has a school-linked mental health
210.7 program, a multi-tier system of supports, and sufficient school support personnel to meet
210.8 the needs of students.

210.9 (b) The commissioner shall provide a report of the findings of the assessment and
210.10 recommendations, including any necessary statutory changes, to the legislative committees
210.11 with jurisdiction over mental health and education by January 15, 2020.

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

210.13 Sec. 26. **REPEALER.**

210.14 Minnesota Statutes 2018, section 254B.03, subdivision 4a, is repealed.

ARTICLE 7

UNIFORM SERVICE STANDARDS

210.17 Section 1. Minnesota Statutes 2018, section 62A.152, subdivision 3, is amended to read:

210.18 **Subd. 3. Provider discrimination prohibited.** All group policies and group subscriber
210.19 contracts that provide benefits for mental or nervous disorder treatments in a hospital must
210.20 provide direct reimbursement for those services if performed by a mental health professional,
210.21 as defined in sections 245.462, subdivision 18, ~~clauses (1) to (5)~~; and 245.4871, subdivision
210.22 27, ~~clauses (1) to (5)~~, to the extent that the services and treatment are within the scope of
210.23 mental health professional licensure.

210.24 This subdivision is intended to provide payment of benefits for mental or nervous disorder
210.25 treatments performed by a licensed mental health professional in a hospital and is not
210.26 intended to change or add benefits for those services provided in policies or contracts to
210.27 which this subdivision applies.

210.28 Sec. 2. Minnesota Statutes 2018, section 62A.3094, subdivision 1, is amended to read:

210.29 **Subdivision 1. Definitions.** (a) For purposes of this section, the terms defined in
210.30 paragraphs (b) to (d) have the meanings given.

211.1 (b) "Autism spectrum disorders" means the conditions as determined by criteria set forth
211.2 in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of
211.3 the American Psychiatric Association.

211.4 (c) "Medically necessary care" means health care services appropriate, in terms of type,
211.5 frequency, level, setting, and duration, to the enrollee's condition, and diagnostic testing
211.6 and preventative services. Medically necessary care must be consistent with generally
211.7 accepted practice parameters as determined by physicians and licensed psychologists who
211.8 typically manage patients who have autism spectrum disorders.

211.9 (d) "Mental health professional" means a mental health professional as ~~defined in section~~
211.10 ~~245.4871, subdivision 27 described in section 245I.16, subdivision 2, clause (1), (2), (3),~~
211.11 (4), or (6), who has training and expertise in autism spectrum disorder and child development.

211.12 Sec. 3. Minnesota Statutes 2018, section 148B.5301, subdivision 2, is amended to read:

211.13 Subd. 2. **Supervision.** (a) To qualify as a LPCC, an applicant must have completed
211.14 4,000 hours of post-master's degree supervised professional practice in the delivery of
211.15 clinical services in the diagnosis and treatment of mental illnesses and disorders in both
211.16 children and adults. The supervised practice shall be conducted according to the requirements
211.17 in paragraphs (b) to (e).

211.18 (b) The supervision must have been received under a contract that defines clinical practice
211.19 and supervision from a mental health professional as defined in section 245.462, subdivision
211.20 ~~18, clauses (1) to (6)~~, or 245.4871, subdivision 27, ~~clauses (1) to (6)~~, or by a board-approved
211.21 supervisor, who has at least two years of postlicensure experience in the delivery of clinical
211.22 services in the diagnosis and treatment of mental illnesses and disorders. All supervisors
211.23 must meet the supervisor requirements in Minnesota Rules, part 2150.5010.

211.24 (c) The supervision must be obtained at the rate of two hours of supervision per 40 hours
211.25 of professional practice. The supervision must be evenly distributed over the course of the
211.26 supervised professional practice. At least 75 percent of the required supervision hours must
211.27 be received in person. The remaining 25 percent of the required hours may be received by
211.28 telephone or by audio or audiovisual electronic device. At least 50 percent of the required
211.29 hours of supervision must be received on an individual basis. The remaining 50 percent
211.30 may be received in a group setting.

211.31 (d) The supervised practice must include at least 1,800 hours of clinical client contact.

211.32 (e) The supervised practice must be clinical practice. Supervision includes the observation
211.33 by the supervisor of the successful application of professional counseling knowledge, skills,

212.1 and values in the differential diagnosis and treatment of psychosocial function, disability,
212.2 or impairment, including addictions and emotional, mental, and behavioral disorders.

212.3 Sec. 4. Minnesota Statutes 2018, section 148E.0555, subdivision 6, is amended to read:

212.4 **Subd. 6. Qualifications during grandfathering for licensure as LICSW.** (a) To be
212.5 licensed as a licensed independent clinical social worker, an applicant for licensure under
212.6 this section must provide evidence satisfactory to the board that the individual has:

212.7 (1) completed a graduate degree in social work from a program accredited by the Council
212.8 on Social Work Education, the Canadian Association of Schools of Social Work, or a similar
212.9 accrediting body designated by the board; or

212.10 (2) completed a graduate degree and is a mental health professional according to section
212.11 245.462, subdivision 18, ~~clauses (1) to (6)~~.

212.12 (b) To be licensed as a licensed independent clinical social worker, an applicant for
212.13 licensure under this section must provide evidence satisfactory to the board that the individual
212.14 has:

212.15 (1) practiced clinical social work as defined in section 148E.010, subdivision 6, including
212.16 both diagnosis and treatment, and has met the supervised practice requirements specified
212.17 in sections 148E.100 to 148E.125, excluding the 1,800 hours of direct clinical client contact
212.18 specified in section 148E.115, subdivision 1, except that supervised practice hours obtained
212.19 prior to August 1, 2011, must meet the requirements in Minnesota Statutes 2010, sections
212.20 148D.100 to 148D.125;

212.21 (2) submitted a completed, signed application and the license fee in section 148E.180;

212.22 (3) for applications submitted electronically, provided an attestation as specified by the
212.23 board;

212.24 (4) submitted the criminal background check fee and a form provided by the board
212.25 authorizing a criminal background check;

212.26 (5) paid the license fee in section 148E.180; and

212.27 (6) not engaged in conduct that was or would be in violation of the standards of practice
212.28 specified in Minnesota Statutes 2010, sections 148D.195 to 148D.240, and sections 148E.195
212.29 to 148E.240. If the applicant has engaged in conduct that was or would be in violation of
212.30 the standards of practice, the board may take action according to sections 148E.255 to
212.31 148E.270.

213.1 (c) An application which is not completed, signed, and accompanied by the correct
213.2 license fee must be returned to the applicant, along with any fee submitted, and is void.

213.3 (d) By submitting an application for licensure, an applicant authorizes the board to
213.4 investigate any information provided or requested in the application. The board may request
213.5 that the applicant provide additional information, verification, or documentation.

213.6 (e) Within one year of the time the board receives an application for licensure, the
213.7 applicant must meet all the requirements and provide all of the information requested by
213.8 the board.

213.9 Sec. 5. Minnesota Statutes 2018, section 148E.120, subdivision 2, is amended to read:

213.10 **Subd. 2. Alternate supervisors.** (a) The board may approve an alternate supervisor as
213.11 determined in this subdivision. The board shall approve up to 25 percent of the required
213.12 supervision hours by a licensed mental health professional who is competent and qualified
213.13 to provide supervision according to the mental health professional's respective licensing
213.14 board, as established by section 245.462, subdivision 18, ~~clauses (1) to (6)~~, or 245.4871,
213.15 subdivision 27, ~~clauses (1) to (6)~~.

213.16 (b) The board shall approve up to 100 percent of the required supervision hours by an
213.17 alternate supervisor if the board determines that:

213.18 (1) there are five or fewer supervisors in the county where the licensee practices social
213.19 work who meet the applicable licensure requirements in subdivision 1;

213.20 (2) the supervisor is an unlicensed social worker who is employed in, and provides the
213.21 supervision in, a setting exempt from licensure by section 148E.065, and who has
213.22 qualifications equivalent to the applicable requirements specified in sections 148E.100 to
213.23 148E.115;

213.24 (3) the supervisor is a social worker engaged in authorized social work practice in Iowa,
213.25 Manitoba, North Dakota, Ontario, South Dakota, or Wisconsin, and has the qualifications
213.26 equivalent to the applicable requirements in sections 148E.100 to 148E.115; or

213.27 (4) the applicant or licensee is engaged in nonclinical authorized social work practice
213.28 outside of Minnesota and the supervisor meets the qualifications equivalent to the applicable
213.29 requirements in sections 148E.100 to 148E.115, or the supervisor is an equivalent mental
213.30 health professional, as determined by the board, who is credentialed by a state, territorial,
213.31 provincial, or foreign licensing agency; or

214.1 (5) the applicant or licensee is engaged in clinical authorized social work practice outside
214.2 of Minnesota and the supervisor meets qualifications equivalent to the applicable
214.3 requirements in section 148E.115, or the supervisor is an equivalent mental health
214.4 professional as determined by the board, who is credentialed by a state, territorial, provincial,
214.5 or foreign licensing agency.

214.6 (c) In order for the board to consider an alternate supervisor under this section, the
214.7 licensee must:

214.8 (1) request in the supervision plan and verification submitted according to section
214.9 148E.125 that an alternate supervisor conduct the supervision; and

214.10 (2) describe the proposed supervision and the name and qualifications of the proposed
214.11 alternate supervisor. The board may audit the information provided to determine compliance
214.12 with the requirements of this section.

214.13 Sec. 6. Minnesota Statutes 2018, section 148F.11, subdivision 1, is amended to read:

214.14 Subdivision 1. **Other professionals.** (a) Nothing in this chapter prevents members of
214.15 other professions or occupations from performing functions for which they are qualified or
214.16 licensed. This exception includes, but is not limited to: licensed physicians; registered nurses;
214.17 licensed practical nurses; licensed psychologists and licensed psychological practitioners;
214.18 members of the clergy provided such services are provided within the scope of regular
214.19 ministries; American Indian medicine men and women; licensed attorneys; probation officers;
214.20 licensed marriage and family therapists; licensed social workers; social workers employed
214.21 by city, county, or state agencies; licensed professional counselors; licensed professional
214.22 clinical counselors; licensed school counselors; registered occupational therapists or
214.23 occupational therapy assistants; Upper Midwest Indian Council on Addictive Disorders
214.24 (UMICAD) certified counselors when providing services to Native American people; city,
214.25 county, or state employees when providing assessments or case management under Minnesota
214.26 Rules, chapter 9530; and individuals defined in section 256B.0623, subdivision 5, clauses
214.27 (1) and (2) to (4), providing integrated dual diagnosis treatment in adult mental health
214.28 rehabilitative programs certified by the Department of Human Services under section
214.29 256B.0622 or 256B.0623.

214.30 (b) Nothing in this chapter prohibits technicians and resident managers in programs
214.31 licensed by the Department of Human Services from discharging their duties as provided
214.32 in Minnesota Rules, chapter 9530.

215.1 (c) Any person who is exempt from licensure under this section must not use a title
215.2 incorporating the words "alcohol and drug counselor" or "licensed alcohol and drug
215.3 counselor" or otherwise hold himself or herself out to the public by any title or description
215.4 stating or implying that he or she is engaged in the practice of alcohol and drug counseling,
215.5 or that he or she is licensed to engage in the practice of alcohol and drug counseling, unless
215.6 that person is also licensed as an alcohol and drug counselor. Persons engaged in the practice
215.7 of alcohol and drug counseling are not exempt from the board's jurisdiction solely by the
215.8 use of one of the titles in paragraph (a).

215.9 Sec. 7. Minnesota Statutes 2018, section 245.462, subdivision 6, is amended to read:

215.10 Subd. 6. **Community support services program.** "Community support services program"
215.11 means services, other than inpatient or residential treatment services, provided or coordinated
215.12 by an identified program and staff under the ~~clinical treatment~~ supervision of a mental health
215.13 professional designed to help adults with serious and persistent mental illness to function
215.14 and remain in the community. A community support services program includes:

- 215.15 (1) client outreach,
- 215.16 (2) medication monitoring,
- 215.17 (3) assistance in independent living skills,
- 215.18 (4) development of employability and work-related opportunities,
- 215.19 (5) crisis assistance,
- 215.20 (6) psychosocial rehabilitation,
- 215.21 (7) help in applying for government benefits, and
- 215.22 (8) housing support services.

215.23 The community support services program must be coordinated with the case management
215.24 services specified in section 245.4711.

215.25 Sec. 8. Minnesota Statutes 2018, section 245.462, subdivision 8, is amended to read:

215.26 Subd. 8. **Day treatment services.** "Day treatment," "day treatment services," or "day
215.27 treatment program" means a ~~structured program of treatment and care provided to an adult~~
215.28 ~~in or by:~~ (1) a hospital accredited by the joint commission on accreditation of health
215.29 organizations and licensed under sections 144.50 to 144.55; (2) a community mental health
215.30 center under section 245.62; or (3) an entity that is ~~under contract with the county board to~~
215.31 ~~operate a program that meets the requirements of section 245.4712, subdivision 2, and~~

216.1 ~~Minnesota Rules, parts 9505.0170 to 9505.0475. Day treatment consists of group~~
216.2 ~~psychotherapy and other intensive therapeutic services that are provided at least two days~~
216.3 ~~a week by a multidisciplinary staff under the clinical supervision of a mental health~~
216.4 ~~professional. Day treatment may include education and consultation provided to families~~
216.5 ~~and other individuals as part of the treatment process. The services are aimed at stabilizing~~
216.6 ~~the adult's mental health status, providing mental health services, and developing and~~
216.7 ~~improving the adult's independent living and socialization skills. The goal of day treatment~~
216.8 ~~is to reduce or relieve mental illness and to enable the adult to live in the community. Day~~
216.9 ~~treatment services are not a part of inpatient or residential treatment services. Day treatment~~
216.10 ~~services are distinguished from day care by their structured therapeutic program of~~
216.11 ~~psychotherapy services. The commissioner may limit medical assistance reimbursement~~
216.12 ~~for day treatment to 15 hours per week per person the treatment services described under~~
216.13 ~~section 256B.0625, subdivision 23.~~

216.14 Sec. 9. Minnesota Statutes 2018, section 245.462, subdivision 9, is amended to read:

216.15 Subd. 9. **Diagnostic assessment.** (a) "Diagnostic assessment" has the meaning given in
216.16 ~~Minnesota Rules, part 9505.0370, subpart 11, and is delivered as provided in Minnesota~~
216.17 ~~Rules, part 9505.0372, subpart 1, items A, B, C, and E. Diagnostic assessment includes a~~
216.18 ~~standard, extended, or brief diagnostic assessment, or an adult update means the assessment~~
216.19 ~~described under section 256B.0671, subdivisions 2 to 4.~~

216.20 (b) ~~A brief diagnostic assessment must include a face-to-face interview with the client~~
216.21 ~~and a written evaluation of the client by a mental health professional or a clinical trainee,~~
216.22 ~~as provided in Minnesota Rules, part 9505.0371, subpart 5, item C. The professional or~~
216.23 ~~clinical trainee must gather initial components of a standard diagnostic assessment, including~~
216.24 ~~the client's:~~

216.25 (1) age;
216.26 (2) description of symptoms, including reason for referral;
216.27 (3) history of mental health treatment;
216.28 (4) cultural influences and their impact on the client; and
216.29 (5) mental status examination.

216.30 (c) ~~On the basis of the initial components, the professional or clinical trainee must draw~~
216.31 ~~a provisional clinical hypothesis. The clinical hypothesis may be used to address the client's~~
216.32 ~~immediate needs or presenting problem.~~

217.1 ~~(d) Treatment sessions conducted under authorization of a brief assessment may be used~~

217.2 ~~to gather additional information necessary to complete a standard diagnostic assessment or~~

217.3 ~~an extended diagnostic assessment.~~

217.4 ~~(e) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1),~~

217.5 ~~unit (b), prior to completion of a client's initial diagnostic assessment, a client is eligible~~

217.6 ~~for psychological testing as part of the diagnostic process.~~

217.7 ~~(f) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1),~~

217.8 ~~unit (c), prior to completion of a client's initial diagnostic assessment, but in conjunction~~

217.9 ~~with the diagnostic assessment process, a client is eligible for up to three individual or family~~

217.10 ~~psychotherapy sessions or family psychoeducation sessions or a combination of the above~~

217.11 ~~sessions not to exceed three sessions.~~

217.12 ~~(g) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item B, subitem (3),~~

217.13 ~~unit (a), a brief diagnostic assessment may be used for a client's family who requires a~~

217.14 ~~language interpreter to participate in the assessment.~~

217.15 Sec. 10. Minnesota Statutes 2018, section 245.462, subdivision 14, is amended to read:

217.16 Subd. 14. **Individual treatment plan.** "Individual treatment plan" means ~~a written plan~~

217.17 ~~of intervention, treatment, and services for an adult with mental illness that is developed~~

217.18 ~~by a service provider under the clinical supervision of a mental health professional on the~~

217.19 ~~basis of a diagnostic assessment. The plan identifies goals and objectives of treatment,~~

217.20 ~~treatment strategy, a schedule for accomplishing treatment goals and objectives, and the~~

217.21 ~~individual responsible for providing treatment to the adult with mental illness the individual~~

217.22 treatment plan described under section 256B.0671, subdivisions 5 and 6.

217.23 Sec. 11. Minnesota Statutes 2018, section 245.462, subdivision 17, is amended to read:

217.24 Subd. 17. **Mental health practitioner.** (a) "Mental health practitioner" means a person

217.25 ~~providing services to adults with mental illness or children with emotional disturbance who~~

217.26 ~~is qualified in at least one of the ways described in paragraphs (b) to (g). A mental health~~

217.27 ~~practitioner for a child client must have training working with children. A mental health~~

217.28 ~~practitioner for an adult client must have training working with adults qualified according~~

217.29 to section 245I.16, subdivision 4.

217.30 ~~(b) For purposes of this subdivision, a practitioner is qualified through relevant~~

217.31 ~~coursework if the practitioner completes at least 30 semester hours or 45 quarter hours in~~

217.32 ~~behavioral sciences or related fields and:~~

- 218.1 (1) has at least 2,000 hours of supervised experience in the delivery of services to adults
218.2 or children with:

218.3 (i) mental illness, substance use disorder, or emotional disturbance; or

218.4 (ii) traumatic brain injury or developmental disabilities and completes training on mental
218.5 illness, recovery from mental illness, mental health de-escalation techniques, co-occurring
218.6 mental illness and substance abuse, and psychotropic medications and side effects;

218.7 (2) is fluent in the non-English language of the ethnic group to which at least 50 percent
218.8 of the practitioner's clients belong, completes 40 hours of training in the delivery of services
218.9 to adults with mental illness or children with emotional disturbance, and receives clinical
218.10 supervision from a mental health professional at least once a week until the requirement of
218.11 2,000 hours of supervised experience is met;

218.12 (3) is working in a day treatment program under section 245.4712, subdivision 2; or

218.13 (4) has completed a practicum or internship that (i) requires direct interaction with adults
218.14 or children served, and (ii) is focused on behavioral sciences or related fields.

218.15 (e) For purposes of this subdivision, a practitioner is qualified through work experience
218.16 if the person:

218.17 (1) has at least 4,000 hours of supervised experience in the delivery of services to adults
218.18 or children with:

218.19 (i) mental illness, substance use disorder, or emotional disturbance; or

218.20 (ii) traumatic brain injury or developmental disabilities and completes training on mental
218.21 illness, recovery from mental illness, mental health de-escalation techniques, co-occurring
218.22 mental illness and substance abuse, and psychotropic medications and side effects; or

218.23 (2) has at least 2,000 hours of supervised experience in the delivery of services to adults
218.24 or children with:

218.25 (i) mental illness, emotional disturbance, or substance use disorder, and receives clinical
218.26 supervision as required by applicable statutes and rules from a mental health professional
218.27 at least once a week until the requirement of 4,000 hours of supervised experience is met;
218.28 or

218.29 (ii) traumatic brain injury or developmental disabilities; completes training on mental
218.30 illness, recovery from mental illness, mental health de-escalation techniques, co-occurring
218.31 mental illness and substance abuse, and psychotropic medications and side effects; and
218.32 receives clinical supervision as required by applicable statutes and rules at least once a week

219.1 from a mental health professional until the requirement of 4,000 hours of supervised
219.2 experience is met.

219.3 (d) For purposes of this subdivision, a practitioner is qualified through a graduate student
219.4 internship if the practitioner is a graduate student in behavioral sciences or related fields
219.5 and is formally assigned by an accredited college or university to an agency or facility for
219.6 clinical training.

219.7 (e) For purposes of this subdivision, a practitioner is qualified by a bachelor's or master's
219.8 degree if the practitioner:

219.9 (1) holds a master's or other graduate degree in behavioral sciences or related fields; or
219.10 (2) holds a bachelor's degree in behavioral sciences or related fields and completes a
219.11 practicum or internship that (i) requires direct interaction with adults or children served,
219.12 and (ii) is focused on behavioral sciences or related fields.

219.13 (f) For purposes of this subdivision, a practitioner is qualified as a vendor of medical
219.14 care if the practitioner meets the definition of vendor of medical care in section 256B.02,
219.15 subdivision 7, paragraphs (b) and (e), and is serving a federally recognized tribe.

219.16 (g) For purposes of medical assistance coverage of diagnostic assessments, explanations
219.17 of findings, and psychotherapy under section 256B.0625, subdivision 65, a mental health
219.18 practitioner working as a clinical trainee means that the practitioner's clinical supervision
219.19 experience is helping the practitioner gain knowledge and skills necessary to practice
219.20 effectively and independently. This may include supervision of direct practice, treatment
219.21 team collaboration, continued professional learning, and job management. The practitioner
219.22 must also:

219.23 (1) comply with requirements for licensure or board certification as a mental health
219.24 professional, according to the qualifications under Minnesota Rules, part 9505.0371, subpart
219.25 5, item A, including supervised practice in the delivery of mental health services for the
219.26 treatment of mental illness; or

219.27 (2) be a student in a bona fide field placement or internship under a program leading to
219.28 completion of the requirements for licensure as a mental health professional according to
219.29 the qualifications under Minnesota Rules, part 9505.0371, subpart 5, item A.

219.30 (h) For purposes of this subdivision, "behavioral sciences or related fields" has the
219.31 meaning given in section 256B.0623, subdivision 5, paragraph (d).

220.1 (i) Notwithstanding the licensing requirements established by a health-related licensing
220.2 board, as defined in section 214.01, subdivision 2, this subdivision supersedes any other
220.3 statute or rule.

220.4 Sec. 12. Minnesota Statutes 2018, section 245.462, subdivision 18, is amended to read:

220.5 Subd. 18. **Mental health professional.** "Mental health professional" means a person
220.6 providing clinical services in the treatment of mental illness who is qualified in at least one
220.7 of the following ways: qualified according to section 245I.16, subdivision 2.

220.8 (1) in psychiatric nursing: a registered nurse who is licensed under sections 148.171 to
220.9 148.285; and:

220.10 (i) who is certified as a clinical specialist or as a nurse practitioner in adult or family
220.11 psychiatric and mental health nursing by a national nurse certification organization; or

220.12 (ii) who has a master's degree in nursing or one of the behavioral sciences or related
220.13 fields from an accredited college or university or its equivalent, with at least 4,000 hours
220.14 of post master's supervised experience in the delivery of clinical services in the treatment
220.15 of mental illness;

220.16 (2) in clinical social work: a person licensed as an independent clinical social worker
220.17 under chapter 148D, or a person with a master's degree in social work from an accredited
220.18 college or university, with at least 4,000 hours of post master's supervised experience in
220.19 the delivery of clinical services in the treatment of mental illness;

220.20 (3) in psychology: an individual licensed by the Board of Psychology under sections
220.21 148.88 to 148.98 who has stated to the Board of Psychology competencies in the diagnosis
220.22 and treatment of mental illness;

220.23 (4) in psychiatry: a physician licensed under chapter 147 and certified by the American
220.24 Board of Psychiatry and Neurology or eligible for board certification in psychiatry, or an
220.25 osteopathic physician licensed under chapter 147 and certified by the American Osteopathic
220.26 Board of Neurology and Psychiatry or eligible for board certification in psychiatry;

220.27 (5) in marriage and family therapy: the mental health professional must be a marriage
220.28 and family therapist licensed under sections 148B.29 to 148B.39 with at least two years of
220.29 post master's supervised experience in the delivery of clinical services in the treatment of
220.30 mental illness;

220.31 (6) in licensed professional clinical counseling, the mental health professional shall be
220.32 a licensed professional clinical counselor under section 148B.5301 with at least 4,000 hours

221.1 ~~of post master's supervised experience in the delivery of clinical services in the treatment~~
221.2 ~~of mental illness; or~~

221.3 ~~(7) in allied fields: a person with a master's degree from an accredited college or university~~
221.4 ~~in one of the behavioral sciences or related fields, with at least 4,000 hours of post master's~~
221.5 ~~supervised experience in the delivery of clinical services in the treatment of mental illness.~~

221.6 Sec. 13. Minnesota Statutes 2018, section 245.462, subdivision 21, is amended to read:

221.7 Subd. 21. **Outpatient services.** "Outpatient services" means mental health services,
221.8 excluding day treatment and community support services programs, provided by or under
221.9 the ~~clinical treatment~~ supervision of a mental health professional to adults with mental
221.10 illness who live outside a hospital. Outpatient services include clinical activities such as
221.11 individual, group, and family therapy; individual treatment planning; diagnostic assessments;
221.12 medication management; and psychological testing.

221.13 Sec. 14. Minnesota Statutes 2018, section 245.462, subdivision 23, is amended to read:

221.14 Subd. 23. **Residential treatment.** "Residential treatment" means a 24-hour-a-day program
221.15 under the ~~clinical treatment~~ supervision of a mental health professional, in a community
221.16 residential setting other than an acute care hospital or regional treatment center inpatient
221.17 unit, that must be licensed as a residential treatment program for adults with mental illness
221.18 under Minnesota Rules, parts 9520.0500 to 9520.0670, or other rules adopted by the
221.19 commissioner.

221.20 Sec. 15. Minnesota Statutes 2018, section 245.462, is amended by adding a subdivision
221.21 to read:

221.22 Subd. 27. **Treatment supervision.** "Treatment supervision" means the treatment
221.23 supervision described under section 245I.18.

221.24 Sec. 16. Minnesota Statutes 2018, section 245.467, subdivision 2, is amended to read:

221.25 Subd. 2. **Diagnostic assessment.** ~~All providers of residential, acute care hospital inpatient,~~
221.26 ~~and regional treatment centers must complete a diagnostic assessment for each of their~~
221.27 ~~clients within five days of admission. Providers of day treatment services must complete a~~
221.28 ~~diagnostic assessment within five days after the adult's second visit or within 30 days after~~
221.29 ~~intake, whichever occurs first. In cases where a diagnostic assessment is available and has~~
221.30 ~~been completed within three years preceding admission, only an adult diagnostic assessment~~
221.31 ~~update is necessary. An "adult diagnostic assessment update" means a written summary by~~

222.1 ~~a mental health professional of the adult's current mental health status and service needs~~
222.2 ~~and includes a face-to-face interview with the adult. If the adult's mental health status has~~
222.3 ~~changed markedly since the adult's most recent diagnostic assessment, a new diagnostic~~
222.4 ~~assessment is required. Compliance with the provisions of this subdivision does not ensure~~
222.5 ~~eligibility for medical assistance reimbursement under chapter 256B.~~ Providers of services
222.6 governed by this section shall complete a diagnostic assessment according to the standards
222.7 of section 256B.0671, including for services to a person not eligible for medical assistance.

222.8 Sec. 17. Minnesota Statutes 2018, section 245.467, subdivision 3, is amended to read:

222.9 **Subd. 3. Individual treatment plans.** ~~All providers of outpatient services, day treatment~~
222.10 ~~services, residential treatment, acute care hospital inpatient treatment, and all regional~~
222.11 ~~treatment centers must develop an individual treatment plan for each of their adult clients.~~
222.12 ~~The individual treatment plan must be based on a diagnostic assessment. To the extent~~
222.13 ~~possible, the adult client shall be involved in all phases of developing and implementing~~
222.14 ~~the individual treatment plan. Providers of residential treatment and acute care hospital~~
222.15 ~~inpatient treatment, and all regional treatment centers must develop the individual treatment~~
222.16 ~~plan within ten days of client intake and must review the individual treatment plan every~~
222.17 ~~90 days after intake. Providers of day treatment services must develop the individual~~
222.18 ~~treatment plan before the completion of five working days in which service is provided or~~
222.19 ~~within 30 days after the diagnostic assessment is completed or obtained, whichever occurs~~
222.20 ~~first. Providers of outpatient services must develop the individual treatment plan within 30~~
222.21 ~~days after the diagnostic assessment is completed or obtained or by the end of the second~~
222.22 ~~session of an outpatient service, not including the session in which the diagnostic assessment~~
222.23 ~~was provided, whichever occurs first. Outpatient and day treatment services providers must~~
222.24 ~~review the individual treatment plan every 90 days after intake.~~ Providers of services
222.25 governed by this section shall complete an individual treatment plan according to the
222.26 standards of section 256B.0671, subdivisions 5 and 6, including for services to a person not
222.27 eligible for medical assistance.

222.28 Sec. 18. Minnesota Statutes 2018, section 245.469, subdivision 1, is amended to read:

222.29 **Subdivision 1. Availability of emergency services.** ~~By July 1, 1988, County boards~~
222.30 ~~must provide or contract for enough emergency services within the county to meet the needs~~
222.31 ~~of adults in the county who are experiencing an emotional crisis or mental illness. Clients~~
222.32 ~~may be required to pay a fee according to section 245.481. Emergency service providers~~
222.33 ~~shall not delay the timely provision of emergency service because of delays in determining~~
222.34 ~~this fee or because of the unwillingness or inability of the client to pay the fee.~~ Emergency

223.1 services must include assessment, crisis intervention, and appropriate case disposition. A
223.2 tribal authority that accepts crisis grant funding has the same responsibilities as county
223.3 boards within the tribal authority's designated service area. Emergency services must:
223.4 (1) promote the safety and emotional stability of adults with mental illness or emotional
223.5 crises;
223.6 (2) minimize further deterioration of adults with mental illness or emotional crises;
223.7 (3) help adults with mental illness or emotional crises to obtain ongoing care and
223.8 treatment; and
223.9 (4) prevent placement in settings that are more intensive, costly, or restrictive than
223.10 necessary and appropriate to meet client needs.; and
223.11 (5) provide support, psychoeducation, and referrals to family members, friends, service
223.12 providers, or other third parties on behalf of a recipient in need of emergency services.

223.13 Sec. 19. Minnesota Statutes 2018, section 245.469, subdivision 2, is amended to read:

223.14 Subd. 2. **Specific requirements.** (a) The county board shall require that all service
223.15 providers of emergency services to adults with mental illness provide immediate direct
223.16 access to a mental health professional during regular business hours. For evenings, weekends,
223.17 and holidays, the service may be by direct toll-free telephone access to a mental health
223.18 professional, a clinical trainee, or a mental health practitioner, or until January 1, 1991, a
223.19 designated person with training in human services who receives clinical supervision from
223.20 a mental health professional.

223.21 (b) The commissioner may waive the requirement in paragraph (a) that the evening,
223.22 weekend, and holiday service be provided by a mental health professional, clinical trainee,
223.23 or mental health practitioner after January 1, 1991, if the county documents that:

223.24 (1) mental health professionals, clinical trainees, or mental health practitioners are
223.25 unavailable to provide this service;

223.26 (2) services are provided by a designated person with training in human services who
223.27 receives clinical treatment supervision from a mental health professional; and

223.28 (3) the service provider is not also the provider of fire and public safety emergency
223.29 services.

223.30 (c) The commissioner may waive the requirement in paragraph (b), clause (3), that the
223.31 evening, weekend, and holiday service not be provided by the provider of fire and public
223.32 safety emergency services if:

224.1 (1) every person who will be providing the first telephone contact has received at least
224.2 eight hours of training on emergency mental health services reviewed by the state advisory
224.3 council on mental health and then approved by the commissioner;

224.4 (2) every person who will be providing the first telephone contact will annually receive
224.5 at least four hours of continued training on emergency mental health services reviewed by
224.6 the state advisory council on mental health and then approved by the commissioner;

224.7 (3) the local social service agency has provided public education about available
224.8 emergency mental health services and can assure potential users of emergency services that
224.9 their calls will be handled appropriately;

224.10 (4) the local social service agency agrees to provide the commissioner with accurate
224.11 data on the number of emergency mental health service calls received;

224.12 (5) the local social service agency agrees to monitor the frequency and quality of
224.13 emergency services; and

224.14 (6) the local social service agency describes how it will comply with paragraph (d).

224.15 (d) Whenever emergency service during nonbusiness hours is provided by anyone other
224.16 than a mental health professional, a mental health professional must be available on call for
224.17 an emergency assessment and crisis intervention services, and must be available for at least
224.18 telephone consultation within 30 minutes.

224.19 Sec. 20. Minnesota Statutes 2018, section 245.470, subdivision 1, is amended to read:

224.20 **Subdivision 1. Availability of outpatient services.** (a) County boards must provide or
224.21 contract for enough outpatient services within the county to meet the needs of adults with
224.22 mental illness residing in the county. Services may be provided directly by the county
224.23 through county-operated mental health centers or mental health clinics approved by the
224.24 commissioner under section 245.69, subdivision 2; by contract with privately operated
224.25 mental health centers or mental health clinics approved by the commissioner under section
224.26 245.69, subdivision 2; by contract with hospital mental health outpatient programs certified
224.27 by the Joint Commission on Accreditation of Hospital Organizations; or by contract with
224.28 a licensed mental health professional ~~as defined in section 245.462, subdivision 18, clauses~~
224.29 ~~(1) to (6)~~. Clients may be required to pay a fee according to section 245.481. Outpatient
224.30 services include:

- 224.31 (1) conducting diagnostic assessments;
224.32 (2) conducting psychological testing;

225.1 (3) developing or modifying individual treatment plans;

225.2 (4) making referrals and recommending placements as appropriate;

225.3 (5) treating an adult's mental health needs through therapy;

225.4 (6) prescribing and managing medication and evaluating the effectiveness of prescribed

225.5 medication; and

225.6 (7) preventing placement in settings that are more intensive, costly, or restrictive than

225.7 necessary and appropriate to meet client needs.

225.8 (b) County boards may request a waiver allowing outpatient services to be provided in

225.9 a nearby trade area if it is determined that the client can best be served outside the county.

225.10 Sec. 21. Minnesota Statutes 2018, section 245.4712, subdivision 2, is amended to read:

225.11 **Subd. 2. Day treatment services provided.** (a) Day treatment services must be developed

225.12 as a part of the community support services available to adults with serious and persistent

225.13 mental illness residing in the county. Adults may be required to pay a fee according to

225.14 section 245.481. Day treatment services must be designed to:

225.15 (1) provide a structured environment for treatment;

225.16 (2) provide support for residing in the community;

225.17 (3) prevent placement in settings that are more intensive, costly, or restrictive than

225.18 necessary and appropriate to meet client need;

225.19 (4) coordinate with or be offered in conjunction with a local education agency's special

225.20 education program; and

225.21 (5) operate on a continuous basis throughout the year.

225.22 (b) For purposes of complying with medical assistance requirements, an adult day

225.23 treatment program must comply with the method of clinical treatment supervision specified

225.24 in Minnesota Rules, part 9505.0371, subpart 4 section 245I.18. The clinical supervision

225.25 must be performed by a qualified supervisor who satisfies the requirements of Minnesota

225.26 Rules, part 9505.0371, subpart 5.

225.27 A day treatment program must demonstrate compliance with this clinical treatment

225.28 supervision requirement by the commissioner's review and approval of the program according

225.29 to Minnesota Rules, part 9505.0372, subpart 8 section 256B.0625, subdivision 23.

225.30 (c) County boards may request a waiver from including day treatment services if they

225.31 can document that:

226.1 (1) an alternative plan of care exists through the county's community support services
226.2 for clients who would otherwise need day treatment services;

226.3 (2) day treatment, if included, would be duplicative of other components of the
226.4 community support services; and

226.5 (3) county demographics and geography make the provision of day treatment services
226.6 cost ineffective and infeasible.

226.7 Sec. 22. Minnesota Statutes 2018, section 245.472, subdivision 2, is amended to read:

226.8 **Subd. 2. Specific requirements.** Providers of residential services must be licensed under
226.9 applicable rules adopted by the commissioner and must ~~be clinically supervised~~ provide
226.10 ~~treatment supervision~~ by a mental health professional. ~~Persons employed in facilities licensed~~
226.11 ~~under Minnesota Rules, parts 9520.0500 to 9520.0670, in the capacity of program director~~
226.12 ~~as of July 1, 1987, in accordance with Minnesota Rules, parts 9520.0500 to 9520.0670, may~~
226.13 ~~be allowed to continue providing clinical supervision within a facility, provided they continue~~
226.14 ~~to be employed as a program direector in a facility licensed under Minnesota Rules, parts~~
226.15 ~~9520.0500 to 9520.0670.~~

226.16 Sec. 23. Minnesota Statutes 2018, section 245.4863, is amended to read:

226.17 **245.4863 INTEGRATED CO-OCCURRING DISORDER TREATMENT.**

226.18 (a) The commissioner shall require individuals who perform chemical dependency
226.19 assessments to screen clients for co-occurring mental health disorders, and staff who perform
226.20 mental health diagnostic assessments to screen for co-occurring substance use disorders.
226.21 Screening tools must be approved by the commissioner. If a client screens positive for a
226.22 co-occurring mental health or substance use disorder, the individual performing the screening
226.23 must document what actions will be taken in response to the results and whether further
226.24 assessments must be performed.

226.25 (b) Notwithstanding paragraph (a), screening is not required when:

- 226.26 (1) the presence of co-occurring disorders was documented for the client in the past 12
226.27 months;
- 226.28 (2) the client is currently receiving co-occurring disorders treatment;
- 226.29 (3) the client is being referred for co-occurring disorders treatment; or
- 226.30 (4) a mental health professional, as ~~defined in Minnesota Rules, part 9505.0370, subpart~~
226.31 ~~18~~ provided by section 245I.16, subdivision 2, who is competent to perform diagnostic

227.1 assessments of co-occurring disorders is performing a diagnostic assessment that meets the
227.2 requirements in Minnesota Rules, part 9533.0090, subpart 5, to identify whether the client
227.3 may have co-occurring mental health and chemical dependency disorders. If an individual
227.4 is identified to have co-occurring mental health and substance use disorders, the assessing
227.5 mental health professional must document what actions will be taken to address the client's
227.6 co-occurring disorders.

227.7 (c) The commissioner shall adopt rules as necessary to implement this section. The
227.8 commissioner shall ensure that the rules are effective on July 1, 2013, thereby establishing
227.9 a certification process for integrated dual disorder treatment providers and a system through
227.10 which individuals receive integrated dual diagnosis treatment if assessed as having both a
227.11 substance use disorder and either a serious mental illness or emotional disturbance.

227.12 (d) The commissioner shall apply for any federal waivers necessary to secure, to the
227.13 extent allowed by law, federal financial participation for the provision of integrated dual
227.14 diagnosis treatment to persons with co-occurring disorders.

227.15 Sec. 24. Minnesota Statutes 2018, section 245.4871, subdivision 9a, is amended to read:

227.16 Subd. 9a. **Crisis assistance planning.** "Crisis assistance planning" means assistance to
227.17 ~~the child, the child's family, and all providers of services to the child to recognize factors~~
227.18 ~~precipitating a mental health crisis, identify behaviors related to the crisis, and be informed~~
227.19 ~~of available resources to resolve the crisis. Crisis assistance requires the development of a~~
227.20 ~~plan which addresses prevention and intervention strategies to be used in a potential crisis.~~
227.21 ~~Other interventions include: (1) arranging for admission to acute care hospital inpatient~~
227.22 ~~treatment; (2) crisis placement; (3) community resources for follow-up; and (4) emotional~~
227.23 ~~support to the family during crisis. Crisis assistance does not include services designed to~~
227.24 ~~secure the safety of a child who is at risk of abuse or neglect or necessary emergency services.~~
227.25 ~~the development of a written plan to assist a child's family with a potential crisis and is~~
227.26 ~~distinct from the immediate provision of mental health mobile crisis intervention services~~
227.27 ~~as defined in section 256B.0944. The plan must address prevention and intervention strategies~~
227.28 ~~to be used in a crisis. The plan identifies factors that might precipitate a crisis, behaviors~~
227.29 ~~related to the emergence of a crisis, and the resources available to resolve a crisis. The plan~~
227.30 ~~must include planning for the following potential needs: (1) arranging for admission to acute~~
227.31 ~~care hospital inpatient treatment; (2) crisis placement; (3) community resources for follow-up;~~
227.32 ~~and (4) emotional support to the family during crisis. Crisis planning excludes services~~
227.33 ~~designed to secure the safety of a child who is at risk of abuse or neglect or necessary~~
227.34 ~~emergency services.~~

228.1 Sec. 25. Minnesota Statutes 2018, section 245.4871, subdivision 10, is amended to read:

228.2 Subd. 10. **Day treatment services.** "Day treatment," "day treatment services," or "day

228.3 treatment program" means a structured program of treatment and care provided to a child

228.4 in:

228.5 (1) an outpatient hospital accredited by the Joint Commission on Accreditation of Health

228.6 Organizations and licensed under sections 144.50 to 144.55;

228.7 (2) a community mental health center under section 245.62;

228.8 (3) an entity that is under contract with the county board to operate a program that meets

228.9 the requirements of section 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170

228.10 to 9505.0475; or

228.11 (4) an entity that operates a program that meets the requirements of section 245.4884,

228.12 subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475, that is under contract

228.13 with an entity that is under contract with a county board; or

228.14 (5) an entity that operates a program certified under section 256B.0943.

228.15 Day treatment consists of group psychotherapy and other intensive therapeutic services

228.16 that are provided for a minimum two-hour time block by a multidisciplinary staff under the

228.17 clinical supervision of a mental health professional. Day treatment may include education

228.18 and consultation provided to families and other individuals as an extension of the treatment

228.19 process. The services are aimed at stabilizing the child's mental health status, and developing

228.20 and improving the child's daily independent living and socialization skills. Day treatment

228.21 services are distinguished from day care by their structured therapeutic program of

228.22 psychotherapy services. Day treatment services are not a part of inpatient hospital or

228.23 residential treatment services.

228.24 A day treatment service must be available to a child up to 15 hours a week throughout

228.25 the year and must be coordinated with, integrated with, or part of an education program

228.26 offered by the child's school.

228.27 Sec. 26. Minnesota Statutes 2018, section 245.4871, subdivision 11a, is amended to read:

228.28 Subd. 11a. **Diagnostic assessment.** (a) "Diagnostic assessment" has the meaning given

228.29 in Minnesota Rules, part 9505.0370, subpart 11, and is delivered as provided in Minnesota

228.30 Rules, part 9505.0372, subpart 1, items A, B, C, and E. Diagnostic assessment includes a

228.31 standard, extended, or brief diagnostic assessment, or an adult update. means the assessment

228.32 described under section 256B.0671, subdivisions 2 to 4.

229.1 (b) A brief diagnostic assessment must include a face-to-face interview with the client
229.2 and a written evaluation of the client by a mental health professional or a clinical trainee,
229.3 as provided in Minnesota Rules, part 9505.0371, subpart 5, item C. The professional or
229.4 clinical trainee must gather initial components of a standard diagnostic assessment, including
229.5 the client's:

229.6 (1) age;

229.7 (2) description of symptoms, including reason for referral;

229.8 (3) history of mental health treatment;

229.9 (4) cultural influences and their impact on the client; and

229.10 (5) mental status examination.

229.11 (c) On the basis of the brief components, the professional or clinical trainee must draw
229.12 a provisional clinical hypothesis. The clinical hypothesis may be used to address the client's
229.13 immediate needs or presenting problem.

229.14 (d) Treatment sessions conducted under authorization of a brief assessment may be used
229.15 to gather additional information necessary to complete a standard diagnostic assessment or
229.16 an extended diagnostic assessment.

229.17 (e) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1),
229.18 unit (b), prior to completion of a client's initial diagnostic assessment, a client is eligible
229.19 for psychological testing as part of the diagnostic process.

229.20 (f) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1),
229.21 unit (c), prior to completion of a client's initial diagnostic assessment, but in conjunction
229.22 with the diagnostic assessment process, a client is eligible for up to three individual or family
229.23 psychotherapy sessions or family psychoeducation sessions or a combination of the above
229.24 sessions not to exceed three sessions.

229.25 Sec. 27. Minnesota Statutes 2018, section 245.4871, subdivision 17, is amended to read:

229.26 Subd. 17. **Family community support services.** "Family community support services"
229.27 means services provided under the clinical supervision of a mental health
229.28 professional and designed to help each child with severe emotional disturbance to function
229.29 and remain with the child's family in the community. Family community support services
229.30 do not include acute care hospital inpatient treatment, residential treatment services, or
229.31 regional treatment center services. Family community support services include:

229.32 (1) client outreach to each child with severe emotional disturbance and the child's family;

230.1 (2) medication monitoring where necessary;

230.2 (3) assistance in developing independent living skills;

230.3 (4) assistance in developing parenting skills necessary to address the needs of the child

230.4 with severe emotional disturbance;

230.5 (5) assistance with leisure and recreational activities;

230.6 (6) crisis assistance, including crisis placement and respite care;

230.7 (7) professional home-based family treatment;

230.8 (8) foster care with therapeutic supports;

230.9 (9) day treatment;

230.10 (10) assistance in locating respite care and special needs day care; and

230.11 (11) assistance in obtaining potential financial resources, including those benefits listed

230.12 in section 245.4884, subdivision 5.

230.13 Sec. 28. Minnesota Statutes 2018, section 245.4871, subdivision 21, is amended to read:

230.14 Subd. 21. **Individual treatment plan.** "Individual treatment plan" means ~~a written plan of intervention, treatment, and services for a child with an emotional disturbance that is developed by a service provider under the clinical supervision of a mental health professional on the basis of a diagnostic assessment. An individual treatment plan for a child must be developed in conjunction with the family unless clinically inappropriate. The plan identifies goals and objectives of treatment, treatment strategy, a schedule for accomplishing treatment goals and objectives, and the individuals responsible for providing treatment to the child with an emotional disturbance~~ the individual treatment plan described under section 256B.0671, subdivisions 5 and 6.

230.23 Sec. 29. Minnesota Statutes 2018, section 245.4871, subdivision 26, is amended to read:

230.24 Subd. 26. **Mental health practitioner.** "Mental health practitioner" has the meaning given in means a person qualified according to section 245.462, subdivision 17 245I.16, subdivision 4.

230.27 Sec. 30. Minnesota Statutes 2018, section 245.4871, subdivision 27, is amended to read:

230.28 Subd. 27. **Mental health professional.** "Mental health professional" means a person ~~providing clinical services in the diagnosis and treatment of children's emotional disorders.~~

230.29 ~~A mental health professional must have training and experience in working with children~~

231.1 ~~eonsistent with the age group to which the mental health professional is assigned. A mental~~
231.2 ~~health professional must be qualified in at least one of the following ways:~~ qualified according
231.3 to section 245I.16, subdivision 2.

231.4 (1) ~~in psychiatric nursing, the mental health professional must be a registered nurse who~~
231.5 ~~is licensed under sections 148.171 to 148.285 and who is certified as a clinical specialist in~~
231.6 ~~child and adolescent psychiatric or mental health nursing by a national nurse certification~~
231.7 ~~organization or who has a master's degree in nursing or one of the behavioral sciences or~~
231.8 ~~related fields from an accredited college or university or its equivalent, with at least 4,000~~
231.9 ~~hours of post master's supervised experience in the delivery of clinical services in the~~
231.10 ~~treatment of mental illness;~~

231.11 (2) ~~in clinical social work, the mental health professional must be a person licensed as~~
231.12 ~~an independent clinical social worker under chapter 148D, or a person with a master's degree~~
231.13 ~~in social work from an accredited college or university, with at least 4,000 hours of~~
231.14 ~~post master's supervised experience in the delivery of clinical services in the treatment of~~
231.15 ~~mental disorders;~~

231.16 (3) ~~in psychology, the mental health professional must be an individual licensed by the~~
231.17 ~~board of psychology under sections 148.88 to 148.98 who has stated to the board of~~
231.18 ~~psychology competencies in the diagnosis and treatment of mental disorders;~~

231.19 (4) ~~in psychiatry, the mental health professional must be a physician licensed under~~
231.20 ~~chapter 147 and certified by the American Board of Psychiatry and Neurology or eligible~~
231.21 ~~for board certification in psychiatry or an osteopathic physician licensed under chapter 147~~
231.22 ~~and certified by the American Osteopathic Board of Neurology and Psychiatry or eligible~~
231.23 ~~for board certification in psychiatry;~~

231.24 (5) ~~in marriage and family therapy, the mental health professional must be a marriage~~
231.25 ~~and family therapist licensed under sections 148B.29 to 148B.39 with at least two years of~~
231.26 ~~post master's supervised experience in the delivery of clinical services in the treatment of~~
231.27 ~~mental disorders or emotional disturbances;~~

231.28 (6) ~~in licensed professional clinical counseling, the mental health professional shall be~~
231.29 ~~a licensed professional clinical counselor under section 148B.5301 with at least 4,000 hours~~
231.30 ~~of post master's supervised experience in the delivery of clinical services in the treatment~~
231.31 ~~of mental disorders or emotional disturbances; or~~

231.32 (7) ~~in allied fields, the mental health professional must be a person with a master's degree~~
231.33 ~~from an accredited college or university in one of the behavioral sciences or related fields,~~

232.1 ~~with at least 4,000 hours of post-master's supervised experience in the delivery of clinical~~
232.2 ~~services in the treatment of emotional disturbances.~~

232.3 Sec. 31. Minnesota Statutes 2018, section 245.4871, subdivision 29, is amended to read:

232.4 Subd. 29. **Outpatient services.** "Outpatient services" means mental health services,
232.5 excluding day treatment and community support services programs, provided by or under
232.6 the ~~clinical~~ treatment supervision of a mental health professional to children with emotional
232.7 disturbances who live outside a hospital. Outpatient services include clinical activities such
232.8 as individual, group, and family therapy; individual treatment planning; diagnostic
232.9 assessments; medication management; and psychological testing.

232.10 Sec. 32. Minnesota Statutes 2018, section 245.4871, subdivision 32, is amended to read:

232.11 Subd. 32. **Residential treatment.** "Residential treatment" means a 24-hour-a-day program
232.12 under the ~~clinical~~ treatment supervision of a mental health professional, in a community
232.13 residential setting other than an acute care hospital or regional treatment center inpatient
232.14 unit, that must be licensed as a residential treatment program for children with emotional
232.15 disturbances under Minnesota Rules, parts 2960.0580 to 2960.0700, or other rules adopted
232.16 by the commissioner.

232.17 Sec. 33. Minnesota Statutes 2018, section 245.4871, subdivision 34, is amended to read:

232.18 Subd. 34. **Therapeutic support of foster care.** "Therapeutic support of foster care"
232.19 means the mental health training and mental health support services and ~~clinical~~ treatment
232.20 supervision provided by a mental health professional to foster families caring for children
232.21 with severe emotional disturbance to provide a therapeutic family environment and support
232.22 for the child's improved functioning. Therapeutic support of foster care includes services
232.23 provided under section 256B.0946.

232.24 Sec. 34. Minnesota Statutes 2018, section 245.4876, subdivision 2, is amended to read:

232.25 Subd. 2. **Diagnostic assessment.** ~~All residential treatment facilities and acute care~~
~~hospital inpatient treatment facilities that provide mental health services for children must~~
~~complete a diagnostic assessment for each of their child clients within five working days~~
~~of admission. Providers of day treatment services for children must complete a diagnostic~~
~~assessment within five days after the child's second visit or 30 days after intake, whichever~~
~~occurs first. In cases where a diagnostic assessment is available and has been completed~~
~~within 180 days preceding admission, only updating is necessary. "Updating" means a~~

233.1 ~~written summary by a mental health professional of the child's current mental health status~~
233.2 ~~and service needs. If the child's mental health status has changed markedly since the child's~~
233.3 ~~most recent diagnostic assessment, a new diagnostic assessment is required. Compliance~~
233.4 ~~with the provisions of this subdivision does not ensure eligibility for medical assistance~~
233.5 ~~reimbursement under chapter 256B. Providers of services governed by this section shall~~
233.6 ~~complete a diagnostic assessment according to the standards of section 256B.0671, including~~
233.7 ~~for services to a person not eligible for medical assistance.~~

233.8 Sec. 35. Minnesota Statutes 2018, section 245.4876, subdivision 3, is amended to read:

233.9 **Subd. 3. Individual treatment plans.** ~~All providers of outpatient services, day treatment~~
233.10 ~~services, professional home-based family treatment, residential treatment, and acute care~~
233.11 ~~hospital inpatient treatment, and all regional treatment centers that provide mental health~~
233.12 ~~services for children must develop an individual treatment plan for each child client. The~~
233.13 ~~individual treatment plan must be based on a diagnostic assessment. To the extent appropriate,~~
233.14 ~~the child and the child's family shall be involved in all phases of developing and~~
233.15 ~~implementing the individual treatment plan. Providers of residential treatment, professional~~
233.16 ~~home-based family treatment, and acute care hospital inpatient treatment, and regional~~
233.17 ~~treatment centers must develop the individual treatment plan within ten working days of~~
233.18 ~~client intake or admission and must review the individual treatment plan every 90 days after~~
233.19 ~~intake, except that the administrative review of the treatment plan of a child placed in a~~
233.20 ~~residential facility shall be as specified in sections 260C.203 and 260C.212, subdivision 9.~~
233.21 ~~Providers of day treatment services must develop the individual treatment plan before the~~
233.22 ~~completion of five working days in which service is provided or within 30 days after the~~
233.23 ~~diagnostic assessment is completed or obtained, whichever occurs first. Providers of~~
233.24 ~~outpatient services must develop the individual treatment plan within 30 days after the~~
233.25 ~~diagnostic assessment is completed or obtained or by the end of the second session of an~~
233.26 ~~outpatient service, not including the session in which the diagnostic assessment was provided,~~
233.27 ~~whichever occurs first. Providers of outpatient and day treatment services must review the~~
233.28 ~~individual treatment plan every 90 days after intake. Providers of services governed by this~~
233.29 ~~section shall complete an individual treatment plan according to the standards of section~~
233.30 ~~256B.0671, subdivisions 5 and 6, including for services to a person not eligible for medical~~
233.31 ~~assistance.~~

233.32 Sec. 36. Minnesota Statutes 2018, section 245.4879, subdivision 1, is amended to read:

233.33 **Subdivision 1. Availability of emergency services.** County boards must provide or
233.34 contract for enough mental health emergency services within the county to meet the needs

234.1 of children, and children's families when clinically appropriate, in the county who are
234.2 experiencing an emotional crisis or emotional disturbance. The county board shall ensure
234.3 that parents, providers, and county residents are informed about when and how to access
234.4 emergency mental health services for children. A child or the child's parent may be required
234.5 to pay a fee according to section 245.481. Emergency service providers shall not delay the
234.6 timely provision of emergency service because of delays in determining this fee or because
234.7 of the unwillingness or inability of the parent to pay the fee. Emergency services must
234.8 include assessment, crisis intervention, and appropriate case disposition. A tribal authority
234.9 that accepts crisis grant funding has the same responsibilities as county boards within the
234.10 tribal authority's designated service area. Emergency services must:

- 234.11 (1) promote the safety and emotional stability of children with emotional disturbances
234.12 or emotional crises;
- 234.13 (2) minimize further deterioration of the child with emotional disturbance or emotional
234.14 crisis;
- 234.15 (3) help each child with an emotional disturbance or emotional crisis to obtain ongoing
234.16 care and treatment; and
- 234.17 (4) prevent placement in settings that are more intensive, costly, or restrictive than
234.18 necessary and appropriate to meet the child's needs.; and
- 234.19 (5) provide support, psychoeducation, and referrals to family members, service providers,
234.20 or other third parties on behalf of a client in need of emergency services.

234.21 Sec. 37. Minnesota Statutes 2018, section 245.4879, subdivision 2, is amended to read:

234.22 **Subd. 2. Specific requirements.** (a) The county board shall require that all service
234.23 providers of emergency services to the child with an emotional disturbance provide immediate
234.24 direct access to a mental health professional during regular business hours. For evenings,
234.25 weekends, and holidays, the service may be by direct toll-free telephone access to a mental
234.26 health professional, a clinical trainee, or a mental health practitioner, or until January 1,
234.27 ~~1991, a designated person with training in human services who receives clinical supervision~~
234.28 ~~from a mental health professional.~~

234.29 (b) The commissioner may waive the requirement in paragraph (a) that the evening,
234.30 weekend, and holiday service be provided by a mental health professional, clinical trainee,
234.31 or mental health practitioner ~~after January 1, 1991~~, if the county documents that:
234.32 (1) mental health professionals, clinical trainees, or mental health practitioners are
234.33 unavailable to provide this service;

235.1 (2) services are provided by a designated person with training in human services who
235.2 receives ~~clinical~~ treatment supervision from a mental health professional; and

235.3 (3) the service provider is not also the provider of fire and public safety emergency
235.4 services.

235.5 (c) The commissioner may waive the requirement in paragraph (b), clause (3), that the
235.6 evening, weekend, and holiday service not be provided by the provider of fire and public
235.7 safety emergency services if:

235.8 (1) every person who will be providing the first telephone contact has received at least
235.9 eight hours of training on emergency mental health services reviewed by the state advisory
235.10 council on mental health and then approved by the commissioner;

235.11 (2) every person who will be providing the first telephone contact will annually receive
235.12 at least four hours of continued training on emergency mental health services reviewed by
235.13 the state advisory council on mental health and then approved by the commissioner;

235.14 (3) the local social service agency has provided public education about available
235.15 emergency mental health services and can assure potential users of emergency services that
235.16 their calls will be handled appropriately;

235.17 (4) the local social service agency agrees to provide the commissioner with accurate
235.18 data on the number of emergency mental health service calls received;

235.19 (5) the local social service agency agrees to monitor the frequency and quality of
235.20 emergency services; and

235.21 (6) the local social service agency describes how it will comply with paragraph (d).

235.22 (d) When emergency service during nonbusiness hours is provided by anyone other than
235.23 a mental health professional, a mental health professional must be available on call for an
235.24 emergency assessment and crisis intervention services, and must be available for at least
235.25 telephone consultation within 30 minutes.

235.26 Sec. 38. Minnesota Statutes 2018, section 245.488, subdivision 1, is amended to read:

235.27 **Subdivision 1. Availability of outpatient services.** (a) County boards must provide or
235.28 contract for enough outpatient services within the county to meet the needs of each child
235.29 with emotional disturbance residing in the county and the child's family. Services may be
235.30 provided directly by the county through county-operated mental health centers or mental
235.31 health clinics approved by the commissioner under section 245.69, subdivision 2; by contract
235.32 with privately operated mental health centers or mental health clinics approved by the

236.1 commissioner under section 245.69, subdivision 2; by contract with hospital mental health
236.2 outpatient programs certified by the Joint Commission on Accreditation of Hospital
236.3 Organizations; or by contract with a licensed mental health professional ~~as defined in section~~
236.4 ~~245.4871, subdivision 27, clauses (1) to (6)~~. A child or a child's parent may be required to
236.5 pay a fee based in accordance with section 245.481. Outpatient services include:

- 236.6 (1) conducting diagnostic assessments;
- 236.7 (2) conducting psychological testing;
- 236.8 (3) developing or modifying individual treatment plans;
- 236.9 (4) making referrals and recommending placements as appropriate;
- 236.10 (5) treating the child's mental health needs through therapy; and
- 236.11 (6) prescribing and managing medication and evaluating the effectiveness of prescribed
236.12 medication.

236.13 (b) County boards may request a waiver allowing outpatient services to be provided in
236.14 a nearby trade area if it is determined that the child requires necessary and appropriate
236.15 services that are only available outside the county.

236.16 (c) Outpatient services offered by the county board to prevent placement must be at the
236.17 level of treatment appropriate to the child's diagnostic assessment.

236.18 Sec. 39. Minnesota Statutes 2018, section 245.696, is amended by adding a subdivision
236.19 to read:

236.20 **Subd. 3. Certification of mental health peer specialists and mental health family**
236.21 **peer specialists.** The commissioner shall develop a process to certify mental health peer
236.22 specialists and mental health family peer specialists according to federal guidelines and
236.23 section 245I.16, subdivisions 10 to 13, for a provider entity to bill for reimbursable services.
236.24 The training and certification curriculum must teach individuals specific skills relevant to
236.25 providing peer support as appropriate for individual or family peers.

236.26 Sec. 40. **[245I.01] PURPOSE AND CITATION.**

236.27 **Subdivision 1. Citation.** This chapter may be cited as the "Mental Health Uniform
236.28 Service Standards Act."

236.29 **Subd. 2. Purpose.** In accordance with sections 245.461 and 245.487, to create a system
236.30 of mental health care that is unified, accountable, and comprehensive, and to promote the
236.31 recovery of Minnesotans from mental illnesses, the state's public policy is to support quality

237.1 outpatient and residential mental health services reimbursable by health insurance programs,
237.2 including medical assistance as well as commercial payers. Further, the state's public policy
237.3 is to ensure the safety, rights, and well-being of individuals served in these programs.

237.4 Subd. 3. **Variances.** If the conditions in section 245A.04, subdivision 9, are met, the
237.5 commissioner may grant variances to the requirements in this chapter that do not affect a
237.6 client's health or safety.

237.7 **Sec. 41. [245I.02] DEFINITIONS.**

237.8 Subdivision 1. **Scope.** For purposes of this chapter the terms in this section have the
237.9 meanings given them.

237.10 Subd. 2. **Approval.** "Approval" means the documented review of, opportunity to request
237.11 changes to, and agreement with a treatment document by a treatment supervisor or by a
237.12 client. Approval may be demonstrated by written signature, secure electronic signature, or
237.13 documented oral approval.

237.14 Subd. 3. **Behavioral sciences or related fields.** "Behavioral sciences or related fields"
237.15 means an education from an accredited college or university in a field including but not
237.16 limited to social work, psychology, sociology, community counseling, family social science,
237.17 child development, child psychology, community mental health, addiction counseling,
237.18 counseling and guidance, special education, and other similar fields as approved by the
237.19 commissioner.

237.20 Subd. 4. **Certified rehabilitation specialist.** "Certified rehabilitation specialist" means
237.21 a staff person qualified according to section 245I.16, subdivision 8.

237.22 Subd. 5. **Child.** "Child" means a client under 18 years of age, or a client under 21 years
237.23 of age who is eligible for a service otherwise provided to persons under 18 years of age.

237.24 Subd. 6. **Client.** "Client" means a person who is seeking or receiving services regulated
237.25 under this chapter. For the purpose of consent to services, this term includes a parent,
237.26 guardian, or other individual authorized to consent to services by law.

237.27 Subd. 7. **Clinical trainee.** "Clinical trainee" means a staff person qualified according
237.28 to section 245I.16, subdivision 6.

237.29 Subd. 8. **Clinician.** "Clinician" means a mental health professional or clinical trainee
237.30 who is performing diagnostic assessment, testing, or psychotherapy.

237.31 Subd. 9. **Commissioner.** "Commissioner" means the commissioner of human services
237.32 or the commissioner's designee.

238.1 **Subd. 10. Diagnostic assessment.** "Diagnostic assessment" means the evaluation and
238.2 report of a client's potential diagnoses conducted by a clinician. For a client receiving
238.3 publicly funded services, a diagnostic assessment must meet the standards of section
238.4 256B.0671, subdivisions 2 to 4.

238.5 **Subd. 11. Diagnostic formulation.** "Diagnostic formulation" means a written analysis
238.6 and explanation of the information obtained from a clinical assessment to develop a
238.7 hypothesis about the cause and nature of the presenting problems and identify a framework
238.8 for developing the most suitable treatment approach.

238.9 **Subd. 12. Individual treatment plan.** "Individual treatment plan" means the formulation
238.10 of planned services that are responsive to the needs and goals of a client. For a client receiving
238.11 publicly funded services, an individual treatment plan must meet the standards of section
238.12 256B.0671, subdivisions 5 and 6.

238.13 **Subd. 13. Mental health behavioral aide.** "Mental health behavioral aide" means a
238.14 staff person qualified according to section 245I.16, subdivision 16.

238.15 **Subd. 14. Mental health certified family peer specialist.** "Mental health certified
238.16 family peer specialist" means a staff person qualified according to section 245I.16,
238.17 subdivision 12.

238.18 **Subd. 15. Mental health certified peer specialist.** "Mental health certified peer
238.19 specialist" means a staff person qualified according to section 245I.16, subdivision 10.

238.20 **Subd. 16. Mental health practitioner.** "Mental health practitioner" means a staff person
238.21 qualified according to section 245I.16, subdivision 4.

238.22 **Subd. 17. Mental health professional.** "Mental health professional" means a staff person
238.23 qualified according to section 245I.16, subdivision 2.

238.24 **Subd. 18. Mental health rehabilitation worker.** "Mental health rehabilitation worker"
238.25 means a staff person qualified according to section 245I.16, subdivision 14.

238.26 **Subd. 19. Personnel file.** "Personnel file" means the set of records under section 245I.13,
238.27 paragraph (a). Personnel files excludes information related to a person's employment not
238.28 enumerated in section 245I.13.

238.29 **Subd. 20. Provider entity.** "Provider entity" means the organization, governmental unit,
238.30 corporation, or other legal body that is enrolled, certified, licensed, or otherwise authorized
238.31 by the commissioner to provide the services described in this chapter.

239.1 **Subd. 21. Responsivity factors.** "Responsivity factors" means the factors other than the
239.2 diagnostic formulation that may modify an individual's treatment needs. This includes
239.3 learning style, ability, cognitive function, cultural background, and personal circumstance.
239.4 Documentation of responsivity factors includes an analysis of how an individual's strengths
239.5 may be reflected in the planned delivery of services.

239.6 **Subd. 22. Risk factors.** "Risk factors" means factors that predispose a client to engage
239.7 in potentially harmful behaviors to themselves or others.

239.8 **Subd. 23. Strengths.** "Strengths" means inner characteristics, virtues, external
239.9 relationships, activities, and connections to resources that contribute to resilience and core
239.10 competencies and can be built on to support recovery.

239.11 **Subd. 24. Trauma.** "Trauma" means an event, series of events, or set of circumstances
239.12 that is experienced by an individual as physically or emotionally harmful or life threatening
239.13 and has lasting adverse effects on the individual's functioning and mental, physical, social,
239.14 emotional, or spiritual well-being. Trauma includes the cumulative emotional or
239.15 psychological harm of group traumatic experiences, transmitted across generations within
239.16 a community, often associated with racial and ethnic population groups in the country who
239.17 have suffered major intergenerational losses.

239.18 **Subd. 25. Treatment supervision.** "Treatment supervision" means the direction and
239.19 evaluation of individual assessment, treatment planning, and service delivery for each client
239.20 when services are delivered by an individual who is not a licensed mental health professional
239.21 or certified rehabilitation specialist as provided by section 245I.18.

239.22 **Sec. 42. [245I.10] TRAINING REQUIRED.**

239.23 **Subdivision 1. Training plan.** A provider entity must develop a plan to ensure that staff
239.24 persons receive orientation and ongoing training. The plan must include:

239.25 (1) a formal process to evaluate the training needs of each staff person. An annual
239.26 performance evaluation satisfies this requirement;

239.27 (2) a description of how the provider entity conducts annual training, including whether
239.28 annual training is based on a staff person's hire date or a specified annual cycle determined
239.29 by the program; and

239.30 (3) a description of how the provider entity determines when a staff person needs
239.31 additional training, including the timelines in which the additional training is provided.

240.1 Subd. 2. Documentation of orientation and training. (a) The provider entity must
240.2 provide training in accordance with the training plan and must document that orientation
240.3 and training was provided. All training programs and materials used by the provider entity
240.4 must be available for review by regulatory agencies. The documentation must include the
240.5 following:

- 240.6 (1) topic covered in the training;
- 240.7 (2) identification of the trainee;
- 240.8 (3) name and credentials of the trainer;
- 240.9 (4) method of evaluating competency upon completion of training;
- 240.10 (5) date of training; and
- 240.11 (6) length of training, in hours.

240.12 (b) Documentation of a continuing education credit accepted by the governing
240.13 health-related licensing board is sufficient for purposes of this subdivision.

240.14 Subd. 3. Orientation. (a) Before providing direct contact services, a staff person must
240.15 receive orientation on:

- 240.16 (1) patient rights as identified in section 144.651;
- 240.17 (2) vulnerable adult and minor maltreatment requirements in sections 245A.65,
240.18 subdivision 3; 626.556, subdivisions 2, 3, and 7; 626.557; and 626.5572;
- 240.19 (3) the Minnesota Health Records Act, including confidentiality, family engagement
240.20 according to section 144.294, and client privacy;
- 240.21 (4) program policies and procedures;
- 240.22 (5) emergency procedures appropriate to the position, including but not limited to fires,
240.23 inclement weather, missing persons, and medical emergencies;
- 240.24 (6) professional boundaries;
- 240.25 (7) behavior management, crisis intervention, and stabilization techniques;
- 240.26 (8) specific needs of individuals served by the program, including but not limited to
240.27 developmental status, cognitive functioning, and physical and mental abilities; and
- 240.28 (9) training related to the specific activities and job functions for which the staff person
240.29 is responsible to carry out, including documentation of the delivery of services.

- 241.1 (b) A staff person must receive orientation on the following topics within 90 calendar
241.2 days of a staff person first providing direct contact services:
- 241.3 (1) trauma-informed care;
- 241.4 (2) family- and person-centered individual treatment plans, seeking partnership with
241.5 parents and identified supports, and shared decision making and engagement;
- 241.6 (3) treatment for co-occurring substance use problems, including the definitions of
241.7 co-occurring disorders, prevalence of co-occurring disorders, common signs and symptoms
241.8 of co-occurring disorders, and the etiology of co-occurring disorders;
- 241.9 (4) psychotropic medications, side effects, and safe medication management;
- 241.10 (5) family systems and promoting culturally appropriate support networks;
- 241.11 (6) culturally responsive treatment practices;
- 241.12 (7) recovery concepts and principles;
- 241.13 (8) building resiliency through a strength-based approach;
- 241.14 (9) person-centered planning and positive support strategies; and
- 241.15 (10) other training relevant to the staff person's role and responsibilities.
- 241.16 (c) A provider entity may deem a staff person to have met an orientation requirement
241.17 in paragraph (b) if the staff person has received equivalent postsecondary education in the
241.18 previous four years or training experience in the previous two years. The training plan must
241.19 describe the process and location for verification and documentation of previous training
241.20 experience.
- 241.21 (d) A provider entity may deem a mental health professional to have met a requirement
241.22 of paragraph (a), clauses (6) to (9), and paragraph (b) after an evaluation of the mental health
241.23 professional's competency, including by interview.
- 241.24 Subd. 4. **Annual training.** (a) A provider entity shall ensure that staff persons who are
241.25 not licensed mental health professionals receive 15 hours of training each year after the first
241.26 year of employment.
- 241.27 (b) A licensed mental health professional must follow specific training requirements as
241.28 determined by the professional's governing health-related licensing board.
- 241.29 (c) All staff persons, including licensed mental health professionals, must receive annual
241.30 training on the topics in subdivision 3, paragraph (a), clauses (2) and (5).

242.1 (d) The selection of additional training topics must be based on program needs and staff
242.2 persons' competency.

242.3 Subd. 5. **Training for services provided to children.** (a) Training and orientation
242.4 required under this section for a staff person working with children must be aligned to the
242.5 developmental characteristics of the children served in the program and address the needs
242.6 of children in the context of the family, support system, and culture. This includes orientation
242.7 under subdivision 3 on the following topics: (1) child development; (2) working with children
242.8 and children's support systems; and (3) adverse childhood experiences, cognitive functioning,
242.9 and physical and mental abilities.

242.10 (b) For a mental health behavioral aide, orientation in the first 90 days of service must
242.11 include a parent team training utilizing a curriculum approved by the commissioner.

242.12 Sec. 43. **[245I.13] PERSONNEL FILES.**

242.13 (a) For each staff person, a provider entity shall maintain a personnel file that includes:

242.14 (1) verification of the staff person's qualifications including training, education, and
242.15 licensure;

242.16 (2) documentation related to the staff person's background study;

242.17 (3) the date of hire;

242.18 (4) the effective date of specific duties and responsibilities including the date that the
242.19 staff person begins direct contact with a client;

242.20 (5) documentation of orientation;

242.21 (6) records of training, license renewal, and educational activities completed during the
242.22 staff person's employment;

242.23 (7) annual job performance evaluations; and

242.24 (8) records of clinical supervision, if applicable.

242.25 (b) Personnel files must be made accessible to the commissioner upon request. Personnel
242.26 files must be readily accessible for review but need not be kept in a single location.

242.27 Sec. 44. **[245I.16] PROVIDER QUALIFICATIONS AND SCOPE OF PRACTICE.**

242.28 Subdivision 1. **Tribal providers.** For purposes of this section, a tribal entity may
242.29 credential an individual under section 256B.02, subdivision 7, paragraphs (b) and (c).

243.1 **Subd. 2. Mental health professional qualifications.** The following individuals may
243.2 provide services as a mental health professional:

- 243.3 (1) a registered nurse who is licensed under sections 148.171 to 148.285 and is certified
243.4 as a (i) clinical nurse specialist in child or adolescent, family, or adult psychiatric and mental
243.5 health nursing by a national certification organization, or (ii) nurse practitioner in adult or
243.6 family psychiatric and mental health nursing by a national nurse certification organization;
- 243.7 (2) a licensed independent clinical social worker as defined in section 148E.050,
243.8 subdivision 5;
- 243.9 (3) a psychologist licensed by the Board of Psychology under sections 148.88 to 148.98;
- 243.10 (4) a physician licensed under chapter 147 if the physician is: (i) certified by the American
243.11 Board of Psychiatry and Neurology; (ii) certified by the American Osteopathic Board of
243.12 Neurology and Psychiatry; or (iii) eligible for board certification in psychiatry;
- 243.13 (5) a marriage and family therapist licensed under sections 148B.29 to 148B.39; or
- 243.14 (6) a licensed professional clinical counselor licensed under section 148B.5301.

243.15 **Subd. 3. Mental health professional scope of practice.** A mental health professional
243.16 shall maintain a valid license with the mental health professional's governing health-related
243.17 licensing board and shall only provide services within the scope of practice as determined
243.18 by the health-related licensing board.

243.19 **Subd. 4. Mental health practitioner qualifications.** (a) An individual who is qualified
243.20 in at least one of the ways described in paragraphs (b) to (d) may serve as a mental health
243.21 practitioner.

- 243.22 (b) An individual is qualified through relevant coursework if the individual completes
243.23 at least 30 semester hours or 45 quarter hours in behavioral sciences or related fields and:
- 243.24 (1) has at least 2,000 hours of supervised experience in the delivery of services to adults
243.25 or children with: (i) mental illness, substance use disorder, or emotional disturbance; or (ii)
243.26 traumatic brain injury or developmental disabilities and completes training on mental illness,
243.27 recovery from mental illness, mental health de-escalation techniques, co-occurring mental
243.28 illness and substance use disorder, and psychotropic medications and side effects;
- 243.29 (2) is fluent in the non-English language of the ethnic group to which at least 50 percent
243.30 of the individual's clients belong, completes 40 hours of training in the delivery of services
243.31 to adults with mental illness or children with emotional disturbance, and receives treatment

244.1 supervision from a mental health professional at least once per week until the requirement
244.2 of 2,000 hours of supervised experience is met;

244.3 (3) is working in a day treatment program under section 245.4712, subdivision 2; or
244.4 (4) has completed a practicum or internship that (i) requires direct interaction with adults
244.5 or children served, and (ii) is focused on behavioral sciences or related fields.

244.6 (c) An individual is qualified through work experience if the individual:

244.7 (1) has at least 4,000 hours of supervised experience in the delivery of services to adults
244.8 or children with: (i) mental illness, substance use disorder, or emotional disturbance; or (ii)
244.9 traumatic brain injury or developmental disabilities and completes training on mental illness,
244.10 recovery from mental illness, mental health de-escalation techniques, co-occurring mental
244.11 illness and substance use disorder, and psychotropic medications and side effects; or

244.12 (2) has at least 2,000 hours of supervised experience in the delivery of services to adults
244.13 or children with: (i) mental illness, emotional disturbance, or substance use disorder, and
244.14 receives treatment supervision as required by applicable statutes and rules from a mental
244.15 health professional at least once per week until the requirement of 4,000 hours of supervised
244.16 experience is met; or (ii) traumatic brain injury or developmental disabilities, completes
244.17 training on mental illness, recovery from mental illness, mental health de-escalation
244.18 techniques, co-occurring mental illness and substance use disorder, and psychotropic
244.19 medications and side effects, and receives treatment supervision as required by applicable
244.20 statutes and rules at least once per week from a mental health professional until the
244.21 requirement of 4,000 hours of supervised experience is met.

244.22 (d) An individual is qualified by a bachelor's or master's degree if the individual: (1)
244.23 holds a master's or other graduate degree in behavioral sciences or related fields; or (2)
244.24 holds a bachelor's degree in behavioral sciences or related fields and completes a practicum
244.25 or internship that (i) requires direct interaction with adults or children served, and (ii) is
244.26 focused on behavioral sciences or related fields.

244.27 **Subd. 5. Mental health practitioner scope of practice.** (a) A mental health practitioner
244.28 must perform services under the treatment supervision of a mental health professional.

244.29 (b) A mental health practitioner may perform client education, functional assessments
244.30 for adult clients, level of care assessments, rehabilitative interventions, and skills building;
244.31 provide direction to a mental health rehabilitation worker or mental health behavioral aide;
244.32 and propose individual treatment plans.

245.1 (c) A mental health practitioner who provides services according to section 256B.0624
245.2 or 256B.0944 may perform crisis assessment and intervention.

245.3 Subd. 6. **Clinical trainee qualifications.** (a) A clinical trainee is a staff person who is
245.4 enrolled in or has completed an accredited graduate program of study intended to prepare
245.5 the individual for independent licensure as a mental health professional and who: (1)
245.6 participates in a practicum or internship supervised by a mental health professional; or (2)
245.7 is completing postgraduate hours, according to the requirements of a health-related licensing
245.8 board.

245.9 (b) A clinical trainee is responsible for notifying and applying to a health-related licensing
245.10 board to ensure the requirements of the health-related licensing board are met. As permitted
245.11 by a health-related licensing board, treatment supervision under this chapter may be integrated
245.12 into a plan to meet the supervisory requirements of the health-related licensing board but
245.13 does not supersede those requirements.

245.14 Subd. 7. **Clinical trainee scope of practice.** (a) A clinical trainee, under treatment
245.15 supervision of a mental health professional, may perform psychotherapy, diagnostic
245.16 assessments, and services that a mental health practitioner may deliver. A clinical trainee
245.17 shall not provide treatment supervision. A clinical trainee may provide direction to a mental
245.18 health behavioral aide or mental health rehabilitation worker.

245.19 (b) A clinical trainee shall not deliver services in violation of the practice act of a
245.20 health-related licensing board, including failure to obtain licensure, if required.

245.21 Subd. 8. **Certified rehabilitation specialist qualifications.** A certified rehabilitation
245.22 specialist shall have:

245.23 (1) a master's degree from an accredited college or university in behavioral sciences or
245.24 related fields as defined in section 245I.02, subdivision 3;

245.25 (2) at least 4,000 hours of postmaster's supervised experience in the delivery of mental
245.26 health services; and

245.27 (3) a valid national certification as a certified rehabilitation counselor or certified
245.28 psychosocial rehabilitation practitioner.

245.29 Subd. 9. **Certified rehabilitation specialist scope of practice.** A certified rehabilitation
245.30 specialist shall provide services based on a client's diagnostic assessment. A certified
245.31 rehabilitation specialist may provide supervision for mental health certified peer specialists,
245.32 mental health practitioners, and mental health rehabilitation workers, but is prohibited from
245.33 performing a diagnostic assessment.

246.1 **Subd. 10. Mental health certified peer specialist qualifications.** A mental health
246.2 certified peer specialist shall:

- 246.3 (1) be 21 years of age or older;
246.4 (2) have been diagnosed with a mental illness;
246.5 (3) be a current or former mental health services client; and
246.6 (4) have a valid certification as a mental health certified peer specialist according to
246.7 section 245.696, subdivision 3.

246.8 **Subd. 11. Mental health certified peer specialist scope of practice.** A mental health
246.9 certified peer specialist shall:

- 246.10 (1) provide peer support that is individualized to the client;
246.11 (2) promote recovery goals, self-sufficiency, self-advocacy, and the development of
246.12 natural supports; and
246.13 (3) support the maintenance of skills learned in other services.

246.14 **Subd. 12. Mental health certified family peer specialist qualifications.** A mental
246.15 health certified family peer specialist shall:

- 246.16 (1) be 21 years of age or older;
246.17 (2) have raised or be currently raising a child with a mental illness;
246.18 (3) have experience navigating the children's mental health system; and
246.19 (4) have a valid certification as a mental health certified family peer specialist according
246.20 to section 245.696, subdivision 3.

246.21 **Subd. 13. Mental health certified family peer specialist scope of practice.** A mental
246.22 health certified family peer specialist shall provide services to increase the child's ability to
246.23 function better within the child's home, school, and community. The mental health certified
246.24 family peer specialist shall:

- 246.25 (1) provide family peer support, to build on strengths of families and help families
246.26 achieve desired outcomes;
246.27 (2) provide nonadversarial advocacy that encourages partnership and promotes positive
246.28 change and growth;
246.29 (3) support families to advocate for culturally appropriate services for a child in each
246.30 treatment setting;

247.1 (4) promote resiliency, self-advocacy, and development of natural supports;
247.2 (5) support the maintenance of skills learned in other services;
247.3 (6) establish and lead parent support groups;
247.4 (7) assist parents to develop coping and problem-solving skills; and
247.5 (8) educate parents on community resources, including resources that connect parents
247.6 with similar experiences.

247.7 **Subd. 14. Mental health rehabilitation worker qualifications.** (a) A mental health
247.8 rehabilitation worker shall (1) be 21 years of age or older; (2) have a high school diploma
247.9 or equivalent; and (3) meet the qualification requirements in paragraph (b).

247.10 (b) In addition to the requirements of paragraph (a), a mental health rehabilitation worker
247.11 shall also:

247.12 (1)(i) be fluent in the non-English language or competent in the culture of the ethnic
247.13 group to which at least 20 percent of the mental health rehabilitation worker's clients belong;
247.14 (ii) during the first 2,000 hours of work, receive monthly documented individual treatment
247.15 supervision by a mental health professional; and
247.16 (iii) receive direct observation in addition to the direct observation requirements of
247.17 section 245I.18, subdivision 5, for a total of not less than twice per month for the first year
247.18 of work;

247.19 (2) have an associate of arts degree;
247.20 (3) have two years of full-time postsecondary education or a total of 15 semester hours
247.21 or 23 quarter hours in behavioral sciences or related fields;

247.22 (4) be a registered nurse;
247.23 (5) have within the previous ten years three years of personal life experience with mental
247.24 illness;
247.25 (6) have within the previous ten years three years of life experience as a primary caregiver
247.26 to an adult with a mental illness, traumatic brain injury, substance use disorder, or
247.27 developmental disability; or
247.28 (7) have within the previous ten years 2,000 hours of supervised work experience in
247.29 delivering mental health services to adults with a mental illness, traumatic brain injury,
247.30 substance use disorder, or developmental disability.

248.1 (c) If the mental health rehabilitation worker provides crisis residential services, intensive
248.2 residential treatment services, partial hospitalization, or day treatment services, the mental
248.3 health rehabilitation worker shall: (1) satisfy paragraph (b), clause (1); and (2) have 40 hours
248.4 of additional continuing education on mental health topics during the first year of
248.5 employment.

248.6 Subd. 15. **Mental health rehabilitation worker scope of practice.** (a) A mental health
248.7 rehabilitation worker under supervision of a mental health practitioner or mental health
248.8 professional may provide rehabilitative mental health services identified in the client's
248.9 individual treatment plan and individual behavior plan.

248.10 (b) A mental health rehabilitation worker who solely acts and is scheduled as overnight
248.11 staff is exempt from the additional qualification requirements in subdivision 14, paragraphs
248.12 (a), clause (3), and (b).

248.13 Subd. 16. **Mental health behavioral aide qualifications.** (a) A level 1 mental health
248.14 behavioral aide shall:

248.15 (1) be 18 years of age or older; and
248.16 (2) have a high school diploma or commissioner of education-selected high school
248.17 equivalency certification; or two years of experience as a primary caregiver to a child with
248.18 severe emotional disturbance within the previous ten years.

248.19 (b) A level 2 mental health behavioral aide shall:

248.20 (1) be 18 years of age or older; and
248.21 (2) have an associate or bachelor's degree or be certified by a program under section
248.22 256B.0943, subdivision 8a.

248.23 Subd. 17. **Mental health behavioral aide scope of practice.** The mental health
248.24 behavioral aid under supervision of a mental health professional may provide rehabilitative
248.25 mental health services identified in the client's individual treatment plan and individual
248.26 behavior plan.

248.27 Sec. 45. **[245I.18] TREATMENT SUPERVISION.**

248.28 Subdivision 1. **Generally.** (a) A provider entity shall ensure that a mental health
248.29 professional provides treatment supervision for each staff person who provides services to
248.30 a client and who is not a mental health professional or certified rehabilitation specialist.
248.31 Treatment supervision shall be based on a staff person's written treatment supervision plan.

249.1 (b) Treatment supervision must focus on the client's treatment needs and the ability of
249.2 the staff person receiving treatment supervision to provide services, including:

- 249.3 (1) review and evaluation of the interventions delivered;
249.4 (2) instruction on alternative strategies if a client is not achieving treatment goals;
249.5 (3) review and evaluation of assessments, treatment plans, and progress notes for accuracy
249.6 and appropriateness;
249.7 (4) approval of diagnostic assessments and individual treatment plans within five business
249.8 days of initial completion by the supervisee;
249.9 (5) instruction on the cultural norms or values of the clients and communities served by
249.10 the provider entity and any impact on treatment;
249.11 (6) evaluation of and feedback on the competencies of direct service staff persons; and
249.12 (7) coaching, teaching, and practicing skills with staff persons.

249.13 (c) A treatment supervisor's responsibility for a supervisee is limited to services provided
249.14 by the associated provider entity. If a supervisee is employed by multiple provider entities,
249.15 each entity is responsible for furnishing the necessary treatment supervision.

249.16 Subd. 2. Permitted modalities. (a) Treatment supervision must be conducted face-to-face,
249.17 including telemedicine, according to the Minnesota Telemedicine Act, sections 62A.67 to
249.18 62A.672.

249.19 (b) Treatment supervision may be conducted using individual, small group, or team
249.20 modalities. "Individual supervision" means one or more mental health professionals and
249.21 one staff person receiving treatment supervision. "Small group supervision" means one or
249.22 more mental health professionals and two to six staff persons receiving treatment supervision.
249.23 "Team supervision" is defined by the service lines for which it may be used.

249.24 Subd. 3. Treatment supervision planning. (a) A written treatment supervision plan
249.25 shall be developed by a mental health professional who is qualified to provide treatment
249.26 supervision and the staff person receiving the treatment supervision. The treatment
249.27 supervision plan must be completed and implemented within 30 days of a new staff person's
249.28 employment. The treatment supervision plan must be reviewed and updated at least annually.

249.29 (b) The treatment supervision plan must include:

- 249.30 (1) the name and qualifications of the staff person receiving treatment supervision;

- 250.1 (2) the name of the provider entity under which the staff person is receiving treatment
250.2 supervision;
- 250.3 (3) the name and licensure of a mental health professional providing treatment
250.4 supervision;
- 250.5 (4) the number of hours of individual and group supervision the staff person receiving
250.6 treatment supervision must complete and the location of the record if the record is kept
250.7 outside of an individual personnel file;
- 250.8 (5) procedures that the staff person receiving treatment supervision shall use to respond
250.9 to client emergencies; and
- 250.10 (6) the authorized scope of practice for the staff person receiving treatment supervision,
250.11 including a description of responsibilities with the provider entity, a description of client
250.12 population, and treatment methods and modalities.
- 250.13 **Subd. 4. Treatment supervision record.** (a) A provider entity shall ensure treatment
250.14 supervision is documented in each staff person's treatment supervision record.
- 250.15 (b) The treatment supervision record must include:
- 250.16 (1) the date and duration of the supervision;
- 250.17 (2) identification of the supervision type as individual, small group, or team supervision;
- 250.18 (3) the name of the mental health professional providing treatment supervision;
- 250.19 (4) subsequent actions that the staff person receiving treatment supervision shall take;
250.20 and
- 250.21 (5) the date and signature of the mental health professional providing treatment
250.22 supervision.
- 250.23 **Subd. 5. Direct observation of mental health rehabilitation workers and behavioral
250.24 aides.** A mental health practitioner, clinical trainee, or mental health professional shall
250.25 directly observe a mental health behavioral aide or a mental health rehabilitation worker
250.26 while the mental health behavioral aide or mental health rehabilitation worker provides
250.27 services to clients. The amount of direct observation shall be no less than twice per month
250.28 for the first six months and once per month thereafter. The staff performing the observation
250.29 shall approve the progress note for the service observed.

251.1 **Sec. 46. [245I.32] CLIENT FILES.**

251.2 Subdivision 1. Generally. A provider entity must maintain a file of current and accurate
251.3 client records on the premises where the service is provided or coordinated. Each entry in
251.4 the record must be signed and dated by the staff person making the entry.

251.5 Subd. 2. Record retention. A provider entity must retain client records of a discharged
251.6 client for a minimum of seven years from the date of discharge. A provider entity that ceases
251.7 to provide treatment service must retain client records for a minimum of seven years from
251.8 the date the provider entity stopped providing the service and must notify the commissioner
251.9 of the location of the client records and the name of the individual responsible for maintaining
251.10 the client records.

251.11 Subd. 3. Contents. Client files must contain the following, as applicable:

251.12 (1) diagnostic assessments;

251.13 (2) functional assessments;

251.14 (3) individual treatment plans;

251.15 (4) individual abuse prevention plans;

251.16 (5) crisis plans;

251.17 (6) documentation of releases of information;

251.18 (7) emergency contacts for the client;

251.19 (8) documentation of the date of service; signature of the person providing the service;

251.20 nature, extent, and units of service; and place of service delivery;

251.21 (9) record of all medication prescribed or administered by staff;

251.22 (10) documentation of any contact made with the client's other mental health providers,
251.23 case manager, family members, primary caregiver, or legal representative or the reason the
251.24 provider did not contact the client's family members or primary caregiver;

251.25 (11) documentation of any contact made with other persons interested in the client,
251.26 including representatives of the courts, corrections systems, or schools;

251.27 (12) written information by the client that the client requests be included in the file;

251.28 (13) health care directive; and

251.29 (14) the date and reason the provider entity's services are discontinued.

252.1 Sec. 47. **[245I.33] DOCUMENTATION STANDARDS.**

252.2 Subdivision 1. Generally. As a condition of payment, a provider entity must ensure that
252.3 documentation complies with this section and Minnesota Rules, parts 9505.2175 and
252.4 9505.2197. The department must recover medical assistance payments for a service not
252.5 documented in a client file according to this section.

252.6 Subd. 2. Documentation standards. A provider entity must ensure that all documentation
252.7 required under this chapter:

252.8 (1) is typed or legible, if handwritten;

252.9 (2) identifies the client or staff person on each page, as applicable;

252.10 (3) is signed and dated by the staff person who completes the documentation, including
252.11 the staff person's credentials; and

252.12 (4) is cosigned and dated by the staff person providing treatment supervision as required
252.13 under this chapter, including the staff person's credentials.

252.14 Subd. 3. Progress notes. A provider entity shall use a progress note to promptly document
252.15 each occurrence of a mental health service provided to a client. A progress note must include
252.16 the following:

252.17 (1) the type of service;

252.18 (2) the date of service, including the start and stop time;

252.19 (3) the location of service;

252.20 (4) the scope of service, including: (i) the goal and objective targeted; (ii) the intervention
252.21 delivered and the methods used; (iii) the client's response or reaction to intervention; (iv)
252.22 the plan for the next session; and (v) the service modality;

252.23 (5) the signature and the printed name and credentials of the staff person who provided
252.24 the service;

252.25 (6) the mental health provider travel documentation requirements under section

252.26 256B.0625, if applicable; and

252.27 (7) other significant observations, including (i) current risk factors the client may be
252.28 experiencing; (ii) emergency interventions; (iii) consultations with or referrals to other
252.29 professionals, family, or significant others; (iv) a summary of the effectiveness of treatment,
252.30 prognosis, or discharge planning; (v) test results and medications; or (vi) changes in mental
252.31 or physical symptoms.

253.1 Sec. 48. Minnesota Statutes 2018, section 254B.05, subdivision 5, is amended to read:

253.2 Subd. 5. **Rate requirements.** (a) The commissioner shall establish rates for substance
253.3 use disorder services and service enhancements funded under this chapter.

253.4 (b) Eligible substance use disorder treatment services include:

253.5 (1) outpatient treatment services that are licensed according to sections 245G.01 to
253.6 245G.17, or applicable tribal license;

253.7 (2) on July 1, 2018, or upon federal approval, whichever is later, comprehensive
253.8 assessments provided according to sections 245.4863, paragraph (a), and 245G.05, and
253.9 ~~Minnesota Rules, part 9530.6422;~~

253.10 (3) on July 1, 2018, or upon federal approval, whichever is later, care coordination
253.11 services provided according to section 245G.07, subdivision 1, paragraph (a), clause (6);

253.12 (4) on July 1, 2018, or upon federal approval, whichever is later, peer recovery support
253.13 services provided according to section 245G.07, subdivision 1, paragraph (a), clause (5);

253.14 (5) on July 1, 2019, or upon federal approval, whichever is later, withdrawal management
253.15 services provided according to chapter 245F;

253.16 (6) medication-assisted therapy services that are licensed according to sections 245G.01
253.17 to 245G.17 and 245G.22, or applicable tribal license;

253.18 (7) medication-assisted therapy plus enhanced treatment services that meet the
253.19 requirements of clause (6) and provide nine hours of clinical services each week;

253.20 (8) high, medium, and low intensity residential treatment services that are licensed
253.21 according to sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license which
253.22 provide, respectively, 30, 15, and five hours of clinical services each week;

253.23 (9) hospital-based treatment services that are licensed according to sections 245G.01 to
253.24 245G.17 or applicable tribal license and licensed as a hospital under sections 144.50 to
253.25 144.56;

253.26 (10) adolescent treatment programs that are licensed as outpatient treatment programs
253.27 according to sections 245G.01 to 245G.18 or as residential treatment programs according
253.28 to Minnesota Rules, parts 2960.0010 to 2960.0220, and 2960.0430 to 2960.0490, or
253.29 applicable tribal license;

253.30 (11) high-intensity residential treatment services that are licensed according to sections
253.31 245G.01 to 245G.17 and 245G.21 or applicable tribal license, which provide 30 hours of
253.32 clinical services each week provided by a state-operated vendor or to clients who have been

254.1 civilly committed to the commissioner, present the most complex and difficult care needs,
254.2 and are a potential threat to the community; and

254.3 (12) room and board facilities that meet the requirements of subdivision 1a.

254.4 (c) The commissioner shall establish higher rates for programs that meet the requirements
254.5 of paragraph (b) and one of the following additional requirements:

254.6 (1) programs that serve parents with their children if the program:

254.7 (i) provides on-site child care during the hours of treatment activity that:

254.8 (A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter
254.9 9503; or

254.10 (B) meets the licensure exclusion criteria of section 245A.03, subdivision 2, paragraph

254.11 (a), clause (6), and meets the requirements under section 245G.19, subdivision 4; or

254.12 (ii) arranges for off-site child care during hours of treatment activity at a facility that is
254.13 licensed under chapter 245A as:

254.14 (A) a child care center under Minnesota Rules, chapter 9503; or

254.15 (B) a family child care home under Minnesota Rules, chapter 9502;

254.16 (2) culturally specific programs as defined in section 254B.01, subdivision 4a, or

254.17 programs or subprograms serving special populations, if the program or subprogram meets
254.18 the following requirements:

254.19 (i) is designed to address the unique needs of individuals who share a common language,
254.20 racial, ethnic, or social background;

254.21 (ii) is governed with significant input from individuals of that specific background; and

254.22 (iii) employs individuals to provide individual or group therapy, at least 50 percent of
254.23 whom are of that specific background, except when the common social background of the
254.24 individuals served is a traumatic brain injury or cognitive disability and the program employs
254.25 treatment staff who have the necessary professional training, as approved by the
254.26 commissioner, to serve clients with the specific disabilities that the program is designed to
254.27 serve;

254.28 (3) programs that offer medical services delivered by appropriately credentialed health
254.29 care staff in an amount equal to two hours per client per week if the medical needs of the
254.30 client and the nature and provision of any medical services provided are documented in the
254.31 client file; and

- 255.1 (4) programs that offer services to individuals with co-occurring mental health and
255.2 chemical dependency problems if:
- 255.3 (i) the program meets the co-occurring requirements in section 245G.20;
- 255.4 (ii) 25 percent of the counseling staff are licensed mental health professionals, as defined
255.5 in section 245.462, subdivision 18, clauses (1) to (6), or are students or licensing candidates
255.6 under the supervision of a licensed alcohol and drug counselor supervisor and licensed
255.7 mental health professional, except that no more than 50 percent of the mental health staff
255.8 may be students or licensing candidates with time documented to be directly related to
255.9 provisions of co-occurring services;
- 255.10 (iii) clients scoring positive on a standardized mental health screen receive a mental
255.11 health diagnostic assessment within ten days of admission;
- 255.12 (iv) the program has standards for multidisciplinary case review that include a monthly
255.13 review for each client that, at a minimum, includes a licensed mental health professional
255.14 and licensed alcohol and drug counselor, and their involvement in the review is documented;
- 255.15 (v) family education is offered that addresses mental health and substance abuse disorders
255.16 and the interaction between the two; and
- 255.17 (vi) co-occurring counseling staff shall receive eight hours of co-occurring disorder
255.18 training annually.
- 255.19 (d) In order to be eligible for a higher rate under paragraph (c), clause (1), a program
255.20 that provides arrangements for off-site child care must maintain current documentation at
255.21 the chemical dependency facility of the child care provider's current licensure to provide
255.22 child care services. Programs that provide child care according to paragraph (c), clause (1),
255.23 must be deemed in compliance with the licensing requirements in section 245G.19.
- 255.24 (e) Adolescent residential programs that meet the requirements of Minnesota Rules,
255.25 parts 2960.0430 to 2960.0490 and 2960.0580 to 2960.0690, are exempt from the requirements
255.26 in paragraph (c), clause (4), items (i) to (iv).
- 255.27 (f) Subject to federal approval, chemical dependency services that are otherwise covered
255.28 as direct face-to-face services may be provided via two-way interactive video. The use of
255.29 two-way interactive video must be medically appropriate to the condition and needs of the
255.30 person being served. Reimbursement shall be at the same rates and under the same conditions
255.31 that would otherwise apply to direct face-to-face services. The interactive video equipment
255.32 and connection must comply with Medicare standards in effect at the time the service is
255.33 provided.

256.1 Sec. 49. Minnesota Statutes 2018, section 256B.0615, subdivision 1, is amended to read:

256.2 Subdivision 1. **Scope.** Medical assistance covers mental health certified peer specialist services, ~~as established in subdivision 2, subject to federal approval, if provided to recipients who are eligible for services under sections 256B.0622, 256B.0623, and 256B.0624 and are provided by a certified peer specialist who has completed the training under subdivision 5~~ is qualified according to section 245I.16, subdivision 10.

256.7 Sec. 50. Minnesota Statutes 2018, section 256B.0616, subdivision 1, is amended to read:

256.8 Subdivision 1. **Scope.** Medical assistance covers mental health certified family peer specialists services, ~~as established in subdivision 2, subject to federal approval, if provided to recipients who have an emotional disturbance or severe emotional disturbance under chapter 245, and are provided by a certified family peer specialist who has completed the training under subdivision 5~~ is qualified according to section 245I.16, subdivision 12. A family peer specialist cannot provide services to the peer specialist's family.

256.14 Sec. 51. Minnesota Statutes 2018, section 256B.0616, subdivision 3, is amended to read:

256.15 Subd. 3. **Eligibility.** Family peer support services may be located in provided to recipients of inpatient hospitalization, partial hospitalization, residential treatment, intensive treatment in foster care, day treatment, children's therapeutic services and supports, or crisis services.

256.18 Sec. 52. Minnesota Statutes 2018, section 256B.0622, subdivision 1, is amended to read:

256.19 Subdivision 1. **Scope.** ~~Subject to federal approval,~~ Medical assistance covers medically necessary, assertive community treatment for clients as defined in subdivision 2a and intensive residential treatment services for clients as defined in subdivision 3, when the services are provided by an entity meeting the standards in this section.

256.23 Sec. 53. Minnesota Statutes 2018, section 256B.0622, subdivision 2, is amended to read:

256.24 Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the meanings given them.

256.26 (b) "ACT team" means the group of interdisciplinary mental health staff who work as a team to provide assertive community treatment.

256.28 (c) "Assertive community treatment" means intensive nonresidential treatment and rehabilitative mental health services provided according to the assertive community treatment model. Assertive community treatment provides a single, fixed point of responsibility for

257.1 treatment, rehabilitation, and support needs for clients. Services are offered 24 hours per
257.2 day, seven days per week, in a community-based setting.

257.3 ~~(d) "Individual treatment plan" means the document that results from a person-centered
257.4 planning process of determining real-life outcomes with clients and developing strategies
257.5 to achieve those outcomes.~~

257.6 ~~(e) "Assertive engagement" means the use of collaborative strategies to engage clients
257.7 to receive services.~~

257.8 ~~(f) "Benefits and finance support" means assisting clients in capably managing financial
257.9 affairs. Services include, but are not limited to, assisting clients in applying for benefits;
257.10 assisting with redetermination of benefits; providing financial crisis management; teaching
257.11 and supporting budgeting skills and asset development; and coordinating with a client's
257.12 representative payee, if applicable.~~

257.13 (d) "Clinical trainee" means a staff person qualified according to section 245I.16,
257.14 subdivision 6.

257.15 ~~(g) (e) "Co-occurring disorder treatment" means the treatment of co-occurring mental
257.16 illness and substance use disorders and is characterized by assertive outreach, stage-wise
257.17 comprehensive treatment, treatment goal setting, and flexibility to work within each stage
257.18 of treatment. Services include, but are not limited to, assessing and tracking clients' stages
257.19 of change readiness and treatment; applying the appropriate treatment based on stages of
257.20 change, such as outreach and motivational interviewing techniques to work with clients in
257.21 earlier stages of change readiness and cognitive behavioral approaches and relapse prevention
257.22 to work with clients in later stages of change; and facilitating access to community supports.~~

257.23 ~~(h) (f) "Crisis assessment and intervention" means mental health crisis response services
257.24 as defined in section 256B.0624, subdivision 2, paragraphs (c) to (e).~~

257.25 ~~(i) "Employment services" means assisting clients to work at jobs of their choosing.
257.26 Services must follow the principles of the individual placement and support (IPS)
257.27 employment model, including focusing on competitive employment; emphasizing individual
257.28 client preferences and strengths; ensuring employment services are integrated with mental
257.29 health services; conducting rapid job searches and systematic job development according
257.30 to client preferences and choices; providing benefits counseling; and offering all services
257.31 in an individualized and time-unlimited manner. Services shall also include educating clients
257.32 about opportunities and benefits of work and school and assisting the client in learning job
257.33 skills, navigating the work place, and managing work relationships.~~

258.1 (j) "Family psychoeducation and support" means services provided to the client's family
258.2 and other natural supports to restore and strengthen the client's unique social and family
258.3 relationships. Services include, but are not limited to, individualized psychoeducation about
258.4 the client's illness and the role of the family and other significant people in the therapeutic
258.5 process; family intervention to restore contact, resolve conflict, and maintain relationships
258.6 with family and other significant people in the client's life; ongoing communication and
258.7 collaboration between the ACT team and the family; introduction and referral to family
258.8 self-help programs and advocacy organizations that promote recovery and family
258.9 engagement, individual supportive counseling, parenting training, and service coordination
258.10 to help clients fulfill parenting responsibilities; coordinating services for the child and
258.11 restoring relationships with children who are not in the client's custody; and coordinating
258.12 with child welfare and family agencies, if applicable. These services must be provided with
258.13 the client's agreement and consent.

258.14 (k) "Housing access support" means assisting clients to find, obtain, retain, and move
258.15 to safe and adequate housing of their choice. Housing access support includes, but is not
258.16 limited to, locating housing options with a focus on integrated independent settings; applying
258.17 for housing subsidies, programs, or resources; assisting the client in developing relationships
258.18 with local landlords; providing tenancy support and advocacy for the individual's tenancy
258.19 rights at the client's home; and assisting with relocation.

258.20 (g) "Individual treatment plan" means a plan described under section 256B.0671,
258.21 subdivisions 5 and 6.

258.22 (h) "Individual treatment team" means a minimum of three members of the ACT
258.23 team who are responsible for consistently carrying out most of a client's assertive community
258.24 treatment services.

258.25 (m) (i) "Intensive residential treatment services treatment team" means all staff who
258.26 provide intensive residential treatment services under this section to clients. At a minimum,
258.27 this includes the clinical supervisor; mental health professionals as defined in section 245.462,
258.28 subdivision 18, clauses (1) to (6); mental health practitioners as defined in section 245.462,
258.29 subdivision 17; mental health rehabilitation workers under section 256B.0623, subdivision
258.30 5, paragraph (a), clause (4); and mental health certified peer specialists under section
258.31 256B.0615.

258.32 (n) (j) "Intensive residential treatment services" means short-term, time-limited services
258.33 provided in a residential setting to clients who are in need of more restrictive settings and
258.34 are at risk of significant functional deterioration if they do not receive these services. Services

259.1 are designed to develop and enhance psychiatric stability, personal and emotional adjustment,
259.2 self-sufficiency, and skills to live in a more independent setting. Services must be directed
259.3 toward a targeted discharge date with specified client outcomes.

259.4 ~~(e) "Medication assistance and support" means assisting clients in accessing medication,~~
259.5 ~~developing the ability to take medications with greater independence, and providing~~
259.6 ~~medication setup. This includes the prescription, administration, and order of medication~~
259.7 ~~by appropriate medical staff.~~

259.8 ~~(p) "Medication education" means educating clients on the role and effects of medications~~
259.9 ~~in treating symptoms of mental illness and the side effects of medications.~~

259.10 (k) "Mental health certified peer specialist" means a staff person qualified according to
259.11 section 245I.16, subdivision 10.

259.12 (l) "Mental health practitioner" means a staff person qualified according to section
259.13 245I.16, subdivision 4.

259.14 (m) "Mental health professional" means a staff person qualified according to section
259.15 245I.16, subdivision 2.

259.16 (n) "Mental health rehabilitation worker" means a staff person qualified according to
259.17 section 245I.16, subdivision 14.

259.18 ~~(e)~~(o) "Overnight staff" means a member of the intensive residential treatment services
259.19 team who is responsible during hours when clients are typically asleep.

259.20 ~~(r)~~(p) "Mental health certified peer specialist services" has the meaning given in section
259.21 256B.0615.

259.22 ~~(s)~~(p) "Physical health services" means any service or treatment to meet the physical
259.23 health needs of the client to support the client's mental health recovery. Services include,
259.24 but are not limited to, education on primary health issues, including wellness education;
259.25 medication administration and monitoring; providing and coordinating medical screening
259.26 and follow-up; scheduling routine and acute medical and dental care visits; tobacco cessation
259.27 strategies; assisting clients in attending appointments; communicating with other providers;
259.28 and integrating all physical and mental health treatment.

259.29 ~~(t)~~(q) "Primary team member" means the person who leads and coordinates the activities
259.30 of the individual treatment team and is the individual treatment team member who has
259.31 primary responsibility for establishing and maintaining a therapeutic relationship with the
259.32 client on a continuing basis.

260.1 (t) "Rehabilitative mental health services" means mental health services that are
260.2 rehabilitative and enable the client to develop and enhance psychiatric stability, social
260.3 competencies, personal and emotional adjustment, independent living, parenting skills, and
260.4 community skills, when these abilities are impaired by the symptoms of mental illness.

260.5 (v) "Symptom management" means supporting clients in identifying and targeting
260.6 the symptoms and occurrence patterns of their mental illness and developing strategies to
260.7 reduce the impact of those symptoms.

260.8 (w) "Therapeutic interventions" means empirically supported techniques to address
260.9 specific symptoms and behaviors such as anxiety, psychotic symptoms, emotional
260.10 dysregulation, and trauma symptoms. Interventions include empirically supported
260.11 psychotherapies including, but not limited to, cognitive behavioral therapy, exposure therapy,
260.12 acceptance and commitment therapy, interpersonal therapy, and motivational interviewing.

260.13 (x) "Wellness self-management and prevention" means a combination of approaches
260.14 to working with the client to build and apply skills related to recovery, and to support the
260.15 client in participating in leisure and recreational activities, civic participation, and meaningful
260.16 structure.

260.17 Sec. 54. Minnesota Statutes 2018, section 256B.0622, subdivision 3a, is amended to read:

260.18 **Subd. 3a. Provider certification and contract requirements for assertive community
260.19 treatment.** (a) The assertive community treatment provider must:

260.20 (1) have a contract with the host county to provide assertive community treatment
260.21 services; and

260.22 (2) have each ACT team be certified by the state following the certification process and
260.23 procedures developed by the commissioner. The certification process determines whether
260.24 the ACT team meets the standards for assertive community treatment under this section ~~as~~
260.25 ~~well as, chapter 245I,~~ and minimum program fidelity standards as measured by a nationally
260.26 recognized fidelity tool approved by the commissioner. Recertification must occur at least
260.27 every three years.

260.28 (b) An ACT team certified under this subdivision must meet the following standards:

260.29 (1) have capacity to recruit, hire, manage, and train required ACT team members;

260.30 (2) have adequate administrative ability to ensure availability of services;

260.31 ~~(3) ensure adequate preservice and ongoing training for staff;~~

261.1 (4) ensure that staff is capable of implementing culturally specific services that are
261.2 culturally responsive and appropriate as determined by the client's culture, beliefs, values,
261.3 and language as identified in the individual treatment plan;

261.4 (5) (3) ensure flexibility in service delivery to respond to the changing and intermittent
261.5 care needs of a client as identified by the client and the individual treatment plan;

261.6 (6) develop and maintain client files, individual treatment plans, and contact charting;

261.7 (7) develop and maintain staff training and personnel files;

261.8 (8) (4) submit information as required by the state;

261.9 (9) (5) keep all necessary records required by law;

261.10 (10) comply with all applicable laws;

261.11 (11) (6) be an enrolled Medicaid provider;

261.12 (12) (7) establish and maintain a quality assurance plan to determine specific service
261.13 outcomes and the client's satisfaction with services; and

261.14 (13) (8) develop and maintain written policies and procedures regarding service provision
261.15 and administration of the provider entity.

261.16 (c) The commissioner may intervene at any time and decertify an ACT team with cause.
261.17 The commissioner shall establish a process for decertification of an ACT team and shall
261.18 require corrective action, medical assistance repayment, or decertification of an ACT team
261.19 that no longer meets the requirements in this section or that fails to meet the clinical quality
261.20 standards or administrative standards provided by the commissioner in the application and
261.21 certification process. The decertification is subject to appeal to the state.

261.22 Sec. 55. Minnesota Statutes 2018, section 256B.0622, subdivision 4, is amended to read:

261.23 **Subd. 4. Provider entity licensure and contract requirements for intensive residential
261.24 treatment services.** (a) The intensive residential treatment services provider entity must:

261.25 (1) be licensed under Minnesota Rules, parts 9520.0500 to 9520.0670;

261.26 (2) not exceed 16 beds per site; and

261.27 (3) comply with the additional standards in this section and chapter 245I.

261.28 (b) The commissioner shall develop procedures for counties and providers to submit
261.29 other documentation as needed to allow the commissioner to determine whether the standards
261.30 in this section are met.

262.1 (c) A provider entity must specify in the provider entity's application what geographic
262.2 area and populations will be served by the proposed program. A provider entity must
262.3 document that the capacity or program specialties of existing programs are not sufficient
262.4 to meet the service needs of the target population. A provider entity must submit evidence
262.5 of ongoing relationships with other providers and levels of care to facilitate referrals to and
262.6 from the proposed program.

262.7 (d) A provider entity must submit documentation that the provider entity requested a
262.8 statement of need from each county board and tribal authority that serves as a local mental
262.9 health authority in the proposed service area. The statement of need must specify if the local
262.10 mental health authority supports or does not support the need for the proposed program and
262.11 the basis for this determination. If a local mental health authority does not respond within
262.12 60 days of the receipt of the request, the commissioner shall determine the need for the
262.13 program based on the documentation submitted by the provider entity.

262.14 Sec. 56. Minnesota Statutes 2018, section 256B.0622, subdivision 5a, is amended to read:

262.15 **Subd. 5a. Standards for intensive residential rehabilitative mental health services.** (a)
262.16 The standards in this subdivision apply to intensive residential mental health services.

262.17 (b) The provider of intensive residential treatment services must have sufficient staff to
262.18 provide 24-hour-per-day coverage to deliver the rehabilitative services described in the
262.19 treatment plan and to safely supervise and direct the activities of clients, given the client's
262.20 level of behavioral and psychiatric stability, cultural needs, and vulnerability. The provider
262.21 must have the capacity within the facility to provide integrated services for chemical
262.22 dependency, illness management services, and family education, when appropriate.

262.23 (c) At a minimum:

262.24 (1) staff must provide direction and supervision whenever clients are present in the
262.25 facility;

262.26 (2) staff must remain awake during all work hours;

262.27 (3) there must be a staffing ratio of at least one to nine clients for each day and evening
262.28 shift. If more than nine clients are present at the residential site, there must be a minimum
262.29 of two staff during day and evening shifts, one of whom must be a mental health practitioner
262.30 or mental health professional;

262.31 (4) if services are provided to clients who need the services of a medical professional,
262.32 the provider shall ensure that these services are provided either by the provider's own medical
262.33 staff or through referral to a medical professional; and

263.1 (5) the provider must ensure the timely availability of a licensed registered nurse, either
263.2 directly employed or under contract, who is responsible for ensuring the effectiveness and
263.3 safety of medication administration in the facility and assessing clients for medication side
263.4 effects and drug interactions.

263.5 (d) Services must be provided by qualified staff as defined in section 256B.0623,
263.6 subdivision 5, ~~who are trained and supervised according to section 256B.0623, subdivision~~
263.7 ~~6, except that mental health rehabilitation workers acting as overnight staff are not required~~
263.8 ~~to comply with section 256B.0623, subdivision 5, paragraph (a), clause (4), item (iv).~~

263.9 (e) The clinical treatment supervisor must be an active member of the intensive residential
263.10 services treatment team. The team must meet with the clinical treatment supervisor at least
263.11 weekly to discuss clients' progress and make rapid adjustments to meet clients' needs. The
263.12 team meeting shall include client-specific case reviews and general treatment discussions
263.13 among team members. Client-specific case reviews and planning must be documented in
263.14 the client's treatment record.

263.15 (f) Treatment staff must have prompt access in person or by telephone to a mental health
263.16 practitioner or mental health professional. The provider must have the capacity to promptly
263.17 and appropriately respond to emergent needs and make any necessary staffing adjustments
263.18 to ensure the health and safety of clients.

263.19 (g) The initial functional assessment must be completed within ten days of intake and
263.20 updated at least every 30 days, or prior to discharge from the service, whichever comes
263.21 first.

263.22 (h) The initial individual treatment plan must be completed within 24 hours of admission.
263.23 Within ten days of admission, the initial treatment plan must be refined and further developed,
263.24 except for providers certified according to Minnesota Rules, parts 9533.0010 to 9533.0180.
263.25 The individual treatment plan must be reviewed with the client and updated at least monthly.

263.26 Sec. 57. Minnesota Statutes 2018, section 256B.0622, subdivision 7, is amended to read:

263.27 **Subd. 7. Assertive community treatment service standards.** (a) ACT teams must
263.28 offer and have the capacity to directly provide the following services:

263.29 (1) assertive engagement using collaborative strategies to encourage clients to receive
263.30 services;

263.31 (2) benefits and finance support; that assists clients to capably manage financial affairs.
263.32 Services include but are not limited to assisting clients in applying for benefits, assisting
263.33 with redetermination of benefits, providing financial crisis management, teaching and

- 264.1 supporting budgeting skills and asset development, and coordinating with a client's
- 264.2 representative payee, if applicable;
- 264.3 (3) co-occurring disorder treatment;
- 264.4 (4) crisis assessment and intervention;
- 264.5 (5) employment services; that assists clients to work at jobs of their choosing. Services
- 264.6 must follow the principles of the individual placement and support employment model,
- 264.7 including focusing on competitive employment, emphasizing individual client preferences
- 264.8 and strengths, ensuring employment services are integrated with mental health services,
- 264.9 conducting rapid job searches and systematic job development according to client preferences
- 264.10 and choices, providing benefits counseling, and offering all services in an individualized
- 264.11 and time-unlimited manner. Services must also include educating clients about opportunities
- 264.12 and benefits of work and school and assisting the client in learning job skills, navigating
- 264.13 the workplace, and managing work relationships;
- 264.14 (6) family psychoeducation and support; provided to the client's family and other natural
- 264.15 supports to restore and strengthen the client's unique social and family relationships. Services
- 264.16 include but are not limited to individualized psychoeducation about the client's illness and
- 264.17 the role of the family and other significant people in the therapeutic process; family
- 264.18 intervention to restore contact, resolve conflict, and maintain relationships with family and
- 264.19 other significant people in the client's life; ongoing communication and collaboration between
- 264.20 the ACT team and the family; introduction and referral to family self-help programs and
- 264.21 advocacy organizations that promote recovery and family engagement, individual supportive
- 264.22 counseling, parenting training, and service coordination to help clients fulfill parenting
- 264.23 responsibilities; coordinating services for the child and restoring relationships with children
- 264.24 who are not in the client's custody; and coordinating with child welfare and family agencies,
- 264.25 if applicable. These services must be provided with the client's agreement and consent;
- 264.26 (7) housing access support; that assists clients to find, obtain, retain, and move to safe
- 264.27 and adequate housing of their choice. Housing access support includes but is not limited to
- 264.28 locating housing options with a focus on integrated independent settings; applying for
- 264.29 housing subsidies, programs, or resources; assisting the client in developing relationships
- 264.30 with local landlords; providing tenancy support and advocacy for the individual's tenancy
- 264.31 rights at the client's home; and assisting with relocation;
- 264.32 (8) medication assistance and support; that assists clients in accessing medication,
- 264.33 developing the ability to take medications with greater independence, and providing

265.1 medication setup. Medication assistance and support includes assisting the client with the
265.2 prescription, administration, and ordering of medication by appropriate medical staff;

265.3 (9) medication education; that educates clients on the role and effects of medications in
265.4 treating symptoms of mental illness and the side effects of medications;

265.5 (10) mental health certified peer specialists services;

265.6 (11) physical health services;

265.7 (12) rehabilitative mental health services;

265.8 (13) symptom management;

265.9 (14) therapeutic interventions;

265.10 (15) wellness self-management and prevention; and

265.11 (16) other services based on client needs as identified in a client's assertive community
265.12 treatment individual treatment plan.

265.13 (b) ACT teams must ensure the provision of all services necessary to meet a client's
265.14 needs as identified in the client's individual treatment plan.

265.15 Sec. 58. Minnesota Statutes 2018, section 256B.0622, subdivision 7a, is amended to read:

265.16 **Subd. 7a. Assertive community treatment team staff requirements and roles. (a)**

265.17 The required treatment staff qualifications and roles for an ACT team are:

265.18 (1) the team leader:

265.19 (i) shall be a licensed mental health professional who is qualified under Minnesota Rules,
265.20 part 9505.0371, subpart 5, item A. Individuals who are not licensed but who are eligible
265.21 for licensure and are otherwise qualified may also fulfill this role but must obtain full
265.22 licensure within 24 months of assuming the role of team leader;

265.23 (ii) must be an active member of the ACT team and provide some direct services to
265.24 clients;

265.25 (iii) must be a single full-time staff member, dedicated to the ACT team, who is
265.26 responsible for overseeing the administrative operations of the team, providing clinical
265.27 oversight treatment supervision of services in conjunction with the psychiatrist or psychiatric
265.28 care provider, and supervising team members to ensure delivery of best and ethical practices;
265.29 and

266.1 (iv) must be available to provide overall ~~clinical oversight~~ treatment supervision to the
266.2 ACT team after regular business hours and on weekends and holidays. The team leader may
266.3 delegate this duty to another qualified member of the ACT team;

266.4 (2) the psychiatric care provider:

266.5 (i) must be a ~~licensed psychiatrist certified by the American Board of Psychiatry and~~
266.6 ~~Neurology or eligible for board certification or certified by the American Osteopathic Board~~
266.7 ~~of Neurology and Psychiatry or eligible for board certification, or a psychiatric nurse who~~
266.8 ~~is qualified under Minnesota Rules, part 9505.0371, subpart 5, item A mental health~~
266.9 ~~professional.~~ The psychiatric care provider must have demonstrated clinical experience
266.10 working with individuals with serious and persistent mental illness;

266.11 (ii) shall collaborate with the team leader in sharing overall clinical responsibility for
266.12 screening and admitting clients; monitoring clients' treatment and team member service
266.13 delivery; educating staff on psychiatric and nonpsychiatric medications, their side effects,
266.14 and health-related conditions; actively collaborating with nurses; and helping provide ~~clinical~~
266.15 treatment supervision to the team;

266.16 (iii) shall fulfill the following functions for assertive community treatment clients:
266.17 provide assessment and treatment of clients' symptoms and response to medications, including
266.18 side effects; provide brief therapy to clients; provide diagnostic and medication education
266.19 to clients, with medication decisions based on shared decision making; monitor clients'
266.20 nonpsychiatric medical conditions and nonpsychiatric medications; and conduct home and
266.21 community visits;

266.22 (iv) shall serve as the point of contact for psychiatric treatment if a client is hospitalized
266.23 for mental health treatment and shall communicate directly with the client's inpatient
266.24 psychiatric care providers to ensure continuity of care;

266.25 (v) shall have a minimum full-time equivalency that is prorated at a rate of 16 hours per
266.26 50 clients. Part-time psychiatric care providers shall have designated hours to work on the
266.27 team, with sufficient blocks of time on consistent days to carry out the provider's clinical,
266.28 supervisory, and administrative responsibilities. No more than two psychiatric care providers
266.29 may share this role;

266.30 (vi) may not provide specific roles and responsibilities by telemedicine unless approved
266.31 by the commissioner; and

267.1 (vii) shall provide psychiatric backup to the program after regular business hours and
267.2 on weekends and holidays. The psychiatric care provider may delegate this duty to another
267.3 qualified psychiatric provider;

267.4 (3) the nursing staff:

267.5 (i) shall consist of one to three registered nurses or advanced practice registered nurses,
267.6 of whom at least one has a minimum of one-year experience working with adults with
267.7 serious mental illness and a working knowledge of psychiatric medications. No more than
267.8 two individuals can share a full-time equivalent position;

267.9 (ii) are responsible for managing medication, administering and documenting medication
267.10 treatment, and managing a secure medication room; and

267.11 (iii) shall develop strategies, in collaboration with clients, to maximize taking medications
267.12 as prescribed; screen and monitor clients' mental and physical health conditions and
267.13 medication side effects; engage in health promotion, prevention, and education activities;
267.14 communicate and coordinate services with other medical providers; facilitate the development
267.15 of the individual treatment plan for clients assigned; and educate the ACT team in monitoring
267.16 psychiatric and physical health symptoms and medication side effects;

267.17 (4) the co-occurring disorder specialist:

267.18 (i) shall be a full-time equivalent co-occurring disorder specialist who has received
267.19 specific training on co-occurring disorders that is consistent with national evidence-based
267.20 practices. The training must include practical knowledge of common substances and how
267.21 they affect mental illnesses, the ability to assess substance use disorders and the client's
267.22 stage of treatment, motivational interviewing, and skills necessary to provide counseling to
267.23 clients at all different stages of change and treatment. The co-occurring disorder specialist
267.24 may also be an individual who is a licensed alcohol and drug counselor as described in
267.25 section 148F.01, subdivision 5, or a counselor who otherwise meets the training, experience,
267.26 and other requirements in section 245G.11, subdivision 5. No more than two co-occurring
267.27 disorder specialists may occupy this role; and

267.28 (ii) shall provide or facilitate the provision of co-occurring disorder treatment to clients.
267.29 The co-occurring disorder specialist shall serve as a consultant and educator to fellow ACT
267.30 team members on co-occurring disorders;

267.31 (5) the vocational specialist:

267.32 (i) shall be a full-time vocational specialist who has at least one-year experience providing
267.33 employment services or advanced education that involved field training in vocational services

268.1 to individuals with mental illness. An individual who does not meet these qualifications
268.2 may also serve as the vocational specialist upon completing a training plan approved by the
268.3 commissioner;

268.4 (ii) shall provide or facilitate the provision of vocational services to clients. The vocational
268.5 specialist serves as a consultant and educator to fellow ACT team members on these services;
268.6 and

268.7 (iii) ~~should~~ shall not refer individuals to receive any type of vocational services or linkage
268.8 by providers outside of the ACT team;

268.9 (6) the mental health certified peer specialist:

268.10 (i) shall be a full-time equivalent ~~mental health certified peer specialist as defined in~~
268.11 ~~section 256B.0615~~. No more than two individuals can share this position. The mental health
268.12 certified peer specialist is a fully integrated team member who provides highly individualized
268.13 services in the community and promotes the self-determination and shared decision-making
268.14 abilities of clients. This requirement may be waived due to workforce shortages upon
268.15 approval of the commissioner;

268.16 (ii) must provide coaching, mentoring, and consultation to the clients to promote recovery,
268.17 self-advocacy, and self-direction, promote wellness management strategies, and assist clients
268.18 in developing advance directives; and

268.19 (iii) must model recovery values, attitudes, beliefs, and personal action to encourage
268.20 wellness and resilience, provide consultation to team members, promote a culture where
268.21 the clients' points of view and preferences are recognized, understood, respected, and
268.22 integrated into treatment, and serve in a manner equivalent to other team members;

268.23 (7) the program administrative assistant shall be a full-time office-based program
268.24 administrative assistant position assigned to solely work with the ACT team, providing a
268.25 range of supports to the team, clients, and families; and

268.26 (8) additional staff:

268.27 (i) shall be based on team size. Additional treatment team staff may include ~~licensed~~
268.28 mental health professionals as ~~defined in Minnesota Rules, part 9505.0371, subpart 5, item~~
268.29 A; mental health practitioners as ~~defined in section 245.462, subdivision 17; a mental health~~
268.30 practitioner working as a clinical trainee according to ~~Minnesota Rules, part 9505.0371,~~
268.31 ~~subpart 5, item C trainees~~; or mental health rehabilitation workers as ~~defined in section~~
268.32 ~~256B.0623, subdivision 5, paragraph (a), clause (4)~~. These individuals shall have the

269.1 knowledge, skills, and abilities required by the population served to carry out rehabilitation
269.2 and support functions; and

269.3 (ii) shall be selected based on specific program needs or the population served.

269.4 (b) Each ACT team must clearly document schedules for all ACT team members.

269.5 (c) Each ACT team member must serve as a primary team member for clients assigned
269.6 by the team leader and are responsible for facilitating the individual treatment plan process
269.7 for those clients. The primary team member for a client is the responsible team member
269.8 knowledgeable about the client's life and circumstances and writes the individual treatment
269.9 plan. The primary team member provides individual supportive therapy or counseling, and
269.10 provides primary support and education to the client's family and support system.

269.11 (d) Members of the ACT team must have strong clinical skills, professional qualifications,
269.12 experience, and competency to provide a full breadth of rehabilitation services. Each staff
269.13 member shall be proficient in their respective discipline and be able to work collaboratively
269.14 as a member of a multidisciplinary team to deliver the majority of the treatment,
269.15 rehabilitation, and support services clients require to fully benefit from receiving assertive
269.16 community treatment.

269.17 (e) Each ACT team member must fulfill training requirements established by the
269.18 commissioner.

269.19 Sec. 59. Minnesota Statutes 2018, section 256B.0622, subdivision 7b, is amended to read:

269.20 Subd. 7b. **Assertive community treatment program size and opportunities.** (a) Each
269.21 ACT team shall maintain an annual average caseload that does not exceed 100 clients.
269.22 Staff-to-client ratios shall be based on team size as follows:

269.23 (1) a small ACT team must:

269.24 (i) employ at least six but no more than seven full-time treatment team staff, excluding
269.25 the program assistant and the psychiatric care provider;

269.26 (ii) serve an annual average maximum of no more than 50 clients;

269.27 (iii) ensure at least one full-time equivalent position for every eight clients served;

269.28 (iv) schedule ACT team staff for at least eight-hour shift coverage on weekdays and
269.29 on-call duty to provide crisis services and deliver services after hours when staff are not
269.30 working;

270.1 (v) provide crisis services during business hours if the small ACT team does not have
270.2 sufficient staff numbers to operate an after-hours on-call system. During all other hours,
270.3 the ACT team may arrange for coverage for crisis assessment and intervention services
270.4 through a reliable crisis-intervention provider as long as there is a mechanism by which the
270.5 ACT team communicates routinely with the crisis-intervention provider and the on-call
270.6 ACT team staff are available to see clients face-to-face when necessary or if requested by
270.7 the crisis-intervention services provider;

270.8 (vi) adjust schedules and provide staff to carry out the needed service activities in the
270.9 evenings or on weekend days or holidays, when necessary;

270.10 (vii) arrange for and provide psychiatric backup during all hours the psychiatric care
270.11 provider is not regularly scheduled to work. If availability of the ACT team's psychiatric
270.12 care provider during all hours is not feasible, alternative psychiatric prescriber backup must
270.13 be arranged and a mechanism of timely communication and coordination established in
270.14 writing; and

270.15 (viii) be composed of, at minimum, one full-time team leader, at least 16 hours each
270.16 week per 50 clients of psychiatric provider time, or equivalent if fewer clients, one full-time
270.17 equivalent nursing, one full-time substance abuse specialist, one full-time equivalent mental
270.18 health certified peer specialist, one full-time vocational specialist, one full-time program
270.19 assistant, and at least one additional full-time ACT team member who has mental health
270.20 professional, clinical trainee, or mental health practitioner status; and

270.21 (2) a midsize ACT team shall:

270.22 (i) be composed of, at minimum, one full-time team leader, at least 16 hours of psychiatry
270.23 time for 51 clients, with an additional two hours for every six clients added to the team, 1.5
270.24 to two full-time equivalent nursing staff, one full-time substance abuse specialist, one
270.25 full-time equivalent mental health certified peer specialist, one full-time vocational specialist,
270.26 one full-time program assistant, and at least 1.5 to two additional full-time equivalent ACT
270.27 members, with at least one dedicated full-time staff member with mental health professional
270.28 status. Remaining team members may have mental health professional, clinical trainee, or
270.29 mental health practitioner status;

270.30 (ii) employ seven or more treatment team full-time equivalents, excluding the program
270.31 assistant and the psychiatric care provider;

270.32 (iii) serve an annual average maximum caseload of 51 to 74 clients;

270.33 (iv) ensure at least one full-time equivalent position for every nine clients served;

271.1 (v) schedule ACT team staff for a minimum of ten-hour shift coverage on weekdays
271.2 and six- to eight-hour shift coverage on weekends and holidays. In addition to these minimum
271.3 specifications, staff are regularly scheduled to provide the necessary services on a
271.4 client-by-client basis in the evenings and on weekends and holidays;

271.5 (vi) schedule ACT team staff on-call duty to provide crisis services and deliver services
271.6 when staff are not working;

271.7 (vii) have the authority to arrange for coverage for crisis assessment and intervention
271.8 services through a reliable crisis-intervention provider as long as there is a mechanism by
271.9 which the ACT team communicates routinely with the crisis-intervention provider and the
271.10 on-call ACT team staff are available to see clients face-to-face when necessary or if requested
271.11 by the crisis-intervention services provider; and

271.12 (viii) arrange for and provide psychiatric backup during all hours the psychiatric care
271.13 provider is not regularly scheduled to work. If availability of the psychiatric care provider
271.14 during all hours is not feasible, alternative psychiatric prescriber backup must be arranged
271.15 and a mechanism of timely communication and coordination established in writing;

271.16 (3) a large ACT team must:

271.17 (i) be composed of, at minimum, one full-time team leader, at least 32 hours each week
271.18 per 100 clients, or equivalent of psychiatry time, three full-time equivalent nursing staff,
271.19 one full-time substance abuse specialist, one full-time equivalent mental health certified
271.20 peer specialist, one full-time vocational specialist, one full-time program assistant, and at
271.21 least two additional full-time equivalent ACT team members, with at least one dedicated
271.22 full-time staff member with mental health professional status. Remaining team members
271.23 may have mental health professional, clinical trainee, or mental health practitioner status;

271.24 (ii) employ nine or more treatment team full-time equivalents, excluding the program
271.25 assistant and psychiatric care provider;

271.26 (iii) serve an annual average maximum caseload of 75 to 100 clients;

271.27 (iv) ensure at least one full-time equivalent position for every nine individuals served;

271.28 (v) schedule staff to work two eight-hour shifts, with a minimum of two staff on the
271.29 second shift providing services at least 12 hours per day weekdays. For weekends and
271.30 holidays, the team must operate and schedule ACT team staff to work one eight-hour shift,
271.31 with a minimum of two staff each weekend day and every holiday;

271.32 (vi) schedule ACT team staff on-call duty to provide crisis services and deliver services
271.33 when staff are not working; and

272.1 (vii) arrange for and provide psychiatric backup during all hours the psychiatric care
272.2 provider is not regularly scheduled to work. If availability of the ACT team psychiatric care
272.3 provider during all hours is not feasible, alternative psychiatric backup must be arranged
272.4 and a mechanism of timely communication and coordination established in writing.

272.5 (b) An ACT team of any size may have a staff-to-client ratio that is lower than the
272.6 requirements described in paragraph (a) upon approval by the commissioner, but may not
272.7 exceed a one-to-ten staff-to-client ratio.

272.8 Sec. 60. Minnesota Statutes 2018, section 256B.0622, subdivision 7d, is amended to read:

272.9 **Subd. 7d. Assertive community treatment assessment and individual treatment**

272.10 **plan.** (a) An initial assessment, including a diagnostic assessment that meets the requirements
272.11 of Minnesota Rules, part 9505.0372, subpart 1, section 256B.0671, subdivisions 2 and 3,
272.12 and a 30-day treatment plan shall be completed the day of the client's admission to assertive
272.13 community treatment by the ACT team leader or the psychiatric care provider, with
272.14 participation by designated ACT team members and the client. The team leader, psychiatric
272.15 care provider, or other mental health professional designated by the team leader or psychiatric
272.16 care provider, must update the client's diagnostic assessment at least annually.

272.17 (b) An initial functional assessment must be completed within ten days of intake and
272.18 updated every six months for assertive community treatment, or prior to discharge from the
272.19 service, whichever comes first.

272.20 (c) Within 30 days of the client's assertive community treatment admission, the ACT
272.21 team shall complete an in-depth assessment of the domains listed under section 245.462,
272.22 subdivision 11a.

272.23 (d) Each part of the in-depth assessment areas shall be completed by each respective
272.24 team specialist or an ACT team member with skill and knowledge in the area being assessed.
272.25 The assessments are based upon all available information, including that from client interview
272.26 family and identified natural supports, and written summaries from other agencies, including
272.27 police, courts, county social service agencies, outpatient facilities, and inpatient facilities,
272.28 where applicable.

272.29 (e) Between 30 and 45 days after the client's admission to assertive community treatment,
272.30 the entire ACT team must hold a comprehensive case conference, where all team members,
272.31 including the psychiatric provider, present information discovered from the completed
272.32 in-depth assessments and provide treatment recommendations. The conference must serve

273.1 as the basis for the first six-month treatment plan, which must be written by the primary
273.2 team member.

273.3 (f) The client's psychiatric care provider, primary team member, and individual treatment
273.4 team members shall assume responsibility for preparing the written narrative of the results
273.5 from the psychiatric and social functioning history timeline and the comprehensive
273.6 assessment.

273.7 (g) The primary team member and individual treatment team members shall be assigned
273.8 by the team leader in collaboration with the psychiatric care provider by the time of the first
273.9 treatment planning meeting or 30 days after admission, whichever occurs first.

273.10 (h) Individual treatment plans must be developed through the following treatment
273.11 planning process:

273.12 (1) The individual treatment plan shall be developed in collaboration with the client and
273.13 the client's preferred natural supports, and guardian, if applicable and appropriate. The ACT
273.14 team shall evaluate, together with each client, the client's needs, strengths, and preferences
273.15 and develop the individual treatment plan collaboratively. The ACT team shall make every
273.16 effort to ensure that the client and the client's family and natural supports, with the client's
273.17 consent, are in attendance at the treatment planning meeting, are involved in ongoing
273.18 meetings related to treatment, and have the necessary supports to fully participate. The
273.19 client's participation in the development of the individual treatment plan shall be documented.

273.20 (2) The client and the ACT team shall work together to formulate and prioritize the
273.21 issues, set goals, research approaches and interventions, and establish the plan. The plan is
273.22 individually tailored so that the treatment, rehabilitation, and support approaches and
273.23 interventions achieve optimum symptom reduction, help fulfill the personal needs and
273.24 aspirations of the client, take into account the cultural beliefs and realities of the individual,
273.25 and improve all the aspects of psychosocial functioning that are important to the client. The
273.26 process supports strengths, rehabilitation, and recovery.

273.27 (3) Each client's individual treatment plan shall identify service needs, strengths and
273.28 capacities, and barriers, and set specific and measurable short- and long-term goals for each
273.29 service need. The individual treatment plan must clearly specify the approaches and
273.30 interventions necessary for the client to achieve the individual goals, when the interventions
273.31 shall happen, and identify which ACT team member shall carry out the approaches and
273.32 interventions.

273.33 (4) The primary team member and the individual treatment team, together with the client
273.34 and the client's family and natural supports with the client's consent, are responsible for

274.1 reviewing and rewriting the treatment goals and individual treatment plan whenever there
274.2 is a major decision point in the client's course of treatment or at least every six months.

274.3 (5) The primary team member shall prepare a summary that thoroughly describes in
274.4 writing the client's and the individual treatment team's evaluation of the client's progress
274.5 and goal attainment, the effectiveness of the interventions, and the satisfaction with services
274.6 since the last individual treatment plan. The client's most recent diagnostic assessment must
274.7 be included with the treatment plan summary.

274.8 (6) The individual treatment plan and review must be ~~signed~~ approved or acknowledged
274.9 by the client, the primary team member, the team leader, the psychiatric care provider, and
274.10 all individual treatment team members. A copy of the ~~signed~~ individual treatment plan is
274.11 made available to the client.

274.12 Sec. 61. Minnesota Statutes 2018, section 256B.0623, subdivision 1, is amended to read:

274.13 Subdivision 1. **Scope.** Medical assistance covers adult rehabilitative mental health
274.14 services as defined in subdivision 2, ~~subject to federal approval~~, if provided to recipients
274.15 as defined in subdivision 3 and provided by a qualified provider entity meeting the standards
274.16 in this section and by a qualified individual provider working within the provider's scope
274.17 of practice and identified in the recipient's individual treatment plan ~~as defined described~~
274.18 in section ~~245.462~~, subdivision ~~14~~ 256B.0671, subdivisions 5 and 6, and if determined to
274.19 be medically necessary according to section 62Q.53.

274.20 Sec. 62. Minnesota Statutes 2018, section 256B.0623, subdivision 2, is amended to read:

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

274.23 (a) "Adult rehabilitative mental health services" means mental health services which are
274.24 rehabilitative and enable the recipient to develop and enhance psychiatric stability, social
274.25 competencies, personal and emotional adjustment, independent living, parenting skills, and
274.26 community skills, when these abilities are impaired by the symptoms of mental illness.
274.27 ~~Adult rehabilitative mental health services are also appropriate when provided to enable a~~
274.28 ~~recipient to retain stability and functioning, if the recipient would be at risk of significant~~
274.29 ~~functional decompensation or more restrictive service settings without these services.~~

274.30 (1) ~~Adult rehabilitative mental health services instruct, assist, and support the recipient~~
274.31 ~~in areas such as: interpersonal communication skills, community resource utilization and~~
274.32 ~~integration skills, crisis assistance, relapse prevention skills, health care directives, budgeting~~

275.1 ~~and shopping skills, healthy lifestyle skills and practices, cooking and nutrition skills,~~
275.2 ~~transportation skills, medication education and monitoring, mental illness symptom~~
275.3 ~~management skills, household management skills, employment related skills, parenting~~
275.4 ~~skills, and transition to community living services.~~

275.5 (2) ~~These services shall be provided to the recipient on a one-to-one basis in the recipient's~~
275.6 ~~home or another community setting or in groups.~~

275.7 (b) "Medication education services" means services provided individually or in groups
275.8 which focus on educating the recipient about mental illness and symptoms; the role and
275.9 effects of medications in treating symptoms of mental illness; and the side effects of
275.10 medications. Medication education is coordinated with medication management services
275.11 and does not duplicate it. Medication education services are provided by physicians,
275.12 pharmacists, physician assistants, or registered nurses.

275.13 (c) "Transition to community living services" means services which maintain continuity
275.14 of contact between the rehabilitation services provider and the recipient and which facilitate
275.15 discharge from a hospital, residential treatment program under Minnesota Rules, chapter
275.16 9505, board and lodging facility, or nursing home. Transition to community living services
275.17 are not intended to provide other areas of adult rehabilitative mental health services.

275.18 Sec. 63. Minnesota Statutes 2018, section 256B.0623, subdivision 3, is amended to read:

275.19 Subd. 3. **Eligibility.** An eligible recipient is an individual who:

275.20 (1) is age 18 or older;
275.21 (2) is diagnosed with a medical condition, such as mental illness or traumatic brain
275.22 injury, for which adult rehabilitative mental health services are needed;
275.23 (3) has substantial disability and functional impairment in three or more of the areas
275.24 listed in section 245.462, subdivision 11a, so that self-sufficiency is markedly reduced; and
275.25 (4) has had a recent diagnostic assessment ~~or an adult diagnostic assessment update~~ by
275.26 a qualified professional that documents adult rehabilitative mental health services are
275.27 medically necessary to address identified disability and functional impairments and individual
275.28 recipient goals.

275.29 Sec. 64. Minnesota Statutes 2018, section 256B.0623, subdivision 4, is amended to read:

275.30 Subd. 4. **Provider entity standards.** (a) The provider entity must be certified by the
275.31 state following the certification process and procedures developed by the commissioner.

276.1 (b) The certification process is a determination as to whether the entity meets the standards
276.2 in this subdivision and chapter 245I. The certification must specify which adult rehabilitative
276.3 mental health services the entity is qualified to provide.

276.4 (c) A noncounty provider entity must obtain additional certification from each county
276.5 in which it will provide services. The additional certification must be based on the adequacy
276.6 of the entity's knowledge of that county's local health and human service system, and the
276.7 ability of the entity to coordinate its services with the other services available in that county.
276.8 A county-operated entity must obtain this additional certification from any other county in
276.9 which it will provide services.

276.10 (d) State-level recertification must occur at least every three years.

276.11 (e) The commissioner may intervene at any time and decertify providers with cause.
276.12 The decertification is subject to appeal to the state. A county board may recommend that
276.13 the state decertify a provider for cause.

276.14 (f) The adult rehabilitative mental health services provider entity must meet the following
276.15 standards:

276.16 (1) have capacity to recruit, hire, manage, and train ~~mental health professionals, mental~~
276.17 ~~health practitioners, and mental health rehabilitation workers~~ qualified staff;

276.18 (2) have adequate administrative ability to ensure availability of services;

276.19 ~~(3) ensure adequate preservice and inservice and ongoing training for staff;~~

276.20 ~~(4) (3) ensure that mental health professionals, mental health practitioners, and mental~~
276.21 ~~health rehabilitation workers~~ staff are skilled in the delivery of the specific adult rehabilitative
276.22 mental health services provided to the individual eligible recipient;

276.23 ~~(5) ensure that staff is capable of implementing culturally specific services that are~~
276.24 ~~culturally competent and appropriate as determined by the recipient's culture, beliefs, values,~~
276.25 ~~and language as identified in the individual treatment plan;~~

276.26 ~~(6) (4) ensure enough flexibility in service delivery to respond to the changing and~~
276.27 intermittent care needs of a recipient as identified by the recipient and the individual treatment
276.28 plan;

276.29 ~~(7) ensure that the mental health professional or mental health practitioner, who is under~~
276.30 ~~the clinical supervision of a mental health professional, involved in a recipient's services~~
276.31 ~~participates in the development of the individual treatment plan;~~

- 277.1 ~~(8)~~(5) assist the recipient in arranging needed crisis assessment, intervention, and
277.2 stabilization services;
- 277.3 ~~(9)~~(6) ensure that services are coordinated with other recipient mental health services
277.4 providers and the county mental health authority and the federally recognized American
277.5 Indian authority and necessary others after obtaining the consent of the recipient. Services
277.6 must also be coordinated with the recipient's case manager or care coordinator if the recipient
277.7 is receiving case management or care coordination services;
- 277.8 ~~(10) develop and maintain recipient files, individual treatment plans, and contact charting;~~
277.9 ~~(11) develop and maintain staff training and personnel files;~~
277.10 ~~(12)~~(7) submit information as required by the state;
277.11 ~~(13) establish and maintain a quality assurance plan to evaluate the outcome of services~~
277.12 ~~provided;~~
277.13 ~~(14)~~(8) keep all necessary records required by law;
277.14 ~~(15)~~(9) deliver services as required by section 245.461;
277.15 ~~(16) comply with all applicable laws;~~
277.16 ~~(17)~~(10) be an enrolled Medicaid provider;
277.17 ~~(18)~~(11) maintain a quality assurance plan to determine specific service outcomes and
277.18 the recipient's satisfaction with services; and
277.19 ~~(19)~~(12) develop and maintain written policies and procedures regarding service
277.20 provision and administration of the provider entity.

277.21 Sec. 65. Minnesota Statutes 2018, section 256B.0623, subdivision 5, is amended to read:

277.22 Subd. 5. **Qualifications of provider staff.** ~~(a)~~ Adult rehabilitative mental health services
277.23 must be provided by qualified individual provider staff of a certified provider entity.
277.24 Individual provider staff must be qualified ~~under~~ as one of the following criteria providers:
277.25 (1) a mental health professional as ~~defined in section 245.462, subdivision 18, clauses~~
277.26 ~~(1) to (6). If the recipient has a current diagnostic assessment by a licensed mental health~~
277.27 ~~professional as defined in section 245.462, subdivision 18, clauses (1) to (6), recommending~~
277.28 ~~receipt of adult mental health rehabilitative services, the definition of mental health~~
277.29 ~~professional for purposes of this section includes a person who is qualified under section~~
277.30 ~~245.462, subdivision 18, clause (7), and who holds a current and valid national certification~~

278.1 ~~as a certified rehabilitation counselor or certified psychosocial rehabilitation practitioner~~
278.2 qualified according to section 245I.16, subdivision 2;

278.3 (2) a certified rehabilitation specialist qualified according to section 245I.16, subdivision
278.4 8;

278.5 (3) a clinical trainee qualified according to section 245I.16, subdivision 6;

278.6 ~~(2)~~ (4) a mental health practitioner as defined in section 245.462, subdivision 17. The
278.7 ~~mental health practitioner must work under the clinical supervision of a mental health~~
278.8 ~~professional qualified according to section 245I.16, subdivision 4;~~

278.9 ~~(3)~~ (5) a mental health certified peer specialist under section 256B.0615. The certified
278.10 ~~peer specialist must work under the clinical supervision of a mental health professional~~
278.11 ~~qualified according to section 245I.16, subdivision 10; or~~

278.12 ~~(4)~~ (6) a mental health rehabilitation worker qualified according to section 245I.16,
278.13 subdivision 14. A mental health rehabilitation worker means a staff person working under
278.14 ~~the direction of a mental health practitioner or mental health professional and under the~~
278.15 ~~clinical supervision of a mental health professional in the implementation of rehabilitative~~
278.16 ~~mental health services as identified in the recipient's individual treatment plan who:~~

278.17 ~~(i) is at least 21 years of age;~~

278.18 ~~(ii) has a high school diploma or equivalent;~~

278.19 ~~(iii) has successfully completed 30 hours of training during the two years immediately~~
278.20 ~~prior to the date of hire, or before provision of direct services, in all of the following areas:~~
278.21 ~~recovery from mental illness, mental health de-escalation techniques, recipient rights,~~
278.22 ~~recipient-centered individual treatment planning, behavioral terminology, mental illness,~~
278.23 ~~co-occurring mental illness and substance abuse, psychotropic medications and side effects,~~
278.24 ~~functional assessment, local community resources, adult vulnerability, recipient~~
278.25 ~~confidentiality; and~~

278.26 ~~(iv) meets the qualifications in paragraph (b).~~

278.27 ~~(b) In addition to the requirements in paragraph (a), a mental health rehabilitation worker~~
278.28 ~~must also meet the qualifications in clause (1), (2), or (3):~~

278.29 ~~(1) has an associates of arts degree, two years of full-time postsecondary education, or~~
278.30 ~~a total of 15 semester hours or 23 quarter hours in behavioral sciences or related fields; is~~
278.31 ~~a registered nurse; or within the previous ten years has:~~

278.32 ~~(i) three years of personal life experience with serious mental illness;~~

279.1 ~~(ii) three years of life experience as a primary caregiver to an adult with a serious mental~~

279.2 ~~illness, traumatic brain injury, substance use disorder, or developmental disability; or~~

279.3 ~~(iii) 2,000 hours of supervised work experience in the delivery of mental health services~~

279.4 ~~to adults with a serious mental illness, traumatic brain injury, substance use disorder, or~~

279.5 ~~developmental disability;~~

279.6 ~~(2)(i) is fluent in the non-English language or competent in the culture of the ethnic~~

279.7 ~~group to which at least 20 percent of the mental health rehabilitation worker's clients belong;~~

279.8 ~~(ii) receives during the first 2,000 hours of work, monthly documented individual clinical~~

279.9 ~~supervision by a mental health professional;~~

279.10 ~~(iii) has 18 hours of documented field supervision by a mental health professional or~~

279.11 ~~mental health practitioner during the first 160 hours of contact work with recipients, and at~~

279.12 ~~least six hours of field supervision quarterly during the following year;~~

279.13 ~~(iv) has review and cosignature of charting of recipient contacts during field supervision~~

279.14 ~~by a mental health professional or mental health practitioner; and~~

279.15 ~~(v) has 15 hours of additional continuing education on mental health topics during the~~

279.16 ~~first year of employment and 15 hours during every additional year of employment; or~~

279.17 ~~(3) for providers of crisis residential services, intensive residential treatment services,~~

279.18 ~~partial hospitalization, and day treatment services:~~

279.19 ~~(i) satisfies clause (2), items (ii) to (iv); and~~

279.20 ~~(ii) has 40 hours of additional continuing education on mental health topics during the~~

279.21 ~~first year of employment.~~

279.22 ~~(c) A mental health rehabilitation worker who solely acts and is scheduled as overnight~~

279.23 ~~staff is not required to comply with paragraph (a), clause (4), item (iv).~~

279.24 ~~(d) For purposes of this subdivision, "behavioral sciences or related fields" means an~~

279.25 ~~education from an accredited college or university and includes but is not limited to social~~

279.26 ~~work, psychology, sociology, community counseling, family social science, child~~

279.27 ~~development, child psychology, community mental health, addiction counseling, counseling~~

279.28 ~~and guidance, special education, and other fields as approved by the commissioner.~~

279.29 Sec. 66. Minnesota Statutes 2018, section 256B.0623, subdivision 6, is amended to read:

279.30 Subd. 6. **Required training and supervision.** (a) ~~Mental health rehabilitation workers~~

279.31 ~~must receive ongoing continuing education training of at least 30 hours every two years in~~

280.1 ~~areas of mental illness and mental health services and other areas specific to the population~~
280.2 ~~being served. Mental health rehabilitation workers must also be subject to the ongoing~~
280.3 ~~direction and clinical supervision standards in paragraphs (c) and (d). Staff must receive~~
280.4 ~~training in accordance with section 245I.10.~~

280.5 ~~(b) Mental health practitioners must receive ongoing continuing education training as~~
280.6 ~~required by their professional license; or if the practitioner is not licensed, the practitioner~~
280.7 ~~must receive ongoing continuing education training of at least 30 hours every two years in~~
280.8 ~~areas of mental illness and mental health services. Mental health practitioners must meet~~
280.9 ~~the ongoing clinical supervision standards in paragraph (e).~~

280.10 ~~(e) Clinical supervision may be provided by a full- or part-time qualified professional~~
280.11 ~~employed by or under contract with the provider entity. Clinical supervision may be provided~~
280.12 ~~by interactive videoconferencing according to procedures developed by the commissioner.~~
280.13 ~~(b) Treatment supervision must be provided according to section 245I.18. A mental health~~
280.14 ~~professional providing clinical treatment supervision of staff delivering adult rehabilitative~~
280.15 ~~mental health services must provide the following guidance:~~

280.16 ~~(1) review the information in the recipient's file;~~
280.17 ~~(2) review and approve initial and updates of individual treatment plans;~~
280.18 ~~(3) (1) meet with mental health rehabilitation workers and practitioners, individually or~~
280.19 ~~in small groups, staff receiving direction at least monthly to discuss treatment topics of~~
280.20 ~~interest to the workers and practitioners;~~
280.21 ~~(4) meet with mental health rehabilitation workers and practitioners, individually or in~~
280.22 ~~small groups, at least monthly to (2) discuss treatment plans of recipients, and approve by~~
280.23 ~~signature and document in the recipient's file any resulting plan updates;~~
280.24 ~~(5) meet at least monthly with the directing mental health practitioner, if there is one,~~
280.25 ~~to (3) review needs of the adult rehabilitative mental health services program, review staff~~
280.26 ~~on-site observations and evaluate mental health rehabilitation workers, plan staff training,~~
280.27 ~~and review program evaluation and development, and consult with the directing practitioner;~~
280.28 ~~and;~~
280.29 ~~(6) be available for urgent consultation as the individual recipient needs or the situation~~
280.30 ~~necessitates.~~

280.31 ~~(d) An adult rehabilitative mental health services provider entity must have a treatment~~
280.32 ~~director who is a mental health practitioner or mental health professional. The treatment~~
280.33 ~~director must ensure the following:~~

281.1 (1) while delivering direct services to recipients, a newly hired mental health rehabilitation
281.2 worker must be directly observed delivering services to recipients by a mental health
281.3 practitioner or mental health professional for at least six hours per 40 hours worked during
281.4 the first 160 hours that the mental health rehabilitation worker works;

281.5 (2) the mental health rehabilitation worker must receive ongoing on-site direct service
281.6 observation by a mental health professional or mental health practitioner for at least six
281.7 hours for every six months of employment;

281.8 (3)(4) review progress notes are reviewed from on-site service observation prepared by
281.9 the mental health rehabilitation worker and mental health practitioner for accuracy and
281.10 consistency with actual recipient contact and the individual treatment plan and goals;

281.11 (4)(5) ensure immediate availability by phone or in person for consultation by a mental
281.12 health professional or a mental health practitioner to the mental health rehabilitation services
281.13 worker during service provision; and

281.14 (5) oversee the identification of changes in individual recipient treatment strategies,
281.15 revise the plan, and communicate treatment instructions and methodologies as appropriate
281.16 to ensure that treatment is implemented correctly;

281.17 (6) model service practices which respect the recipient, include the recipient in planning
281.18 and implementation of the individual treatment plan, recognize the recipient's strengths,
281.19 collaborate and coordinate with other involved parties and providers;

281.20 (7)(6) ensure that mental health practitioners and mental health rehabilitation workers
281.21 are able to effectively communicate with the recipients, significant others, and providers;
281.22 and.

281.23 (8) oversee the record of the results of on-site observation and charting evaluation and
281.24 corrective actions taken to modify the work of the mental health practitioners and mental
281.25 health rehabilitation workers.

281.26 (e) A mental health practitioner who is providing treatment direction for a provider entity
281.27 must receive supervision at least monthly from a mental health professional to:

281.28 (1) identify and plan for general needs of the recipient population served;

281.29 (2) identify and plan to address provider entity program needs and effectiveness;

281.30 (3) identify and plan provider entity staff training and personnel needs and issues; and

281.31 (4) plan, implement, and evaluate provider entity quality improvement programs.

282.1 Sec. 67. Minnesota Statutes 2018, section 256B.0623, subdivision 7, is amended to read:

282.2 Subd. 7. **Personnel file.** The adult rehabilitative mental health services provider entity

282.3 must maintain a personnel file on each staff in accordance with section 245I.13. Each file

282.4 must contain:

282.5 (1) an annual performance review;

282.6 (2) a summary of on-site service observations and charting review;

282.7 (3) a criminal background check of all direct service staff;

282.8 (4) evidence of academic degree and qualifications;

282.9 (5) a copy of professional license;

282.10 (6) any job performance recognition and disciplinary actions;

282.11 (7) any individual staff written input into own personnel file;

282.12 (8) all clinical supervision provided; and

282.13 (9) documentation of compliance with continuing education requirements.

282.14 Sec. 68. Minnesota Statutes 2018, section 256B.0623, subdivision 8, is amended to read:

282.15 Subd. 8. **Diagnostic assessment.** Providers of adult rehabilitative mental health services

282.16 must obtain or complete a diagnostic assessment as defined in according to section 245.462,

282.17 subdivision 9, within five days after the recipient's second visit or within 30 days after

282.18 intake, whichever occurs first. In cases where a diagnostic assessment is available that

282.19 reflects the recipient's current status, and has been completed within three years preceding

282.20 admission, an adult diagnostic assessment update must be completed. An update shall include

282.21 a face-to-face interview with the recipient and a written summary by a mental health

282.22 professional of the recipient's current mental health status and service needs. If the recipient's

282.23 mental health status has changed significantly since the adult's most recent diagnostic

282.24 assessment, a new diagnostic assessment is required 256B.0671, subdivisions 2 and 3.

282.25 Sec. 69. Minnesota Statutes 2018, section 256B.0623, subdivision 10, is amended to read:

282.26 Subd. 10. **Individual treatment plan.** All providers of adult rehabilitative mental health

282.27 services must develop and implement an individual treatment plan for each recipient. The

282.28 provisions in clauses (1) and (2) apply: according to section 256B.0671, subdivisions 5 and

282.29 6.

283.1 (1) Individual treatment plan means a plan of intervention, treatment, and services for
283.2 an individual recipient written by a mental health professional or by a mental health
283.3 practitioner under the clinical supervision of a mental health professional. The individual
283.4 treatment plan must be based on diagnostic and functional assessments. To the extent
283.5 possible, the development and implementation of a treatment plan must be a collaborative
283.6 process involving the recipient, and with the permission of the recipient, the recipient's
283.7 family and others in the recipient's support system. Providers of adult rehabilitative mental
283.8 health services must develop the individual treatment plan within 30 calendar days of intake.
283.9 The treatment plan must be updated at least every six months thereafter, or more often when
283.10 there is significant change in the recipient's situation or functioning, or in services or service
283.11 methods to be used, or at the request of the recipient or the recipient's legal guardian.

283.12 (2) The individual treatment plan must include:

283.13 (i) a list of problems identified in the assessment;
283.14 (ii) the recipient's strengths and resources;
283.15 (iii) concrete, measurable goals to be achieved, including time frames for achievement;
283.16 (iv) specific objectives directed toward the achievement of each one of the goals;
283.17 (v) documentation of participants in the treatment planning. The recipient, if possible,
283.18 must be a participant. The recipient or the recipient's legal guardian must sign the treatment
283.19 plan, or documentation must be provided why this was not possible. A copy of the plan
283.20 must be given to the recipient or legal guardian. Referral to formal services must be arranged,
283.21 including specific providers where applicable;
283.22 (vi) cultural considerations, resources, and needs of the recipient must be included;
283.23 (vii) planned frequency and type of services must be initiated; and
283.24 (viii) clear progress notes on outcome of goals.

283.25 (3) The individual community support plan defined in section 245.462, subdivision 12,
283.26 may serve as the individual treatment plan if there is involvement of a mental health case
283.27 manager, and with the approval of the recipient. The individual community support plan
283.28 must include the criteria in clause (2).

283.29 Sec. 70. Minnesota Statutes 2018, section 256B.0623, subdivision 11, is amended to read:

283.30 Subd. 11. **Recipient file.** Providers of adult rehabilitative mental health services must
283.31 maintain a file for each recipient that contains the following information: according to
283.32 section 245I.32.

284.1 (1) diagnostic assessment or verification of its location that is current and that was
284.2 reviewed by a mental health professional who is employed by or under contract with the
284.3 provider entity;

284.4 (2) functional assessments;

284.5 (3) individual treatment plans signed by the recipient and the mental health professional,
284.6 or if the recipient refused to sign the plan, the date and reason stated by the recipient as to
284.7 why the recipient would not sign the plan;

284.8 (4) recipient history;

284.9 (5) signed release forms;

284.10 (6) recipient health information and current medications;

284.11 (7) emergency contacts for the recipient;

284.12 (8) case records which document the date of service, the place of service delivery,
284.13 signature of the person providing the service, nature, extent and units of service, and place
284.14 of service delivery;

284.15 (9) contacts, direct or by telephone, with recipient's family or others, other providers,
284.16 or other resources for service coordination;

284.17 (10) summary of recipient case reviews by staff; and

284.18 (11) written information by the recipient that the recipient requests be included in the
284.19 file.

284.20 Sec. 71. Minnesota Statutes 2018, section 256B.0623, subdivision 12, is amended to read:

284.21 Subd. 12. **Additional requirements.** (a) Providers of adult rehabilitative mental health
284.22 services must comply with the requirements relating to referrals for case management in
284.23 section 245.467, subdivision 4.

284.24 (b) Adult rehabilitative mental health services are provided for most recipients in the
284.25 recipient's home and community. Services may also be provided at the home of a relative
284.26 or significant other, job site, psychosocial clubhouse, drop-in center, social setting, classroom,
284.27 or other places in the community. Except for "transition to community services," the place
284.28 of service does not include a regional treatment center, nursing home, residential treatment
284.29 facility licensed under Minnesota Rules, parts 9520.0500 to 9520.0670 (Rule 36), or an
284.30 acute care hospital.

285.1 (c) Adult rehabilitative mental health services may be provided in group settings if
285.2 appropriate to each participating recipient's needs and treatment plan. A group is defined
285.3 as two to ten clients, at least one of whom is a recipient, who is concurrently receiving a
285.4 service which is identified in this section. The service and group must be specified in the
285.5 recipient's treatment plan. No more than two qualified staff may bill Medicaid for services
285.6 provided to the same group of recipients. If two adult rehabilitative mental health workers
285.7 bill for recipients in the same group session, they must each bill for different recipients.

285.8 (d) Adult rehabilitative mental health services are appropriate if provided to enable a
285.9 recipient to retain stability and functioning, when the recipient is at risk of significant
285.10 functional decompensation or requiring more restrictive service settings without these
285.11 services.

285.12 (e) Adult rehabilitative mental health services instruct, assist, and support the recipient
285.13 in areas including: interpersonal communication skills, community resource utilization and
285.14 integration skills, crisis planning, relapse prevention skills, health care directives, budgeting
285.15 and shopping skills, healthy lifestyle skills and practices, cooking and nutrition skills,
285.16 transportation skills, medication education and monitoring, mental illness symptom
285.17 management skills, household management skills, employment-related skills, parenting
285.18 skills, and transition to community living services.

285.19 Sec. 72. Minnesota Statutes 2018, section 256B.0624, subdivision 2, is amended to read:

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

285.22 (a) "Mental health crisis" is an adult behavioral, emotional, or psychiatric situation
285.23 which, but for the provision of crisis response services, would likely result in significantly
285.24 reduced levels of functioning in primary activities of daily living, or in an emergency
285.25 situation, or in the placement of the recipient in a more restrictive setting, including, but
285.26 not limited to, inpatient hospitalization.

285.27 (b) "Mental health emergency" is an adult behavioral, emotional, or psychiatric situation
285.28 which causes an immediate need for mental health services and is consistent with section
285.29 62Q.55.

285.30 A mental health crisis or emergency is determined for medical assistance service
285.31 reimbursement by a physician, a mental health professional, or ~~crisis mental health~~
285.32 ~~practitioner~~ qualified member of a crisis team with input from the recipient whenever
285.33 possible.

286.1 (c) "Mental health crisis assessment" means an immediate face-to-face assessment by
286.2 a physician, a mental health professional, or ~~mental health practitioner under the clinical~~
286.3 ~~supervision of a mental health professional, qualified member of a crisis team~~ following a
286.4 screening that suggests that the adult may be experiencing a mental health crisis or mental
286.5 health emergency situation. It includes, when feasible, assessing whether the person might
286.6 be willing to voluntarily accept treatment, determining whether the person has an advance
286.7 directive, and obtaining information and history from involved family members or caretakers.

286.8 (d) "Mental health mobile crisis intervention services" means face-to-face, short-term
286.9 intensive mental health services initiated during a mental health crisis or mental health
286.10 emergency to help the recipient cope with immediate stressors, identify and utilize available
286.11 resources and strengths, engage in voluntary treatment, and begin to return to the recipient's
286.12 baseline level of functioning. The services, including screening and treatment plan
286.13 recommendations, must be culturally and linguistically appropriate.

286.14 (1) This service is provided on site by a mobile crisis intervention team outside of an
286.15 inpatient hospital setting. Mental health mobile crisis intervention services must be available
286.16 24 hours a day, seven days a week.

286.17 (2) The initial screening must consider other available services to determine which
286.18 service intervention would best address the recipient's needs and circumstances.

286.19 (3) The mobile crisis intervention team must be available to meet promptly face-to-face
286.20 with a person in mental health crisis or emergency in a community setting or hospital
286.21 emergency room.

286.22 (4) The intervention must consist of a mental health crisis assessment and a crisis
286.23 treatment plan.

286.24 (5) The team must be available to individuals who are experiencing a co-occurring
286.25 substance use disorder, who do not need the level of care provided in a detoxification facility.

286.26 (6) The treatment plan must include recommendations for any needed crisis stabilization
286.27 services for the recipient, including engagement in treatment planning and family
286.28 psychoeducation.

286.29 (e) "Mental health crisis stabilization services" means individualized mental health
286.30 services provided to a recipient following crisis intervention services which are designed
286.31 to restore the recipient to the recipient's prior functional level. Mental health crisis
286.32 stabilization services may be provided in the recipient's home, the home of a family member
286.33 or friend of the recipient, another community setting, or a short-term supervised, licensed

287.1 residential program. Mental health crisis stabilization does not include partial hospitalization
287.2 or day treatment. Mental health crisis stabilization services includes family psychoeducation.

287.3 (f) "Clinical trainee" means a person qualified according to section 245I.16, subdivision
287.4 6.

287.5 (g) "Mental health certified family peer specialist" means a person qualified according
287.6 to section 245I.16, subdivision 12.

287.7 (h) "Mental health certified peer specialist" means a person qualified according to section
287.8 245I.16, subdivision 10.

287.9 (i) "Mental health practitioner" means a person qualified according to section 245I.16,
287.10 subdivision 4.

287.11 (j) "Mental health professional" means a person qualified according to section 245I.16,
287.12 subdivision 2.

287.13 (k) "Mental health rehabilitation worker" means a person qualified according to section
287.14 245I.16, subdivision 14.

287.15 Sec. 73. Minnesota Statutes 2018, section 256B.0624, subdivision 4, is amended to read:

287.16 Subd. 4. **Provider entity standards.** (a) A provider entity is an entity that meets the
287.17 standards listed in paragraph (c) and:

287.18 (1) is a county board operated entity; or

287.19 (2) is an Indian health service facility or facility owned and operated by a tribe or a tribal
287.20 organization operating under United States Code, title 25, section 450f; or

287.21 (3) is a provider entity that is under contract with the county board in the county where
287.22 the potential crisis or emergency is occurring. To provide services under this section, the
287.23 provider entity must directly provide the services; or if services are subcontracted, the
287.24 provider entity must maintain responsibility for services and billing.

287.25 (b) A provider entity that provides crisis stabilization services in a residential setting
287.26 under subdivision 7 is not required to meet the requirements of paragraph (a), clauses (1)
287.27 and (2) to (3), and paragraph (c), clauses (9), (20), and (21), but must meet all other
287.28 requirements of this subdivision. Upon approval by the commissioner, a residential crisis
287.29 services provider meeting relevant standards for supervision and assessment may allow a
287.30 practitioner to perform a crisis assessment to establish eligibility for admission to the
287.31 program. A provider performing an assessment under this paragraph shall not bill separately
287.32 beyond the daily rate for the residential stabilization program.

- 288.1 (c) The adult mental health crisis response services provider entity must have the capacity
288.2 to meet and carry out the requirements in chapter 245I and the following standards:
- 288.3 (1) has the capacity to recruit, hire, and manage and train ~~mental health professionals,~~
288.4 ~~practitioners, and rehabilitation workers~~ qualified staff;
- 288.5 (2) has adequate administrative ability to ensure availability of services;
- 288.6 (3) is able to ensure adequate preservice and in-service training;
- 288.7 (4) is able to ensure that staff providing these services are skilled in the delivery of
288.8 mental health crisis response services to recipients;
- 288.9 (5) is able to ensure that staff are capable of implementing culturally specific treatment
288.10 identified in the individual treatment plan that is meaningful and appropriate as determined
288.11 by the recipient's culture, beliefs, values, and language;
- 288.12 (6) is able to ensure enough flexibility to respond to the changing intervention and care
288.13 needs of a recipient as identified by the recipient during the service partnership between
288.14 the recipient and providers;
- 288.15 (7) is able to ensure that ~~mental health professionals and mental health practitioners~~ staff
288.16 have the communication tools and procedures to communicate and consult promptly about
288.17 crisis assessment and interventions as services occur;
- 288.18 (8) is able to coordinate these services with county emergency services, community
288.19 hospitals, ambulance, transportation services, social services, law enforcement, and mental
288.20 health crisis services through regularly scheduled interagency meetings;
- 288.21 (9) is able to ensure that mental health crisis assessment and mobile crisis intervention
288.22 services are available 24 hours a day, seven days a week;
- 288.23 (10) is able to ensure that services are coordinated with other mental health service
288.24 providers, county mental health authorities, or federally recognized American Indian
288.25 authorities and others as necessary, with the consent of the adult. Services must also be
288.26 coordinated with the recipient's case manager if the adult is receiving case management
288.27 services;
- 288.28 (11) is able to coordinate services with detoxification or withdrawal management services
288.29 to ensure a recipient receives care that is responsive to the recipient's chemical and mental
288.30 health needs;
- 288.31 (12) is able to ensure that crisis intervention services are provided in a manner consistent
288.32 with sections 245.461 to 245.486;

289.1 ~~(12)~~ (13) is able to submit information as required by the state;

289.2 ~~(13)~~ (14) maintains staff training and personnel files, including documentation of staff
289.3 completion of required training modules;

289.4 ~~(14)~~ (15) is able to establish and maintain a quality assurance and evaluation plan to
289.5 evaluate the outcomes of services and recipient satisfaction, including notifying recipients
289.6 of the process by which the provider, county, or tribe accepts and responds to concerns;

289.7 ~~(15)~~ (16) is able to keep records as required by applicable laws;

289.8 ~~(16)~~ (17) is able to comply with all applicable laws and statutes;

289.9 ~~(17)~~ (18) is an enrolled medical assistance provider; and

289.10 ~~(18)~~ (19) develops and maintains written policies and procedures regarding service
289.11 provision and administration of the provider entity, including safety of staff and recipients
289.12 in high-risk situations; ,

289.13 (20) is able to respond to a call for crisis services in a designated service area or according
289.14 to a written agreement with the local mental health authority for an adjacent area; and

289.15 (21) documents protocol used when delivering services by telemedicine, according to
289.16 sections 62A.67 to 62A.672, including responsibilities of the originating site, means to
289.17 promote recipient safety, timeliness for connection and response, and steps to take in the
289.18 event of a lost connection.

289.19 Sec. 74. Minnesota Statutes 2018, section 256B.0624, subdivision 5, is amended to read:

289.20 Subd. 5. **Mobile crisis intervention staff qualifications.** ~~For provision of adult mental~~
289.21 ~~health mobile crisis intervention services, a mobile crisis intervention team is comprised of~~
289.22 ~~at least two mental health professionals as defined in section 245.462, subdivision 18, clauses~~
289.23 ~~(1) to (6), or a combination of at least one mental health professional and one mental health~~
289.24 ~~practitioner as defined in section 245.462, subdivision 17, with the required mental health~~
289.25 ~~crisis training and under the clinical supervision of a mental health professional on the team.~~

289.26 (a) Mobile crisis intervention team staff must be qualified to provide services as mental
289.27 health professionals, mental health practitioners, clinical trainees, mental health certified
289.28 family peer specialists, or mental health certified peer specialists.

289.29 (b) A mobile crisis intervention team is comprised of at least two members, one of whom
289.30 must be qualified as a mental health professional. A second member must be qualified as
289.31 a mental health professional, clinical trainee, or mental health practitioner. A provider entity
289.32 must consider the needs of the area served when adding staff.

290.1 (c) Mental health crisis assessment and intervention services must be led by a mental
290.2 health professional, or under the supervision of a mental health professional according to
290.3 subdivision 9, by a clinical trainee or mental health practitioner.

290.4 (d) The team must have at least two people with at least one member providing on-site
290.5 crisis intervention services when needed. Team members must be experienced in mental
290.6 health assessment, crisis intervention techniques, treatment engagement strategies, working
290.7 with families, and clinical decision-making under emergency conditions and have knowledge
290.8 of local services and resources. The team must recommend and coordinate the team's services
290.9 with appropriate local resources such as the county social services agency, mental health
290.10 services, and local law enforcement when necessary.

290.11 Sec. 75. Minnesota Statutes 2018, section 256B.0624, subdivision 6, is amended to read:

290.12 **Subd. 6. Crisis assessment and mobile intervention treatment planning.** (a) Prior to
290.13 initiating mobile crisis intervention services, a screening of the potential crisis situation
290.14 must be conducted. The screening may use the resources of crisis assistance planning and
290.15 emergency services as defined in sections 245.462, subdivision 6, and 245.469, subdivisions
290.16 1 and 2. The screening must gather information, determine whether a crisis situation exists,
290.17 identify parties involved, and determine an appropriate response.

290.18 (b) In conducting the screening, a provider shall:

290.19 (1) employ evidence-based practices as identified by the commissioner in collaboration
290.20 with the commissioner of health to reduce the risk of the recipient's suicide and self-injurious
290.21 behavior;

290.22 (2) work with the recipient to establish a plan and time frame for responding to the crisis,
290.23 including immediate needs for support by telephone or text message until a face-to-face
290.24 response arrives;

290.25 (3) document significant factors related to the determination of a crisis, including prior
290.26 calls to the crisis team, recent presentation at an emergency department, known calls to 911
290.27 or law enforcement, or the presence of third parties with knowledge of a potential recipient's
290.28 history or current needs;

290.29 (4) screen for the needs of a third-party caller, including a recipient who primarily
290.30 identifies as a family member or a caregiver but also presents signs of a crisis; and

290.31 (5) provide psychoeducation, including education on the available means for reducing
290.32 self-harm, to relevant third parties, including family members or other persons living in the
290.33 home.

291.1 (c) A provider entity shall consider the following to indicate a positive screening unless

291.2 the provider entity documents specific evidence to show why crisis response was clinically
291.3 inappropriate:

291.4 (1) the recipient presented in an emergency department or urgent care setting, and the

291.5 health care team at that location requested crisis services; or

291.6 (2) a peace officer requested crisis services for a recipient who may be subject to

291.7 transportation under section 253B.05 for a mental health crisis.

291.8 ~~(b)~~ (d) If a crisis exists, a crisis assessment must be completed. A crisis assessment

291.9 evaluates any immediate needs for which emergency services are needed and, as time
291.10 permits, the recipient's current life situation, sources of stress, mental health problems and

291.11 symptoms, strengths, cultural considerations, support network, vulnerabilities, current

291.12 functioning, and the recipient's preferences as communicated directly by the recipient, or

291.13 as communicated in a health care directive as described in chapters 145C and 253B, the

291.14 treatment plan described under paragraph (d), a crisis prevention plan, or a wellness recovery

291.15 action plan.

291.16 ~~(e)~~ (e) If the crisis assessment determines mobile crisis intervention services are needed,

291.17 the intervention services must be provided promptly. As opportunity presents during the
291.18 intervention, at least two members of the mobile crisis intervention team must confer directly

291.19 or by telephone about the assessment, treatment plan, and actions taken and needed. At least

291.20 one of the team members must be on site providing crisis intervention services. If providing

291.21 on-site crisis intervention services, a mental health practitioner must seek ~~clinical~~ treatment

291.22 supervision as required in subdivision 9.

291.23 (f) Direct contact with the recipient is not required before initiating a crisis assessment

291.24 or intervention service. A crisis team may gather relevant information from a third party at

291.25 the scene to establish the need for services and potential safety factors. A crisis assessment

291.26 is provided face-to-face by a mobile crisis intervention team outside of an inpatient hospital

291.27 setting. A service must be provided promptly and respond to the recipient's location whenever

291.28 possible, including community or clinical settings. As clinically appropriate, a mobile crisis

291.29 intervention team must coordinate a response with other health care providers if a recipient

291.30 requires detoxification, withdrawal management, or medical stabilization services in addition

291.31 to crisis services.

291.32 ~~(d)~~ (g) The mobile crisis intervention team must develop an initial, brief crisis treatment

291.33 plan as soon as appropriate but no later than 24 hours after the initial face-to-face intervention.

291.34 The plan must address the needs and problems noted in the crisis assessment and include

292.1 measurable short-term goals, cultural considerations, and frequency and type of services to
292.2 be provided to achieve the goals and reduce or eliminate the crisis. The treatment plan must
292.3 be updated as needed to reflect current goals and services.

292.4 ~~(e)~~ (h) The team must document which short-term goals have been met and when no
292.5 further crisis intervention services are required. If after an assessment a crisis provider entity
292.6 refers a recipient to an intensive setting, including an emergency department, in-patient
292.7 hospitalization, or crisis residential treatment, one of the crisis team members who performed
292.8 or conferred on the assessment must immediately contact the provider entity and consult
292.9 with the triage nurse or other staff responsible for intake. The crisis team member must
292.10 convey key findings or concerns that led to the referral. The consultation shall occur with
292.11 the recipient's consent, the recipient's legal guardian's consent, or as allowed by section
292.12 144.293, subdivision 5. Any available written documentation, including a crisis treatment
292.13 plan, must be sent no later than the next business day.

292.14 ~~(f)~~ (i) If the recipient's crisis is stabilized, but the recipient needs a referral to other
292.15 services, the team must provide referrals to these services. If the recipient has a case manager,
292.16 planning for other services must be coordinated with the case manager. If the recipient is
292.17 unable to follow up on the referral, the team must link the recipient to the service and follow
292.18 up to ensure the recipient is receiving the service.

292.19 ~~(g)~~ (j) If the recipient's crisis is stabilized and the recipient does not have an advance
292.20 directive, the case manager or crisis team shall offer to work with the recipient to develop
292.21 one.

292.22 Sec. 76. Minnesota Statutes 2018, section 256B.0624, subdivision 8, is amended to read:

292.23 Subd. 8. **Adult crisis stabilization staff qualifications.** (a) Adult mental health crisis
292.24 stabilization services must be provided by qualified individual staff of a qualified provider
292.25 entity. Individual provider staff must ~~have the following qualifications be:~~

292.26 (1) ~~be a mental health professional as defined in section 245.462, subdivision 18, clauses~~
292.27 ~~(1) to (6);~~

292.28 (2) ~~be a mental health practitioner as defined in section 245.462, subdivision 17. The~~
292.29 ~~mental health practitioner must work under the clinical supervision of a mental health~~
292.30 ~~professional;~~

292.31 (3) ~~be a mental health certified peer specialist under section 256B.0615. The certified~~
292.32 ~~peer specialist must work under the clinical supervision of a mental health professional; or~~

293.1 (4) be a mental health rehabilitation worker ~~who meets the criteria in section 256B.0623, subdivision 5, paragraph (a), clause (4); works under the direction of a mental health practitioner as defined in section 245.462, subdivision 17, or under direction of a mental health professional; and works under the clinical supervision of a mental health professional.~~

293.5 (b) Mental health practitioners, clinical trainees, and mental health rehabilitation workers must have completed at least 30 hours of training in crisis intervention and stabilization during the past two years.

293.8 Sec. 77. Minnesota Statutes 2018, section 256B.0624, subdivision 9, is amended to read:

293.9 Subd. 9. **Supervision.** Mental health practitioners or clinical trainees may provide crisis assessment and mobile crisis intervention services if the following clinical treatment supervision requirements are met:

293.12 (1) the mental health provider entity must accept full responsibility for the services provided;

293.14 (2) the mental health professional of the provider entity, who is an employee or under contract with the provider entity, must be immediately available by phone or in person for clinical supervision;

293.17 (3) the mental health professional is consulted, in person or by phone, during the first three hours when a mental health practitioner or clinical trainee provides on-site service;

293.19 (4) the mental health professional must:

293.20 (i) review and approve of the tentative crisis assessment and crisis treatment plan;

293.21 (ii) document the consultation; and

293.22 (iii) sign the crisis assessment and treatment plan within the next business day; and

293.23 ~~(5) if the mobile crisis intervention services continue into a second calendar day, a mental health professional must contact the recipient face-to-face on the second day to provide services and update the crisis treatment plan; and~~

293.26 ~~(6)~~ (5) the on-site observation must be documented in the recipient's record and signed by the mental health professional.

293.28 Sec. 78. Minnesota Statutes 2018, section 256B.0624, subdivision 10, is amended to read:

293.29 Subd. 10. **Recipient file.** Providers of mobile crisis intervention or crisis stabilization services must maintain a file for each recipient containing the following information:

294.1 (1) individual crisis treatment plans signed by the recipient, mental health professional,
294.2 and mental health practitioner who developed the crisis treatment plan, or if the recipient
294.3 refused to sign the plan, the date and reason stated by the recipient as to why the recipient
294.4 would not sign the plan;

294.5 (2) signed release forms;

294.6 (3) recipient health information and current medications;

294.7 (4) emergency contacts for the recipient;

294.8 (5) case records which document the date of service, place of service delivery, signature
294.9 of the person providing the service, and the nature, extent, and units of service. Direct or
294.10 telephone contact with the recipient's family or others should be documented;

294.11 (6) required ~~clinical~~ treatment supervision by mental health professionals;

294.12 (7) summary of the recipient's case reviews by staff;

294.13 (8) any written information by the recipient that the recipient wants in the file; and

294.14 (9) an advance directive, if there is one available.

294.15 Documentation in the file must comply with all requirements of the commissioner.

294.16 Sec. 79. Minnesota Statutes 2018, section 256B.0624, subdivision 11, is amended to read:

294.17 Subd. 11. **Treatment plan.** The individual crisis stabilization treatment plan must include,
294.18 at a minimum:

294.19 (1) a list of problems identified in the assessment;

294.20 (2) a list of the recipient's strengths and resources;

294.21 (3) concrete, measurable short-term goals and tasks to be achieved, including time frames
294.22 for achievement;

294.23 (4) specific objectives directed toward the achievement of each one of the goals;

294.24 (5) documentation of the participants involved in the service planning. The recipient, if
294.25 possible, must be a participant. The recipient or the recipient's legal guardian must sign the
294.26 service plan or documentation must be provided why this was not possible. A copy of the
294.27 plan must be given to the recipient and the recipient's legal guardian. The plan should include
294.28 services arranged, including specific providers where applicable;

294.29 (6) planned frequency and type of services initiated;

294.30 (7) a crisis response action plan if a crisis should occur;

295.1 (8) clear progress notes on outcome of goals;

295.2 (9) a written plan must be completed within 24 hours of beginning services with the
295.3 recipient; and

295.4 (10) a treatment plan must be developed by a mental health professional, clinical trainee,

295.5 or mental health practitioner ~~under the clinical supervision of a mental health professional~~.

295.6 The mental health professional must approve and sign all treatment plans.

295.7 Sec. 80. Minnesota Statutes 2018, section 256B.0625, subdivision 3b, is amended to read:

295.8 Subd. 3b. **Telemedicine services.** (a) Medical assistance covers medically necessary
295.9 services and consultations delivered by a licensed health care provider via telemedicine in
295.10 the same manner as if the service or consultation was delivered in person. Coverage is
295.11 limited to three telemedicine services per enrollee per calendar week. Telemedicine services
295.12 shall be paid at the full allowable rate.

295.13 (b) The commissioner shall establish criteria that a health care provider must attest to
295.14 in order to demonstrate the safety or efficacy of delivering a particular service via
295.15 telemedicine. The attestation may include that the health care provider:

295.16 (1) has identified the categories or types of services the health care provider will provide
295.17 via telemedicine;

295.18 (2) has written policies and procedures specific to telemedicine services that are regularly
295.19 reviewed and updated;

295.20 (3) has policies and procedures that adequately address patient safety before, during,
295.21 and after the telemedicine service is rendered;

295.22 (4) has established protocols addressing how and when to discontinue telemedicine
295.23 services; and

295.24 (5) has an established quality assurance process related to telemedicine services.

295.25 (c) As a condition of payment, a licensed health care provider must document each
295.26 occurrence of a health service provided by telemedicine to a medical assistance enrollee.
295.27 Health care service records for services provided by telemedicine must meet the requirements
295.28 set forth in Minnesota Rules, part 9505.2175, subparts 1 and 2, and must document:

295.29 (1) the type of service provided by telemedicine;

295.30 (2) the time the service began and the time the service ended, including an a.m. and p.m.
295.31 designation;

296.1 (3) the licensed health care provider's basis for determining that telemedicine is an
296.2 appropriate and effective means for delivering the service to the enrollee;

296.3 (4) the mode of transmission of the telemedicine service and records evidencing that a
296.4 particular mode of transmission was utilized;

296.5 (5) the location of the originating site and the distant site;

296.6 (6) if the claim for payment is based on a physician's telemedicine consultation with
296.7 another physician, the written opinion from the consulting physician providing the
296.8 telemedicine consultation; and

296.9 (7) compliance with the criteria attested to by the health care provider in accordance
296.10 with paragraph (b).

296.11 (d) For purposes of this subdivision, unless otherwise covered under this chapter,
296.12 "telemedicine" is defined as the delivery of health care services or consultations while the
296.13 patient is at an originating site and the licensed health care provider is at a distant site. A
296.14 communication between licensed health care providers, or a licensed health care provider
296.15 and a patient that consists solely of a telephone conversation, e-mail, or facsimile transmission
296.16 does not constitute telemedicine consultations or services. Telemedicine may be provided
296.17 by means of real-time two-way, interactive audio and visual communications, including the
296.18 application of secure video conferencing or store-and-forward technology to provide or
296.19 support health care delivery, which facilitate the assessment, diagnosis, consultation,
296.20 treatment, education, and care management of a patient's health care.

296.21 (e) For purposes of this section, "licensed health care provider" means a licensed health
296.22 care provider under section 62A.671, subdivision 6, a clinical trainee, and a mental health
296.23 practitioner defined under section 245.462, subdivision 17, ~~or 245.4871, subdivision 26~~,
296.24 working under the general supervision of a mental health professional; "health care provider"
296.25 is defined under section 62A.671, subdivision 3; and "originating site" is defined under
296.26 section 62A.671, subdivision 7.

296.27 Sec. 81. Minnesota Statutes 2018, section 256B.0625, subdivision 5, is amended to read:

296.28 Subd. 5. **Community mental health center services.** Medical assistance covers
296.29 community mental health center services provided by a community mental health center
296.30 that meets the requirements in paragraphs (a) to (j).

296.31 (a) The provider is licensed under Minnesota Rules, parts 9520.0750 to 9520.0870, and
296.32 in compliance with requirements under chapter 245I and section 256B.0671.

297.1 (b) The provider provides mental health services under the ~~clinical treatment~~ supervision

297.2 of a mental health professional who is licensed for independent practice at the doctoral level
297.3 or by a board-certified psychiatrist or a psychiatrist who is eligible for board certification.

297.4 ~~Clinical supervision has the meaning given in Minnesota Rules, part 9505.0370, subpart 6.~~

297.5 Treatment supervision means the treatment supervision described under section 245I.18.

297.6 (c) The provider must be a private nonprofit corporation or a governmental agency and

297.7 have a community board of directors as specified by section 245.66.

297.8 (d) The provider must have a sliding fee scale that meets the requirements in section

297.9 245.481, and agree to serve within the limits of its capacity all individuals residing in its

297.10 service delivery area.

297.11 (e) At a minimum, the provider must provide the following outpatient mental health

297.12 services: diagnostic assessment; explanation of findings; and family, group, and individual

297.13 psychotherapy, including crisis intervention psychotherapy services; ~~multiple family group~~

297.14 ~~psychotherapy~~, psychological testing, and medication management. In addition, the provider

297.15 must provide or be capable of providing upon request of the local mental health authority

297.16 day treatment services, multiple family group psychotherapy, and professional home-based

297.17 mental health services. The provider must have the capacity to provide such services to

297.18 specialized populations such as the elderly, families with children, persons who are seriously

297.19 and persistently mentally ill, and children who are seriously emotionally disturbed.

297.20 (f) The provider must be capable of providing the services specified in paragraph (e) to

297.21 individuals who are dually diagnosed with both a mental illness or emotional disturbance;

297.22 ~~and ehemical dependency~~ substance use disorder, and to individuals who are dually diagnosed

297.23 with a mental illness or emotional disturbance and developmental disability.

297.24 (g) The provider must provide 24-hour emergency care services or demonstrate the

297.25 capacity to assist recipients in need of such services to access such services on a 24-hour

297.26 basis.

297.27 (h) The provider must have a contract with the local mental health authority to provide

297.28 one or more of the services specified in paragraph (e).

297.29 (i) The provider must agree, upon request of the local mental health authority, to enter

297.30 into a contract with the county to provide mental health services not reimbursable under

297.31 the medical assistance program.

297.32 (j) The provider may not be enrolled with the medical assistance program as both a

297.33 hospital and a community mental health center. The community mental health center's

298.1 administrative, organizational, and financial structure must be separate and distinct from
298.2 that of the hospital.

298.3 Sec. 82. Minnesota Statutes 2018, section 256B.0625, subdivision 5l, is amended to read:

298.4 **Subd. 5l. Intensive mental health outpatient treatment.** (a) Medical assistance covers
298.5 intensive mental health outpatient treatment for dialectical behavioral therapy for adults.

298.6 The commissioner shall establish:

298.7 (1) certification procedures to ensure that providers of these services are qualified and
298.8 meet the standards in chapter 245I; and

298.9 (2) treatment protocols including required service components and criteria for admission,
298.10 continued treatment, and discharge.

298.11 (b) "Dialectical behavior therapy" means an evidence-based treatment approach provided
298.12 in an intensive outpatient treatment program using a combination of individualized
298.13 rehabilitative and psychotherapeutic interventions. A dialectical behavior therapy program
298.14 involves the following service components: individual dialectical behavior therapy, group
298.15 skills training, telephone coaching, and team consultation meetings.

298.16 (c) To be eligible for dialectical behavior therapy a client must:

298.17 (1) be 18 years of age or older;

298.18 (2) have mental health needs that cannot be met with other available community-based
298.19 services or that must be provided concurrently with other community-based services;

298.20 (3) meet one of the following criteria:

298.21 (i) have a diagnosis of borderline personality disorder; or

298.22 (ii) have multiple mental health diagnoses, exhibit behaviors characterized by impulsivity
298.23 or intentional self-harm, and be at significant risk of death, morbidity, disability, or severe
298.24 dysfunction across multiple life areas;

298.25 (4) understand and be cognitively capable of participating in dialectical behavior therapy
298.26 as an intensive therapy program and be able and willing to follow program policies and
298.27 rules ensuring safety of self and others; and

298.28 (5) be at significant risk of one or more of the following if dialectical behavior therapy
298.29 is not provided:

298.30 (i) having a mental health crisis;

298.31 (ii) requiring a more restrictive setting including hospitalization;

- 299.1 (iii) decompensation; or
- 299.2 (iv) engaging in intentional self-harm behavior.
- 299.3 (d) Individual dialectical behavior therapy combines individualized rehabilitative and
- 299.4 psychotherapeutic interventions to treat suicidal and other dysfunctional behaviors and
- 299.5 reinforce the use of adaptive skillful behaviors. Individual dialectical behavior therapy must
- 299.6 be provided by a mental health professional or a clinical trainee. The mental health
- 299.7 professional or clinical trainee must:
- 299.8 (1) identify, prioritize, and sequence behavioral targets;
- 299.9 (2) treat behavioral targets;
- 299.10 (3) generalize dialectical behavior therapy skills to the client's natural environment
- 299.11 through telephone coaching outside of the treatment session;
- 299.12 (4) measure the client's progress toward dialectical behavior therapy targets;
- 299.13 (5) help the client manage mental health crises and life-threatening behaviors; and
- 299.14 (6) help the client learn and apply effective behaviors when working with other treatment
- 299.15 providers.
- 299.16 (e) Group skills training combines individualized psychotherapeutic and psychiatric
- 299.17 rehabilitative interventions conducted in a group setting to reduce the client's suicidal and
- 299.18 other dysfunctional coping behaviors and restore function. Group skills training must teach
- 299.19 the client adaptive skills in the following areas:
- 299.20 (1) mindfulness;
- 299.21 (2) interpersonal effectiveness;
- 299.22 (3) emotional regulation; and
- 299.23 (4) distress tolerance.
- 299.24 (f) Group skills training must be provided by two mental health professionals, or by a
- 299.25 mental health professional co-facilitating with a clinical trainee or a mental health practitioner
- 299.26 as specified in section 245I.16, subdivision 4. Individual skills training must be provided
- 299.27 by a mental health professional, a clinical trainee, or a mental health practitioner as specified
- 299.28 in section 245I.16, subdivision 4.
- 299.29 (g) A program must be certified by the commissioner as a dialectical behavior therapy
- 299.30 provider. To qualify for certification, a provider must:

300.1 (1) hold current accreditation as a dialectical behavior therapy program from a nationally
300.2 recognized certification body approved by the commissioner;

300.3 (2) submit to the commissioner's inspection;

300.4 (3) provide evidence that the dialectical behavior therapy program's policies, procedures,
300.5 and practices continuously meet the requirements of this subdivision;

300.6 (4) be enrolled as a MHCP provider;

300.7 (5) collect and report client outcomes as specified by the commissioner; and

300.8 (6) have a manual that outlines the dialectical behavior therapy program's policies,
300.9 procedures, and practices that meet the requirements of this subdivision.

300.10 Sec. 83. Minnesota Statutes 2018, section 256B.0625, subdivision 19c, is amended to
300.11 read:

300.12 Subd. 19c. **Personal care.** Medical assistance covers personal care assistance services
300.13 provided by an individual who is qualified to provide the services according to subdivision
300.14 19a and sections 256B.0651 to 256B.0654, provided in accordance with a plan, and
300.15 supervised by a qualified professional.

300.16 "Qualified professional" means a mental health professional as defined in section 245.462,
300.17 subdivision 18, ~~clauses (1) to (6)~~, or 245.4871, subdivision 27, ~~clauses (1) to (6)~~; a registered
300.18 nurse as defined in sections 148.171 to 148.285, a licensed social worker as defined in
300.19 sections 148E.010 and 148E.055, or a qualified designated coordinator under section
300.20 245D.081, subdivision 2. The qualified professional shall perform the duties required in
300.21 section 256B.0659.

300.22 Sec. 84. Minnesota Statutes 2018, section 256B.0625, subdivision 23, is amended to read:

300.23 Subd. 23. **Adult day treatment services.** (a) Medical assistance covers adult day
300.24 treatment services as specified in sections 245.462, subdivision 8, and 245.4871, subdivision
300.25 10, that are provided under contract with the county board. The commissioner may set
300.26 authorization thresholds for day treatment for adults according to subdivision 25. Medical
300.27 assistance covers day treatment services for children as specified under section 256B.0943.
300.28 Adult day treatment payment is limited to the conditions in paragraphs (b) to (e).

300.29 (b) Adult day treatment is an intensive psychotherapeutic treatment to reduce or relieve
300.30 the effects of mental illness to enable the client to benefit from a lower level of care and to
300.31 live and function more independently in the community. Adult day treatment services must

301.1 stabilize the client's mental health status and develop and improve the client's independent
301.2 living and socialization skills. Adult day treatment must consist of at least one hour of group
301.3 psychotherapy and must include group time focused on rehabilitative interventions or other
301.4 therapeutic services that are provided by a multidisciplinary staff person. Adult day treatment
301.5 services are not a part of inpatient or residential treatment services.

301.6 (c) To be eligible for medical assistance payment, an adult day treatment service must:

301.7 (1) be reviewed by and approved by the commissioner;

301.8 (2) be provided to a group of clients by a multidisciplinary staff person under the
301.9 treatment supervision of a mental health professional as described under section 245I.18;

301.10 (3) be available to the client at least two days a week for at least three consecutive hours
301.11 per day. The adult day treatment may be longer than three hours per day, but medical
301.12 assistance must not reimburse a provider for more than 15 hours per week;

301.13 (4) include group psychotherapy by a mental health professional or clinical trainee and
301.14 daily rehabilitative interventions by a mental health professional qualified according to
301.15 section 245I.16, subdivision 2, clinical trainee qualified according to section 245I.16,
301.16 subdivision 6, or mental health practitioner qualified according to section 245I.16, subdivision
301.17 4;

301.18 (5) be included in the client's individual treatment plan as described under section
301.19 256B.0671, subdivisions 5 and 6, as appropriate. The individual treatment plan must include
301.20 attainable, measurable goals related to services and must be completed before the first adult
301.21 day treatment session. The vendor must review the client's progress and update the treatment
301.22 plan at least every 30 days until the client is discharged and include an available discharge
301.23 plan for the client in the treatment plan; and

301.24 (6) document the daily interventions provided and the client's response according to
301.25 section 245I.33.

301.26 (d) To be eligible for adult day treatment, a client must:

301.27 (1) be 18 years of age or older;

301.28 (2) not be residing in a nursing facility, hospital, institute of mental disease, or regional
301.29 treatment center unless the client has an active discharge plan that indicates a move to an
301.30 independent living arrangement within 180 days;

301.31 (3) have a diagnosis of mental illness as determined by a diagnostic assessment;

302.1 (4) have the capacity to engage in the rehabilitative nature, the structured setting, and
302.2 the therapeutic parts of psychotherapy and skills activities of an adult day treatment program
302.3 and demonstrate measurable improvements in the client's functioning related to the client's
302.4 mental illness that would result from participating in the adult day treatment program;

302.5 (5) have at least three areas of functional impairment as determined by a functional
302.6 assessment with the domains prescribed by section 245.462, subdivision 11a;

302.7 (6) have a level of care determination that supports the need for the level of intensity
302.8 and duration of an adult day treatment program; and

302.9 (7) be determined to need adult day treatment services by a mental health professional
302.10 who must deem the adult day treatment services medically necessary.

302.11 (e) The following services are not covered by medical assistance as an adult day treatment
302.12 service:

302.13 (1) a service that is primarily recreation-oriented or that is provided in a setting that is
302.14 not medically supervised. This includes sports activities, exercise groups, craft hours, leisure
302.15 time, social hours, meal or snack time, trips to community activities, and tours;

302.16 (2) a social or educational service that does not have or cannot reasonably be expected
302.17 to have a therapeutic outcome related to the client's mental illness;

302.18 (3) consultation with other providers or service agency staff persons about the care or
302.19 progress of a client;

302.20 (4) prevention or education programs provided to the community;

302.21 (5) day treatment for clients with primary diagnoses of alcohol or other drug abuse;

302.22 (6) day treatment provided in the client's home;

302.23 (7) psychotherapy for more than two hours per day; and

302.24 (8) participation in meal preparation and eating that is not part of a clinical treatment
302.25 plan to address the client's eating disorder.

302.26 Sec. 85. Minnesota Statutes 2018, section 256B.0625, subdivision 42, is amended to read:

302.27 Subd. 42. **Mental health professional.** Notwithstanding Minnesota Rules, part
302.28 9505.0175, subpart 28, the definition of a mental health professional shall include a person
302.29 who is qualified as specified in section 245.462, subdivision 18, ~~clauses (1) to (6)~~; or
302.30 245.4871, subdivision 27, ~~clauses (1) to (6)~~, for the purpose of this section and Minnesota
302.31 Rules, parts 9505.0170 to 9505.0475.

303.1 Sec. 86. Minnesota Statutes 2018, section 256B.0625, subdivision 48, is amended to read:

303.2 Subd. 48. **Psychiatric consultation to primary care practitioners.** Medical assistance
303.3 covers consultation provided by a ~~psychiatrist, a psychologist, an advanced practice registered~~
303.4 ~~nurse certified in psychiatric mental health, a licensed independent clinical social worker,~~
303.5 ~~as defined in section 245.462, subdivision 18, clause (2), or a licensed marriage and family~~
303.6 ~~therapist, as defined in section 245.462, subdivision 18, clause (5), mental health professional~~
303.7 ~~except one licensed under section 148B.5301~~ via telephone, e-mail, facsimile, or other
303.8 means of communication to primary care practitioners, including pediatricians. The need
303.9 for consultation and the receipt of the consultation must be documented in the patient record
303.10 maintained by the primary care practitioner. If the patient consents, and subject to federal
303.11 limitations and data privacy provisions, the consultation may be provided without the patient
303.12 present.

303.13 Sec. 87. Minnesota Statutes 2018, section 256B.0625, subdivision 49, is amended to read:

303.14 Subd. 49. **Community health worker.** (a) Medical assistance covers the care
303.15 coordination and patient education services provided by a community health worker if the
303.16 community health worker has: (1) received a certificate from the Minnesota State Colleges
303.17 and Universities System approved community health worker curriculum; or

303.18 (2) at least five years of supervised experience with an enrolled physician, registered
303.19 nurse, advanced practice registered nurse, mental health professional as defined in section
303.20 245.462, subdivision 18, clauses (1) to (6), and section 245.4871, subdivision 27, clauses
303.21 (1) to (5), or dentist, or at least five years of supervised experience by a certified public
303.22 health nurse operating under the direct authority of an enrolled unit of government.

303.23 Community health workers eligible for payment under clause (2) must complete the
303.24 certification program by January 1, 2010, to continue to be eligible for payment.

303.25 (b) Community health workers must work under the supervision of a medical assistance
303.26 enrolled physician, registered nurse, advanced practice registered nurse, mental health
303.27 professional as defined in section 245.462, subdivision 18, clauses (1) to (6), and section
303.28 245.4871, subdivision 27, clauses (1) to (5), or dentist, or work under the supervision of a
303.29 certified public health nurse operating under the direct authority of an enrolled unit of
303.30 government.

303.31 (c) Care coordination and patient education services covered under this subdivision
303.32 include, but are not limited to, services relating to oral health and dental care.

304.1 Sec. 88. Minnesota Statutes 2018, section 256B.0625, subdivision 56a, is amended to
304.2 read:

304.3 **Subd. 56a. Post-arrest community-based service coordination.** (a) Medical assistance
304.4 covers post-arrest community-based service coordination for an individual who:

304.5 (1) has been identified as having a mental illness or substance use disorder using a
304.6 screening tool approved by the commissioner;

304.7 (2) does not require the security of a public detention facility and is not considered an
304.8 inmate of a public institution as defined in Code of Federal Regulations, title 42, section
304.9 435.1010;

304.10 (3) meets the eligibility requirements in section 256B.056; and

304.11 (4) has agreed to participate in post-arrest community-based service coordination through
304.12 a diversion contract in lieu of incarceration.

304.13 (b) Post-arrest community-based service coordination means navigating services to
304.14 address a client's mental health, chemical health, social, economic, and housing needs, or
304.15 any other activity targeted at reducing the incidence of jail utilization and connecting
304.16 individuals with existing covered services available to them, including, but not limited to,
304.17 targeted case management, waiver case management, or care coordination.

304.18 (c) Post-arrest community-based service coordination must be provided by an individual
304.19 who is an employee of a county or is under contract with a county to provide post-arrest
304.20 community-based coordination and is qualified under one of the following criteria:

304.21 (1) a licensed mental health professional as defined in section 245.462, subdivision 18;
304.22 ~~clauses (1) to (6);~~

304.23 (2) a mental health practitioner as defined in section 245.462, subdivision 17, working
304.24 under the clinical treatment supervision of a mental health professional; or

304.25 (3) a certified peer specialist under section 256B.0615, working under the clinical
304.26 treatment supervision of a mental health professional; or

304.27 (4) a clinical trainee.

304.28 (d) Reimbursement is allowed for up to 60 days following the initial determination of
304.29 eligibility.

304.30 (e) Providers of post-arrest community-based service coordination shall annually report
304.31 to the commissioner on the number of individuals served, and number of the
304.32 community-based services that were accessed by recipients. The commissioner shall ensure

305.1 that services and payments provided under post-arrest community-based service coordination
305.2 do not duplicate services or payments provided under section 256B.0625, subdivision 20,
305.3 256B.0753, 256B.0755, or 256B.0757.

305.4 (f) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of cost for
305.5 post-arrest community-based service coordination services shall be provided by the county
305.6 providing the services, from sources other than federal funds or funds used to match other
305.7 federal funds.

305.8 Sec. 89. Minnesota Statutes 2018, section 256B.0625, subdivision 61, is amended to read:

305.9 Subd. 61. **Family psychoeducation services.** ~~Effective July 1, 2013, or upon federal~~
305.10 ~~approval, whichever is later,~~ Medical assistance covers family psychoeducation services
305.11 provided to a child up to age 21 with a diagnosed mental health condition when identified
305.12 in the child's individual treatment plan and provided by a licensed mental health professional;
305.13 ~~as defined in Minnesota Rules, part 9505.0371, subpart 5, item A,~~ or a clinical trainee, ~~as~~
305.14 ~~defined in Minnesota Rules, part 9505.0371, subpart 5, item C,~~ who has determined it
305.15 medically necessary to involve family members in the child's care. For the purposes of this
305.16 subdivision, "family psychoeducation services" means information or demonstration provided
305.17 to an individual or family as part of an individual, family, multifamily group, or peer group
305.18 session to explain, educate, and support the child and family in understanding a child's
305.19 symptoms of mental illness, the impact on the child's development, and needed components
305.20 of treatment and skill development so that the individual, family, or group can help the child
305.21 to prevent relapse, prevent the acquisition of comorbid disorders, and achieve optimal mental
305.22 health and long-term resilience.

305.23 Sec. 90. Minnesota Statutes 2018, section 256B.0625, subdivision 62, is amended to read:

305.24 Subd. 62. **Mental health clinical care consultation.** ~~Effective July 1, 2013, or upon~~
305.25 ~~federal approval, whichever is later,~~ Medical assistance covers clinical care consultation
305.26 for a person up to age 21 who is diagnosed with a complex mental health condition or a
305.27 mental health condition that co-occurs with other complex and chronic conditions, when
305.28 described in the person's individual treatment plan and provided by a licensed mental health
305.29 professional, ~~as defined in Minnesota Rules, part 9505.0371, subpart 5, item A,~~ or a clinical
305.30 trainee, ~~as defined in Minnesota Rules, part 9505.0371, subpart 5, item C.~~ For the purposes
305.31 of this subdivision, "clinical care consultation" means communication from a treating mental
305.32 health professional to other providers or educators not under the clinical supervision of the
305.33 treating mental health professional who are working with the same client to inform, inquire,

306.1 and instruct regarding the client's symptoms; strategies for effective engagement, care, and
306.2 intervention needs; and treatment expectations across service settings; and to direct and
306.3 coordinate clinical service components provided to the client and family.

306.4 Sec. 91. Minnesota Statutes 2018, section 256B.0625, subdivision 65, is amended to read:

306.5 **Subd. 65. Outpatient mental health services.** For the purposes of this section, "clinical
306.6 trainee" has the meaning given in section 245I.16, subdivision 6. Medical assistance covers
306.7 diagnostic assessment, explanation of findings, and psychotherapy according to Minnesota
306.8 Rules, part 9505.0372, subdivision 69 and section 256B.0671 when the mental health
306.9 services are performed by a mental health practitioner working as a clinical trainee according
306.10 to section 245.462, subdivision 17, paragraph (g).

306.11 Sec. 92. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision
306.12 to read:

306.13 **Subd. 66. Neuropsychological assessment.** (a) "Neuropsychological assessment" means
306.14 a specialized clinical assessment of the client's underlying cognitive abilities related to
306.15 thinking, reasoning, and judgment that is conducted by a qualified neuropsychologist. A
306.16 neuropsychological assessment must include a face-to-face interview with the client,
306.17 interpretation of the test results, and preparation and completion of a report.

306.18 (b) A client is eligible for a neuropsychological assessment if at least one of the following
306.19 criteria is met:

306.20 (1) there is a known or strongly suspected brain disorder based on medical history or
306.21 neurological evaluation, including a history of significant head trauma, brain tumor, stroke,
306.22 seizure disorder, multiple sclerosis, neurodegenerative disorder, significant exposure to
306.23 neurotoxins, central nervous system infection, metabolic or toxic encephalopathy, fetal
306.24 alcohol syndrome, or congenital malformation of the brain; or

306.25 (2) there are cognitive or behavioral symptoms that suggest that the client has an organic
306.26 condition that cannot be readily attributed to functional psychopathology or suspected
306.27 neuropsychological impairment in addition to functional psychopathology. This includes:

- 306.28 (i) poor memory or impaired problem solving;
306.29 (ii) change in mental status evidenced by lethargy, confusion, or disorientation;
306.30 (iii) deterioration in level of functioning;
306.31 (iv) marked behavioral or personality change;

307.1 (v) in children or adolescents, significant delays in academic skill acquisition or poor
307.2 attention relative to peers;

307.3 (vi) in children or adolescents, significant plateau in expected development of cognitive,
307.4 social, emotional, or physical function relative to peers; and

307.5 (vii) in children or adolescents, significant inability to develop expected knowledge,
307.6 skills, or abilities as required to adapt to new or changing cognitive, social, emotional, or
307.7 physical demands.

307.8 (c) The neuropsychological assessment must be conducted by a neuropsychologist
307.9 competent in the area of neuropsychological assessment who:

307.10 (1) was awarded a diploma by the American Board of Clinical Neuropsychology, the
307.11 American Board of Professional Neuropsychology, or the American Board of Pediatric
307.12 Neuropsychology;

307.13 (2) earned a doctoral degree in psychology from an accredited university training program
307.14 and:

307.15 (i) completed an internship or its equivalent in a clinically relevant area of professional
307.16 psychology;

307.17 (ii) completed the equivalent of two full-time years of experience and specialized training,
307.18 at least one of which is at the postdoctoral level, supervised by a clinical neuropsychologist
307.19 in the study and practice of clinical neuropsychology and related neurosciences; and

307.20 (iii) holds a current license to practice psychology independently according to sections
307.21 144.88 to 144.98;

307.22 (3) is licensed or credentialed by another state's board of psychology examiners in the
307.23 specialty of neuropsychology using requirements equivalent to requirements specified by
307.24 one of the boards named in clause (1); or

307.25 (4) was approved by the commissioner as an eligible provider of neuropsychological
307.26 assessment prior to December 31, 2010.

307.27 Sec. 93. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision
307.28 to read:

307.29 Subd. 67. **Neuropsychological testing.** (a) "Neuropsychological testing" means
307.30 administering standardized tests and measures designed to evaluate the client's ability to
307.31 attend to, process, interpret, comprehend, communicate, learn, and recall information and
307.32 use problem solving and judgment.

- 308.1 (b) Medical assistance covers neuropsychological testing when the client:
- 308.2 (1) has a significant mental status change that is not a result of a metabolic disorder and
- 308.3 that has failed to respond to treatment;
- 308.4 (2) is a child or adolescent with a significant plateau in expected development of
- 308.5 cognitive, social, emotional, or physical function relative to peers;
- 308.6 (3) is a child or adolescent with a significant inability to develop expected knowledge,
- 308.7 skills, or abilities as required to adapt to new or changing cognitive, social, physical, or
- 308.8 emotional demands; or
- 308.9 (4) has a significant behavioral change, memory loss, or suspected neuropsychological
- 308.10 impairment in addition to functional psychopathology, or other organic brain injury or one
- 308.11 of the following:
- 308.12 (i) traumatic brain injury;
- 308.13 (ii) stroke;
- 308.14 (iii) brain tumor;
- 308.15 (iv) substance use disorder;
- 308.16 (v) cerebral anoxic or hypoxic episode;
- 308.17 (vi) central nervous system infection or other infectious disease;
- 308.18 (vii) neoplasms or vascular injury of the central nervous system;
- 308.19 (viii) neurodegenerative disorders;
- 308.20 (ix) demyelinating disease;
- 308.21 (x) extrapyramidal disease;
- 308.22 (xi) exposure to systemic or intrathecal agents or cranial radiation known to be associated
- 308.23 with cerebral dysfunction;
- 308.24 (xii) systemic medical conditions known to be associated with cerebral dysfunction,
- 308.25 including renal disease, hepatic encephalopathy, cardiac anomaly, sickle cell disease, and
- 308.26 related hematologic anomalies, and autoimmune disorders, including lupus, erythematosis,
- 308.27 or celiac disease;
- 308.28 (xiii) congenital genetic or metabolic disorders known to be associated with cerebral
- 308.29 dysfunction, including phenylketonuria, craniofacial syndromes, or congenital hydrocephalus;
- 308.30 (xiv) severe or prolonged nutrition or malabsorption syndromes; or

309.1 (xv) a condition presenting in a manner difficult for a clinician to distinguish between
309.2 the neurocognitive effects of a neurogenic syndrome, including dementia or encephalopathy;
309.3 and a major depressive disorder when adequate treatment for major depressive disorder has
309.4 not resulted in improvement in neurocognitive function; or another disorder, including
309.5 autism, selective mutism, anxiety disorder, or reactive attachment disorder.

309.6 (c) Neuropsychological testing must be administered or clinically supervised by a
309.7 neuropsychologist qualified as defined in subdivision 66, paragraph (c).

309.8 (d) Neuropsychological testing is not covered when performed: (1) primarily for
309.9 educational purposes; (2) primarily for vocational counseling or training; (3) for personnel
309.10 or employment testing; (4) as a routine battery of psychological tests given at inpatient
309.11 admission or during a continued stay; or (5) for legal or forensic purposes.

309.12 Sec. 94. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision
309.13 to read:

309.14 Subd. 68. **Psychological testing.** (a) "Psychological testing" means the use of tests or
309.15 other psychometric instruments to determine the status of the client's mental, intellectual,
309.16 and emotional functioning.

309.17 (b) The psychological testing must:

309.18 (1) be administered or clinically supervised by a licensed psychologist qualified according
309.19 to section 245I.16, subdivision 2, clause (3), competent in the area of psychological testing;
309.20 and

309.21 (2) be validated in a face-to-face interview between the client and a licensed psychologist
309.22 or a clinical psychology trainee qualified according to section 245I.16, subdivision 6, under
309.23 the treatment supervision of a licensed psychologist according to section 245I.18.

309.24 (c) The administration, scoring, and interpretation of the psychological tests must be
309.25 done under the treatment supervision of a licensed psychologist when performed by a
309.26 technician, psychometrist, or psychological assistant or as part of a computer-assisted
309.27 psychological testing program. The report resulting from the psychological testing must be
309.28 signed by the psychologist conducting the face-to-face interview, placed in the client's
309.29 record, and released to each person authorized by the client.

310.1 Sec. 95. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision
310.2 to read:

310.3 Subd. 69. Psychotherapy. (a) "Psychotherapy" means treatment of a client with mental
310.4 illness that applies to the most appropriate psychological, psychiatric, psychosocial, or
310.5 interpersonal method that conforms to prevailing community standards of professional
310.6 practice to meet the mental health needs of the client. Medical assistance covers
310.7 psychotherapy if conducted by a mental health professional qualified according to section
310.8 245I.16, subdivision 2, or a clinical trainee qualified according to section 245I.16, subdivision
310.9 6.

310.10 (b) Individual psychotherapy is psychotherapy designed for one client.

310.11 (c) Family psychotherapy is designed for the client and one or more family members or
310.12 the client's primary caregiver whose participation is necessary to accomplish the client's
310.13 treatment goals. Family members or primary caregivers participating in a therapy session
310.14 do not need to be eligible for medical assistance. For purposes of this paragraph, "primary
310.15 caregiver whose participation is necessary to accomplish the client's treatment goals" excludes
310.16 shift or facility staff persons at the client's residence. Medical assistance payment for family
310.17 psychotherapy is limited to face-to-face sessions at which the client is present throughout
310.18 the family psychotherapy session unless the mental health professional believes the client's
310.19 absence from the family psychotherapy session is necessary to carry out the client's individual
310.20 treatment plan. If the client is excluded, the mental health professional must document the
310.21 reason for and the length of time of the exclusion. The mental health professional must also
310.22 document any reason a member of the client's family is excluded.

310.23 (d) Group psychotherapy is appropriate for a client who, because of the nature of the
310.24 client's emotional, behavioral, or social dysfunctions, can derive mutual benefit from
310.25 treatment in a group setting. For a group of three to eight persons, one mental health
310.26 professional or clinical trainee is required to conduct the group. For a group of nine to 12
310.27 persons, a team of at least two mental health professionals or two clinical trainees or one
310.28 mental health professional and one clinical trainee is required to co-conduct the group.
310.29 Medical assistance payment is limited to a group of no more than 12 persons.

310.30 (e) A multiple-family group psychotherapy session is eligible for medical assistance
310.31 payment if the psychotherapy session is designed for at least two but not more than five
310.32 families. Multiple-family group psychotherapy is clearly directed toward meeting the
310.33 identified treatment needs of each client as indicated in each client's treatment plan. If the
310.34 client is excluded, the mental health professional or clinical trainee must document the

311.1 reason for and the length of time of the exclusion. The mental health professional or clinical
311.2 trainee must document any reason a member of the client's family is excluded.

311.3 Sec. 96. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision
311.4 to read:

311.5 Subd. 70. **Partial hospitalization.** "Partial hospitalization" means a provider's
311.6 time-limited, structured program of psychotherapy and other therapeutic services, as defined
311.7 in United States Code, title 42, chapter 7, subchapter XVIII, part E, section 1395x(ff), that
311.8 is provided in an outpatient hospital facility or community mental health center that meets
311.9 Medicare requirements to provide partial hospitalization services. Partial hospitalization is
311.10 a covered service when it is an appropriate alternative to inpatient hospitalization for a client
311.11 who is experiencing an acute episode of mental illness that meets the criteria for an inpatient
311.12 hospital admission under Minnesota Rules, part 9505.0520, subpart 1, and who has the
311.13 family and community resources necessary and appropriate to support the client's residence
311.14 in the community. Partial hospitalization consists of multiple intensive short-term therapeutic
311.15 services provided by a multidisciplinary staff person to treat the client's mental illness.

311.16 Sec. 97. [256B.0671] CLIENT ELIGIBILITY FOR MENTAL HEALTH SERVICES.

311.17 Subdivision 1. **Generally.** (a) The provider must use a diagnostic assessment or crisis
311.18 assessment to determine a client's eligibility for mental health services, except as provided
311.19 in this section.

311.20 (b) Prior to completion of a client's initial diagnostic assessment, a client is eligible for:

311.21 (1) one explanation of findings;

311.22 (2) one psychological testing;

311.23 (3) any combination of individual psychotherapy sessions, family psychotherapy sessions,
311.24 group psychotherapy sessions, and individual or family psychoeducation sessions not to
311.25 exceed three sessions; and

311.26 (4) crisis assessment and intervention services provided according to section 256B.0624
311.27 or 256B.0944.

311.28 (c) Based on the needs identified in a crisis assessment as specified in section 256B.0624
311.29 or 256B.0944, a client may receive: (1) crisis stabilization services; and (2) any combination
311.30 of individual psychotherapy sessions, family psychotherapy sessions, or family
311.31 psychoeducation sessions not to exceed ten sessions within a 12-month period without prior
311.32 authorization.

312.1 (d) Based on the needs identified in a brief diagnostic assessment, a client may receive
312.2 a combination of individual psychotherapy sessions, family psychotherapy sessions, or
312.3 family psychoeducation sessions not to exceed ten sessions within a 12-month period without
312.4 prior authorization for any new client or for an existing client who is projected to need fewer
312.5 than ten sessions in the next 12 months.

312.6 (e) If the amount of services or intensity required by the client exceeds the coverage
312.7 limits in this section, a provider shall complete a standard diagnostic assessment.

312.8 (f) A new standard diagnostic assessment must be completed:

312.9 (1) when the client requires services of a greater number or intensity than those permitted
312.10 by paragraphs (b) to (d);

312.11 (2) at least annually following the initial diagnostic assessment if additional services are
312.12 needed and the client does not meet the criteria for brief assessment.

312.13 (3) when the client's mental health condition has changed markedly since the client's
312.14 most recent diagnostic assessment; or

312.15 (4) when the client's current mental health condition does not meet the criteria of the
312.16 client's current diagnosis.

312.17 (g) For an existing client, a new standard diagnostic assessment shall include a written
312.18 update of the parts where significant new or changed information exists, and documentation
312.19 where there has not been significant change, including discussion with the client about
312.20 changes in the client's life situation, functioning, presenting problems, and progress on
312.21 treatment goals since the last diagnostic assessment was completed.

312.22 Subd. 1a. **Continuity of services.** (a) For any client served with a diagnostic assessment
312.23 completed under Minnesota Rules, parts 9505.0370 to 9505.0372, before the effective date,
312.24 the diagnostic assessment must be valid for one calendar year after completion.

312.25 (b) For any client served with an individual treatment plan completed under section
312.26 256B.0622, 256B.0623, 256B.0943, 256B.0946, or 256B.0947 or Minnesota Rules, parts
312.27 9505.0370 to 9505.0372, the individual treatment plan must be valid until its expiration
312.28 date.

312.29 (c) This subdivision expires July 1, 2021.

312.30 Subd. 2. **Diagnostic assessment.** To be eligible for medical assistance payment, a
312.31 diagnostic assessment must (1) identify at least one mental health diagnosis and recommend

313.1 mental health services to develop the client's mental health services and treatment plan, or
313.2 (2) include a finding that the client does not meet the criteria for a mental health disorder.

313.3 Subd. 3. Standard diagnostic assessment requirements. (a) A standard diagnostic
313.4 assessment must include a face-to-face interview with the client and contain a written
313.5 evaluation of a client by a mental health professional or clinical trainee. The standard
313.6 diagnostic assessment must be completed within the cultural context of the client.

313.7 (b) The clinician shall gather and document information related to the client's current
313.8 life situation and the client's:

313.9 (1) age;

313.10 (2) current living situation, including household membership and housing status;

313.11 (3) basic needs status;

313.12 (4) education level and employment status;

313.13 (5) significant personal relationships, including the client's evaluation of relationship
313.14 quality;

313.15 (6) strengths and resources, including the extent and quality of social networks;

313.16 (7) belief systems;

313.17 (8) current medications; and

313.18 (9) immediate risks to health and safety.

313.19 (c) The clinician shall gather and document information related to the elements of the
313.20 assessment, including the client's:

313.21 (1) perceptions of the client's condition;

313.22 (2) description of symptoms, including reason for referral;

313.23 (3) history of mental health treatment; and

313.24 (4) cultural influences and the impact on the client.

313.25 (d) A clinician completing a diagnostic assessment shall use professional judgment in
313.26 making inquiries under this paragraph. If information cannot be obtained without
313.27 retraumatizing the client or harming the client's willingness to engage in treatment, the
313.28 clinician shall document which topics require further attention in the course of treatment.
313.29 A clinician must, as clinically appropriate, include the following information related to a
313.30 client in a diagnostic assessment:

- 314.1 (1) important developmental incidents;
- 314.2 (2) maltreatment, trauma, potential brain injuries, or abuse issues;
- 314.3 (3) history of alcohol and drug usage and treatment; and
- 314.4 (4) health history and family health history, including physical, chemical, and mental
- 314.5 health history.
- 314.6 (e) The clinician must perform and document the following components of the
- 314.7 assessment:
- 314.8 (1) the client's mental status examination;
- 314.9 (2) information gathered concerning the client's baseline measurements; symptoms;
- 314.10 behavior; skills; abilities; resources; vulnerabilities; safety needs, including client data
- 314.11 adequate to support findings based on the current edition of the Diagnostic and Statistical
- 314.12 Manual of Mental Disorders, published by the American Psychiatric Association; and any
- 314.13 differential diagnosis;
- 314.14 (3) for a child younger than 6 years of age, a clinician may use the current edition of the
- 314.15 DC: 0-5 Diagnostic Classification of Mental Health and Development Disorders of Infancy
- 314.16 and Early Childhood instead of the Diagnostic and Statistical Manual of Mental Disorders;
- 314.17 (4) the screenings used to determine the client's substance use, abuse, or dependency
- 314.18 and other standardized screening instruments determined by the commissioner;
- 314.19 (5) use of standardized outcome measurements by the provider as determined and
- 314.20 periodically updated by the commissioner; and
- 314.21 (6) a case conceptualization that explains: (i) the diagnostic formulation made based on
- 314.22 the information gathered through the interview, assessment, available psychological testing,
- 314.23 and collateral information; (ii) the needs of the client; (iii) risk factors; (iv) strengths; and
- 314.24 (v) responsivity factors.
- 314.25 (f) The diagnostic assessment must include recommendations, client and family
- 314.26 participation in assessment and service preferences, and referrals to services required by
- 314.27 law.
- 314.28 Subd. 4. **Brief diagnostic assessment requirements.** (a) A brief diagnostic assessment
- 314.29 must include a face-to-face interview with the client and a written evaluation of the client
- 314.30 by a mental health professional or a clinical trainee. The mental health professional or
- 314.31 clinical trainee must gather initial components of a standard diagnostic assessment, including
- 314.32 the client's:

- 315.1 (1) age;
- 315.2 (2) description of symptoms, including reason for referral;
- 315.3 (3) history of mental health treatment;
- 315.4 (4) cultural influences and their impact on the client; and
- 315.5 (5) mental status examination.
- 315.6 (b) On the basis of the initial components, the mental health professional or clinical
- 315.7 trainee must draw a provisional diagnostic formulation. The diagnostic formulation may be
- 315.8 used to address the client's immediate needs or presenting problem.
- 315.9 (c) Treatment sessions conducted under authorization of a brief diagnostic assessment
- 315.10 may be used to gather additional information necessary to complete a standard diagnostic
- 315.11 assessment if coverage limits in subdivision 1 will be exceeded.
- 315.12 Subd. 5. **Individual treatment plan.** Medical assistance payment is available only for
- 315.13 mental health services provided in accordance with the client's written individual treatment
- 315.14 plan, with the following exceptions: (1) services that do not require a standard diagnostic
- 315.15 assessment prior to service delivery; (2) service plan development; and (3) re-engagement
- 315.16 of a client as described in subdivision 6, clause (6).
- 315.17 Subd. 6. **Individual treatment plan; required elements.** An individual treatment plan
- 315.18 must:
- 315.19 (1) be based on the information in the client's diagnostic assessment and baselines;
- 315.20 (2) identify goals and objectives of treatment, the treatment strategy, the schedule for
- 315.21 accomplishing treatment goals and measurable objectives, and the individuals responsible
- 315.22 for providing treatment services and supports;
- 315.23 (3) be developed after completion of the client's diagnostic assessment, within three
- 315.24 visits unless otherwise specified by a service line;
- 315.25 (4) for a child client, be developed through a child-centered, family-driven, culturally
- 315.26 appropriate planning process, including allowing parents and guardians to observe or
- 315.27 participate in individual and family treatment services, assessment, and treatment planning.
- 315.28 For an adult client, the individual treatment plan must be developed through a
- 315.29 person-centered, culturally appropriate planning process, including allowing identified
- 315.30 supports to observe or participate in treatment services, assessment, and treatment planning;

316.1 (5) be reviewed at least every 90 days unless otherwise specified by the requirements
316.2 of a service line and revised to document treatment progress on each treatment objective
316.3 and next goals or, if progress is not documented, to document changes in treatment; and

316.4 (6) be approved by the client, the client's parent, or other person authorized by law to
316.5 consent to mental health services for the client. If approval cannot be obtained, a mental
316.6 health professional shall make efforts to obtain approval from an authorized person for a
316.7 period of 30 days following the date the previous individual treatment plan expired. A client
316.8 shall not be denied service in this time period solely on the basis of an unapproved individual
316.9 treatment plan. A provider entity may continue to bill for otherwise eligible services during
316.10 a period of re-engagement.

316.11 Sec. 98. Minnesota Statutes 2018, section 256B.0941, subdivision 1, is amended to read:

316.12 Subdivision 1. **Eligibility.** (a) An individual who is eligible for mental health treatment
316.13 services in a psychiatric residential treatment facility must meet all of the following criteria:

316.14 (1) before admission, services are determined to be medically necessary by the state's
316.15 medical review agent according to Code of Federal Regulations, title 42, section 441.152;

316.16 (2) is younger than 21 years of age at the time of admission. Services may continue until
316.17 the individual meets criteria for discharge or reaches 22 years of age, whichever occurs
316.18 first;

316.19 (3) has a mental health diagnosis as defined in the most recent edition of the Diagnostic
316.20 and Statistical Manual for Mental Disorders, as well as clinical evidence of severe aggression,
316.21 or a finding that the individual is a risk to self or others;

316.22 (4) has functional impairment and a history of difficulty in functioning safely and
316.23 successfully in the community, school, home, or job; an inability to adequately care for
316.24 one's physical needs; or caregivers, guardians, or family members are unable to safely fulfill
316.25 the individual's needs;

316.26 (5) requires psychiatric residential treatment under the direction of a physician to improve
316.27 the individual's condition or prevent further regression so that services will no longer be
316.28 needed;

316.29 (6) utilized and exhausted other community-based mental health services, or clinical
316.30 evidence indicates that such services cannot provide the level of care needed; and

317.1 (7) was referred for treatment in a psychiatric residential treatment facility by a qualified
317.2 mental health professional licensed as defined in section 245.4871, subdivision 27, ~~clauses~~
317.3 ~~(1) to (6)~~.

317.4 (b) A mental health professional making a referral shall submit documentation to the
317.5 state's medical review agent containing all information necessary to determine medical
317.6 necessity, including a standard diagnostic assessment completed within 180 days of the
317.7 individual's admission. Documentation shall include evidence of family participation in the
317.8 individual's treatment planning and signed consent for services.

317.9 Sec. 99. Minnesota Statutes 2018, section 256B.0943, subdivision 1, is amended to read:

317.10 Subdivision 1. **Definitions.** For purposes of this section, the following terms have the
317.11 meanings given them.

317.12 (a) "Children's therapeutic services and supports" means the flexible package of mental
317.13 health services for children who require varying therapeutic and rehabilitative levels of
317.14 intervention to treat a diagnosed emotional disturbance, ~~as defined in section 245.4871,~~
317.15 ~~subdivision 15, or a diagnosed mental illness, as defined in section 245.462, subdivision~~
317.16 20. The services are time-limited interventions that are delivered using various treatment
317.17 modalities and combinations of services designed to reach treatment outcomes identified
317.18 in the individual treatment plan.

317.19 (b) ~~"Clinical supervision" means the overall responsibility of the mental health~~
317.20 ~~professional for the control and direction of individualized treatment planning, service~~
317.21 ~~delivery, and treatment review for each client. A mental health professional who is an~~
317.22 ~~enrolled Minnesota health care program provider accepts full professional responsibility~~
317.23 ~~for a supervisee's actions and decisions, instructs the supervisee in the supervisee's work,~~
317.24 ~~and oversees or directs the supervisee's work.~~

317.25 (e) ~~(b)~~ "Clinical trainee" means a mental health practitioner who meets the qualifications
317.26 specified in Minnesota Rules, part 9505.0371, subpart 5, item C means a staff person
317.27 qualified according to section 245I.16, subdivision 6.

317.28 (d) "Crisis assistance" has the meaning given in section 245.4871, subdivision 9a. Crisis
317.29 assistance entails the development of a written plan to assist a child's family to contend with
317.30 a potential crisis and is distinct from the immediate provision of crisis intervention services.

317.31 (c) "Crisis planning" means the development of a written plan to assist a child's family
317.32 with a potential crisis and is distinct from the immediate provision of crisis intervention
317.33 services. The plan addresses prevention and intervention strategies to be used in a crisis.

318.1 The plan identifies factors that might precipitate a mental health crisis, behaviors related to
318.2 the emergence of a crisis, and resources available to resolve a crisis. The plan also must
318.3 address the following potentialities: (1) arranging for admission to acute care hospital
318.4 inpatient treatment; (2) crisis placement; (3) community resources for follow-up; and (4)
318.5 emotional support to the family during crisis.

318.6 ~~(e)~~ (d) "Culturally competent provider" means a provider who understands and can
318.7 utilize to a client's benefit the client's culture when providing services to the client. A provider
318.8 may be culturally competent because the provider is of the same cultural or ethnic group
318.9 as the client or the provider has developed the knowledge and skills through training and
318.10 experience to provide services to culturally diverse clients.

318.11 ~~(f)~~ (e) "Day treatment program" for children means a site-based structured mental health
318.12 program consisting of psychotherapy for three or more individuals and individual or group
318.13 skills training provided by a multidisciplinary treatment team, under the clinical treatment
318.14 supervision of a mental health professional.

318.15 ~~(g)~~ (f) "Diagnostic assessment" ~~has the meaning given in Minnesota Rules, part~~
318.16 9505.0372, subpart 1 means the assessment described under section 256B.0671, subdivisions
318.17 2 and 3.

318.18 ~~(h)~~ (g) "Direct service time" means the time that a mental health professional, clinical
318.19 trainee, mental health practitioner, or mental health behavioral aide spends face-to-face with
318.20 a client and the client's family or providing covered telemedicine services. Direct service
318.21 time includes time in which the provider obtains a client's history, develops a client's
318.22 treatment plan, records individual treatment outcomes, or provides service components of
318.23 children's therapeutic services and supports. Direct service time does not include time doing
318.24 work before and after providing direct services, including scheduling or maintaining clinical
318.25 records.

318.26 ~~(i)~~ (h) "Direction of mental health behavioral aide" means the activities of a mental
318.27 health professional, clinical trainee, or mental health practitioner in guiding the mental
318.28 health behavioral aide in providing services to a client. The direction of a mental health
318.29 behavioral aide must be based on the client's individualized treatment plan and meet the
318.30 requirements in subdivision 6, paragraph (b), clause (5).

318.31 ~~(j)~~ (i) "Emotional disturbance" has the meaning given in section 245.4871, subdivision
318.32 15.

318.33 ~~(k)~~ (j) "Individual behavioral plan" means a plan of intervention, treatment, and services
318.34 for a child written by a mental health professional, clinical trainee, or mental health

319.1 practitioner, under the ~~clinical treatment~~ supervision of a mental health professional, to
319.2 guide the work of the mental health behavioral aide. The individual behavioral plan may
319.3 be incorporated into the child's individual treatment plan so long as the behavioral plan is
319.4 separately communicable to the mental health behavioral aide.

319.5 ~~(k) "Individual treatment plan" has the meaning given in Minnesota Rules, part~~
319.6 ~~9505.0371, subpart 7 means the plan described under section 256B.0671, subdivisions 5~~
319.7 ~~and 6.~~

319.8 ~~(m) (l) "Mental health behavioral aide services" means medically necessary one-on-one~~
319.9 ~~activities performed by a trained paraprofessional qualified as provided in subdivision 7,~~
319.10 ~~paragraph (b), clause (3), to assist a child retain or generalize psychosocial skills as previously~~
319.11 ~~trained by a mental health professional, clinical trainee, or mental health practitioner and~~
319.12 ~~as described in the child's individual treatment plan and individual behavior plan. Activities~~
319.13 ~~involve working directly with the child or child's family as provided in subdivision 9,~~
319.14 ~~paragraph (b), clause (4).~~

319.15 (m) "Mental health certified family peer specialist" means a staff person qualified
319.16 according to section 245I.16, subdivision 12.

319.17 ~~(n) "Mental health practitioner" has the meaning given in means a staff person qualified~~
319.18 ~~according to section 245.462, subdivision 17, except that a practitioner working in a day~~
319.19 ~~treatment setting may qualify as a mental health practitioner if the practitioner holds a~~
319.20 ~~bachelor's degree in one of the behavioral sciences or related fields from an accredited~~
319.21 ~~college or university, and: (1) has at least 2,000 hours of clinically supervised experience~~
319.22 ~~in the delivery of mental health services to clients with mental illness; (2) is fluent in the~~
319.23 ~~language, other than English, of the cultural group that makes up at least 50 percent of the~~
319.24 ~~practitioner's clients, completes 40 hours of training on the delivery of services to clients~~
319.25 ~~with mental illness, and receives clinical supervision from a mental health professional at~~
319.26 ~~least once per week until meeting the required 2,000 hours of supervised experience; or (3)~~
319.27 ~~receives 40 hours of training on the delivery of services to clients with mental illness within~~
319.28 ~~six months of employment, and clinical supervision from a mental health professional at~~
319.29 ~~least once per week until meeting the required 2,000 hours of supervised experience 245I.16,~~
319.30 subdivision 4.

319.31 ~~(o) "Mental health professional" means an individual as defined in Minnesota Rules,~~
319.32 ~~part 9505.0370, subpart 18 a staff person qualified according to section 245I.16, subdivision~~
319.33 2.

319.34 (p) "Mental health service plan development" includes:

320.1 (1) the development, review, and revision of a child's individual treatment plan, as
320.2 ~~provided in Minnesota Rules, part 9505.0371, subpart 7 according to section 256B.0671,~~
320.3 ~~subdivisions 5 and 6~~, including involvement of the client or client's parents, primary
320.4 caregiver, or other person authorized to consent to mental health services for the client, and
320.5 including arrangement of treatment and support activities specified in the individual treatment
320.6 plan; and

320.7 (2) administering standardized outcome measurement instruments, determined and
320.8 updated by the commissioner, as periodically needed to evaluate the effectiveness of
320.9 treatment for children receiving clinical services and reporting outcome measures, as required
320.10 by the commissioner.

320.11 (q) "Mental illness," for persons at least age 18 but under age 21, has the meaning given
320.12 in section 245.462, subdivision 20, paragraph (a).

320.13 (r) "Psychotherapy" means the treatment of mental or emotional disorders or
320.14 maladjustment by psychological means. Psychotherapy may be provided in many modalities
320.15 ~~in accordance with Minnesota Rules, part 9505.0372, subpart 6~~, including patient and/or
320.16 family psychotherapy; family psychotherapy; psychotherapy for crisis; group psychotherapy;
320.17 or multiple-family psychotherapy. ~~Beginning with the American Medical Association's~~
320.18 ~~Current Procedural Terminology, standard edition, 2014, the procedure "individual~~
320.19 ~~psychotherapy" is replaced with "patient and/or family psychotherapy," a substantive change~~
320.20 ~~that permits the therapist to work with the client's family without the client present to obtain~~
320.21 ~~information about the client or to explain the client's treatment plan to the family.~~
320.22 Psychotherapy ~~for crisis~~ is appropriate ~~for crisis response~~ when a child has become
320.23 dysregulated or experienced new trauma since the diagnostic assessment was completed
320.24 and needs psychotherapy to address issues not currently included in the child's individual
320.25 treatment plan.

320.26 (s) "Rehabilitative services" or "psychiatric rehabilitation services" means ~~a series of~~ ~~multidisciplinary combination of psychiatric and psychosocial interventions to:~~ (1) restore
320.27 a child or adolescent to an age-appropriate developmental trajectory that had been disrupted
320.28 by a psychiatric illness; or (2) enable the child to self-monitor, compensate for, cope with,
320.29 counteract, or replace psychosocial skills deficits or maladaptive skills acquired over the
320.31 course of a psychiatric illness. Psychiatric rehabilitation services for children combine
320.32 ~~coordinated~~ psychotherapy to address internal psychological, emotional, and intellectual
320.33 processing deficits, and skills training to restore personal and social functioning. Psychiatric
320.34 rehabilitation services establish a progressive series of goals with each achievement building

321.1 upon a prior achievement. ~~Continuing progress toward goals is expected, and rehabilitative~~
321.2 ~~potential ceases when successive improvement is not observable over a period of time.~~

321.3 (t) "Skills training" means individual, family, or group training, delivered by or under
321.4 the supervision of a mental health professional, designed to facilitate the acquisition of
321.5 psychosocial skills that are medically necessary to rehabilitate the child to an age-appropriate
321.6 developmental trajectory heretofore disrupted by a psychiatric illness or to enable the child
321.7 to self-monitor, compensate for, cope with, counteract, or replace skills deficits or
321.8 maladaptive skills acquired over the course of a psychiatric illness. Skills training is subject
321.9 to the service delivery requirements under subdivision 9, paragraph (b), clause (2).

321.10 (u) "Treatment supervision" means the supervision described under section 245I.18.

321.11 Sec. 100. Minnesota Statutes 2018, section 256B.0943, subdivision 2, is amended to read:

321.12 Subd. 2. **Covered service components of children's therapeutic services and**
321.13 **supports.** (a) ~~Subject to federal approval,~~ Medical assistance covers medically necessary
321.14 children's therapeutic services and supports as defined in this section that an eligible provider
321.15 entity certified under subdivision 4 provides to a client eligible under subdivision 3.

321.16 (b) The service components of children's therapeutic services and supports are:

321.17 (1) patient and/or family psychotherapy, family psychotherapy, psychotherapy for crisis,
321.18 and group psychotherapy;

321.19 (2) individual, family, or group skills training provided by a mental health professional
321.20 or mental health practitioner;

321.21 (3) crisis ~~assistance~~ planning;

321.22 (4) mental health behavioral aide services;

321.23 (5) direction of a mental health behavioral aide;

321.24 (6) mental health service plan development; and

321.25 (7) children's day treatment.

321.26 Sec. 101. Minnesota Statutes 2018, section 256B.0943, subdivision 3, is amended to read:

321.27 Subd. 3. **Determination of client eligibility.** A client's eligibility to receive children's
321.28 therapeutic services and supports under this section shall be determined based on a diagnostic
321.29 assessment by a mental health professional or ~~a mental health practitioner who meets the~~
321.30 ~~requirements of a clinical trainee as defined in Minnesota Rules, part 9505.0371, subpart~~

322.1 ~~5, item C,~~ that is performed within one year before the initial start of service. The diagnostic
322.2 assessment must meet the requirements for a standard ~~or extended~~ diagnostic assessment
322.3 ~~as defined in Minnesota Rules, part 9505.0372, subpart 1, items B and C, and:~~

322.4 (1) ~~include current diagnoses, including any differential diagnosis, in accordance with~~
322.5 ~~all criteria for a complete diagnosis and diagnostic profile as specified in the current edition~~
322.6 ~~of the Diagnostic and Statistical Manual of the American Psychiatric Association, or, for~~
322.7 ~~children under age five, as six, follow the requirements~~ specified in the current edition of
322.8 the Diagnostic Classification of Mental Health Disorders of Infancy and Early Childhood;

322.9 (2) determine whether a child under age 18 has a diagnosis of emotional disturbance or,
322.10 if the person is between the ages of 18 and 21, whether the person has a mental illness;

322.11 (3) document children's therapeutic services and supports as medically necessary to
322.12 address an identified disability, functional impairment, and the individual client's needs and
322.13 goals; and

322.14 (4) be used in the development of the individualized treatment plan; and.

322.15 ~~(5) be completed annually until age 18. For individuals between age 18 and 21, unless~~
322.16 ~~a client's mental health condition has changed markedly since the client's most recent~~
322.17 ~~diagnostic assessment, annual updating is necessary. For the purpose of this section,~~
322.18 ~~"updating" means an adult diagnostic update as defined in Minnesota Rules, part 9505.0371,~~
322.19 ~~subpart 2, item E.~~

322.20 Sec. 102. Minnesota Statutes 2018, section 256B.0943, subdivision 4, is amended to read:

322.21 Subd. 4. **Provider entity certification.** (a) The commissioner shall establish an initial
322.22 provider entity application and certification process and recertification process to determine
322.23 whether a provider entity has an administrative and clinical infrastructure that meets the
322.24 requirements in subdivisions 5 and 6. A provider entity must be certified for the three core
322.25 rehabilitation services of psychotherapy, skills training, and crisis assistance planning. The
322.26 commissioner shall recertify a provider entity at least every three years. The commissioner
322.27 shall establish a process for decertification of a provider entity and shall require corrective
322.28 action, medical assistance repayment, or decertification of a provider entity that no longer
322.29 meets the requirements in this section or that fails to meet the clinical quality standards or
322.30 administrative standards provided by the commissioner in the application and certification
322.31 process.

322.32 (b) For purposes of this section, a provider entity must meet all requirements in chapter
322.33 245I and be:

- 323.1 (1) an Indian health services facility or a facility owned and operated by a tribe or tribal
323.2 organization operating as a 638 facility under Public Law 93-638 certified by the state;

323.3 (2) a county-operated entity certified by the state; or

323.4 (3) a noncounty entity certified by the state.

323.5 Sec. 103. Minnesota Statutes 2018, section 256B.0943, subdivision 5, is amended to read:

323.6 **Subd. 5. Provider entity administrative infrastructure requirements.** (a) To be an
323.7 eligible provider entity under this section, a provider entity must have an administrative
323.8 infrastructure that establishes authority and accountability for decision making and oversight
323.9 of functions, including finance, personnel, system management, clinical practice, and
323.10 individual treatment outcomes measurement. An eligible provider entity shall demonstrate
323.11 the availability, by means of employment or contract, of at least one backup mental health
323.12 professional in the event of the primary mental health professional's absence. The provider
323.13 must have written policies and procedures that it reviews and updates every three years and
323.14 distributes to staff initially and upon each subsequent update.

323.15 (b) The administrative infrastructure written policies and procedures must be in
323.16 accordance with sections 245I.10 and 245I.13 and must include:

323.17 (1) personnel procedures, including a process for: (i) recruiting, hiring, training, and
323.18 retention of culturally and linguistically competent providers; (ii) conducting a criminal
323.19 background check on all direct service providers and volunteers; (iii) investigating, reporting,
323.20 and acting on violations of ethical conduct standards; (iv) investigating, reporting, and acting
323.21 on violations of data privacy policies that are compliant with federal and state laws; (v)
323.22 utilizing volunteers, including screening applicants, training and supervising volunteers,
323.23 and providing liability coverage for volunteers; and (vi) documenting that each ~~mental~~
323.24 ~~health professional, mental health practitioner, or mental health behavioral aide meets the~~
323.25 ~~applicable provider qualification criteria staff person meets the applicable qualifications~~
323.26 ~~under section 245I.16, training criteria under subdivision 8 section 245I.10, and clinical~~
323.27 ~~treatment supervision or direction of a mental health behavioral aide requirements under~~
323.28 ~~subdivision 6 section 245I.18;~~

323.29 (2) fiscal procedures, including internal fiscal control practices and a process for collecting
323.30 revenue that is compliant with federal and state laws;

323.31 (3) a client-specific treatment outcomes measurement system, including baseline
323.32 measures, to measure a client's progress toward achieving mental health rehabilitation goals.
323.33 ~~Effective July 1, 2017,~~ To be eligible for medical assistance payment, a provider entity must

324.1 report individual client outcomes to the commissioner, using instruments and protocols
324.2 approved by the commissioner; and

324.3 (4) a process to establish and maintain individual client records in accordance with
324.4 section 245I.32. The client's records must include:

324.5 (i) the client's personal information;

324.6 (ii) forms applicable to data privacy;

324.7 (iii) the client's diagnostic assessment, updates, results of tests, individual treatment
324.8 plan, and individual behavior plan, if necessary;

324.9 (iv) documentation of service delivery as specified under subdivision 6;

324.10 (v) telephone contacts;

324.11 (vi) discharge plan; and

324.12 (vii) if applicable, insurance information.

324.13 (c) A provider entity that uses a restrictive procedure with a client must meet the
324.14 requirements of section 245.8261.

324.15 Sec. 104. Minnesota Statutes 2018, section 256B.0943, subdivision 6, is amended to read:

324.16 Subd. 6. **Provider entity clinical infrastructure requirements.** (a) To be an eligible
324.17 provider entity under this section, a provider entity must have a clinical infrastructure that
324.18 utilizes diagnostic assessment, individualized treatment plans, service delivery, and individual
324.19 treatment plan review that are culturally competent, child-centered, and family-driven to
324.20 achieve maximum benefit for the client. The provider entity must review, and update as
324.21 necessary, the clinical policies and procedures every three years, must distribute the policies
324.22 and procedures to staff initially and upon each subsequent update, and must train staff
324.23 accordingly.

324.24 (b) The clinical infrastructure written policies and procedures must include policies and
324.25 procedures for:

324.26 (1) providing or obtaining a client's diagnostic assessment, including a diagnostic
324.27 assessment performed by an outside or independent clinician, that identifies acute and
324.28 chronic clinical disorders, co-occurring medical conditions, and sources of psychological
324.29 and environmental problems, including baselines, and a functional assessment. The functional
324.30 assessment component must clearly summarize the client's individual strengths and needs.
324.31 When required components of the diagnostic assessment, such as baseline measures, are

325.1 not provided in an outside or independent assessment or when baseline measures cannot be
325.2 attained in a ~~one-session~~ standard diagnostic assessment, the provider entity must determine
325.3 the missing information within 30 days and amend the child's diagnostic assessment or
325.4 incorporate the baselines into the child's individual treatment plan;

325.5 (2) developing an individual treatment plan ~~that according to section 256B.0671,~~
325.6 ~~subdivisions 5 and 6;~~

325.7 ~~(i) is based on the information in the client's diagnostic assessment and baselines;~~

325.8 ~~(ii) identified goals and objectives of treatment, treatment strategy, schedule for
325.9 accomplishing treatment goals and objectives, and the individuals responsible for providing
325.10 treatment services and supports;~~

325.11 ~~(iii) is developed after completion of the client's diagnostic assessment by a mental health
325.12 professional or clinical trainee and before the provision of children's therapeutic services
325.13 and supports;~~

325.14 ~~(iv) is developed through a child-centered, family-driven, culturally appropriate planning
325.15 process, including allowing parents and guardians to observe or participate in individual
325.16 and family treatment services, assessment, and treatment planning;~~

325.17 ~~(v) is reviewed at least once every 90 days and revised to document treatment progress
325.18 on each treatment objective and next goals or, if progress is not documented, to document
325.19 changes in treatment; and~~

325.20 ~~(vi) is signed by the clinical supervisor and by the client or by the client's parent or other
325.21 person authorized by statute to consent to mental health services for the client. A client's
325.22 parent may approve the client's individual treatment plan by secure electronic signature or
325.23 by documented oral approval that is later verified by written signature;~~

325.24 (3) developing an individual behavior plan that documents ~~treatment strategies and~~
325.25 ~~describes interventions~~ to be provided by the mental health behavioral aide. The individual
325.26 behavior plan must include:

325.27 (i) detailed instructions on the ~~treatment strategies to be provided~~ psychosocial skills to
325.28 be practiced;

325.29 (ii) time allocated to each ~~treatment strategy~~ intervention;

325.30 (iii) methods of documenting the child's behavior;

325.31 (iv) methods of monitoring the child's progress in reaching objectives; and

326.1 (v) goals to increase or decrease targeted behavior as identified in the individual treatment
326.2 plan;

326.3 (4) providing ~~clinical treatment~~ supervision plans for mental health practitioners and
326.4 mental health behavioral aides according to section 245I.18. A mental health professional
326.5 must document the clinical supervision the professional provides by cosigning individual
326.6 treatment plans and making entries in the client's record on supervisory activities. The
326.7 clinical supervisor also shall document supervisee specific supervision in the supervisee's
326.8 personnel file. Clinical Treatment supervision does not include the authority to make or
326.9 terminate court-ordered placements of the child. A clinical supervisor must be available for
326.10 urgent consultation as required by the individual client's needs or the situation. Clinical
326.11 supervision may occur individually or in a small group to discuss treatment and review
326.12 progress toward goals. The focus of clinical supervision must be the client's treatment needs
326.13 and progress and the mental health practitioner's or behavioral aide's ability to provide
326.14 services;

326.15 (4a) meeting day treatment program conditions in items (i) to (iii):

326.16 (i) the ~~clinical treatment~~ supervisor must be present and available on the premises more
326.17 than 50 percent of the time in a provider's standard working week during which the supervisee
326.18 is providing a mental health service;

326.19 (ii) the ~~treatment supervisor must review and approve the client's diagnosis and the~~
326.20 client's individual treatment plan or a change in the diagnosis or individual treatment plan
326.21 ~~must be made by or reviewed, approved, and signed by the clinical supervisor~~; and

326.22 (iii) every 30 days, the ~~clinical treatment~~ supervisor must review and sign the record
326.23 indicating the supervisor has reviewed the client's care for all activities in the preceding
326.24 30-day period;

326.25 (4b) meeting the ~~clinical treatment~~ supervision standards in items (i) to ~~(iv)~~ and (ii) for
326.26 all other services provided under CTSS:

326.27 (i) ~~medical assistance shall reimburse for services provided by a mental health practitioner~~
326.28 ~~who is delivering services that fall within the scope of the practitioner's practice and who~~
326.29 ~~is supervised by a mental health professional who accepts full professional responsibility~~;

326.30 (ii) ~~medical assistance shall reimburse for services provided by a mental health behavioral~~
326.31 ~~aide who is delivering services that fall within the scope of the aide's practice and who is~~
326.32 ~~supervised by a mental health professional who accepts full professional responsibility and~~
326.33 ~~has an approved plan for clinical supervision of the behavioral aide. Plans must be developed~~

327.1 ~~in accordance with supervision standards defined in Minnesota Rules, part 9505.0371,~~
327.2 ~~subpart 4, items A to D;~~

327.3 ~~(iii)~~ (i) the mental health professional is required to be present at the site of service
327.4 delivery for observation as clinically appropriate when the mental health practitioner or
327.5 mental health behavioral aide is providing CTSS services; and

327.6 ~~(iv)~~ (ii) when conducted, the on-site presence of the mental health professional must be
327.7 documented in the child's record and signed by the mental health professional who accepts
327.8 full professional responsibility;

327.9 (5) providing direction to a mental health behavioral aide. For entities that employ mental
327.10 health behavioral aides, the ~~clinical treatment~~ supervisor must be employed by the provider
327.11 entity or other provider certified to provide mental health behavioral aide services to ensure
327.12 necessary and appropriate oversight for the client's treatment and continuity of care. The
327.13 ~~mental health professional or mental health practitioner staff~~ giving direction must begin
327.14 with the goals on the individualized treatment plan, and instruct the mental health behavioral
327.15 aide on how to implement therapeutic activities and interventions that will lead to goal
327.16 attainment. The ~~professional or practitioner staff~~ giving direction must also instruct the
327.17 mental health behavioral aide about the client's diagnosis, functional status, and other
327.18 characteristics that are likely to affect service delivery. Direction must also include
327.19 determining that the mental health behavioral aide has the skills to interact with the client
327.20 and the client's family in ways that convey personal and cultural respect and that the aide
327.21 actively solicits information relevant to treatment from the family. The aide must be able
327.22 to clearly explain or demonstrate the activities the aide is doing with the client and the
327.23 activities' relationship to treatment goals. Direction is more didactic than is supervision and
327.24 requires the ~~professional or practitioner staff~~ providing it to continuously evaluate the mental
327.25 health behavioral aide's ability to carry out the activities of the individualized treatment
327.26 plan and the individualized behavior plan. When providing direction, the ~~professional or~~
327.27 ~~practitioner staff~~ must:

327.28 (i) review progress notes prepared by the mental health behavioral aide for accuracy and
327.29 consistency with diagnostic assessment, treatment plan, and behavior goals and the
327.30 professional or practitioner must approve and sign the progress notes;

327.31 (ii) identify changes in treatment strategies, revise the individual behavior plan, and
327.32 communicate treatment instructions and methodologies as appropriate to ensure that treatment
327.33 is implemented correctly;

328.1 (iii) demonstrate family-friendly behaviors that support healthy collaboration among
328.2 the child, the child's family, and providers as treatment is planned and implemented;

328.3 (iv) ensure that the mental health behavioral aide is able to effectively communicate
328.4 with the child, the child's family, and the provider; and

328.5 (v) record the results of any evaluation and corrective actions taken to modify the work
328.6 of the mental health behavioral aide;

328.7 (6) providing service delivery that implements the individual treatment plan and meets
328.8 the requirements under subdivision 9; and

328.9 (7) individual treatment plan review. The review must determine the extent to which
328.10 the services have met each of the goals and objectives in the treatment plan. The review
328.11 must assess the client's progress and ensure that services and treatment goals continue to
328.12 be necessary and appropriate to the client and the client's family or foster family. ~~Revision~~
328.13 ~~of the individual treatment plan does not require a new diagnostic assessment unless the~~
328.14 ~~client's mental health status has changed markedly. The updated treatment plan must be~~
328.15 ~~signed by the clinical supervisor and by the client, if appropriate, and by the client's parent~~
328.16 ~~or other person authorized by statute to give consent to the mental health services for the~~
328.17 ~~child.~~

328.18 Sec. 105. Minnesota Statutes 2018, section 256B.0943, subdivision 7, is amended to read:

328.19 **Subd. 7. Qualifications of individual and team providers.** (a) An individual or team
328.20 provider working within the scope of the provider's practice or qualifications may provide
328.21 service components of children's therapeutic services and supports that are identified as
328.22 medically necessary in a client's individual treatment plan.

328.23 (b) An individual provider must be qualified as:

328.24 (1) a mental health professional ~~as defined in subdivision 1, paragraph (e); or~~
328.25 (2) a mental health practitioner or clinical trainee. ~~The mental health practitioner or~~
328.26 ~~clinical trainee must work under the clinical supervision of a mental health professional; or~~
328.27 (3) a mental health behavioral aide ~~working under the clinical supervision of a mental~~
328.28 ~~health professional to implement the rehabilitative mental health services previously~~
328.29 ~~introduced by a mental health professional or practitioner and identified in the client's~~
328.30 ~~individual treatment plan and individual behavior plan.; or~~

328.31 (4) a mental health certified family peer specialist.

328.32 (A) A level I mental health behavioral aide must:

329.1 (i) ~~be at least 18 years old;~~

329.2 (ii) ~~have a high school diploma or commissioner of education-selected high school~~

329.3 ~~equivalency certification or two years of experience as a primary caregiver to a child with~~

329.4 ~~severe emotional disturbance within the previous ten years; and~~

329.5 (iii) ~~meet preservice and continuing education requirements under subdivision 8.~~

329.6 (B) ~~A level II mental health behavioral aide must:~~

329.7 (i) ~~be at least 18 years old;~~

329.8 (ii) ~~have an associate or bachelor's degree or 4,000 hours of experience in delivering~~

329.9 ~~clinical services in the treatment of mental illness concerning children or adolescents or~~

329.10 ~~complete a certificate program established under subdivision 8a; and~~

329.11 (iii) ~~meet preservice and continuing education requirements in subdivision 8.~~

329.12 (c) ~~A day treatment multidisciplinary team must include at least one mental health~~

329.13 ~~professional or clinical trainee and one mental health practitioner.~~

329.14 Sec. 106. Minnesota Statutes 2018, section 256B.0943, subdivision 8, is amended to read:

329.15 Subd. 8. **Required preservice and continuing education.** (a) A provider entity shall

329.16 establish a plan to provide preservice and continuing education for staff according to section

329.17 245I.10. The plan must clearly describe the type of training necessary to maintain current

329.18 skills and obtain new skills and that relates to the provider entity's goals and objectives for

329.19 services offered.

329.20 (b) ~~A provider that employs a mental health behavioral aide under this section must~~

329.21 ~~require the mental health behavioral aide to complete 30 hours of preservice training. The~~

329.22 ~~preservice training must include parent team training. The preservice training must include~~

329.23 ~~15 hours of in-person training of a mental health behavioral aide in mental health services~~

329.24 ~~delivery and eight hours of parent team training. Curricula for parent team training must be~~

329.25 ~~approved in advance by the commissioner. Components of parent team training include:~~

329.26 (1) partnering with parents;

329.27 (2) fundamentals of family support;

329.28 (3) fundamentals of policy and decision making;

329.29 (4) defining equal partnership;

329.30 (5) complexities of the parent and service provider partnership in multiple service delivery

329.31 systems due to system strengths and weaknesses;

330.1 (6) sibling impacts;

330.2 (7) support networks; and

330.3 (8) community resources.

330.4 (e) A provider entity that employs a mental health practitioner and a mental health
330.5 behavioral aide to provide children's therapeutic services and supports under this section
330.6 must require the mental health practitioner and mental health behavioral aide to complete
330.7 20 hours of continuing education every two calendar years. The continuing education must
330.8 be related to serving the needs of a child with emotional disturbance in the child's home
330.9 environment and the child's family.

330.10 (d) The provider entity must document the mental health practitioner's or mental health
330.11 behavioral aide's annual completion of the required continuing education. The documentation
330.12 must include the date, subject, and number of hours of the continuing education, and
330.13 attendance records, as verified by the staff member's signature, job title, and the instructor's
330.14 name. The provider entity must keep documentation for each employee, including records
330.15 of attendance at professional workshops and conferences, at a central location and in the
330.16 employee's personnel file.

330.17 Sec. 107. Minnesota Statutes 2018, section 256B.0943, subdivision 9, is amended to read:

330.18 Subd. 9. **Service delivery criteria.** (a) In delivering services under this section, a certified
330.19 provider entity must ensure that:

330.20 (1) each individual provider's caseload size permits the provider to deliver services to
330.21 both clients with severe, complex needs and clients with less intensive needs; the provider's
330.22 caseload size should reasonably enable enables the provider to play an active role in service
330.23 planning, monitoring, and delivering services to meet the client's and client's family's needs,
330.24 as specified in each client's individual treatment plan;

330.25 (2) site-based programs, including day treatment programs, provide staffing and facilities
330.26 to ensure the client's health, safety, and protection of rights, and that the programs are able
330.27 to implement each client's individual treatment plan; and

330.28 (3) a day treatment program is provided to a group of clients by a multidisciplinary team
330.29 under the clinical supervision of a mental health professional. The day treatment
330.30 program must be provided in and by: (i) an outpatient hospital accredited by the Joint
330.31 Commission on Accreditation of Health Organizations and licensed under sections 144.50
330.32 to 144.55; (ii) a community mental health center under section 245.62; or (iii) an entity that
330.33 is certified under subdivision 4 to operate a program that meets the requirements of section

331.1 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475. The day
331.2 treatment program must stabilize the client's mental health status while developing and
331.3 improving the client's independent living and socialization skills. The goal of the day
331.4 treatment program must be to reduce or relieve the effects of mental illness and provide
331.5 training to enable the client to live in the community. The program must be available
331.6 year-round at least three to five days per week, two or three hours per day, unless the normal
331.7 five-day school week is shortened by a holiday, weather-related cancellation, or other
331.8 districtwide reduction in a school week. A child transitioning into or out of day treatment
331.9 must receive a minimum treatment of one day a week for a two-hour time block. The
331.10 two-hour time block must include at least one hour of patient and/or family or group
331.11 psychotherapy. The remainder of the structured treatment program may include patient
331.12 and/or family or group psychotherapy, and individual or group skills training, if included
331.13 in the client's individual treatment plan. Day treatment programs are not part of inpatient
331.14 or residential treatment services. When a day treatment group that meets the minimum group
331.15 size requirement temporarily falls below the minimum group size because of a member's
331.16 temporary absence, medical assistance covers a group session conducted for the group
331.17 members in attendance. A day treatment program may provide fewer than the minimally
331.18 required hours for a particular child during a billing period in which the child is transitioning
331.19 into, or out of, the program.

331.20 (b) To be eligible for medical assistance payment, a provider entity must deliver the
331.21 service components of children's therapeutic services and supports in compliance with the
331.22 following requirements:

331.23 (1) patient and/or family, family, and group psychotherapy must be delivered as specified
331.24 in Minnesota Rules, part 9505.0372, subpart 6 section 256B.0625, subdivision 69.
331.25 Psychotherapy to address the child's underlying mental health disorder must be documented
331.26 as part of the child's ongoing treatment. A provider must deliver, or arrange for, medically
331.27 necessary psychotherapy, unless the child's parent or caregiver chooses not to receive it.
331.28 When a provider delivering other services to a child under this section deems it not medically
331.29 necessary to provide psychotherapy to the child for a period of 90 days or longer, the provider
331.30 entity must document the medical reasons why psychotherapy is not necessary. When a
331.31 provider determines that a child needs psychotherapy but psychotherapy cannot be delivered
331.32 due to a shortage of licensed mental health professionals in the child's community, the
331.33 provider must document the lack of access in the child's medical record;

331.34 (2) individual, family, or group skills training ~~must be provided by a mental health~~
331.35 ~~professional or a mental health practitioner who is delivering services that fall within the~~

332.1 ~~scope of the provider's practice and is supervised by a mental health professional who~~
332.2 ~~accepts full professional responsibility for the training.~~ Skills training is subject to the
332.3 following requirements:

332.4 (i) a mental health professional, clinical trainee, or mental health practitioner shall provide
332.5 skills training;

332.6 (ii) skills training delivered to a child or the child's family must be targeted to the specific
332.7 deficits or maladaptations of the child's mental health disorder and must be prescribed in
332.8 the child's individual treatment plan;

332.9 (iii) the mental health professional delivering or supervising the delivery of skills training
332.10 must document any underlying psychiatric condition and must document how skills training
332.11 is being used in conjunction with psychotherapy to address the underlying condition;

332.12 (iv) skills training delivered to the child's family must teach skills needed by parents or
332.13 primary caregivers to enhance the child's skill development, to help the child utilize daily
332.14 life skills taught by a mental health professional, clinical trainee, or mental health practitioner,
332.15 and to develop or maintain a home environment that supports the child's progressive use of
332.16 skills;

332.17 (v) group skills training may be provided to multiple recipients who, because of the
332.18 nature of their emotional, behavioral, or social dysfunction, can derive mutual benefit from
332.19 interaction in a group setting, which must be staffed as follows:

332.20 (A) one mental health professional or one clinical trainee or mental health practitioner
332.21 ~~under supervision of a licensed mental health professional~~ must work with a group of three
332.22 to eight clients; or

332.23 (B) any combination of two mental health professionals, two clinical trainees, or mental
332.24 health practitioners under supervision of a licensed mental health professional, or one mental
332.25 health professional or clinical trainee and one mental health practitioner must work with a
332.26 group of nine to 12 clients;

332.27 (vi) a mental health professional, clinical trainee, or mental health practitioner must have
332.28 taught the psychosocial skill before a mental health behavioral aide may practice that skill
332.29 with the client; and

332.30 (vii) for group skills training, when a skills group that meets the minimum group size
332.31 requirement temporarily falls below the minimum group size because of a group member's
332.32 temporary absence, the provider may conduct the session for the group members in
332.33 attendance;

333.1 (3) crisis ~~assistance~~ planning to a child and family must include development of a written
333.2 plan that anticipates the particular factors specific to the child that may precipitate a
333.3 psychiatric crisis for the child in the near future. The written plan must document actions
333.4 that the family should be prepared to take to resolve or stabilize a crisis, such as advance
333.5 arrangements for direct intervention and support services to the child and the child's family.
333.6 Crisis ~~assistance~~ planning must include preparing resources designed to address abrupt or
333.7 substantial changes in the functioning of the child or the child's family when sudden change
333.8 in behavior or a loss of usual coping mechanisms is observed, or the child begins to present
333.9 a danger to self or others;

333.10 (4) mental health behavioral aide services must be medically necessary treatment services,
333.11 identified in the child's individual treatment plan and individual behavior plan, ~~which are~~
333.12 ~~performed minimally by a paraprofessional qualified according to subdivision 7, paragraph~~
333.13 ~~(b), clause (3), and which are designed to improve the functioning of the child in the~~
333.14 progressive use of developmentally appropriate psychosocial skills. Activities involve
333.15 working directly with the child, child-peer groupings, or child-family groupings to practice,
333.16 repeat, reintroduce, and master the skills defined in subdivision 1, paragraph (t), as previously
333.17 taught by a mental health professional, clinical trainee, or mental health practitioner including:

333.18 (i) providing cues or prompts in skill-building peer-to-peer or parent-child interactions
333.19 so that the child progressively recognizes and responds to the cues independently;

333.20 (ii) performing as a practice partner or role-play partner;

333.21 (iii) reinforcing the child's accomplishments;

333.22 (iv) generalizing skill-building activities in the child's multiple natural settings;

333.23 (v) assigning further practice activities; and

333.24 (vi) intervening as necessary to redirect the child's target behavior and to de-escalate
333.25 behavior that puts the child or other person at risk of injury.

333.26 To be eligible for medical assistance payment, mental health behavioral aide services must
333.27 be delivered to a child who has been diagnosed with an emotional disturbance or a mental
333.28 illness, as provided in subdivision 1, paragraph (a). The mental health behavioral aide must
333.29 implement treatment strategies in the individual treatment plan and the individual behavior
333.30 plan as developed by the mental health professional, clinical trainee, or mental health
333.31 practitioner providing direction for the mental health behavioral aide. The mental health
333.32 behavioral aide must document the delivery of services in written progress notes. Progress

334.1 notes must reflect implementation of the treatment strategies, as performed by the mental
334.2 health behavioral aide and the child's responses to the treatment strategies;

334.3 (5) direction of a mental health behavioral aide must include ~~the following:~~

334.4 ~~(i) ongoing face-to-face observation of the mental health behavioral aide delivering~~
334.5 ~~services to a child by a mental health professional or mental health practitioner for at least~~
334.6 ~~a total of one hour during every 40 hours of service provided to a child; and~~

334.7 ~~(ii) immediate accessibility of the mental health professional, clinical trainee, or mental~~
334.8 ~~health practitioner to the mental health behavioral aide during service provision; and~~

334.9 (6) mental health service plan development must be performed in consultation with the
334.10 child's family and, when appropriate, with other key participants in the child's life by the
334.11 child's treating mental health professional or clinical trainee or by a mental health practitioner
334.12 and approved by the treating mental health professional. Treatment plan drafting consists
334.13 of development, review, and revision by face-to-face or electronic communication. The
334.14 provider must document events, including the time spent with the family and other key
334.15 participants in the child's life to ~~review, revise, and sign~~ approve the individual treatment
334.16 plan. ~~Notwithstanding Minnesota Rules, part 9505.0371, subpart 7, medical assistance~~
334.17 ~~covers service plan development before completion of the child's individual treatment plan.~~
334.18 Service plan development is covered only if a treatment plan is completed for the child. If
334.19 upon review it is determined that a treatment plan was not completed for the child, the
334.20 commissioner shall recover the payment for the service plan development; and.

334.21 ~~(7) to be eligible for payment, a diagnostic assessment must be complete with regard to~~
334.22 ~~all required components, including multiple assessment appointments required for an~~
334.23 ~~extended diagnostic assessment and the written report. Dates of the multiple assessment~~
334.24 ~~appointments must be noted in the client's clinical record.~~

334.25 Sec. 108. Minnesota Statutes 2018, section 256B.0943, subdivision 11, is amended to
334.26 read:

334.27 Subd. 11. **Documentation and billing.** (a) A provider entity must document the services
334.28 it provides under this section according to section 245I.33. The provider entity must ensure
334.29 that documentation complies with Minnesota Rules, parts 9505.2175 and 9505.2197. Services
334.30 billed under this section that are not documented according to this subdivision shall be
334.31 subject to monetary recovery by the commissioner. Billing for covered service components
334.32 under subdivision 2, paragraph (b), must not include anything other than direct service time.

335.1 (b) An individual mental health provider must promptly document the following in a
335.2 client's record after providing services to the client:

335.3 (1) each occurrence of the client's mental health service, including the date, type, start
335.4 and stop times, scope of the service as described in the child's individual treatment plan,
335.5 and outcome of the service compared to baselines and objectives;

335.6 (2) the name, dated signature, and credentials of the person who delivered the service;

335.7 (3) contact made with other persons interested in the client, including representatives
335.8 of the courts, corrections systems, or schools. The provider must document the name and
335.9 date of each contact;

335.10 (4) any contact made with the client's other mental health providers, case manager,
335.11 family members, primary caregiver, legal representative, or the reason the provider did not
335.12 contact the client's family members, primary caregiver, or legal representative, if applicable;

335.13 (5) required clinical supervision directly related to the identified client's services and
335.14 needs, as appropriate, with co-signatures of the supervisor and supervisee; and

335.15 (6) the date when services are discontinued and reasons for discontinuation of services.

335.16 Sec. 109. Minnesota Statutes 2018, section 256B.0944, subdivision 1, is amended to read:

335.17 Subdivision 1. **Definitions.** For purposes of this section, the following terms have the
335.18 meanings given them.

335.19 (a) "Mental health crisis" means a child's behavioral, emotional, or psychiatric situation
335.20 that, but for the provision of crisis response services to the child, would likely result in
335.21 significantly reduced levels of functioning in primary activities of daily living, an emergency
335.22 situation, or the child's placement in a more restrictive setting, including, but not limited
335.23 to, inpatient hospitalization.

335.24 (b) "Mental health emergency" means a child's behavioral, emotional, or psychiatric
335.25 situation that causes an immediate need for mental health services and is consistent with
335.26 section 62Q.55. A physician, mental health professional, or ~~crisis mental health practitioner~~
335.27 qualified member of a crisis team determines a mental health crisis or emergency for medical
335.28 assistance reimbursement with input from the client and the client's family, if possible.

335.29 (c) "Mental health crisis assessment" means an immediate face-to-face assessment by
335.30 a physician, mental health professional, or ~~mental health practitioner under the clinical~~
335.31 supervision of a mental health professional qualified member of a crisis team, following a

336.1 screening that suggests the child may be experiencing a mental health crisis or mental health
336.2 emergency situation.

336.3 (d) "Mental health mobile crisis intervention services" means face-to-face, short-term
336.4 intensive mental health services initiated during a mental health crisis or mental health
336.5 emergency. Mental health mobile crisis services must help the recipient cope with immediate
336.6 stressors, identify and utilize available resources and strengths, and begin to return to the
336.7 recipient's baseline level of functioning. Mental health mobile services ~~must be provided~~
336.8 ~~on site by a mobile crisis intervention team outside of an emergency room, urgent care, or~~
336.9 ~~an inpatient hospital setting, including screening and treatment plan recommendations,~~
336.10 must be culturally and linguistically appropriate.

336.11 (e) "Mental health crisis stabilization services" means individualized mental health
336.12 services provided to a recipient following crisis intervention services that are designed to
336.13 restore the recipient to the recipient's prior functional level. The individual treatment plan
336.14 recommending mental health crisis stabilization must be completed by the intervention team
336.15 or by staff after an inpatient or urgent care visit. Mental health crisis stabilization services
336.16 may be provided in the recipient's home, the home of a family member or friend of the
336.17 recipient, schools, another community setting, or a short-term supervised, licensed residential
336.18 program if the service is not included in the facility's cost pool or per diem. Mental health
336.19 crisis stabilization is not reimbursable when provided as part of a partial hospitalization or
336.20 day treatment program.

336.21 (f) "Clinical trainee" means a person qualified according to section 245I.16, subdivision
336.22 6.

336.23 (g) "Mental health certified family peer specialist" means a person qualified according
336.24 to section 245I.16, subdivision 12.

336.25 (h) "Mental health practitioner" means a person qualified according to section 245I.16,
336.26 subdivision 4.

336.27 (i) "Mental health professional" means a person qualified according to section 245I.16,
336.28 subdivision 2.

336.29 Sec. 110. Minnesota Statutes 2018, section 256B.0944, subdivision 3, is amended to read:

336.30 Subd. 3. **Eligibility.** An eligible recipient is an individual who:

- 336.31 (1) is eligible for medical assistance;
- 336.32 (2) is under age 18 or between the ages of 18 and 21;

337.1 (3) is screened as possibly experiencing a mental health crisis or mental health emergency
337.2 where a mental health crisis assessment is needed; and

337.3 (4) is assessed as experiencing a mental health crisis or mental health emergency, and
337.4 mental health mobile crisis intervention or mental health crisis stabilization services are
337.5 determined to be medically necessary; and

337.6 (5) meets the criteria for emotional disturbance or mental illness.

337.7 Sec. 111. Minnesota Statutes 2018, section 256B.0944, subdivision 4, is amended to read:

337.8 **Subd. 4. Provider entity standards.** (a) A crisis intervention and crisis stabilization
337.9 provider entity must meet the administrative and clinical standards specified in section
337.10 256B.0943, subdivisions 5 and 6, meet the standards listed in paragraph (b), and be:

337.11 (1) an Indian health service facility or facility owned and operated by a tribe or a tribal
337.12 organization operating under ~~Public Law 93-638 as a 638 facility United States Code, title~~
337.13 25, section 450f;

337.14 (2) a county board-operated entity; or

337.15 (3) a provider entity that is under contract with the county board in the county where
337.16 the potential crisis or emergency is occurring.

337.17 (b) The children's mental health crisis response services provider entity must:

337.18 (1) ensure that mental health crisis assessment and mobile crisis intervention services
337.19 are available 24 hours a day, seven days a week;

337.20 (2) coordinate services with detoxification or withdrawal management services to ensure
337.21 a recipient receives care that is responsive to the recipient's chemical and mental health
337.22 needs;

337.23 (3) directly provide the services or, if services are subcontracted, the provider entity
337.24 must maintain clinical responsibility for services and billing;

337.25 (3) (4) ensure that crisis intervention services are provided in a manner consistent with
337.26 sections 245.487 to 245.4889; and

337.27 (5) maintain staff training, documentation, and personnel files, including documentation
337.28 of staff completion of required training modules according to sections 245I.32 and 245I.33;

337.29 (6) establish and maintain a quality assurance and evaluation plan to evaluate the
337.30 outcomes of services and recipient satisfaction, including notifying recipients of the process
337.31 by which the county or tribe accepts and responds to concerns;

338.1 ~~(4)(7)~~ develop and maintain written policies and procedures regarding service provision
338.2 that include safety of staff and recipients in high-risk situations; ;

338.3 (8) respond to a call for crisis services in a designated service area, or according to a
338.4 written agreement with the local mental health authority for an adjacent area; and

338.5 (9) document protocol used when delivering services by telemedicine, according to
338.6 sections 62A.67 to 62A.672, including responsibilities of the originating site, the means to
338.7 promote recipient safety, the timelines for connection and response, and the steps to take
338.8 in the event of a lost connection.

338.9 Sec. 112. Minnesota Statutes 2018, section 256B.0944, subdivision 5, is amended to read:

338.10 Subd. 5. **Mobile crisis intervention staff qualifications.** (a) ~~To provide children's~~
338.11 ~~mental health mobile crisis intervention services, a mobile crisis intervention team must~~
338.12 ~~include:~~

338.13 ~~(1) at least two mental health professionals as defined in section 256B.0943, subdivision~~
338.14 ~~1, paragraph (o); or~~

338.15 ~~(2) a combination of at least one mental health professional and one mental health~~
338.16 ~~practitioner as defined in section 245.4871, subdivision 26, with the required mental health~~
338.17 ~~crisis training and under the clinical supervision of a mental health professional on the team.~~
338.18 (a) Mobile crisis intervention team staff must be qualified to provide services as mental
338.19 health professionals, mental health practitioners, clinical trainees, or mental health certified
338.20 family peer specialists.

338.21 (b) A mobile crisis intervention team is comprised of at least two members, one of whom
338.22 must be qualified as a mental health professional. A second member must be qualified as
338.23 a mental health professional, clinical trainee, or mental health practitioner. Additional staff
338.24 must be added to reflect the needs of the area served.

338.25 (c) Mental health crisis assessment and intervention services must be led by a mental
338.26 health professional, or under the supervision of a mental health professional according to
338.27 subdivision 9, by a clinical trainee or mental health practitioner.

338.28 ~~(b) (d) The team must have at least two people with~~ at least one member providing
338.29 on-site crisis intervention services when needed. Team members must be experienced in
338.30 mental health assessment, crisis intervention techniques, and clinical decision making under
338.31 emergency conditions and have knowledge of local services and resources. The team must
338.32 recommend and coordinate the team's services with appropriate local resources, including

339.1 the county social services agency, mental health service providers, and local law enforcement,
339.2 if necessary.

339.3 Sec. 113. Minnesota Statutes 2018, section 256B.0944, subdivision 6, is amended to read:

339.4 **Subd. 6. Initial screening and crisis assessment planning.** (a) Before initiating mobile
339.5 crisis intervention services, a screening of the potential crisis situation must be conducted.
339.6 The screening may use the resources of crisis ~~assistance~~ planning and emergency services
339.7 as defined in sections 245.4871, subdivision 14, and 245.4879, subdivisions 1 and 2. The
339.8 screening must gather information, determine whether a crisis situation exists, identify the
339.9 parties involved, and determine an appropriate response.

339.10 (b) In conducting the screening, a provider shall:

339.11 (1) employ evidence-based practices as identified by the commissioner in collaboration
339.12 with the commissioner of health to reduce the risk of the recipient's suicide and self-injurious
339.13 behavior;

339.14 (2) work with the recipient to establish a plan and time frame for responding to the crisis,
339.15 including immediate needs for support by telephone or text message until a face-to-face
339.16 response arrives;

339.17 (3) document significant factors related to the determination of a crisis, including prior
339.18 calls to the crisis team, recent presentation at an emergency department, known calls to 911
339.19 or law enforcement, or the presence of third parties with knowledge of a potential recipient's
339.20 history or current needs;

339.21 (4) screen for the needs of a third-party caller, including a recipient who primarily
339.22 identifies as a family member or a caregiver but also presents signs of a crisis; and

339.23 (5) provide psychoeducation, including education on the available means for reducing
339.24 self-harm, to relevant third parties, including family members or other persons living in the
339.25 home.

339.26 (c) A provider entity shall consider the following to indicate a positive screening unless
339.27 the provider entity documents specific evidence to show why crisis response was clinically
339.28 inappropriate:

339.29 (1) the recipient presented in an emergency department or urgent care setting, and the
339.30 health care team at that location requested crisis services;

339.31 (2) a peace officer requested crisis services for a recipient who may be subject to
339.32 transportation under section 253B.05 for a mental health crisis.

340.1 ~~(b)~~(d) If a crisis exists, a crisis assessment must be completed. A crisis assessment must
340.2 evaluate any immediate needs for which emergency services are needed and, as time permits,
340.3 the recipient's current life situation, sources of stress, mental health problems and symptoms,
340.4 strengths, cultural considerations, support network, vulnerabilities, and current functioning.

340.5 ~~(e)~~(e) If the crisis assessment determines mobile crisis intervention services are needed,
340.6 the intervention services must be provided promptly. As the opportunity presents itself
340.7 during the intervention, at least two members of the mobile crisis intervention team must
340.8 confer directly or by telephone about the assessment, treatment plan, and actions taken and
340.9 needed. At least one of the team members must be on site providing crisis intervention
340.10 services. If providing on-site crisis intervention services, a mental health practitioner must
340.11 seek ~~clinical~~ treatment supervision as required under subdivision 9.

340.12 (f) Direct contact with the recipient is not required before initiating a crisis assessment
340.13 or intervention service. A crisis team may gather relevant information from a third party at
340.14 the scene to establish the need for services and potential safety factors. A crisis assessment
340.15 is provided face-to-face by a mobile crisis intervention team outside of an inpatient hospital
340.16 setting. A service must be provided promptly and respond to the recipient's location whenever
340.17 possible, including community or clinical settings. As clinically appropriate, a mobile crisis
340.18 intervention team must coordinate a response with other health care providers if a recipient
340.19 requires detoxification, withdrawal management, or medical stabilization services in addition
340.20 to crisis services.

340.21 ~~(d)~~(g) The mobile crisis intervention team must develop an initial, brief crisis treatment
340.22 plan as soon as appropriate but no later than 24 hours after the initial face-to-face intervention.
340.23 The plan must address the needs and problems noted in the crisis assessment and include
340.24 measurable short-term goals, cultural considerations, and frequency and type of services to
340.25 be provided to achieve the goals and reduce or eliminate the crisis. The crisis treatment plan
340.26 must be updated as needed to reflect current goals and services. The team must involve the
340.27 client and the client's family in developing and implementing the plan.

340.28 ~~(e)~~(h) The team must document in progress notes which short-term goals have been
340.29 met and when no further crisis intervention services are required. If after an assessment a
340.30 crisis provider entity refers a recipient to an intensive setting, including an emergency
340.31 department, in-patient hospitalization, or residential treatment, one of the crisis team members
340.32 who performed or conferred on the assessment must immediately contact the provider entity
340.33 and consult with the triage nurse or other staff responsible for intake. The crisis team member
340.34 must convey key findings or concerns that led to the referral. The consultation must occur
340.35 with the recipient's consent, the recipient's legal guardian's consent, or as allowed by section

341.1 144.293, subdivision 5. Any available written documentation, including a crisis treatment
341.2 plan, must be sent no later than the next business day.

341.3 (f) (i) If the client's crisis is stabilized, but the client needs a referral for mental health
341.4 crisis stabilization services or to other services, the team must provide a referral to these
341.5 services. If the recipient has a case manager, planning for other services must be coordinated
341.6 with the case manager.

341.7 Sec. 114. Minnesota Statutes 2018, section 256B.0944, subdivision 7, is amended to read:

341.8 **Subd. 7. Crisis stabilization services.** Crisis stabilization services ~~must be provided by~~
341.9 ~~a mental health professional or a mental health practitioner, as defined in section 245.462,~~
341.10 ~~subdivision 17, who works under the clinical supervision of a mental health professional~~
341.11 ~~and for a crisis stabilization services provider entity and~~ must meet the following standards:

341.12 (1) a crisis stabilization treatment plan must be developed which meets the criteria in
341.13 subdivision 8;

341.14 (2) services must be delivered according to the treatment plan and include face-to-face
341.15 contact with the recipient by qualified staff for further assessment, help with referrals,
341.16 updating the crisis stabilization treatment plan, supportive counseling, skills training, and
341.17 collaboration with other service providers in the community; and

341.18 (3) staff other than a mental health practitioners professional must have completed at
341.19 least 30 hours of training in crisis intervention and stabilization during the past two years.

341.20 Sec. 115. Minnesota Statutes 2018, section 256B.0944, subdivision 8, is amended to read:

341.21 **Subd. 8. Treatment plan.** (a) The individual crisis stabilization treatment plan must
341.22 include, at a minimum:

341.23 (1) a list of problems identified in the assessment;

341.24 (2) a list of the recipient's strengths and resources;

341.25 (3) concrete, measurable short-term goals and tasks to be achieved, including time frames
341.26 for achievement of the goals;

341.27 (4) specific objectives directed toward the achievement of each goal;

341.28 (5) documentation of the participants involved in the service planning;

341.29 (6) planned frequency and type of services initiated;

341.30 (7) a crisis response action plan if a crisis should occur; and

342.1 (8) clear progress notes on the outcome of goals.

342.2 (b) The client, if clinically appropriate, must be a participant in the development of the
342.3 crisis stabilization treatment plan. The client or the client's legal guardian must sign the
342.4 service plan or documentation must be provided why this was not possible. A copy of the
342.5 plan must be given to the client and the client's legal guardian. The plan should include
342.6 services arranged, including specific providers where applicable.

342.7 (c) A treatment plan must be developed by a mental health professional, clinical trainee,
342.8 or mental health practitioner ~~under the clinical supervision of a mental health professional~~.
342.9 A written plan must be completed within 24 hours of beginning services with the client.

342.10 Sec. 116. Minnesota Statutes 2018, section 256B.0944, subdivision 9, is amended to read:

342.11 Subd. 9. **Supervision.** ~~(a)~~ A mental health practitioner or clinical trainee may provide
342.12 crisis assessment and mobile crisis intervention services if the following ~~clinical treatment~~
342.13 supervision requirements are met:

342.14 (1) the mental health provider entity must accept full responsibility for the services
342.15 provided;

342.16 (2) the mental health professional of the provider entity, who is an employee or under
342.17 contract with the provider entity, must be immediately available by telephone or in person
342.18 for ~~clinical treatment~~ supervision;

342.19 (3) the mental health professional is consulted, in person or by telephone, during the
342.20 first three hours when a mental health practitioner provides on-site service; and

342.21 (4) the mental health professional must review and approve the tentative crisis assessment
342.22 and crisis treatment plan, document the consultation, and sign the crisis assessment and
342.23 treatment plan within the next business day.

342.24 ~~(b) If the mobile crisis intervention services continue into a second calendar day, a mental~~
342.25 ~~health professional must contact the client face-to-face on the second day to provide services~~
342.26 ~~and update the crisis treatment plan. The on-site observation must be documented in the~~
342.27 ~~client's record and signed by the mental health professional.~~

342.28 Sec. 117. Minnesota Statutes 2018, section 256B.0946, subdivision 1, is amended to read:

342.29 Subdivision 1. **Required covered service components.** ~~(a) Effective May 23, 2013,~~
342.30 ~~and subject to federal approval,~~ Medical assistance covers medically necessary intensive
342.31 treatment services described under paragraph (b) that are provided by a provider entity

343.1 eligible under subdivision 3 to a client eligible under subdivision 2 who is placed in a foster
343.2 home licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or placed in a foster
343.3 home licensed under the regulations established by a federally recognized Minnesota tribe.

343.4 (b) Intensive treatment services to children with mental illness residing in foster family
343.5 settings that comprise specific required service components provided in clauses (1) to (5)
343.6 are reimbursed by medical assistance when they meet the following standards:

343.7 (1) psychotherapy provided by a mental health professional as defined in Minnesota
343.8 Rules, part 9505.0371, subpart 5, item A, or a clinical trainee, as defined in Minnesota
343.9 Rules, part 9505.0371, subpart 5, item C;

343.10 (2) crisis assistance planning provided according to standards for children's therapeutic
343.11 services and supports in section 256B.0943;

343.12 (3) individual, family, and group psychoeducation services, defined in subdivision 1a,
343.13 paragraph (e)(o), provided by a mental health professional or a clinical trainee;

343.14 (4) clinical care consultation, as defined in subdivision 1a, and provided by a mental
343.15 health professional or a clinical trainee; and

343.16 (5) service delivery payment requirements as provided under subdivision 4.

343.17 Sec. 118. Minnesota Statutes 2018, section 256B.0946, subdivision 1a, is amended to
343.18 read:

343.19 Subd. 1a. **Definitions.** For the purposes of this section, the following terms have the
343.20 meanings given them.

343.21 (a) "Clinical care consultation" means communication from a treating clinician to other
343.22 providers working with the same client to inform, inquire, and instruct regarding the client's
343.23 symptoms, strategies for effective engagement, care and intervention needs, and treatment
343.24 expectations across service settings, including but not limited to the client's school, social
343.25 services, day care, probation, home, primary care, medication prescribers, disabilities
343.26 services, and other mental health providers and to direct and coordinate clinical service
343.27 components provided to the client and family.

343.28 (b) "Clinical supervision" means the documented time a clinical supervisor and supervisee
343.29 spend together to discuss the supervisee's work, to review individual client cases, and for
343.30 the supervisee's professional development. It includes the documented oversight and
343.31 supervision responsibility for planning, implementation, and evaluation of services for a
343.32 client's mental health treatment.

344.1 ~~(e) "Clinical supervisor" means the mental health professional who is responsible for clinical supervision.~~

344.3 ~~(d)~~ (b) "Clinical trainee" has the meaning given in Minnesota Rules, part 9505.0371, subpart 5, item C means a staff person qualified according to section 245I.16, subdivision 6;

344.6 ~~(e)~~ (c) "Crisis assistance planning" has the meaning given in section 245.4871, subdivision 9a, including the development of a plan that addresses prevention and intervention strategies to be used in a potential crisis, but does not include actual crisis intervention.

344.9 ~~(f)~~ (d) "Culturally appropriate" means providing mental health services in a manner that incorporates the child's cultural influences, as defined in Minnesota Rules, part 9505.0370, subpart 9, into interventions as a way to maximize resiliency factors and utilize cultural strengths and resources to promote overall wellness.

344.13 ~~(g)~~ (e) "Culture" means the distinct ways of living and understanding the world that are used by a group of people and are transmitted from one generation to another or adopted by an individual.

344.16 ~~(h)~~ (f) "Diagnostic assessment" has the meaning given in Minnesota Rules, part 9505.0370, subpart 11 means an assessment described under section 256B.0671, subdivisions 2 and 3.

344.19 ~~(i)~~ (g) "Family" means a person who is identified by the client or the client's parent or guardian as being important to the client's mental health treatment. Family may include, but is not limited to, parents, foster parents, children, spouse, committed partners, former spouses, persons related by blood or adoption, persons who are a part of the client's permanency plan, or persons who are presently residing together as a family unit.

344.24 ~~(j)~~ (h) "Foster care" has the meaning given in section 260C.007, subdivision 18.

344.25 ~~(k)~~ (i) "Foster family setting" means the foster home in which the license holder resides.

344.26 ~~(l)~~ (j) "Individual treatment plan" has the meaning given in Minnesota Rules, part 9505.0370, subpart 15 means the plan described under section 256B.0671, subdivisions 5 and 6.

344.29 ~~(m)~~ (m) "Mental health practitioner" has the meaning given in section 245.462, subdivision 17, and a mental health practitioner working as a clinical trainee according to Minnesota Rules, part 9505.0371, subpart 5, item C.

345.1 (k) "Mental health certified family peer specialist" means a staff person qualified
345.2 according to section 245I.16, subdivision 12.

345.3 (n) (1) "Mental health professional" has the meaning given in Minnesota Rules, part
345.4 9505.0370, subpart 18 means a staff person qualified according to section 245I.16,
345.5 subdivision 2.

345.6 ~~(e)~~ (m) "Mental illness" has the meaning given in Minnesota Rules, part 9505.0370,
345.7 subpart 20 section 245.462, subdivision 20, paragraph (a), and includes emotional disturbance
345.8 as defined in section 245.4871, subdivision 15.

345.9 ~~(p)~~ (n) "Parent" has the meaning given in section 260C.007, subdivision 25.

345.10 ~~(q)~~ (o) "Psychoeducation services" means information or demonstration provided to an
345.11 individual, family, or group to explain, educate, and support the individual, family, or group
345.12 in understanding a child's symptoms of mental illness, the impact on the child's development,
345.13 and needed components of treatment and skill development so that the individual, family,
345.14 or group can help the child to prevent relapse, prevent the acquisition of comorbid disorders,
345.15 and achieve optimal mental health and long-term resilience.

345.16 ~~(r)~~ (p) "Psychotherapy" has the meaning given in Minnesota Rules, part 9505.0370,
345.17 subpart 27 section 256B.0625, subdivision 69.

345.18 ~~(s)~~ (q) "Team consultation and treatment planning" means the coordination of treatment
345.19 plans and consultation among providers in a group concerning the treatment needs of the
345.20 child, including disseminating the child's treatment service schedule to all members of the
345.21 service team. Team members must include all mental health professionals working with the
345.22 child, a parent, the child unless the team lead or parent deem it clinically inappropriate, and
345.23 at least two of the following: an individualized education program case manager; probation
345.24 agent; children's mental health case manager; child welfare worker, including adoption or
345.25 guardianship worker; primary care provider; foster parent; and any other member of the
345.26 child's service team.

345.27 (r) "Trauma" has the meaning given in section 245I.02, subdivision 24.

345.28 (s) "Treatment supervision" means the supervision described under section 245I.18.

345.29 (t) "Treatment supervisor" means the mental health professional who is responsible for
345.30 treatment supervision.

346.1 Sec. 119. Minnesota Statutes 2018, section 256B.0946, subdivision 2, is amended to read:

346.2 Subd. 2. **Determination of client eligibility.** (a) An eligible recipient is an individual, from birth through age 20, who is currently placed in a foster home licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, and has received a diagnostic assessment and an evaluation of level of care needed, as defined in paragraphs (a)(b) and (b)(c).

346.6 (a)(b) The diagnostic assessment must:

346.7 ~~(1) meet criteria described in Minnesota Rules, part 9505.0372, subpart 1, and be conducted by a mental health professional or a clinical trainee;~~

346.9 ~~(2) determine whether or not a child meets the criteria for mental illness, as defined in Minnesota Rules, part 9505.0370, subpart 20;~~

346.11 ~~(3)~~(1) document that intensive treatment services are medically necessary within a foster family setting to ameliorate identified symptoms and functional impairments; and

346.13 ~~(4)~~(2) be performed within 180 days before the start of service; and

346.14 ~~(5) be completed as either a standard or extended diagnostic assessment annually to determine continued eligibility for the service.~~

346.16 (b)(c) The evaluation of level of care must be conducted by the placing county, tribe, or case manager in conjunction with the diagnostic assessment ~~as described by Minnesota Rules, part 9505.0372, subpart 1, item B~~, using a validated tool approved by the commissioner of human services and not subject to the rulemaking process, consistent with section 245.4885, subdivision 1, paragraph (d), the result of which evaluation demonstrates that the child requires intensive intervention without 24-hour medical monitoring. The commissioner shall update the list of approved level of care tools annually and publish on the department's website.

346.24 Sec. 120. Minnesota Statutes 2018, section 256B.0946, subdivision 3, is amended to read:

346.25 Subd. 3. **Eligible mental health services providers.** (a) Eligible providers for intensive children's mental health services in a foster family setting must be certified by the state and have a service provision contract with a county board or a reservation tribal council and must be able to demonstrate the ability to provide all of the services required in this section and meet the requirements under chapter 245I.

346.30 (b) For purposes of this section, a provider agency must be:

346.31 (1) a county-operated entity certified by the state;

347.1 (2) an Indian Health Services facility operated by a tribe or tribal organization under
347.2 funding authorized by United States Code, title 25, sections 450f to 450n, or title 3 of the
347.3 Indian Self-Determination Act, Public Law 93-638, section 638 (facilities or providers); or
347.4 (3) a noncounty entity.

347.5 (c) Certified providers that do not meet the service delivery standards required in this
347.6 section shall be subject to a decertification process.

347.7 (d) For the purposes of this section, all services delivered to a client must be provided
347.8 by a mental health professional ~~or~~, a clinical trainee, or a mental health certified family peer
347.9 specialist.

347.10 Sec. 121. Minnesota Statutes 2018, section 256B.0946, subdivision 4, is amended to read:

347.11 **Subd. 4. Service delivery payment requirements.** (a) To be eligible for payment under
347.12 this section, a provider must develop and practice written policies and procedures for
347.13 intensive treatment in foster care, consistent with subdivision 1, paragraph (b), and comply
347.14 with the following requirements in paragraphs (b) to ~~(n)~~ (m).

347.15 ~~(b) A qualified clinical supervisor, as defined in and performing in compliance with~~
347.16 ~~Minnesota Rules, part 9505.0371, subpart 5, item D, must supervise the treatment and~~
347.17 ~~provision of services described in this section.~~

347.18 ~~(c) Each client receiving treatment services must receive an extended diagnostic~~
347.19 ~~assessment, as described in Minnesota Rules, part 9505.0372, subpart 1, item C, within 30~~
347.20 ~~days of enrollment in this service unless the client has a previous extended diagnostic~~
347.21 ~~assessment that the client, parent, and mental health professional agree still accurately~~
347.22 ~~describes the client's current mental health functioning.~~

347.23 ~~(b) For children under age six, each client must receive a diagnostic assessment according~~
347.24 ~~to the requirements in the current edition of the Diagnostic Classification of Mental Health~~
347.25 ~~Disorders of Infancy and Early Childhood.~~

347.26 ~~(d) (c) Each previous and current mental health, school, and physical health treatment~~
347.27 provider must be contacted to request documentation of treatment and assessments that the
347.28 eligible client has received. This information must be reviewed and incorporated into the
347.29 diagnostic assessment and team consultation and treatment planning review process.

347.30 ~~(e) (d) Each client receiving treatment must be assessed for a trauma history, and the~~
347.31 client's treatment plan must document how the results of the assessment will be incorporated
347.32 into treatment.

348.1 ~~(f)~~ (e) Each client receiving treatment services must have an individual treatment plan
348.2 that is reviewed, evaluated, and ~~signed~~ approved every 90 days using the team consultation
348.3 and treatment planning process, as defined in subdivision 1a, paragraph ~~(s)~~ (p).

348.4 ~~(g)~~ (f) Clinical care consultation, as defined in subdivision 1a, paragraph (a), must be
348.5 provided in accordance with the client's individual treatment plan.

348.6 ~~(h)~~ (g) Each client must have a crisis ~~assistance~~ plan within ten days of initiating services
348.7 and must have access to clinical phone support 24 hours per day, seven days per week,
348.8 during the course of treatment. The crisis plan must demonstrate coordination with the local
348.9 or regional mobile crisis intervention team.

348.10 ~~(i)~~ (h) Services must be delivered and documented at least three days per week, equaling
348.11 at least six hours of treatment per week, unless reduced units of service are specified on the
348.12 treatment plan as part of transition or on a discharge plan to another service or level of care.
348.13 Documentation must comply with Minnesota Rules, parts 9505.2175 and 9505.2197.

348.14 ~~(j)~~ (i) Location of service delivery must be in the client's home, day care setting, school,
348.15 or other community-based setting that is specified on the client's individualized treatment
348.16 plan.

348.17 ~~(k)~~ (j) Treatment must be developmentally and culturally appropriate for the client.

348.18 ~~(l)~~ (k) Services must be delivered in continual collaboration and consultation with the
348.19 client's medical providers and, in particular, with prescribers of psychotropic medications,
348.20 including those prescribed on an off-label basis. Members of the service team must be aware
348.21 of the medication regimen and potential side effects.

348.22 ~~(m)~~ (l) Parents, siblings, foster parents, and members of the child's permanency plan
348.23 must be involved in treatment and service delivery unless otherwise noted in the treatment
348.24 plan.

348.25 ~~(n)~~ (m) Transition planning for the child must be conducted starting with the first
348.26 treatment plan and must be addressed throughout treatment to support the child's permanency
348.27 plan and postdischarge mental health service needs.

348.28 Sec. 122. Minnesota Statutes 2018, section 256B.0946, subdivision 6, is amended to read:

348.29 Subd. 6. **Excluded services.** (a) Services in clauses (1) to (7) are not covered under this
348.30 section and are not eligible for medical assistance payment as components of intensive
348.31 treatment in foster care services, but may be billed separately:

348.32 (1) inpatient psychiatric hospital treatment;

- 349.1 (2) mental health targeted case management;
- 349.2 (3) partial hospitalization;
- 349.3 (4) medication management;
- 349.4 (5) children's mental health day treatment services;
- 349.5 (6) crisis response services under section 256B.0944; and
- 349.6 (7) transportation.
- 349.7 (b) Children receiving intensive treatment in foster care services are not eligible for
349.8 medical assistance reimbursement for the following services while receiving intensive
349.9 treatment in foster care:
- 349.10 (1) psychotherapy and skills training components of children's therapeutic services and
349.11 supports under section 256B.0625, subdivision 35b;
- 349.12 (2) mental health behavioral aide services as defined in section 256B.0943, subdivision
349.13 1, paragraph ~~(m)~~(l);
- 349.14 (3) home and community-based waiver services;
- 349.15 (4) mental health residential treatment; and
- 349.16 (5) room and board costs as defined in section 256I.03, subdivision 6.
- 349.17 Sec. 123. Minnesota Statutes 2018, section 256B.0947, subdivision 1, is amended to read:
- 349.18 Subdivision 1. **Scope.** ~~Effective November 1, 2011, and subject to federal approval,~~
349.19 Medical assistance covers medically necessary, intensive nonresidential rehabilitative mental
349.20 health services as defined in subdivision 2, for recipients as defined in subdivision 3, when
349.21 the services are provided by an entity meeting the standards in this section.
- 349.22 Sec. 124. Minnesota Statutes 2018, section 256B.0947, subdivision 2, is amended to read:
- 349.23 Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings
349.24 given them.
- 349.25 (a) "Intensive nonresidential rehabilitative mental health services" means child
349.26 rehabilitative mental health services as defined in section 256B.0943, except that these
349.27 services are provided by a multidisciplinary staff using ~~a total team~~an approach consistent
349.28 with assertive community treatment, as adapted for youth, and are directed to recipients
349.29 ~~ages 16, 17, 18, 19, or 20 with a serious mental illness or co-occurring mental illness and~~
349.30 ~~substance abuse addiction~~ who require intensive services to prevent admission to an inpatient

350.1 psychiatric hospital or placement in a residential treatment facility or who require intensive
350.2 services to step down from inpatient or residential care to community-based care.

350.3 (b) "Co-occurring mental illness and substance abuse addiction" means a dual diagnosis
350.4 of at least one form of mental illness and at least one substance use disorder. Substance use
350.5 disorders include alcohol or drug abuse or dependence, excluding nicotine use.

350.6 (c) "Diagnostic assessment" ~~has the meaning given to it in Minnesota Rules, part~~
350.7 ~~9505.0370, subpart 11. A diagnostic assessment must be provided according to Minnesota~~
350.8 ~~Rules, part 9505.0372, subpart 1, means the assessment described under section 256B.0671,~~
350.9 ~~subdivisions 2 and 3, and for this section must incorporate a determination of the youth's~~
350.10 necessary level of care using a standardized functional assessment instrument approved and
350.11 periodically updated by the commissioner.

350.12 (d) "Education specialist" means an individual with knowledge and experience working
350.13 with youth regarding special education requirements and goals, special education plans,
350.14 and coordination of educational activities with health care activities.

350.15 (e) "Housing access support" means an ancillary activity to help an individual find,
350.16 obtain, retain, and move to safe and adequate housing. Housing access support does not
350.17 provide monetary assistance for rent, damage deposits, or application fees.

350.18 (f) "Integrated dual disorders treatment" means the integrated treatment of co-occurring
350.19 mental illness and substance use disorders by a team of cross-trained clinicians within the
350.20 same program, and is characterized by assertive outreach, stage-wise comprehensive
350.21 treatment, treatment goal setting, and flexibility to work within each stage of treatment.

350.22 (g) "Medication education services" means services provided individually or in groups,
350.23 which focus on:

350.24 (1) educating the client and client's family or significant nonfamilial supporters about
350.25 mental illness and symptoms;

350.26 (2) the role and effects of medications in treating symptoms of mental illness; and

350.27 (3) the side effects of medications.

350.28 Medication education is coordinated with medication management services and does not
350.29 duplicate it. Medication education services are provided by physicians, pharmacists, or
350.30 registered nurses with certification in psychiatric and mental health care.

351.1 (h) "Peer specialist" means an employed team member who is a mental health certified
351.2 peer specialist according to section 256B.0615 and also a former children's mental health
351.3 consumer who:

351.4 (1) ~~provides direct services to clients including social, emotional, and instrumental~~
351.5 ~~support and outreach;~~

351.6 (2) ~~assists younger peers to identify and achieve specific life goals;~~

351.7 (3) ~~works directly with clients to promote the client's self-determination, personal~~
351.8 ~~responsibility, and empowerment;~~

351.9 (4) ~~assists youth with mental illness to regain control over their lives and their~~
351.10 ~~developmental process in order to move effectively into adulthood;~~

351.11 (5) ~~provides training and education to other team members, consumer advocacy~~
351.12 ~~organizations, and clients on resiliency and peer support; and~~

351.13 (6) ~~meets the following criteria:~~

351.14 (i) ~~is at least 22 years of age;~~

351.15 (ii) ~~has had a diagnosis of mental illness, as defined in Minnesota Rules, part 9505.0370,~~
351.16 ~~subpart 20, or co-occurring mental illness and substance abuse addiction;~~

351.17 (iii) ~~is a former consumer of child and adolescent mental health services, or a former or~~
351.18 ~~current consumer of adult mental health services for a period of at least two years;~~

351.19 (iv) ~~has at least a high school diploma or equivalent;~~

351.20 (v) ~~has successfully completed training requirements determined and periodically updated~~
351.21 ~~by the commissioner;~~

351.22 (vi) ~~is willing to disclose the individual's own mental health history to team members~~
351.23 ~~and clients; and~~

351.24 (vii) ~~must be free of substance use problems for at least one year.~~

351.25 (i) ~~"Provider agency" means a for-profit or nonprofit organization established to~~
351.26 ~~administer an assertive community treatment for youth team.~~

351.27 (j) "Substance use disorders" means one or more of the disorders defined in the
351.28 Diagnostic and Statistical Manual of Mental Disorders, current edition.

351.29 (k) "Transition services" means:

352.1 (1) activities, materials, consultation, and coordination that ensures continuity of the
352.2 client's care in advance of and in preparation for the client's move from one stage of care
352.3 or life to another by maintaining contact with the client and assisting the client to establish
352.4 provider relationships;

352.5 (2) providing the client with knowledge and skills needed posttransition;

352.6 (3) establishing communication between sending and receiving entities;

352.7 (4) supporting a client's request for service authorization and enrollment; and

352.8 (5) establishing and enforcing procedures and schedules.

352.9 A youth's transition from the children's mental health system and services to the adult
352.10 mental health system and services and return to the client's home and entry or re-entry into
352.11 community-based mental health services following discharge from an out-of-home placement
352.12 or inpatient hospital stay.

352.13 ~~(1)~~ (k) "Treatment team" means all staff who provide services to recipients under this
352.14 section.

352.15 Sec. 125. Minnesota Statutes 2018, section 256B.0947, subdivision 3, is amended to read:

352.16 Subd. 3. **Client eligibility.** An eligible recipient is an individual who:

352.17 (1) is age 16, 17, 18, 19, or 20; and

352.18 (2) is diagnosed with a serious mental illness or co-occurring mental illness and substance
352.19 abuse addiction, for which intensive nonresidential rehabilitative mental health services are
352.20 needed;

352.21 (3) has received a level-of-care determination, using an instrument approved by the
352.22 commissioner, that indicates a need for intensive integrated intervention without 24-hour
352.23 medical monitoring and a need for extensive collaboration among multiple providers;

352.24 (4) has a functional impairment and a history of difficulty in functioning safely and
352.25 successfully in the community, school, home, or job; or who is likely to need services from
352.26 the adult mental health system within the next two years; and

352.27 (5) has had a recent diagnostic assessment, as provided in Minnesota Rules, part
352.28 9505.0372, subpart 1, by a mental health professional who is qualified under Minnesota
352.29 Rules, part 9505.0371, subpart 5, item A, that documents that intensive nonresidential
352.30 rehabilitative mental health services are medically necessary to ameliorate identified
352.31 symptoms and functional impairments and to achieve individual transition goals.

353.1 Sec. 126. Minnesota Statutes 2018, section 256B.0947, subdivision 3a, is amended to
353.2 read:

353.3 **Subd. 3a. Required service components.** ~~(a) Subject to federal approval, medical~~
353.4 ~~assistance covers all medically necessary intensive nonresidential rehabilitative mental~~
353.5 ~~health services and supports, as defined in this section, under a single daily rate per client.~~
353.6 ~~Services and supports must be delivered by an eligible provider under subdivision 5 to an~~
353.7 ~~eligible client under subdivision 3.~~

353.8 ~~(b)~~ **(a)** Intensive nonresidential rehabilitative mental health services, supports, and
353.9 ancillary activities covered by the single daily rate per client must include the following,
353.10 as needed by the individual client:

353.11 (1) individual, family, and group psychotherapy;

353.12 (2) individual, family, and group skills training, as defined in section 256B.0943,
353.13 subdivision 1, paragraph (t);

353.14 (3) crisis ~~assistance planning~~ as defined in section 245.4871, subdivision 9a, which
353.15 ~~includes recognition of factors precipitating a mental health crisis, identification of behaviors~~
353.16 ~~related to the crisis, and the development of a plan to address prevention, intervention, and~~
353.17 ~~follow-up strategies to be used in the lead-up to or onset of, and conclusion of, a mental~~
353.18 ~~health crisis; crisis assistance does not mean crisis response services or crisis intervention~~
353.19 ~~services provided in section 256B.0944~~ 256B.0943, subdivision 1, paragraph (c);

353.20 (4) medication management provided by a physician or an advanced practice registered
353.21 nurse with certification in psychiatric and mental health care;

353.22 (5) mental health case management as provided in section 256B.0625, subdivision 20;

353.23 (6) medication education services ~~as defined in this section~~;

353.24 (7) care coordination by a client-specific lead worker assigned by and responsible to the
353.25 treatment team;

353.26 (8) psychoeducation of and consultation and coordination with the client's biological,
353.27 adoptive, or foster family and, in the case of a youth living independently, the client's
353.28 immediate nonfamilial support network;

353.29 (9) clinical consultation to a client's employer or school or to other service agencies or
353.30 to the courts to assist in managing the mental illness or co-occurring disorder and to develop
353.31 client support systems;

354.1 (10) coordination with, or performance of, crisis intervention and stabilization services
354.2 as defined in section 256B.0944;

354.3 (11) assessment of a client's treatment progress and effectiveness of services using
354.4 standardized outcome measures published by the commissioner;

354.5 (12) transition services as defined in this section;

354.6 (13) integrated dual disorders treatment as defined in this section; and

354.7 (14) housing access support.

354.8 ~~(e)~~ (b) The provider shall ensure and document the following by means of performing
354.9 the required function or by contracting with a qualified person or entity:

354.10 (1) client access to crisis intervention services, as defined in section 256B.0944, and
354.11 available 24 hours per day and seven days per week; and

354.12 ~~(2) completion of an extended diagnostic assessment, as defined in Minnesota Rules,~~
354.13 ~~part 9505.0372, subpart 1, item C;~~ and

354.14 ~~(3)~~ (2) determination of the client's needed level of care using an instrument approved
354.15 and periodically updated by the commissioner.

354.16 Sec. 127. Minnesota Statutes 2018, section 256B.0947, subdivision 5, is amended to read:

354.17 **Subd. 5. Standards for intensive nonresidential rehabilitative providers.** (a) Services
354.18 must be provided by a provider entity as provided in subdivision 4.

354.19 (b) The treatment team for intensive nonresidential rehabilitative mental health services
354.20 comprises both permanently employed core team members and client-specific team members
354.21 as follows:

354.22 (1) ~~The core treatment team is an entity that operates under the direction of an~~
354.23 ~~independently licensed mental health professional, who is qualified under Minnesota Rules,~~
354.24 ~~part 9505.0371, subpart 5, item A, and that assumes comprehensive clinical responsibility~~
354.25 ~~for clients.~~ Based on professional qualifications and client needs, clinically qualified core
354.26 team members are assigned on a rotating basis as the client's lead worker to coordinate a
354.27 client's care. The core team must comprise at least four full-time equivalent direct care staff
354.28 and must include, ~~but is not limited to~~ at a minimum:

354.29 (i) ~~an independently licensed a~~ mental health professional, ~~qualified under Minnesota~~
354.30 ~~Rules, part 9505.0371, subpart 5, item A,~~ who serves as team leader to provide administrative
354.31 direction and clinical treatment supervision to the team;

355.1 (ii) an advanced-practice registered nurse with certification in psychiatric or mental
355.2 health care or a board-certified child and adolescent psychiatrist, either of which must be
355.3 credentialed to prescribe medications;

355.4 (iii) a licensed alcohol and drug counselor who is also trained in mental health
355.5 interventions; and

355.6 (iv) a peer specialist ~~as defined in subdivision 2, paragraph (h).~~

355.7 (2) The core team may also include any of the following:

355.8 (i) additional mental health professionals;

355.9 (ii) a vocational specialist;

355.10 (iii) an educational specialist;

355.11 (iv) a child and adolescent psychiatrist who may be retained on a consultant basis;

355.12 (v) a mental health practitioner, ~~as defined in~~ qualified according to section 245.4871,
355.13 subdivision 26 ~~245I.16~~, subdivision 4;

355.14 (vi) a mental health manager, as defined in section 245.4871, subdivision 4; ~~and~~

355.15 (vii) a housing access specialist; ~~and~~

355.16 (viii) a clinical trainee qualified according to section 245I.16, subdivision 6.

355.17 (3) A treatment team may include, in addition to those in ~~elause clauses~~ (1) ~~or~~ and (2),
355.18 ad hoc members not employed by the team who consult on a specific client and who must
355.19 accept overall clinical direction from the treatment team for the duration of the client's
355.20 placement with the treatment team and must be paid by the provider agency at the rate for
355.21 ~~a typical session by that provider with that client or at a rate negotiated with the client-specific~~
355.22 ~~member entity~~. Client-specific treatment team members may include:

355.23 (i) the mental health professional treating the client prior to placement with the treatment
355.24 team;

355.25 (ii) the client's current substance abuse counselor, if applicable;

355.26 (iii) a lead member of the client's individualized education program team or school-based
355.27 mental health provider, if applicable;

355.28 (iv) a representative from the client's health care home or primary care clinic, as needed
355.29 to ensure integration of medical and behavioral health care;

356.1 (v) the client's probation officer or other juvenile justice representative, if applicable;

356.2 and

356.3 (vi) the client's current vocational or employment counselor, if applicable.

356.4 (c) The clinical treatment supervisor shall be an active member of the treatment team
356.5 and shall function as a practicing clinician at least on a part-time basis. The treatment team
356.6 shall meet with the clinical treatment supervisor at least weekly to discuss recipients' progress
356.7 and make rapid adjustments to meet recipients' needs. The team meeting must include
356.8 client-specific case reviews and general treatment discussions among team members.
356.9 Client-specific case reviews and planning must be documented in the individual client's
356.10 treatment record.

356.11 (d) The staffing ratio must not exceed ten clients to one full-time equivalent treatment
356.12 team position.

356.13 (e) The treatment team shall serve no more than 80 clients at any one time. Should local
356.14 demand exceed the team's capacity, an additional team must be established rather than
356.15 exceed this limit.

356.16 (f) Nonclinical staff shall have prompt access in person or by telephone to a mental
356.17 health practitioner or mental health professional. The provider shall have the capacity to
356.18 promptly and appropriately respond to emergent needs and make any necessary staffing
356.19 adjustments to assure the health and safety of clients.

356.20 (g) The intensive nonresidential rehabilitative mental health services provider shall
356.21 participate in evaluation of the assertive community treatment for youth (Youth ACT) model
356.22 as conducted by the commissioner, including the collection and reporting of data and the
356.23 reporting of performance measures as specified by contract with the commissioner.

356.24 (h) A regional treatment team may serve multiple counties.

356.25 Sec. 128. Minnesota Statutes 2018, section 256B.0947, subdivision 6, is amended to read:

356.26 **Subd. 6. Service standards.** The standards in this subdivision apply to intensive
356.27 nonresidential rehabilitative mental health services.

356.28 (a) The treatment team shall use team treatment, not an individual treatment model.

356.29 (b) Services must be available at times that meet client needs.

356.30 (c) The initial functional assessment must be completed within ten days of intake and
356.31 updated at least every three months or prior to discharge from the service, whichever comes
356.32 first.

357.1 (d) An individual treatment plan must be completed for each client, according to criteria
357.2 specified in section ~~256B.0943, subdivision 6, paragraph (b), clause (2)~~ 256B.0671,
357.3 subdivisions 5 and 6, and, additionally, must:

357.4 (1) be completed in consultation with the client's current therapist and key providers and
357.5 provide for ongoing consultation with the client's current therapist to ensure therapeutic
357.6 continuity and to facilitate the client's return to the community;

357.7 (2) if a need for substance use disorder treatment is indicated by validated assessment:

357.8 (i) identify goals, objectives, and strategies of substance use disorder treatment; develop
357.9 a schedule for accomplishing treatment goals and objectives; and identify the individuals
357.10 responsible for providing treatment services and supports; and

357.11 (ii) ~~be reviewed at least once every 90 days and revised, if necessary;~~

357.12 (3) ~~be signed by the clinical supervisor and by the client and, if the client is a minor, by
357.13 the client's parent or other person authorized by statute to consent to mental health treatment
357.14 and substance use disorder treatment for the client; and~~

357.15 (4) (3) provide for the client's transition out of intensive nonresidential rehabilitative
357.16 mental health services by defining the team's actions to assist the client and subsequent
357.17 providers in the transition to less intensive or "stepped down" services.

357.18 (e) The treatment team shall actively and assertively engage the client's family members
357.19 and significant others by establishing communication and collaboration with the family and
357.20 significant others and educating the family and significant others about the client's mental
357.21 illness, symptom management, and the family's role in treatment, unless the team knows or
357.22 has reason to suspect that the client has suffered or faces a threat of suffering any physical
357.23 or mental injury, abuse, or neglect from a family member or significant other.

357.24 (f) For a client age 18 or older, the treatment team may disclose to a family member,
357.25 other relative, or a close personal friend of the client, or other person identified by the client,
357.26 the protected health information directly relevant to such person's involvement with the
357.27 client's care, as provided in Code of Federal Regulations, title 45, part 164.502(b). If the
357.28 client is present, the treatment team shall obtain the client's agreement, provide the client
357.29 with an opportunity to object, or reasonably infer from the circumstances, based on the
357.30 exercise of professional judgment, that the client does not object. If the client is not present
357.31 or is unable, by incapacity or emergency circumstances, to agree or object, the treatment
357.32 team may, in the exercise of professional judgment, determine whether the disclosure is in
357.33 the best interests of the client and, if so, disclose only the protected health information that

358.1 is directly relevant to the family member's, relative's, friend's, or client-identified person's
358.2 involvement with the client's health care. The client may orally agree or object to the
358.3 disclosure and may prohibit or restrict disclosure to specific individuals.

358.4 (g) The treatment team shall provide interventions to promote positive interpersonal
358.5 relationships.

358.6 Sec. 129. Minnesota Statutes 2018, section 256B.0947, subdivision 7a, is amended to
358.7 read:

358.8 Subd. 7a. **Noncovered services.** (a) The rate for intensive rehabilitative mental health
358.9 services does not include medical assistance payment for services in clauses (1) to (7).
358.10 Services not covered under this paragraph may be billed separately:

358.11 (1) inpatient psychiatric hospital treatment;

358.12 (2) partial hospitalization;

358.13 (3) children's mental health day treatment services;

358.14 (4) physician services outside of care provided by a psychiatrist serving as a member of
358.15 the treatment team;

358.16 (5) room and board costs, as defined in section 256I.03, subdivision 6;

358.17 (6) home and community-based waiver services; and

358.18 (7) other mental health services identified in the child's individualized education program.

358.19 (b) The following services are not covered under this section and are not eligible for
358.20 medical assistance payment while youth are receiving intensive rehabilitative mental health
358.21 services:

358.22 (1) mental health residential treatment; and

358.23 (2) mental health behavioral aide services, as defined in section 256B.0943, subdivision
358.24 1, paragraph ~~(m)~~(l).

358.25 Sec. 130. Minnesota Statutes 2018, section 256B.0949, subdivision 2, is amended to read:

358.26 Subd. 2. **Definitions.** (a) The terms used in this section have the meanings given in this
358.27 subdivision.

358.28 (b) "Agency" means the legal entity that is enrolled with Minnesota health care programs
358.29 as a medical assistance provider according to Minnesota Rules, part 9505.0195, to provide
358.30 EIDBI services and that has the legal responsibility to ensure that its employees or contractors

359.1 carry out the responsibilities defined in this section. Agency includes a licensed individual
359.2 professional who practices independently and acts as an agency.

359.3 (c) "Autism spectrum disorder or a related condition" or "ASD or a related condition"
359.4 means either autism spectrum disorder (ASD) as defined in the current version of the
359.5 Diagnostic and Statistical Manual of Mental Disorders (DSM) or a condition that is found
359.6 to be closely related to ASD, as identified under the current version of the DSM, and meets
359.7 all of the following criteria:

359.8 (1) is severe and chronic;

359.9 (2) results in impairment of adaptive behavior and function similar to that of a person
359.10 with ASD;

359.11 (3) requires treatment or services similar to those required for a person with ASD; and

359.12 (4) results in substantial functional limitations in three core developmental deficits of
359.13 ASD: social interaction; nonverbal or social communication; and restrictive, repetitive
359.14 behaviors or hyperreactivity or hyporeactivity to sensory input; and may include deficits or
359.15 a high level of support in one or more of the following domains:

359.16 (i) self-regulation;

359.17 (ii) self-care;

359.18 (iii) behavioral challenges;

359.19 (iv) expressive communication;

359.20 (v) receptive communication;

359.21 (vi) cognitive functioning; or

359.22 (vii) safety.

359.23 (d) "Person" means a person under 21 years of age.

359.24 (e) "Clinical supervision" means the overall responsibility for the control and direction
359.25 of EIDBI service delivery, including individual treatment planning, staff supervision,
359.26 individual treatment plan progress monitoring, and treatment review for each person. Clinical
359.27 supervision is provided by a qualified supervising professional (QSP) who takes full
359.28 professional responsibility for the service provided by each supervisee.

359.29 (f) "Commissioner" means the commissioner of human services, unless otherwise
359.30 specified.

360.1 (g) "Comprehensive multidisciplinary evaluation" or "CMDE" means a comprehensive
360.2 evaluation of a person to determine medical necessity for EIDBI services based on the
360.3 requirements in subdivision 5.

360.4 (h) "Department" means the Department of Human Services, unless otherwise specified.

360.5 (i) "Early intensive developmental and behavioral intervention benefit" or "EIDBI
360.6 benefit" means a variety of individualized, intensive treatment modalities approved by the
360.7 commissioner that are based in behavioral and developmental science consistent with best
360.8 practices on effectiveness.

360.9 (j) "Generalizable goals" means results or gains that are observed during a variety of
360.10 activities over time with different people, such as providers, family members, other adults,
360.11 and people, and in different environments including, but not limited to, clinics, homes,
360.12 schools, and the community.

360.13 (k) "Incident" means when any of the following occur:

360.14 (1) an illness, accident, or injury that requires first aid treatment;

360.15 (2) a bump or blow to the head; or

360.16 (3) an unusual or unexpected event that jeopardizes the safety of a person or staff,
360.17 including a person leaving the agency unattended.

360.18 (l) "Individual treatment plan" or "ITP" means the person-centered, individualized written
360.19 plan of care that integrates and coordinates person and family information from the CMDE
360.20 for a person who meets medical necessity for the EIDBI benefit. An individual treatment
360.21 plan must meet the standards in subdivision 6.

360.22 (m) "Legal representative" means the parent of a child who is under 18 years of age, a
360.23 court-appointed guardian, or other representative with legal authority to make decisions
360.24 about service for a person. For the purpose of this subdivision, "other representative with
360.25 legal authority to make decisions" includes a health care agent or an attorney-in-fact
360.26 authorized through a health care directive or power of attorney.

360.27 (n) "Mental health professional" has the meaning given in section 245.4871, subdivision
360.28 27, ~~clauses (1) to (6).~~

360.29 (o) "Person-centered" means a service that both responds to the identified needs, interests,
360.30 values, preferences, and desired outcomes of the person or the person's legal representative
360.31 and respects the person's history, dignity, and cultural background and allows inclusion and
360.32 participation in the person's community.

361.1 (p) "Qualified EIDBI provider" means a person who is a QSP or a level I, level II, or
361.2 level III treatment provider.

361.3 Sec. 131. **DIRECTION TO COMMISSIONER; SINGLE COMPREHENSIVE**

361.4 **LICENSE STRUCTURE.**

361.5 The commissioner of human services, in consultation with counties, tribes, managed
361.6 care organizations, provider organizations, advocacy groups, and individuals and families
361.7 served, shall develop recommendations to provide a single comprehensive license structure
361.8 for mental health service programs, including community mental health centers according
361.9 to Minnesota Rules, part 9520.0750, intensive residential treatment services, assertive
361.10 community treatment, adult rehabilitative mental health services, children's therapeutic
361.11 services and supports, intensive rehabilitative mental health services, intensive treatment
361.12 in foster care, and children's residential treatment programs currently approved under
361.13 Minnesota Rules, chapter 2960. The recommendations must prioritize program integrity,
361.14 the welfare of individuals and families served, improved integration of mental health and
361.15 substance use disorder services, and the reduction of administrative burden on providers.

361.16 Sec. 132. REPEALER.

361.17 (a) Minnesota Statutes 2018, sections 245.462, subdivision 4a; 256B.0615, subdivisions
361.18 2, 4, and 5; 256B.0616, subdivisions 2, 4, and 5; 256B.0943, subdivision 10; 256B.0944,
361.19 subdivision 10; 256B.0946, subdivision 5; and 256B.0947, subdivision 9, are repealed.

361.20 (b) Minnesota Rules, parts 9505.0370; 9505.0371; 9505.0372; 9520.0010; 9520.0020;
361.21 9520.0030; 9520.0040; 9520.0050; 9520.0060; 9520.0070; 9520.0080; 9520.0090;
361.22 9520.0100; 9520.0110; 9520.0120; 9520.0130; 9520.0140; 9520.0150; 9520.0160;
361.23 9520.0170; 9520.0180; 9520.0190; 9520.0200; 9520.0210; and 9520.0230, are repealed.

ARTICLE 8

HEALTH CARE

361.26 Section 1. Minnesota Statutes 2018, section 13.69, subdivision 1, is amended to read:

361.27 Subdivision 1. **Classifications.** (a) The following government data of the Department
361.28 of Public Safety are private data:

361.29 (1) medical data on driving instructors, licensed drivers, and applicants for parking
361.30 certificates and special license plates issued to physically disabled persons;

362.1 (2) other data on holders of a disability certificate under section 169.345, except that (i)
362.2 data that are not medical data may be released to law enforcement agencies, and (ii) data
362.3 necessary for enforcement of sections 169.345 and 169.346 may be released to parking
362.4 enforcement employees or parking enforcement agents of statutory or home rule charter
362.5 cities and towns;

362.6 (3) Social Security numbers in driver's license and motor vehicle registration records,
362.7 except that Social Security numbers must be provided to the Department of Revenue for
362.8 purposes of tax administration, the Department of Labor and Industry for purposes of
362.9 workers' compensation administration and enforcement, the judicial branch for purposes of
362.10 debt collection, and the Department of Natural Resources for purposes of license application
362.11 administration, and except that the last four digits of the Social Security number must be
362.12 provided to the Department of Human Services for purposes of recovery of Minnesota health
362.13 care program benefits paid; and

362.14 (4) data on persons listed as standby or temporary custodians under section 171.07,
362.15 subdivision 11, except that the data must be released to:

362.16 (i) law enforcement agencies for the purpose of verifying that an individual is a designated
362.17 caregiver; or

362.18 (ii) law enforcement agencies who state that the license holder is unable to communicate
362.19 at that time and that the information is necessary for notifying the designated caregiver of
362.20 the need to care for a child of the license holder.

362.21 The department may release the Social Security number only as provided in clause (3)
362.22 and must not sell or otherwise provide individual Social Security numbers or lists of Social
362.23 Security numbers for any other purpose.

362.24 (b) The following government data of the Department of Public Safety are confidential
362.25 data: data concerning an individual's driving ability when that data is received from a member
362.26 of the individual's family.

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

362.28 Sec. 2. Minnesota Statutes 2018, section 16A.724, subdivision 2, is amended to read:

362.29 Subd. 2. **Transfers.** (a) Notwithstanding section 295.581, to the extent available resources
362.30 in the health care access fund exceed expenditures in that fund, effective for the biennium
362.31 beginning July 1, 2007, the commissioner of management and budget shall transfer the
362.32 excess funds from the health care access fund to the general fund on June 30 of each year,
362.33 provided that the amount transferred in fiscal year 2016 shall not exceed \$48,000,000, the

363.1 amount in fiscal year 2017 shall not exceed \$122,000,000, and the amount in any fiscal
363.2 biennium thereafter shall not exceed \$244,000,000. The purpose of this transfer is to meet
363.3 the rate increase required under ~~Laws 2003, First Special Session chapter 14, article 13C,~~
363.4 ~~section 2, subdivision 6~~ section 256B.688.

363.5 (b) For fiscal years 2006 to 2011, MinnesotaCare shall be a forecasted program, and, if
363.6 necessary, the commissioner shall reduce these transfers from the health care access fund
363.7 to the general fund to meet annual MinnesotaCare expenditures or, if necessary, transfer
363.8 sufficient funds from the general fund to the health care access fund to meet annual
363.9 MinnesotaCare expenditures.

363.10 Sec. 3. Minnesota Statutes 2018, section 245A.02, subdivision 5a, is amended to read:

363.11 Subd. 5a. **Controlling individual.** (a) "Controlling individual" means an owner of a
363.12 program or service provider licensed under this chapter and the following individuals, if
363.13 applicable:

363.14 (1) each officer of the organization, including the chief executive officer and chief
363.15 financial officer;

363.16 (2) the individual designated as the authorized agent under section 245A.04, subdivision
363.17 1, paragraph (b);

363.18 (3) the individual designated as the compliance officer under section 256B.04, subdivision
363.19 21, paragraph ~~(b)~~(g); and

363.20 (4) each managerial official whose responsibilities include the direction of the
363.21 management or policies of a program.

363.22 (b) Controlling individual does not include:

363.23 (1) a bank, savings bank, trust company, savings association, credit union, industrial
363.24 loan and thrift company, investment banking firm, or insurance company unless the entity
363.25 operates a program directly or through a subsidiary;

363.26 (2) an individual who is a state or federal official, or state or federal employee, or a
363.27 member or employee of the governing body of a political subdivision of the state or federal
363.28 government that operates one or more programs, unless the individual is also an officer,
363.29 owner, or managerial official of the program, receives remuneration from the program, or
363.30 owns any of the beneficial interests not excluded in this subdivision;

363.31 (3) an individual who owns less than five percent of the outstanding common shares of
363.32 a corporation:

364.1 (i) whose securities are exempt under section 80A.45, clause (6); or
364.2 (ii) whose transactions are exempt under section 80A.46, clause (2);
364.3 (4) an individual who is a member of an organization exempt from taxation under section
364.4 290.05, unless the individual is also an officer, owner, or managerial official of the program
364.5 or owns any of the beneficial interests not excluded in this subdivision. This clause does
364.6 not exclude from the definition of controlling individual an organization that is exempt from
364.7 taxation; or
364.8 (5) an employee stock ownership plan trust, or a participant or board member of an
364.9 employee stock ownership plan, unless the participant or board member is a controlling
364.10 individual according to paragraph (a).

364.11 (c) For purposes of this subdivision, "managerial official" means an individual who has
364.12 the decision-making authority related to the operation of the program, and the responsibility
364.13 for the ongoing management of or direction of the policies, services, or employees of the
364.14 program. A site director who has no ownership interest in the program is not considered to
364.15 be a managerial official for purposes of this definition.

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

364.17 Sec. 4. Minnesota Statutes 2018, section 245D.081, subdivision 3, is amended to read:

364.18 **Subd. 3. Program management and oversight.** (a) The license holder must designate
364.19 a managerial staff person or persons to provide program management and oversight of the
364.20 services provided by the license holder. The designated manager is responsible for the
364.21 following:

364.22 (1) maintaining a current understanding of the licensing requirements sufficient to ensure
364.23 compliance throughout the program as identified in section 245A.04, subdivision 1, paragraph
364.24 (e), and when applicable, as identified in section 256B.04, subdivision 21, paragraph (b)
364.25 (g);

364.26 (2) ensuring the duties of the designated coordinator are fulfilled according to the
364.27 requirements in subdivision 2;

364.28 (3) ensuring the program implements corrective action identified as necessary by the
364.29 program following review of incident and emergency reports according to the requirements
364.30 in section 245D.11, subdivision 2, clause (7). An internal review of incident reports of
364.31 alleged or suspected maltreatment must be conducted according to the requirements in
364.32 section 245A.65, subdivision 1, paragraph (b);

365.1 (4) evaluation of satisfaction of persons served by the program, the person's legal
365.2 representative, if any, and the case manager, with the service delivery and progress towards
365.3 toward accomplishing outcomes identified in sections 245D.07 and 245D.071, and ensuring
365.4 and protecting each person's rights as identified in section 245D.04;

365.5 (5) ensuring staff competency requirements are met according to the requirements in
365.6 section 245D.09, subdivision 3, and ensuring staff orientation and training is provided
365.7 according to the requirements in section 245D.09, subdivisions 4, 4a, and 5;

365.8 (6) ensuring corrective action is taken when ordered by the commissioner and that the
365.9 terms and conditions of the license and any variances are met; and

365.10 (7) evaluating the information identified in clauses (1) to (6) to develop, document, and
365.11 implement ongoing program improvements.

365.12 (b) The designated manager must be competent to perform the duties as required and
365.13 must minimally meet the education and training requirements identified in subdivision 2,
365.14 paragraph (b), and have a minimum of three years of supervisory level experience in a
365.15 program providing direct support services to persons with disabilities or persons age 65 and
365.16 older.

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

365.18 Sec. 5. Minnesota Statutes 2018, section 256.962, subdivision 5, is amended to read:

365.19 Subd. 5. **Incentive program.** Beginning January 1, 2008, the commissioner shall establish
365.20 an incentive program for organizations and licensed insurance producers under chapter 60K
365.21 that directly identify and assist potential enrollees in filling out and submitting an application.
365.22 For each applicant who is successfully enrolled in MinnesotaCare or medical assistance,
365.23 the commissioner, within the available appropriation, shall pay the organization or licensed
365.24 insurance producer a ~~\$25~~ \$70 application assistance bonus. The organization or licensed
365.25 insurance producer may provide an applicant a gift certificate or other incentive upon
365.26 enrollment.

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

365.28 Sec. 6. Minnesota Statutes 2018, section 256.969, subdivision 9, is amended to read:

365.29 Subd. 9. **Disproportionate numbers of low-income patients served.** (a) For admissions
365.30 occurring on or after July 1, 1993, the medical assistance disproportionate population
365.31 adjustment shall comply with federal law and shall be paid to a hospital, excluding regional
365.32 treatment centers and facilities of the federal Indian Health Service, with a medical assistance

366.1 inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined
366.2 as follows:

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

366.10 (2) for a hospital with a medical assistance inpatient utilization rate above one standard
366.11 deviation above the mean, the adjustment must be determined by multiplying the adjustment
366.12 that would be determined under clause (1) for that hospital by 1.1. The commissioner shall
366.13 report annually on the number of hospitals likely to receive the adjustment authorized by
366.14 this paragraph. The commissioner shall specifically report on the adjustments received by
366.15 public hospitals and public hospital corporations located in cities of the first class.

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

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

366.25 (d) Effective July 1, 2015, disproportionate share hospital (DSH) payments shall be paid
366.26 in accordance with a new methodology using 2012 as the base year. Annual payments made
366.27 under this paragraph shall equal the total amount of payments made for 2012. A licensed
366.28 children's hospital shall receive only a single DSH factor for children's hospitals. Other
366.29 DSH factors may be combined to arrive at a single factor for each hospital that is eligible
366.30 for DSH payments. The new methodology shall make payments only to hospitals located
366.31 in Minnesota and include the following factors:

366.32 (1) a licensed children's hospital with at least 1,000 fee-for-service discharges in the
366.33 base year shall receive a factor of 0.868. A licensed children's hospital with less than 1,000
366.34 fee-for-service discharges in the base year shall receive a factor of 0.7880;

367.1 (2) a hospital that has in effect for the initial rate year a contract with the commissioner

367.2 to provide extended psychiatric inpatient services under section 256.9693 shall receive a

367.3 factor of 0.0160;

367.4 (3) a hospital that has received payment from the fee-for-service program for at least 20

367.5 transplant services in the base year shall receive a factor of 0.0435;

367.6 (4) a hospital that has a medical assistance utilization rate in the base year between 20

367.7 percent up to one standard deviation above the statewide mean utilization rate shall receive

367.8 a factor of 0.0468;

367.9 (5) a hospital that has a medical assistance utilization rate in the base year that is at least

367.10 one standard deviation above the statewide mean utilization rate but is less than three standard

367.11 deviations above the mean shall receive a factor of 0.2300; and

367.12 (6) a hospital that has a medical assistance utilization rate in the base year that is at least

367.13 three standard deviations above the statewide mean utilization rate shall receive a factor of

367.14 0.3711.

367.15 (e) Any payments or portion of payments made to a hospital under this subdivision that

367.16 are subsequently returned to the commissioner because the payments are found to exceed

367.17 the hospital-specific DSH limit for that hospital shall be redistributed, proportionate to the

367.18 number of fee-for-service discharges, to other DSH-eligible non-children's hospitals that

367.19 have a medical assistance utilization rate that is at least one standard deviation above the

367.20 mean.

367.21 (f) An additional payment adjustment shall be established by the commissioner under

367.22 this subdivision for a hospital that provides high levels of administering high-cost drugs to

367.23 enrollees in fee-for-service medical assistance. The commissioner shall consider factors

367.24 including fee-for-service medical assistance utilization rates and payments made for drugs

367.25 purchased through the 340B drug purchasing program and administered to fee-for-service

367.26 enrollees. If any part of this adjustment exceeds a hospital's hospital-specific disproportionate

367.27 share hospital limit, the commissioner shall make a payment to the hospital that equals the

367.28 nonfederal share of the amount that exceeds the limit. The total nonfederal share of the

367.29 amount of the payment adjustment under this paragraph shall not exceed \$1,500,000.

367.30 **EFFECTIVE DATE.** This section is effective for discharges on or after April 1, 2019.

367.31 Sec. 7. Minnesota Statutes 2018, section 256B.04, subdivision 21, is amended to read:

367.32 Subd. 21. **Provider enrollment.** (a) The commissioner shall enroll providers and conduct

367.33 screening activities as required by Code of Federal Regulations, title 42, section 455, subpart

368.1 E. A provider providing services from multiple locations must enroll each location separately.
368.2 The commissioner may deny a provider's incomplete application if a provider fails to respond
368.3 to the commissioner's request for additional information within 60 days of the request. The
368.4 commissioner must conduct a background study under chapter 245C, including a review
368.5 of databases in section 245C.08, subdivision 1, paragraph (a), clauses (1) to (5), for a provider
368.6 described in this paragraph. The background study requirement may be satisfied if the
368.7 commissioner conducted a fingerprint-based background study on the provider that includes
368.8 a review of databases in section 245C.08, subdivision 1, paragraph (a), clauses (1) to (5).

368.9 (b) The commissioner shall revalidate each: (1) provider under this subdivision at least
368.10 once every five years; and (2) personal care assistance agency under this subdivision once
368.11 every three years.

368.12 (c) The commissioner shall conduct revalidation as follows:

368.13 (1) provide 30-day notice of the revalidation due date including instructions for
368.14 revalidation and a list of materials the provider must submit;

368.15 (2) if a provider fails to submit all required materials by the due date, notify the provider
368.16 of the deficiency within 30 days after the due date and allow the provider an additional 30
368.17 days from the notification date to comply; and

368.18 (3) if a provider fails to remedy a deficiency within the 30-day time period, give 60-day
368.19 notice of termination and immediately suspend the provider's ability to bill. The provider
368.20 does not have the right to appeal suspension of ability to bill.

368.21 (d) If a provider fails to comply with any individual provider requirement or condition
368.22 of participation, the commissioner may suspend the provider's ability to bill until the provider
368.23 comes into compliance. The commissioner's decision to suspend the provider is not subject
368.24 to an administrative appeal.

368.25 (e) All correspondence and notifications, including notifications of termination and other
368.26 actions, must be delivered electronically to a provider's MN-ITS mailbox. For a provider
368.27 that does not have a MN-ITS account and mailbox, notice must be sent by first-class mail.
368.28 This paragraph does not apply to correspondences and notifications related to background
368.29 studies.

368.30 (f) If the commissioner or the Centers for Medicare and Medicaid Services determines
368.31 that a provider is designated "high-risk," the commissioner may withhold payment from
368.32 providers within that category upon initial enrollment for a 90-day period. The withholding
368.33 for each provider must begin on the date of the first submission of a claim.

369.1 ~~(b)~~ (g) An enrolled provider that is also licensed by the commissioner under chapter
369.2 245A, or is licensed as a home care provider by the Department of Health under chapter
369.3 144A and has a home and community-based services designation on the home care license
369.4 under section 144A.484, must designate an individual as the entity's compliance officer.

369.5 The compliance officer must:

369.6 (1) develop policies and procedures to assure adherence to medical assistance laws and
369.7 regulations and to prevent inappropriate claims submissions;

369.8 (2) train the employees of the provider entity, and any agents or subcontractors of the
369.9 provider entity including billers, on the policies and procedures under clause (1);

369.10 (3) respond to allegations of improper conduct related to the provision or billing of
369.11 medical assistance services, and implement action to remediate any resulting problems;

369.12 (4) use evaluation techniques to monitor compliance with medical assistance laws and
369.13 regulations;

369.14 (5) promptly report to the commissioner any identified violations of medical assistance
369.15 laws or regulations; and

369.16 (6) within 60 days of discovery by the provider of a medical assistance reimbursement
369.17 overpayment, report the overpayment to the commissioner and make arrangements with
369.18 the commissioner for the commissioner's recovery of the overpayment.

369.19 The commissioner may require, as a condition of enrollment in medical assistance, that a
369.20 provider within a particular industry sector or category establish a compliance program that
369.21 contains the core elements established by the Centers for Medicare and Medicaid Services.

369.22 ~~(e)~~ (h) The commissioner may revoke the enrollment of an ordering or rendering provider
369.23 for a period of not more than one year, if the provider fails to maintain and, upon request
369.24 from the commissioner, provide access to documentation relating to written orders or requests
369.25 for payment for durable medical equipment, certifications for home health services, or
369.26 referrals for other items or services written or ordered by such provider, when the
369.27 commissioner has identified a pattern of a lack of documentation. A pattern means a failure
369.28 to maintain documentation or provide access to documentation on more than one occasion.
369.29 Nothing in this paragraph limits the authority of the commissioner to sanction a provider
369.30 under the provisions of section 256B.064.

369.31 ~~(d)~~ (i) The commissioner shall terminate or deny the enrollment of any individual or
369.32 entity if the individual or entity has been terminated from participation in Medicare or under
369.33 the Medicaid program or Children's Health Insurance Program of any other state.

370.1 ~~(e)~~(j) As a condition of enrollment in medical assistance, the commissioner shall require
370.2 that a provider designated "moderate" or "high-risk" by the Centers for Medicare and
370.3 Medicaid Services or the commissioner permit the Centers for Medicare and Medicaid
370.4 Services, its agents, or its designated contractors and the state agency, its agents, or its
370.5 designated contractors to conduct unannounced on-site inspections of any provider location.
370.6 The commissioner shall publish in the Minnesota Health Care Program Provider Manual a
370.7 list of provider types designated "limited," "moderate," or "high-risk," based on the criteria
370.8 and standards used to designate Medicare providers in Code of Federal Regulations, title
370.9 42, section 424.518. The list and criteria are not subject to the requirements of chapter 14.
370.10 The commissioner's designations are not subject to administrative appeal.

370.11 ~~(f)~~(k) As a condition of enrollment in medical assistance, the commissioner shall require
370.12 that a high-risk provider, or a person with a direct or indirect ownership interest in the
370.13 provider of five percent or higher, consent to criminal background checks, including
370.14 fingerprinting, when required to do so under state law or by a determination by the
370.15 commissioner or the Centers for Medicare and Medicaid Services that a provider is designated
370.16 high-risk for fraud, waste, or abuse.

370.17 ~~(g)~~(l)(1) Upon initial enrollment, reenrollment, and notification of revalidation, all
370.18 durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) medical suppliers
370.19 meeting the durable medical equipment provider and supplier definition in clause (3),
370.20 operating in Minnesota and receiving Medicaid funds must purchase a surety bond that is
370.21 annually renewed and designates the Minnesota Department of Human Services as the
370.22 obligee, and must be submitted in a form approved by the commissioner. For purposes of
370.23 this clause, the following medical suppliers are not required to obtain a surety bond: a
370.24 federally qualified health center, a home health agency, the Indian Health Service, a
370.25 pharmacy, and a rural health clinic.

370.26 (2) At the time of initial enrollment or reenrollment, durable medical equipment providers
370.27 and suppliers defined in clause (3) must purchase a surety bond of \$50,000. If a revalidating
370.28 provider's Medicaid revenue in the previous calendar year is up to and including \$300,000,
370.29 the provider agency must purchase a surety bond of \$50,000. If a revalidating provider's
370.30 Medicaid revenue in the previous calendar year is over \$300,000, the provider agency must
370.31 purchase a surety bond of \$100,000. The surety bond must allow for recovery of costs and
370.32 fees in pursuing a claim on the bond.

370.33 (3) "Durable medical equipment provider or supplier" means a medical supplier that can
370.34 purchase medical equipment or supplies for sale or rental to the general public and is able

371.1 to perform or arrange for necessary repairs to and maintenance of equipment offered for
371.2 sale or rental.

371.3 ~~(h)~~ (m) The Department of Human Services may require a provider to purchase a surety
371.4 bond as a condition of initial enrollment, reenrollment, reinstatement, or continued enrollment
371.5 if: (1) the provider fails to demonstrate financial viability, (2) the department determines
371.6 there is significant evidence of or potential for fraud and abuse by the provider, or (3) the
371.7 provider or category of providers is designated high-risk pursuant to paragraph ~~(a)~~ (f) and
371.8 as per Code of Federal Regulations, title 42, section 455.450. The surety bond must be in
371.9 an amount of \$100,000 or ten percent of the provider's payments from Medicaid during the
371.10 immediately preceding 12 months, whichever is greater. The surety bond must name the
371.11 Department of Human Services as an obligee and must allow for recovery of costs and fees
371.12 in pursuing a claim on the bond. This paragraph does not apply if the provider currently
371.13 maintains a surety bond under the requirements in section 256B.0659 or 256B.85.

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

371.15 Sec. 8. Minnesota Statutes 2018, section 256B.04, subdivision 22, is amended to read:

371.16 Subd. 22. **Application fee.** (a) The commissioner must collect and retain federally
371.17 required nonrefundable application fees to pay for provider screening activities in accordance
371.18 with Code of Federal Regulations, title 42, section 455, subpart E. The enrollment application
371.19 must be made under the procedures specified by the commissioner, in the form specified
371.20 by the commissioner, and accompanied by an application fee described in paragraph (b),
371.21 or a request for a hardship exception as described in the specified procedures. Application
371.22 fees must be deposited in the provider screening account in the special revenue fund.

371.23 Amounts in the provider screening account are appropriated to the commissioner for costs
371.24 associated with the provider screening activities required in Code of Federal Regulations,
371.25 title 42, section 455, subpart E. ~~The commissioner shall conduct screening activities as~~
371.26 ~~required by Code of Federal Regulations, title 42, section 455, subpart E, and as otherwise~~
371.27 ~~provided by law, to include database checks, unannounced pre- and postenrollment site~~
371.28 ~~visits, fingerprinting, and criminal background studies. The commissioner must revalidate~~
371.29 ~~all providers under this subdivision at least once every five years.~~

371.30 (b) The application fee under this subdivision is \$532 for the calendar year 2013. For
371.31 calendar year 2014 and subsequent years, the fee:

371.32 (1) is adjusted by the percentage change to the Consumer Price Index for all urban
371.33 consumers, United States city average, for the 12-month period ending with June of the
371.34 previous year. The resulting fee must be announced in the Federal Register;

372.1 (2) is effective from January 1 to December 31 of a calendar year;

372.2 (3) is required on the submission of an initial application, an application to establish a
372.3 new practice location, an application for reenrollment when the provider is not enrolled at
372.4 the time of application of reenrollment, or at revalidation when required by federal regulation;
372.5 and

372.6 (4) must be in the amount in effect for the calendar year during which the application
372.7 for enrollment, new practice location, or reenrollment is being submitted.

372.8 (c) The application fee under this subdivision cannot be charged to:

372.9 (1) providers who are enrolled in Medicare or who provide documentation of payment
372.10 of the fee to, and enrollment with, another state, unless the commissioner is required to
372.11 rescreen the provider;

372.12 (2) providers who are enrolled but are required to submit new applications for purposes
372.13 of reenrollment;

372.14 (3) a provider who enrolls as an individual; and

372.15 (4) group practices and clinics that bill on behalf of individually enrolled providers
372.16 within the practice who have reassigned their billing privileges to the group practice or
372.17 clinic.

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

372.19 Sec. 9. Minnesota Statutes 2018, section 256B.055, subdivision 2, is amended to read:

372.20 Subd. 2. **Subsidized foster children.** Medical assistance may be paid for a child eligible
372.21 for or receiving foster care maintenance payments under Title IV-E of the Social Security
372.22 Act, United States Code, title 42, sections 670 to 676, and for a child who is not eligible for
372.23 Title IV-E of the Social Security Act but who is determined eligible for foster care or kinship
372.24 assistance under chapter 256N.

372.25 **EFFECTIVE DATE.** This section is effective January 1, 2020, or upon federal approval,
372.26 whichever is later. The commissioner of human services shall notify the revisor of statutes
372.27 when federal approval is obtained.

372.28 Sec. 10. Minnesota Statutes 2018, section 256B.056, subdivision 3, is amended to read:

372.29 Subd. 3. **Asset limitations for certain individuals.** (a) To be eligible for medical
372.30 assistance, a person must not individually own more than \$3,000 in assets, or if a member
372.31 of a household with two family members, husband and wife, or parent and child, the

373.1 household must not own more than \$6,000 in assets, plus \$200 for each additional legal
373.2 dependent. In addition to these maximum amounts, an eligible individual or family may
373.3 accrue interest on these amounts, but they must be reduced to the maximum at the time of
373.4 an eligibility redetermination. The accumulation of the clothing and personal needs allowance
373.5 according to section 256B.35 must also be reduced to the maximum at the time of the
373.6 eligibility redetermination. The value of assets that are not considered in determining
373.7 eligibility for medical assistance is the value of those assets excluded under the Supplemental
373.8 Security Income program for aged, blind, and disabled persons, with the following
373.9 exceptions:

373.10 (1) household goods and personal effects are not considered;
373.11 (2) capital and operating assets of a trade or business that the local agency determines
373.12 are necessary to the person's ability to earn an income are not considered;
373.13 (3) motor vehicles are excluded to the same extent excluded by the Supplemental Security
373.14 Income program;

373.15 (4) assets designated as burial expenses are excluded to the same extent excluded by the
373.16 Supplemental Security Income program. Burial expenses funded by annuity contracts or
373.17 life insurance policies must irrevocably designate the individual's estate as contingent
373.18 beneficiary to the extent proceeds are not used for payment of selected burial expenses;

373.19 (5) for a person who no longer qualifies as an employed person with a disability due to
373.20 loss of earnings, assets allowed while eligible for medical assistance under section 256B.057,
373.21 subdivision 9, are not considered for 12 months, beginning with the first month of ineligibility
373.22 as an employed person with a disability, to the extent that the person's total assets remain
373.23 within the allowed limits of section 256B.057, subdivision 9, paragraph (d);

373.24 (6) ~~when a person enrolled in medical assistance under section 256B.057, subdivision~~
373.25 ~~9, is age 65 or older and has been enrolled during each of the 24 consecutive months before~~
373.26 ~~the person's 65th birthday, the assets owned by the person and the person's spouse must be~~
373.27 ~~disregarded, up to the limits of section 256B.057, subdivision 9, paragraph (d), when~~
373.28 ~~determining eligibility for medical assistance under section 256B.055, subdivision 7. a~~
373.29 ~~designated employment incentives asset account is disregarded when determining eligibility~~
373.30 ~~for medical assistance for a person age 65 years or older under section 256B.055, subdivision~~
373.31 ~~7. An employment incentives asset account must only be designated by a person who has~~
373.32 ~~been enrolled in medical assistance under section 256B.057, subdivision 9, for a~~
373.33 ~~24-consecutive-month period. A designated employment incentives asset account contains~~
373.34 ~~qualified assets owned by the person and the person's spouse in the last month of enrollment~~

374.1 in medical assistance under section 256B.057, subdivision 9. Qualified assets include
374.2 retirement and pension accounts, medical expense accounts, and up to \$17,000 of the person's
374.3 other nonexcluded assets. An employment incentives asset account is no longer designated
374.4 when a person loses medical assistance eligibility for a calendar month or more before
374.5 turning age 65. A person who loses medical assistance eligibility before age 65 can establish
374.6 a new designated employment incentives asset account by establishing a new
374.7 24-consecutive-month period of enrollment under section 256B.057, subdivision 9. The
374.8 income of a spouse of a person enrolled in medical assistance under section 256B.057,
374.9 subdivision 9, during each of the 24 consecutive months before the person's 65th birthday
374.10 must be disregarded when determining eligibility for medical assistance under section
374.11 256B.055, subdivision 7. Persons eligible under this clause are not subject to the provisions
374.12 in section 256B.059; and

374.13 (7) effective July 1, 2009, certain assets owned by American Indians are excluded as
374.14 required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public
374.15 Law 111-5. For purposes of this clause, an American Indian is any person who meets the
374.16 definition of Indian according to Code of Federal Regulations, title 42, section 447.50.

374.17 (b) No asset limit shall apply to persons eligible under section 256B.055, subdivision
374.18 15.

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

374.20 Sec. 11. Minnesota Statutes 2018, section 256B.0625, subdivision 13, is amended to read:

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

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

374.29 (c) For the purpose of this subdivision and subdivision 13d, an "active pharmaceutical
374.30 ingredient" is defined as a substance that is represented for use in a drug and when used in
374.31 the manufacturing, processing, or packaging of a drug becomes an active ingredient of the
374.32 drug product. An "excipient" is defined as an inert substance used as a diluent or vehicle
374.33 for a drug. The commissioner shall establish a list of active pharmaceutical ingredients and

375.1 excipients which are included in the medical assistance formulary. Medical assistance covers
375.2 selected active pharmaceutical ingredients and excipients used in compounded prescriptions
375.3 when the compounded combination is specifically approved by the commissioner or when
375.4 a commercially available product:

375.5 (1) is not a therapeutic option for the patient;
375.6 (2) does not exist in the same combination of active ingredients in the same strengths
375.7 as the compounded prescription; and

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

375.10 (d) Medical assistance covers the following over-the-counter drugs when prescribed by
375.11 a licensed practitioner or by a licensed pharmacist who meets standards established by the
375.12 commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family
375.13 planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults
375.14 with documented vitamin deficiencies, vitamins for children under the age of seven and
375.15 pregnant or nursing women, and any other over-the-counter drug identified by the
375.16 commissioner, in consultation with the Formulary Committee, as necessary, appropriate,
375.17 and cost-effective for the treatment of certain specified chronic diseases, conditions, or
375.18 disorders, and this determination shall not be subject to the requirements of chapter 14. A
375.19 pharmacist may prescribe over-the-counter medications as provided under this paragraph
375.20 for purposes of receiving reimbursement under Medicaid. When prescribing over-the-counter
375.21 drugs under this paragraph, licensed pharmacists must consult with the recipient to determine
375.22 necessity, provide drug counseling, review drug therapy for potential adverse interactions,
375.23 and make referrals as needed to other health care professionals. ~~Over-the-counter medications~~
375.24 ~~must be dispensed in a quantity that is the lowest of: (1) the number of dosage units contained~~
375.25 ~~in the manufacturer's original package; (2) the number of dosage units required to complete~~
375.26 ~~the patient's course of therapy; or (3) if applicable, the number of dosage units dispensed~~
375.27 ~~from a system using retrospective billing, as provided under subdivision 13e, paragraph~~
375.28 (b).

375.29 (e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable
375.30 under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and
375.31 Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible
375.32 for drug coverage as defined in the Medicare Prescription Drug, Improvement, and
375.33 Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these
375.34 individuals, medical assistance may cover drugs from the drug classes listed in United States

376.1 Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to
376.2 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall
376.3 not be covered.

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

376.8 **EFFECTIVE DATE.** This section is effective April 1, 2019, or upon federal approval,
376.9 whichever is later. The commissioner of human services shall notify the revisor of statutes
376.10 when federal approval is obtained.

376.11 Sec. 12. Minnesota Statutes 2018, section 256B.0625, subdivision 13e, is amended to
376.12 read:

376.13 Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall
376.14 be the lower of the actual acquisition ingredient costs of the drugs ~~or the maximum allowable~~
376.15 cost by the commissioner plus the fixed professional dispensing fee; or the usual and
376.16 customary price charged to the public. The usual and customary price means the lowest
376.17 price charged by the provider to a patient who pays for the prescription by cash, check, or
376.18 charge account and includes prices the pharmacy charges to a patient enrolled in a
376.19 prescription savings club or prescription discount club administered by the pharmacy or
376.20 pharmacy chain. The amount of payment basis must be reduced to reflect all discount
376.21 amounts applied to the charge by any third-party provider/insurer agreement or contract for
376.22 submitted charges to medical assistance programs. The net submitted charge may not be
376.23 greater than the patient liability for the service. The pharmacy professional dispensing fee
376.24 shall be \$3.65 \$10.48 for legend prescription drugs, ~~except that prescriptions filled with~~
376.25 legend drugs meeting the definition of "covered outpatient drugs" according to United States
376.26 Code, title 42, section 1396r-8(k)(2). The dispensing fee for intravenous solutions ~~which~~
376.27 that must be compounded by the pharmacist shall be \$8 \$10.48 per bag, \$14 per bag for
376.28 cancer chemotherapy products, and \$30 per bag for ~~total parenteral nutritional products~~
376.29 dispensed in one liter quantities, or \$44 per bag for ~~total parenteral nutritional products~~
376.30 dispensed in quantities greater than one liter. The professional dispensing fee for
376.31 prescriptions filled with over-the-counter drugs meeting the definition of covered outpatient
376.32 drugs shall be \$10.48 for dispensed quantities equal to or greater than the number of units
376.33 contained in the manufacturer's original package. The professional dispensing fee shall be
376.34 prorated based on the percentage of the package dispensed when the pharmacy dispenses

377.1 a quantity less than the number of units contained in the manufacturer's original package.

377.2 The pharmacy dispensing fee for prescribed over-the-counter drugs not meeting the definition

377.3 of covered outpatient drugs shall be \$3.65, except that the fee shall be \$1.31 for

377.4 retrospectively billing pharmacies when billing for quantities less than the number of units

377.5 contained in the manufacturer's original package. Actual acquisition cost includes quantity

377.6 and other special discounts except time and cash discounts. The actual acquisition cost of

377.7 a drug shall be estimated by the commissioner at wholesale acquisition cost plus four percent

377.8 for independently owned pharmacies located in a designated rural area within Minnesota,

377.9 and at wholesale acquisition cost plus two percent for all other pharmacies. A pharmacy is

377.10 "independently owned" if it is one of four or fewer pharmacies under the same ownership

377.11 nationally. A "designated rural area" means an area defined as a small rural area or isolated

377.12 rural area according to the four category classification of the Rural Urban Commuting Area

377.13 system developed for the United States Health Resources and Services Administration.

377.14 Effective January 1, 2014, the actual acquisition for quantities equal to or greater than the

377.15 number of units contained in the manufacturer's original package and shall be prorated based

377.16 on the percentage of the package dispensed when the pharmacy dispenses a quantity less

377.17 than the number of units contained in the manufacturer's original package. The ingredient

377.18 cost of a drug acquired through for a provider participating in the federal 340B Drug Pricing

377.19 Program shall be estimated by the commissioner at wholesale acquisition cost minus 40

377.20 percent either the 340B Drug Pricing Program ceiling price established by the Health

377.21 Resources and Services Administration or the National Average Drug Acquisition Cost

377.22 (NADAC), whichever is lower. Wholesale acquisition cost is defined as the manufacturer's

377.23 list price for a drug or biological to wholesalers or direct purchasers in the United States,

377.24 not including prompt pay or other discounts, rebates, or reductions in price, for the most

377.25 recent month for which information is available, as reported in wholesale price guides or

377.26 other publications of drug or biological pricing data. The maximum allowable cost of a

377.27 multisource drug may be set by the commissioner and it shall be comparable to, but the

377.28 actual acquisition cost of the drug product and no higher than, the maximum amount paid

377.29 by other third party payors in this state who have maximum allowable cost programs the

377.30 NADAC of the generic product. Establishment of the amount of payment for drugs shall

377.31 not be subject to the requirements of the Administrative Procedure Act.

377.32 (b) Pharmacies dispensing prescriptions to residents of long-term care facilities using

377.33 an automated drug distribution system meeting the requirements of section 151.58, or a

377.34 packaging system meeting the packaging standards set forth in Minnesota Rules, part

377.35 6800.2700, that govern the return of unused drugs to the pharmacy for reuse, may employ

377.36 retrospective billing for prescription drugs dispensed to long-term care facility residents. A

378.1 retrospectively billing pharmacy must submit a claim only for the quantity of medication
378.2 used by the enrolled recipient during the defined billing period. A retrospectively billing
378.3 pharmacy must use a billing period not less than one calendar month or 30 days.

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

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

378.24 (e) The basis for determining the amount of payment for drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the provider, 106 percent of the average sales price as determined by the United States Department of Health and Human Services pursuant to title XVIII, section 1847a of the federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner. If average sales price is unavailable, the amount of payment must be lower of the usual and customary cost submitted by the provider, the wholesale acquisition cost, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner. Effective January 1, 2014, The commissioner shall discount the payment rate for drugs obtained through the federal 340B Drug Pricing Program by ~~20~~ 28.6 percent. The payment for drugs administered in an outpatient setting shall be made to the administering facility

379.1 or practitioner. A retail or specialty pharmacy dispensing a drug for administration in an
379.2 outpatient setting is not eligible for direct reimbursement.

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

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

379.23 (h) The commissioner shall contract with a vendor to conduct a cost of dispensing survey
379.24 for all pharmacies that are physically located in the state of Minnesota that dispense outpatient
379.25 drugs under medical assistance. The commissioner shall ensure that the vendor has prior
379.26 experience in conducting cost of dispensing surveys. Each pharmacy enrolled with the
379.27 department to dispense outpatient prescription drugs to fee-for-service members must
379.28 respond to the cost of dispensing survey. The commissioner may sanction a pharmacy under
379.29 section 256B.064 for failure to respond. The commissioner shall require the vendor to
379.30 measure a single statewide cost of dispensing for all responding pharmacies to measure the
379.31 mean, mean weighted by total prescription volume, mean weighted by medical assistance
379.32 prescription volume, median, median weighted by total prescription volume, and median
379.33 weighted by total medical assistance prescription volume. The commissioner shall post a
379.34 copy of the final cost of dispensing survey report on the department's website. The initial
379.35 survey must be completed no later than January 1, 2021, and repeated every three years.

380.1 The commissioner shall provide a summary of the results of each cost of dispensing survey
380.2 and provide recommendations for any changes to the dispensing fee to the chairs and ranking
380.3 members of the legislative committees with jurisdiction over medical assistance pharmacy
380.4 reimbursement.

380.5 (i) The commissioner shall increase the ingredient cost reimbursement calculated in
380.6 paragraphs (a) and (f) by two percent for prescription and nonprescription drugs subject to
380.7 the wholesale drug distributor tax under section 295.52.

380.8 **EFFECTIVE DATE.** This section is effective April 1, 2019, or upon federal approval,
380.9 whichever is later. Paragraph (i) expires if federal approval is denied. The commissioner
380.10 of human services shall inform the revisor of statutes when federal approval is obtained or
380.11 denied.

380.12 Sec. 13. Minnesota Statutes 2018, section 256B.0625, subdivision 13f, is amended to read:

380.13 Subd. 13f. **Prior authorization.** (a) The Formulary Committee shall review and
380.14 recommend drugs which require prior authorization. The Formulary Committee shall
380.15 establish general criteria to be used for the prior authorization of brand-name drugs for
380.16 which generically equivalent drugs are available, but the committee is not required to review
380.17 each brand-name drug for which a generically equivalent drug is available.

380.18 (b) Prior authorization may be required by the commissioner before certain formulary
380.19 drugs are eligible for payment. The Formulary Committee may recommend drugs for prior
380.20 authorization directly to the commissioner. The commissioner may also request that the
380.21 Formulary Committee review a drug for prior authorization. Before the commissioner may
380.22 require prior authorization for a drug:

380.23 (1) the commissioner must provide information to the Formulary Committee on the
380.24 impact that placing the drug on prior authorization may have on the quality of patient care
380.25 and on program costs, information regarding whether the drug is subject to clinical abuse
380.26 or misuse, and relevant data from the state Medicaid program if such data is available;

380.27 (2) the Formulary Committee must review the drug, taking into account medical and
380.28 clinical data and the information provided by the commissioner; and

380.29 (3) the Formulary Committee must hold a public forum and receive public comment for
380.30 an additional 15 days.

380.31 The commissioner must provide a 15-day notice period before implementing the prior
380.32 authorization.

381.1 (c) Except as provided in subdivision 13j, prior authorization shall not be required or
381.2 utilized for any atypical antipsychotic drug prescribed for the treatment of mental illness
381.3 if:

- 381.4 (1) there is no generically equivalent drug available; and
381.5 (2) the drug was initially prescribed for the recipient prior to July 1, 2003; or
381.6 (3) the drug is part of the recipient's current course of treatment.

381.7 This paragraph applies to any multistate preferred drug list or supplemental drug rebate
381.8 program established or administered by the commissioner. Prior authorization shall
381.9 automatically be granted for 60 days for brand name drugs prescribed for treatment of mental
381.10 illness within 60 days of when a generically equivalent drug becomes available, provided
381.11 that the brand name drug was part of the recipient's course of treatment at the time the
381.12 generically equivalent drug became available.

381.13 ~~(d) Prior authorization shall not be required or utilized for any antihemophilic factor~~
381.14 ~~drug prescribed for the treatment of hemophilia and blood disorders where there is no~~
381.15 ~~generically equivalent drug available if the prior authorization is used in conjunction with~~
381.16 ~~any supplemental drug rebate program or multistate preferred drug list established or~~
381.17 ~~administered by the commissioner.~~

381.18 ~~(e)~~(d) The commissioner may require prior authorization for brand name drugs whenever
381.19 a generically equivalent product is available, even if the prescriber specifically indicates
381.20 "dispense as written-brand necessary" on the prescription as required by section 151.21,
381.21 subdivision 2.

381.22 ~~(f)~~(e) Notwithstanding this subdivision, the commissioner may automatically require
381.23 prior authorization, for a period not to exceed 180 days, for any drug that is approved by
381.24 the United States Food and Drug Administration on or after July 1, 2005. The 180-day
381.25 period begins no later than the first day that a drug is available for shipment to pharmacies
381.26 within the state. The Formulary Committee shall recommend to the commissioner general
381.27 criteria to be used for the prior authorization of the drugs, but the committee is not required
381.28 to review each individual drug. In order to continue prior authorizations for a drug after the
381.29 180-day period has expired, the commissioner must follow the provisions of this subdivision.

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

382.1 Sec. 14. Minnesota Statutes 2018, section 256B.0625, subdivision 17, is amended to read:

382.2 Subd. 17. **Transportation costs.** (a) "Nonemergency medical transportation service"

382.3 means motor vehicle transportation provided by a public or private person that serves

382.4 Minnesota health care program beneficiaries who do not require emergency ambulance

382.5 service, as defined in section 144E.001, subdivision 3, to obtain covered medical services.

382.6 (b) Medical assistance covers medical transportation costs incurred solely for obtaining

382.7 emergency medical care or transportation costs incurred by eligible persons in obtaining

382.8 emergency or nonemergency medical care when paid directly to an ambulance company,

382.9 nonemergency medical transportation company, or other recognized providers of

382.10 transportation services. Medical transportation must be provided by:

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

382.12 subdivision;

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

382.14 (3) taxicabs that meet the requirements of this subdivision;

382.15 (4) public transit, as defined in section 174.22, subdivision 7; or

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

382.17 (c) Medical assistance covers nonemergency medical transportation provided by

382.18 nonemergency medical transportation providers enrolled in the Minnesota health care

382.19 programs. All nonemergency medical transportation providers must comply with the

382.20 operating standards for special transportation service as defined in sections 174.29 to 174.30

382.21 and Minnesota Rules, chapter 8840, and ~~in consultation with the Minnesota Department of~~

382.22 ~~Transportation all drivers must be individually enrolled with the commissioner and reported~~

382.23 ~~on the claim as the individual who provided the service.~~ All nonemergency medical

382.24 transportation providers shall bill for nonemergency medical transportation services in

382.25 accordance with Minnesota health care programs criteria. Publicly operated transit systems,

382.26 volunteers, and not-for-hire vehicles are exempt from the requirements outlined in this

382.27 paragraph.

382.28 (d) An organization may be terminated, denied, or suspended from enrollment if:

382.29 (1) the provider has not initiated background studies on the individuals specified in

382.30 section 174.30, subdivision 10, paragraph (a), clauses (1) to (3); or

382.31 (2) the provider has initiated background studies on the individuals specified in section

382.32 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:

- 383.1 (i) the commissioner has sent the provider a notice that the individual has been
383.2 disqualified under section 245C.14; and
- 383.3 (ii) the individual has not received a disqualification set-aside specific to the special
383.4 transportation services provider under sections 245C.22 and 245C.23.
- 383.5 (e) The administrative agency of nonemergency medical transportation must:
- 383.6 (1) adhere to the policies defined by the commissioner in consultation with the
383.7 Nonemergency Medical Transportation Advisory Committee;
- 383.8 (2) pay nonemergency medical transportation providers for services provided to
383.9 Minnesota health care programs beneficiaries to obtain covered medical services;
- 383.10 (3) provide data monthly to the commissioner on appeals, complaints, no-shows, canceled
383.11 trips, and number of trips by mode; and
- 383.12 (4) by July 1, 2016, in accordance with subdivision 18e, utilize a web-based single
383.13 administrative structure assessment tool that meets the technical requirements established
383.14 by the commissioner, reconciles trip information with claims being submitted by providers,
383.15 and ensures prompt payment for nonemergency medical transportation services.
- 383.16 (f) Until the commissioner implements the single administrative structure and delivery
383.17 system under subdivision 18e, clients shall obtain their level-of-service certificate from the
383.18 commissioner or an entity approved by the commissioner that does not dispatch rides for
383.19 clients using modes of transportation under paragraph (i), clauses (4), (5), (6), and (7).
- 383.20 (g) The commissioner may use an order by the recipient's attending physician or a medical
383.21 or mental health professional to certify that the recipient requires nonemergency medical
383.22 transportation services. Nonemergency medical transportation providers shall perform
383.23 driver-assisted services for eligible individuals, when appropriate. Driver-assisted service
383.24 includes passenger pickup at and return to the individual's residence or place of business,
383.25 assistance with admittance of the individual to the medical facility, and assistance in
383.26 passenger securement or in securing of wheelchairs, child seats, or stretchers in the vehicle.
- 383.27 Nonemergency medical transportation providers must take clients to the health care
383.28 provider using the most direct route, and must not exceed 30 miles for a trip to a primary
383.29 care provider or 60 miles for a trip to a specialty care provider, unless the client receives
383.30 authorization from the local agency.
- 383.31 Nonemergency medical transportation providers may not bill for separate base rates for
383.32 the continuation of a trip beyond the original destination. Nonemergency medical
383.33 transportation providers must maintain trip logs, which include pickup and drop-off times,

384.1 signed by the medical provider or client, whichever is deemed most appropriate, attesting
384.2 to mileage traveled to obtain covered medical services. Clients requesting client mileage
384.3 reimbursement must sign the trip log attesting mileage traveled to obtain covered medical
384.4 services.

384.5 (h) The administrative agency shall use the level of service process established by the
384.6 commissioner in consultation with the Nonemergency Medical Transportation Advisory
384.7 Committee to determine the client's most appropriate mode of transportation. If public transit
384.8 or a certified transportation provider is not available to provide the appropriate service mode
384.9 for the client, the client may receive a onetime service upgrade.

384.10 (i) The covered modes of transportation are:

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

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

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

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

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

384.24 (6) protected transport, which includes transport provided to a client who has received
384.25 a prescreening that has deemed other forms of transportation inappropriate and who requires
384.26 a provider: (i) with a protected vehicle that is not an ambulance or police car and has safety
384.27 locks, a video recorder, and a transparent thermoplastic partition between the passenger and
384.28 the vehicle driver; and (ii) who is certified as a protected transport provider; and

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

384.32 (j) The local agency shall be the single administrative agency and shall administer and
384.33 reimburse for modes defined in paragraph (i) according to paragraphs (m) and (n) when the

385.1 commissioner has developed, made available, and funded the web-based single administrative
385.2 structure, assessment tool, and level of need assessment under subdivision 18e. The local
385.3 agency's financial obligation is limited to funds provided by the state or federal government.

385.4 (k) The commissioner shall:

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

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

385.8 (3) investigate all complaints and appeals.

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

385.13 (m) Payments for nonemergency medical transportation must be paid based on the client's
385.14 assessed mode under paragraph (h), not the type of vehicle used to provide the service. The
385.15 medical assistance reimbursement rates for nonemergency medical transportation services
385.16 that are payable by or on behalf of the commissioner for nonemergency medical
385.17 transportation services are:

385.18 (1) \$0.22 per mile for client reimbursement;

385.19 (2) up to 100 percent of the Internal Revenue Service business deduction rate for volunteer
385.20 transport;

385.21 (3) equivalent to the standard fare for unassisted transport when provided by public
385.22 transit, and \$11 for the base rate and \$1.30 per mile when provided by a nonemergency
385.23 medical transportation provider;

385.24 (4) \$13 for the base rate and \$1.30 per mile for assisted transport;

385.25 (5) \$18 for the base rate and \$1.55 per mile for lift-equipped/ramp transport;

385.26 (6) \$75 for the base rate and \$2.40 per mile for protected transport; and

385.27 (7) \$60 for the base rate and \$2.40 per mile for stretcher transport, and \$9 per trip for
385.28 an additional attendant if deemed medically necessary.

385.29 (n) The base rate for nonemergency medical transportation services in areas defined
385.30 under RUCA to be super rural is equal to 111.3 percent of the respective base rate in

386.1 paragraph (m), clauses (1) to (7). The mileage rate for nonemergency medical transportation
386.2 services in areas defined under RUCA to be rural or super rural areas is:

386.3 (1) for a trip equal to 17 miles or less, equal to 125 percent of the respective mileage
386.4 rate in paragraph (m), clauses (1) to (7); and

386.5 (2) for a trip between 18 and 50 miles, equal to 112.5 percent of the respective mileage
386.6 rate in paragraph (m), clauses (1) to (7).

386.7 (o) For purposes of reimbursement rates for nonemergency medical transportation
386.8 services under paragraphs (m) and (n), the zip code of the recipient's place of residence
386.9 shall determine whether the urban, rural, or super rural reimbursement rate applies.

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

386.13 (q) The commissioner, when determining reimbursement rates for nonemergency medical
386.14 transportation under paragraphs (m) and (n), shall exempt all modes of transportation listed
386.15 under paragraph (i) from Minnesota Rules, part 9505.0445, item R, subitem (2).

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

386.17 Sec. 15. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision
386.18 to read:

386.19 **Subd. 17d. Transportation services oversight.** The commissioner shall contract with
386.20 a vendor or dedicate staff to oversee providers of nonemergency medical transportation
386.21 services pursuant to the commissioner's authority in section 256B.04 and Minnesota Rules,
386.22 parts 9505.2160 to 9505.2245.

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

386.24 Sec. 16. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision
386.25 to read:

386.26 **Subd. 17e. Transportation provider termination.** (a) A terminated nonemergency
386.27 medical transportation provider, including all named individuals on the current enrollment
386.28 disclosure form and known or discovered affiliates of the nonemergency medical
386.29 transportation provider, is not eligible to enroll as a nonemergency medical transportation
386.30 provider for five years following the termination.

387.1 (b) After the five-year period in paragraph (a), if a provider seeks to reenroll as a
387.2 nonemergency medical transportation provider, the provider must be placed on a one-year
387.3 probation period. During a provider's probation period the commissioner shall complete
387.4 unannounced site visits and request documentation to review compliance with program
387.5 requirements.

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

387.7 Sec. 17. Minnesota Statutes 2018, section 256B.0625, subdivision 57, is amended to read:

387.8 Subd. 57. **Payment for Part B Medicare crossover claims.** (a) Effective for services
387.9 provided on or after January 1, 2012, medical assistance payment for an enrollee's
387.10 cost-sharing associated with Medicare Part B is limited to an amount up to the medical
387.11 assistance total allowed, when the medical assistance rate exceeds the amount paid by
387.12 Medicare.

387.13 (b) Excluded from this limitation are payments for mental health services and payments
387.14 for dialysis services provided to end-stage renal disease patients. The exclusion for mental
387.15 health services does not apply to payments for physician services provided by psychiatrists
387.16 and advanced practice nurses with a specialty in mental health.

387.17 (c) Excluded from this limitation are payments to federally qualified health centers,
387.18 Indian Health Services, and rural health clinics.

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

387.20 Sec. 18. Minnesota Statutes 2018, section 256B.064, subdivision 1a, is amended to read:

387.21 Subd. 1a. **Grounds for sanctions against vendors.** (a) The commissioner may impose
387.22 sanctions against a vendor of medical care for any of the following: (1) fraud, theft, or abuse
387.23 in connection with the provision of medical care to recipients of public assistance; (2) a
387.24 pattern of presentment of false or duplicate claims or claims for services not medically
387.25 necessary; (3) a pattern of making false statements of material facts for the purpose of
387.26 obtaining greater compensation than that to which the vendor is legally entitled; (4)
387.27 suspension or termination as a Medicare vendor; (5) refusal to grant the state agency access
387.28 during regular business hours to examine all records necessary to disclose the extent of
387.29 services provided to program recipients and appropriateness of claims for payment; (6)
387.30 failure to repay an overpayment or a fine finally established under this section; (7) failure
387.31 to correct errors in the maintenance of health service or financial records for which a fine
387.32 was imposed or after issuance of a warning by the commissioner; and (8) any reason for

388.1 which a vendor could be excluded from participation in the Medicare program under section
388.2 1128, 1128A, or 1866(b)(2) of the Social Security Act.

388.3 (b) The commissioner may impose sanctions against a pharmacy provider for failure to
388.4 respond to a cost of dispensing survey under section 256B.0625, subdivision 13e, paragraph
388.5 (h).

388.6 **EFFECTIVE DATE.** This section is effective April 1, 2019.

388.7 Sec. 19. Minnesota Statutes 2018, section 256B.0659, subdivision 21, is amended to read:

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

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

388.15 (2) proof of surety bond coverage for each business location providing services. Upon
388.16 new enrollment, or if the provider's Medicaid revenue in the previous calendar year is up
388.17 to and including \$300,000, the provider agency must purchase a surety bond of \$50,000. If
388.18 the Medicaid revenue in the previous year is over \$300,000, the provider agency must
388.19 purchase a surety bond of \$100,000. The surety bond must be in a form approved by the
388.20 commissioner, must be renewed annually, and must allow for recovery of costs and fees in
388.21 pursuing a claim on the bond;

388.22 (3) proof of fidelity bond coverage in the amount of \$20,000 for each business location
388.23 providing service;

388.24 (4) proof of workers' compensation insurance coverage identifying the business location
388.25 where personal care assistance services are provided;

388.26 (5) proof of liability insurance coverage identifying the business location where personal
388.27 care assistance services are provided and naming the department as a certificate holder;

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

388.31 (7) (6) a copy of the personal care assistance provider agency's written policies and
388.32 procedures including: hiring of employees; training requirements; service delivery; and

389.1 employee and consumer safety including process for notification and resolution of consumer
389.2 grievances, identification and prevention of communicable diseases, and employee
389.3 misconduct;

389.4 ~~(8)(7)~~ copies of all other forms the personal care assistance provider agency uses in the
389.5 course of daily business including, but not limited to:

389.6 (i) a copy of the personal care assistance provider agency's time sheet if the time sheet
389.7 varies from the standard time sheet for personal care assistance services approved by the
389.8 commissioner, and a letter requesting approval of the personal care assistance provider
389.9 agency's nonstandard time sheet;

389.10 (ii) the personal care assistance provider agency's template for the personal care assistance
389.11 care plan; and

389.12 (iii) the personal care assistance provider agency's template for the written agreement
389.13 in subdivision 20 for recipients using the personal care assistance choice option, if applicable;

389.14 ~~(9)(8)~~ a list of all training and classes that the personal care assistance provider agency
389.15 requires of its staff providing personal care assistance services;

389.16 ~~(10)(9)~~ documentation that the personal care assistance provider agency and staff have
389.17 successfully completed all the training required by this section;

389.18 ~~(11)(10)~~ documentation of the agency's marketing practices;

389.19 ~~(12)(11)~~ disclosure of ownership, leasing, or management of all residential properties
389.20 that is used or could be used for providing home care services;

389.21 ~~(13)(12)~~ documentation that the agency will use the following percentages of revenue
389.22 generated from the medical assistance rate paid for personal care assistance services for
389.23 employee personal care assistant wages and benefits: 72.5 percent of revenue in the personal
389.24 care assistance choice option and 72.5 percent of revenue from other personal care assistance
389.25 providers. The revenue generated by the qualified professional and the reasonable costs
389.26 associated with the qualified professional shall not be used in making this calculation; and

389.27 ~~(14)(13)~~ effective May 15, 2010, documentation that the agency does not burden
389.28 recipients' free exercise of their right to choose service providers by requiring personal care
389.29 assistants to sign an agreement not to work with any particular personal care assistance
389.30 recipient or for another personal care assistance provider agency after leaving the agency
389.31 and that the agency is not taking action on any such agreements or requirements regardless
389.32 of the date signed.

390.1 (b) Personal care assistance provider agencies shall provide the information specified
390.2 in paragraph (a) to the commissioner at the time the personal care assistance provider agency
390.3 enrolls as a vendor or upon request from the commissioner. The commissioner shall collect
390.4 the information specified in paragraph (a) from all personal care assistance providers
390.5 beginning July 1, 2009.

390.6 (c) All personal care assistance provider agencies shall require all employees in
390.7 management and supervisory positions and owners of the agency who are active in the
390.8 day-to-day management and operations of the agency to complete mandatory training as
390.9 determined by the commissioner before submitting an application for enrollment of the
390.10 agency as a provider. All personal care assistance provider agencies shall also require
390.11 qualified professionals to complete the training required by subdivision 13 before submitting
390.12 an application for enrollment of the agency as a provider. Employees in management and
390.13 supervisory positions and owners who are active in the day-to-day operations of an agency
390.14 who have completed the required training as an employee with a personal care assistance
390.15 provider agency do not need to repeat the required training if they are hired by another
390.16 agency, if they have completed the training within the past three years. By September 1,
390.17 2010, the required training must be available with meaningful access according to title VI
390.18 of the Civil Rights Act and federal regulations adopted under that law or any guidance from
390.19 the United States Health and Human Services Department. The required training must be
390.20 available online or by electronic remote connection. The required training must provide for
390.21 competency testing. Personal care assistance provider agency billing staff shall complete
390.22 training about personal care assistance program financial management. This training is
390.23 effective July 1, 2009. Any personal care assistance provider agency enrolled before that
390.24 date shall, if it has not already, complete the provider training within 18 months of July 1,
390.25 2009. Any new owners or employees in management and supervisory positions involved
390.26 in the day-to-day operations are required to complete mandatory training as a requisite of
390.27 working for the agency. Personal care assistance provider agencies certified for participation
390.28 in Medicare as home health agencies are exempt from the training required in this
390.29 subdivision. When available, Medicare-certified home health agency owners, supervisors,
390.30 or managers must successfully complete the competency test.

390.31 (d) All surety bonds, fidelity bonds, workers compensation insurance, and liability
390.32 insurance required by this subdivision must be maintained continuously. After initial
390.33 enrollment, a provider must submit proof of bonds and required coverages at any time at
390.34 the request of the commissioner. Services provided while there are lapses in coverage are
390.35 not eligible for payment. Lapses in coverage may result in sanctions, including termination.

391.1 The commissioner shall send instructions and a due date to submit the requested information
391.2 to the personal care assistance provider agency.

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

391.4 **Sec. 20. [256B.688] PROVIDER TAX RATE INCREASE.**

391.5 (a) The commissioner shall increase the total payments to managed care plans under
391.6 section 256B.69 by an amount equal to the cost increases to the managed care plans from
391.7 the elimination of:

391.8 (1) the exemption from the taxes imposed under section 297I.05, subdivision 5, for
391.9 premiums paid by the state for medical assistance and the MinnesotaCare program; and

391.10 (2) the exemption of gross revenues subject to the taxes imposed under sections 295.50
391.11 to 295.57, for payments paid by the state for services provided under medical assistance
391.12 and the MinnesotaCare program. Any increase based on clause (2) must be reflected in
391.13 provider rates paid by the managed care plan unless the managed care plan is a staff model
391.14 health plan company.

391.15 (b) The commissioner shall increase by two percent the fee-for-service payments under
391.16 medical assistance and the MinnesotaCare program for services subject to the hospital,
391.17 surgical center, or health care provider taxes under sections 295.50 to 295.57.

391.18 Sec. 21. Minnesota Statutes 2018, section 256B.766, is amended to read:

391.19 **256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.**

391.20 **Subdivision 1. Generally.** (a) Effective for services provided on or after July 1, 2009,
391.21 total payments for basic care services, shall be reduced by three percent, except that for the
391.22 period July 1, 2009, through June 30, 2011, total payments shall be reduced by 4.5 percent
391.23 for the medical assistance and general assistance medical care programs, prior to third-party
391.24 liability and spenddown calculation. Effective July 1, 2010, the commissioner shall classify
391.25 physical therapy services, occupational therapy services, and speech-language pathology
391.26 and related services as basic care services. The reduction in this paragraph shall apply to
391.27 physical therapy services, occupational therapy services, and speech-language pathology
391.28 and related services provided on or after July 1, 2010.

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

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

392.4 (d) Effective for services provided on or after September 1, 2011, through June 30, 2013,
392.5 total payments for ambulatory surgery centers facility fees, medical supplies and durable
392.6 medical equipment not subject to a volume purchase contract, prosthetics and orthotics,
392.7 renal dialysis services, laboratory services, public health nursing services, physical therapy
392.8 services, occupational therapy services, speech therapy services, eyeglasses not subject to
392.9 a volume purchase contract, hearing aids not subject to a volume purchase contract, and
392.10 anesthesia services shall be reduced by three percent from the rates in effect on August 31,
392.11 2011.

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

392.19 (f) Payments for medical supplies and durable medical equipment not subject to a volume
392.20 purchase contract, and prosthetics and orthotics, provided on or after July 1, 2014, through
392.21 June 30, 2015, shall be decreased by .33 percent. Payments for medical supplies and durable
392.22 medical equipment not subject to a volume purchase contract, and prosthetics and orthotics,
392.23 provided on or after July 1, 2015, shall be increased by three percent from the rates as
392.24 determined under paragraphs (i) and (j).

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

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

393.1 (i) Effective for services provided on or after July 1, 2015, the following categories of
393.2 medical supplies and durable medical equipment shall be individually priced items: enteral
393.3 nutrition and supplies, customized and other specialized tracheostomy tubes and supplies,
393.4 electric patient lifts, and durable medical equipment repair and service. This paragraph does
393.5 not apply to medical supplies and durable medical equipment subject to a volume purchase
393.6 contract, products subject to the preferred diabetic testing supply program, and items provided
393.7 to dually eligible recipients when Medicare is the primary payer for the item. The
393.8 commissioner shall not apply any medical assistance rate reductions to durable medical
393.9 equipment as a result of Medicare competitive bidding.

393.10 (j) Effective for services provided on or after July 1, 2015, medical assistance payment
393.11 rates for durable medical equipment, prosthetics, orthotics, or supplies shall be increased
393.12 as follows:

393.13 (1) payment rates for durable medical equipment, prosthetics, orthotics, or supplies that
393.14 were subject to the Medicare competitive bid that took effect in January of 2009 shall be
393.15 increased by 9.5 percent; and

393.16 (2) payment rates for durable medical equipment, prosthetics, orthotics, or supplies on
393.17 the medical assistance fee schedule, whether or not subject to the Medicare competitive bid
393.18 that took effect in January of 2009, shall be increased by 2.94 percent, with this increase
393.19 being applied after calculation of any increased payment rate under clause (1).

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

393.26 (k) (i) Effective for nonpressure support ventilators provided on or after January 1, 2016,
393.27 the rate shall be the lower of the submitted charge or the Medicare fee schedule rate. Effective
393.28 for pressure support ventilators provided on or after January 1, 2016, the rate shall be the
393.29 lower of the submitted charge or 47 percent above the Medicare fee schedule rate. For
393.30 payments made in accordance with this paragraph, if, and to the extent that, the commissioner
393.31 identifies that the state has received federal financial participation for ventilators in excess
393.32 of the amount allowed effective January 1, 2018, under United States Code, title 42, section
393.33 1396b(i)(27), the state shall repay the excess amount to the Centers for Medicare and
393.34 Medicaid Services with state funds and maintain the full payment rate under this paragraph.

394.1 **Subd. 2. Durable medical equipment.** (a) Notwithstanding Minnesota Rules, part
394.2 9505.0445, item S, this subdivision governs medical assistance rates for medical supplies
394.3 and equipment described under this subdivision. Payment rates for all durable medical
394.4 equipment, prosthetics, orthotics, or supplies that are not subject to a volume purchase
394.5 contract, preferred product program, or competitively bid contract, and not reimbursed under
394.6 paragraph (b), shall be the lesser of the provider's submitted charges or the Medicare non-rural
394.7 fee schedule amount applicable on the date of service, with no increase or decrease described
394.8 in subdivision 1.

394.9 (b) Payment rates for durable medical equipment, prosthetics, orthotics, or supplies that
394.10 are not subject to a volume purchase contract, preferred product program, or competitively
394.11 bid contract for which Medicare has not established a payment amount shall be the lesser
394.12 of the provider's submitted charges, or the alternative payment methodology rate described
394.13 in paragraphs (c) to (h), with no increase or decrease described in subdivision 1.

394.14 (c) The alternate payment methodology rate is calculated from either:

394.15 (1) at least 100 paid claim lines, as priced under paragraph (f), provided by at least ten
394.16 different providers within one calendar month for services that are provided at least 100
394.17 times in a calendar month; or

394.18 (2) at least 20 paid claim lines, as priced under paragraph (f), submitted by at least five
394.19 different providers within two consecutive quarters for services that are not provided 100
394.20 times in a calendar month.

394.21 (d) The alternate payment methodology rate is the mean of the payment per unit of the
394.22 claim lines, with the top and bottom ten percent of claim lines, by amount of payment per
394.23 unit, excluded from the calculation of the mean.

394.24 (e) The alternate payment methodology rate is added to the commissioner's fee schedule
394.25 on the first day of a calendar month, or the first day of a calendar quarter if claims from
394.26 more than one month are used to determine the rate. The alternate payment methodology
394.27 rate is subject to Medicare's inflation or deflation factor on January 1 of each year unless
394.28 the rate was calculated and posted to the fee schedule after July 1 of the previous year.

394.29 (f) Not more than once every three years, the commissioner must evaluate the alternate
394.30 payment methodology rate for reasonableness by reviewing invoices from at least 20 paid
394.31 claim lines and five different providers for services provided during one calendar month,
394.32 or one quarter if necessary to obtain the required sample. If the evaluation demonstrates
394.33 that the alternate payment methodology rate is more than five percent higher or lower than
394.34 the provider's actual acquisition cost plus 20 percent, the commissioner shall recalculate

395.1 and update the alternate payment methodology fee schedule according to paragraphs (c) to
395.2 (e). If the evaluation demonstrates that the alternate payment methodology fee schedule
395.3 rate is not five percent higher or lower than the provider's actual acquisition cost plus 20
395.4 percent, or a sufficient sample of claims according to paragraph (a) cannot be collected due
395.5 to low utilization, the commissioner shall maintain the previously calculated alternate
395.6 payment methodology fee schedule.

395.7 (g) Until sufficient data is available to calculate the alternative payment methodology
395.8 rate, the payment is based on the provider's actual acquisition cost plus 20 percent as
395.9 documented on an invoice submitted by the provider. The payment may be based on a quote
395.10 the provider received from a vendor showing the provider's actual acquisition cost only if
395.11 the durable medical equipment, prosthetic, orthotic, or supply requires authorization and
395.12 the rate is required to complete the authorization.

395.13 (h) When procuring goods or services under competitive bidding authority in section
395.14 256B.04, the commissioner may establish a payment rate for the procured services, or
395.15 establish a fee schedule, based on the following:

- 395.16 (1) the contracted rate established through a competitive procurement process;
395.17 (2) actual acquisition cost plus 20 percent consistent with paragraph (f); or
395.18 (3) a rate or rate methodology established by an administrative rule.

395.19 Sec. 22. Minnesota Statutes 2018, section 256B.767, is amended to read:

395.20 **256B.767 MEDICARE PAYMENT LIMIT.**

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

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

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

396.3 (d) ~~Effective July 1, 2015,~~ This section shall not apply to durable medical equipment,
396.4 prosthetics, orthotics, or supplies specified in section 256B.766, paragraph (k).

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

396.8 Sec. 23. Laws 2003, First Special Session chapter 14, article 13C, section 2, subdivision
396.9 6, as amended by Laws 2004, chapter 272, article 2, section 4; Laws 2005, First Special
396.10 Session chapter 4, article 5, section 18; and Laws 2005, First Special Session chapter 4,
396.11 article 9, section 11, is amended to read:

396.12 **Subd. 6. Basic Health Care Grants**

396.13 Summary by Fund

396.14 General 1,290,454,000 1,475,996,000

396.15 Health Care Access 254,121,000 282,689,000

396.16 **UPDATING FEDERAL POVERTY**

396.17 **GUIDELINES.** Annual updates to the federal
396.18 poverty guidelines are effective each July 1,
396.19 following publication by the United States
396.20 Department of Health and Human Services
396.21 for health care programs under Minnesota
396.22 Statutes, chapters 256, 256B, 256D, and 256L.

396.23 The amounts that may be spent from this
396.24 appropriation for each purpose are as follows:

396.25 (a) MinnesotaCare Grants

396.26 Health Care Access 253,371,000 281,939,000

396.27 **MINNESOTACARE FEDERAL**

396.28 **RECEIPTS.** Receipts received as a result of
396.29 federal participation pertaining to
396.30 administrative costs of the Minnesota health
396.31 care reform waiver shall be deposited as
396.32 nondedicated revenue in the health care access

397.1 fund. Receipts received as a result of federal
397.2 participation pertaining to grants shall be
397.3 deposited in the federal fund and shall offset
397.4 health care access funds for payments to
397.5 providers.

397.6 **MINNESOTACARE FUNDING.** The
397.7 commissioner may expend money
397.8 appropriated from the health care access fund
397.9 for MinnesotaCare in either fiscal year of the
397.10 biennium.

397.11 (b) MA Basic Health Care Grants - Families
397.12 and Children

397.13 General 427,769,000 489,545,000

397.14 **SERVICES TO PREGNANT WOMEN.**

397.15 The commissioner shall use available federal
397.16 money for the State-Children's Health
397.17 Insurance Program for medical assistance
397.18 services provided to pregnant women who are
397.19 not otherwise eligible for federal financial
397.20 participation beginning in fiscal year 2003.
397.21 This federal money shall be deposited in the
397.22 federal fund and shall offset general funds for
397.23 payments to providers. Notwithstanding
397.24 section 14, this paragraph shall not expire.

397.25 **MANAGED CARE RATE INCREASE. (a)**

397.26 ~~Effective January 1, 2004, the commissioner~~
397.27 ~~of human services shall increase the total~~
397.28 ~~payments to managed care plans under~~
397.29 ~~Minnesota Statutes, section 256B.69, by an~~
397.30 ~~amount equal to the cost increases to the~~
397.31 ~~managed care plans from by the elimination~~
397.32 ~~of: (1) the exemption from the taxes imposed~~
397.33 ~~under Minnesota Statutes, section 297I.05,~~
397.34 ~~subdivision 5, for premiums paid by the state~~

398.1 ~~for medical assistance, general assistance~~
398.2 ~~medical care, and the MinnesotaCare program;~~
398.3 ~~and (2) the exemption of gross revenues~~
398.4 ~~subject to the taxes imposed under Minnesota~~
398.5 ~~Statutes, sections 295.50 to 295.57, for~~
398.6 ~~payments paid by the state for services~~
398.7 ~~provided under medical assistance, general~~
398.8 ~~assistance medical care, and the~~
398.9 ~~MinnesotaCare program. Any increase based~~
398.10 ~~on clause (2) must be reflected in provider~~
398.11 ~~rates paid by the managed care plan unless the~~
398.12 ~~managed care plan is a staff model health plan~~
398.13 ~~company.~~

398.14 (b) The commissioner of human services shall
398.15 ~~increase by the applicable tax rate in effect~~
398.16 ~~under Minnesota Statutes, section 295.52, the~~
398.17 ~~fee-for-service payments under medical~~
398.18 ~~assistance, general assistance medical care,~~
398.19 ~~and the MinnesotaCare program for services~~
398.20 ~~subject to the hospital, surgical center, or~~
398.21 ~~health care provider taxes under Minnesota~~
398.22 ~~Statutes, sections 295.50 to 295.57, effective~~
398.23 ~~for services rendered on or after January 1,~~
398.24 ~~2004.~~

398.25 (c) The commissioner of finance shall transfer
398.26 from the health care access fund to the general
398.27 fund the following amounts in the fiscal years
398.28 indicated: 2004, \$16,587,000; 2005,
398.29 \$46,322,000; 2006, \$49,413,000; and 2007,
398.30 \$58,695,000.

398.31 (d) Notwithstanding section 14, these
398.32 provisions shall not expire.

398.33 (c) MA Basic Health Care Grants - Elderly
398.34 and Disabled

399.1 General 610,518,000 743,858,000

399.2 **DELAY MEDICAL ASSISTANCE**

399.3 **FEE-FOR-SERVICE - ACUTE CARE.** The
399.4 following payments in fiscal year 2005 from
399.5 the Medicaid Management Information
399.6 System that would otherwise have been made
399.7 to providers for medical assistance and general
399.8 assistance medical care services shall be
399.9 delayed and included in the first payment in
399.10 fiscal year 2006:

399.11 (1) for hospitals, the last two payments; and
399.12 (2) for nonhospital providers, the last payment.

399.13 This payment delay shall not include payments
399.14 to skilled nursing facilities, intermediate care
399.15 facilities for mental retardation, prepaid health
399.16 plans, home health agencies, personal care
399.17 nursing providers, and providers of only
399.18 waiver services. The provisions of Minnesota
399.19 Statutes, section 16A.124, shall not apply to
399.20 these delayed payments. Notwithstanding
399.21 section 14, this provision shall not expire.

399.22 **DEAF AND HARD-OF-HEARING**

399.23 **SERVICES.** If, after making reasonable
399.24 efforts, the service provider for mental health
399.25 services to persons who are deaf or hearing
399.26 impaired is not able to earn \$227,000 through
399.27 participation in medical assistance intensive
399.28 rehabilitation services in fiscal year 2005, the
399.29 commissioner shall transfer \$227,000 minus
399.30 medical assistance earnings achieved by the
399.31 grantee to deaf and hard-of-hearing grants to
399.32 enable the provider to continue providing
399.33 services to eligible persons.

399.34 (d) General Assistance Medical Care Grants

400.1 General 239,861,000 229,960,000

400.2 (e) Health Care Grants - Other Assistance

400.3 General 3,067,000 3,407,000

400.4 Health Care Access 750,000 750,000

400.5 **MINNESOTA PRESCRIPTION DRUG**

400.6 **DEDICATED FUND.** Of the general fund

400.7 appropriation, \$284,000 in fiscal year 2005 is

400.8 appropriated to the commissioner for the

400.9 prescription drug dedicated fund established

400.10 under the prescription drug discount program.

400.11 **DENTAL ACCESS GRANTS**

400.12 **CARRYOVER AUTHORITY.** Any unspent

400.13 portion of the appropriation from the health

400.14 care access fund in fiscal years 2002 and 2003

400.15 for dental access grants under Minnesota

400.16 Statutes, section 256B.53, shall not cancel but

400.17 shall be allowed to carry forward to be spent

400.18 in the biennium beginning July 1, 2003, for

400.19 these purposes.

400.20 **STOP-LOSS FUND ACCOUNT.** The

400.21 appropriation to the purchasing alliance

400.22 stop-loss fund account established under

400.23 Minnesota Statutes, section 256.956,

400.24 subdivision 2, for fiscal years 2004 and 2005

400.25 shall only be available for claim

400.26 reimbursements for qualifying enrollees who

400.27 are members of purchasing alliances that meet

400.28 the requirements described under Minnesota

400.29 Statutes, section 256.956, subdivision 1,

400.30 paragraph (f), clauses (1), (2), and (3).

400.31 (f) Prescription Drug Program

400.32 General 9,239,000 9,226,000

400.33 **PRESCRIPTION DRUG ASSISTANCE**

400.34 **PROGRAM.** Of the general fund

401.1 appropriation, \$702,000 in fiscal year 2004
401.2 and \$887,000 in fiscal year 2005 are for the
401.3 commissioner to establish and administer the
401.4 prescription drug assistance program through
401.5 the Minnesota board on aging.

401.6 **REBATE REVENUE RECAPTURE.** Any
401.7 funds received by the state from a drug
401.8 manufacturer due to errors in the
401.9 pharmaceutical pricing used by the
401.10 manufacturer in determining the prescription
401.11 drug rebate are appropriated to the
401.12 commissioner to augment funding of the
401.13 prescription drug program established in
401.14 Minnesota Statutes, section 256.955.

401.15 Sec. 24. **REPEALER.**

401.16 Minnesota Statutes 2018, section 256B.0659, subdivision 22, is repealed.

ARTICLE 9

ONECARE BUY-IN

401.19 Section 1. Minnesota Statutes 2018, section 62J.497, subdivision 1, is amended to read:

401.20 Subdivision 1. **Definitions.** (a) For the purposes of this section, the following terms have
401.21 the meanings given.

401.22 (b) "Backward compatible" means that the newer version of a data transmission standard
401.23 would retain, at a minimum, the full functionality of the versions previously adopted, and
401.24 would permit the successful completion of the applicable transactions with entities that
401.25 continue to use the older versions.

401.26 (c) "Dispense" or "dispensing" has the meaning given in section 151.01, subdivision 30.
401.27 Dispensing does not include the direct administering of a controlled substance to a patient
401.28 by a licensed health care professional.

401.29 (d) "Dispenser" means a person authorized by law to dispense a controlled substance,
401.30 pursuant to a valid prescription.

401.31 (e) "Electronic media" has the meaning given under Code of Federal Regulations, title
401.32 45, part 160.103.

402.1 (f) "E-prescribing" means the transmission using electronic media of prescription or
402.2 prescription-related information between a prescriber, dispenser, pharmacy benefit manager,
402.3 or group purchaser, either directly or through an intermediary, including an e-prescribing
402.4 network. E-prescribing includes, but is not limited to, two-way transmissions between the
402.5 point of care and the dispenser and two-way transmissions related to eligibility, formulary,
402.6 and medication history information.

402.7 (g) "Electronic prescription drug program" means a program that provides for
402.8 e-prescribing.

402.9 (h) "Group purchaser" has the meaning given in section 62J.03, subdivision 6-, excluding
402.10 state and federal health care programs under chapters 256B, 256L, and 256T.

402.11 (i) "HL7 messages" means a standard approved by the standards development
402.12 organization known as Health Level Seven.

402.13 (j) "National Provider Identifier" or "NPI" means the identifier described under Code
402.14 of Federal Regulations, title 45, part 162.406.

402.15 (k) "NCPDP" means the National Council for Prescription Drug Programs, Inc.

402.16 (l) "NCPDP Formulary and Benefits Standard" means the National Council for
402.17 Prescription Drug Programs Formulary and Benefits Standard, Implementation Guide,
402.18 Version 1, Release 0, October 2005.

402.19 (m) "NCPDP SCRIPT Standard" means the National Council for Prescription Drug
402.20 Programs Prescriber/Pharmacist Interface SCRIPT Standard, Implementation Guide Version
402.21 8, Release 1 (Version 8.1), October 2005, or the most recent standard adopted by the Centers
402.22 for Medicare and Medicaid Services for e-prescribing under Medicare Part D as required
402.23 by section 1860D-4(e)(4)(D) of the Social Security Act, and regulations adopted under it.
402.24 The standards shall be implemented according to the Centers for Medicare and Medicaid
402.25 Services schedule for compliance. Subsequently released versions of the NCPDP SCRIPT
402.26 Standard may be used, provided that the new version of the standard is backward compatible
402.27 to the current version adopted by the Centers for Medicare and Medicaid Services.

402.28 (n) "Pharmacy" has the meaning given in section 151.01, subdivision 2.

402.29 (o) "Prescriber" means a licensed health care practitioner, other than a veterinarian, as
402.30 defined in section 151.01, subdivision 23.

402.31 (p) "Prescription-related information" means information regarding eligibility for drug
402.32 benefits, medication history, or related health or drug information.

403.1 (q) "Provider" or "health care provider" has the meaning given in section 62J.03,
403.2 subdivision 8.

403.3 **EFFECTIVE DATE.** This section is effective January 1, 2022.

403.4 **Sec. 2. [256B.0371] ADMINISTRATION OF DENTAL SERVICES.**

403.5 **Subdivision 1. Contract for dental administration services.** (a) Effective January 1,
403.6 2022, the commissioner shall contract with up to two dental administrators to administer
403.7 dental services for all recipients of medical assistance and MinnesotaCare.

403.8 (b) The dental administrator must provide administrative services including but not
403.9 limited to:

403.10 (1) provider recruitment, contracting, and assistance;

403.11 (2) recipient outreach and assistance;

403.12 (3) utilization management and review for medical necessity of dental services;

403.13 (4) dental claims processing;

403.14 (5) coordination with other services;

403.15 (6) management of fraud and abuse;

403.16 (7) monitoring of access to dental services;

403.17 (8) performance measurement;

403.18 (9) quality improvement and evaluation requirements; and

403.19 (10) management of third-party liability requirements.

403.20 (c) Payments to contracted dental providers must be at the rates established under section
403.21 256B.76.

403.22 **EFFECTIVE DATE.** This section is effective January 1, 2022.

403.23 Sec. 3. Minnesota Statutes 2018, section 256B.0644, is amended to read:

403.24 **256B.0644 REIMBURSEMENT UNDER OTHER STATE HEALTH CARE**
403.25 **PROGRAMS.**

403.26 (a) A vendor of medical care, as defined in section 256B.02, subdivision 7, and a health
403.27 maintenance organization, as defined in chapter 62D, must participate as a provider or
403.28 contractor in the medical assistance program and MinnesotaCare as a condition of
403.29 participating as a provider in health insurance plans and programs or contractor for state

404.1 employees established under section 43A.18, the public employees insurance program under
404.2 section 43A.316, for health insurance plans offered to local statutory or home rule charter
404.3 city, county, and school district employees, the workers' compensation system under section
404.4 176.135, and insurance plans provided through the Minnesota Comprehensive Health
404.5 Association under sections 62E.01 to 62E.19. The limitations on insurance plans offered to
404.6 local government employees shall not be applicable in geographic areas where provider
404.7 participation is limited by managed care contracts with the Department of Human Services.
404.8 This section does not apply to dental service providers providing dental services outside
404.9 the seven-county metropolitan area.

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

404.12 (1) the provider accepts new medical assistance and MinnesotaCare patients;
404.13 (2) for providers other than dental service providers, at least 20 percent of the provider's
404.14 patients are covered by medical assistance and MinnesotaCare as their primary source of
404.15 coverage; or
404.16 (3) for dental service providers providing dental services in the seven-county metropolitan
404.17 area, at least ten percent of the provider's patients are covered by medical assistance and
404.18 MinnesotaCare as their primary source of coverage, or the provider accepts new medical
404.19 assistance and MinnesotaCare patients who are children with special health care needs. For
404.20 purposes of this section, "children with special health care needs" means children up to age
404.21 18 who: (i) require health and related services beyond that required by children generally;
404.22 and (ii) have or are at risk for a chronic physical, developmental, behavioral, or emotional
404.23 condition, including: bleeding and coagulation disorders; immunodeficiency disorders;
404.24 cancer; endocrinopathy; developmental disabilities; epilepsy, cerebral palsy, and other
404.25 neurological diseases; visual impairment or deafness; Down syndrome and other genetic
404.26 disorders; autism; fetal alcohol syndrome; and other conditions designated by the
404.27 commissioner after consultation with representatives of pediatric dental providers and
404.28 consumers.

404.29 (c) Patients seen on a volunteer basis by the provider at a location other than the provider's
404.30 usual place of practice may be considered in meeting the participation requirement in this
404.31 section. The commissioner shall establish participation requirements for health maintenance
404.32 organizations. The commissioner shall provide lists of participating medical assistance
404.33 providers on a quarterly basis to the commissioner of management and budget, the
404.34 commissioner of labor and industry, and the commissioner of commerce. Each of the

405.1 commissioners shall develop and implement procedures to exclude as participating providers
405.2 in the program or programs under their jurisdiction those providers who do not participate
405.3 in the medical assistance program. The commissioner of management and budget shall
405.4 implement this section through contracts with participating health and dental carriers.

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

405.8 (e) A vendor of medical care, as defined in section 256B.02, subdivision 7, that dispenses
405.9 outpatient prescription drugs in accordance with chapter 151 must participate as a provider
405.10 or contractor in the MinnesotaCare program as a condition of participating as a provider in
405.11 the medical assistance program.

405.12 **EFFECTIVE DATE.** This section is effective January 1, 2022.

405.13 Sec. 4. Minnesota Statutes 2018, section 256B.69, subdivision 6d, is amended to read:

405.14 Subd. 6d. **Prescription drugs.** The commissioner may exclude or modify coverage for
405.15 prescription drugs from the prepaid managed care contracts entered into under this section
405.16 ~~in order to increase savings to the state by collecting additional prescription drug rebates.~~
405.17 ~~The contracts must maintain incentives for the managed care plan to manage drug costs and~~
405.18 ~~utilization and may require that the managed care plans maintain an open drug formulary.~~
405.19 ~~In order to manage drug costs and utilization, the contracts may authorize the managed care~~
405.20 ~~plans to use preferred drug lists and prior authorization. This subdivision is contingent on~~
405.21 ~~federal approval of the managed care contract changes and the collection of additional~~
405.22 ~~prescription drug rebates.~~

405.23 **EFFECTIVE DATE.** This section is effective January 1, 2022.

405.24 Sec. 5. Minnesota Statutes 2018, section 256B.76, subdivision 2, is amended to read:

405.25 Subd. 2. **Dental reimbursement.** (a) Effective for services rendered on or after October
405.26 1, 1992, the commissioner shall make payments for dental services as follows:

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

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

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

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

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

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

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

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

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

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

406.28 (j) Effective for services rendered on or after January 1, 2014, payment rates for dental
406.29 services shall be increased by five percent from the rates in effect on December 31, 2013.
406.30 This increase does not apply to state-operated dental clinics in paragraph (f), federally
406.31 qualified health centers, rural health centers, and Indian health services. Effective January
406.32 1, 2014, payments made to managed care plans and county-based purchasing plans under

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

407.3 (k) Effective for services rendered on or after July 1, 2015, through December 31, 2016,
407.4 the commissioner shall increase payment rates for services furnished by dental providers
407.5 located outside of the seven-county metropolitan area by the maximum percentage possible
407.6 above the rates in effect on June 30, 2015, while remaining within the limits of funding
407.7 appropriated for this purpose. This increase does not apply to state-operated dental clinics
407.8 in paragraph (f), federally qualified health centers, rural health centers, and Indian health
407.9 services. Effective January 1, 2016, through December 31, 2016, payments to managed care
407.10 plans and county-based purchasing plans under sections 256B.69 and 256B.692 shall reflect
407.11 the payment increase described in this paragraph. The commissioner shall require managed
407.12 care and county-based purchasing plans to pass on the full amount of the increase, in the
407.13 form of higher payment rates to dental providers located outside of the seven-county
407.14 metropolitan area.

407.15 (l) Effective for services provided on or after January 1, 2017, through December 31,
407.16 2021, the commissioner shall increase payment rates by 9.65 percent for dental services
407.17 provided outside of the seven-county metropolitan area. This increase does not apply to
407.18 state-operated dental clinics in paragraph (f), federally qualified health centers, rural health
407.19 centers, or Indian health services. Effective January 1, 2017, payments to managed care
407.20 plans and county-based purchasing plans under sections 256B.69 and 256B.692 shall reflect
407.21 the payment increase described in this paragraph.

407.22 (m) Effective for services provided on or after July 1, 2017, through December 31, 2021,
407.23 the commissioner shall increase payment rates by 23.8 percent for dental services provided
407.24 to enrollees under the age of 21. This rate increase does not apply to state-operated dental
407.25 clinics in paragraph (f), federally qualified health centers, rural health centers, or Indian
407.26 health centers. This rate increase does not apply to managed care plans and county-based
407.27 purchasing plans.

407.28 (n) Effective for dental services provided on or after January 1, 2022, the commissioner
407.29 shall increase payment rates by 54 percent. This rate increase does not apply to state-operated
407.30 dental clinics in paragraph (f), federally qualified health centers, rural health centers, or
407.31 Indian health centers.

407.32 Sec. 6. Minnesota Statutes 2018, section 256B.76, subdivision 4, is amended to read:

407.33 Subd. 4. **Critical access dental providers.** (a) The commissioner shall increase
407.34 reimbursements to dentists and dental clinics deemed by the commissioner to be critical

408.1 access dental providers. For dental services rendered on or after July 1, 2016, through
408.2 December 31, 2021, the commissioner shall increase reimbursement by 37.5 percent above
408.3 the reimbursement rate that would otherwise be paid to the critical access dental provider,
408.4 except as specified under paragraph (b). The commissioner shall pay the managed care
408.5 plans and county-based purchasing plans in amounts sufficient to reflect increased
408.6 reimbursements to critical access dental providers as approved by the commissioner.

408.7 (b) For dental services rendered on or after July 1, 2016, by a dental clinic or dental
408.8 group that meets the critical access dental provider designation under paragraph (d), clause
408.9 (4), and is owned and operated by a health maintenance organization licensed under chapter
408.10 62D, the commissioner shall increase reimbursement by 35 percent above the reimbursement
408.11 rate that would otherwise be paid to the critical access provider.

408.12 (c) Critical access dental payments made under paragraph (a) or (b) for dental services
408.13 provided by a critical access dental provider to an enrollee of a managed care plan or
408.14 county-based purchasing plan must not reflect any capitated payments or cost-based payments
408.15 from the managed care plan or county-based purchasing plan. The managed care plan or
408.16 county-based purchasing plan must base the additional critical access dental payment on
408.17 the amount that would have been paid for that service had the dental provider been paid
408.18 according to the managed care plan or county-based purchasing plan's fee schedule that
408.19 applies to dental providers that are not paid under a capitated payment or cost-based payment.

408.20 (d) The commissioner shall designate the following dentists and dental clinics as critical
408.21 access dental providers:

408.22 (1) nonprofit community clinics that:

408.23 (i) have nonprofit status in accordance with chapter 317A;
408.24 (ii) have tax exempt status in accordance with the Internal Revenue Code, section
408.25 501(c)(3);

408.26 (iii) are established to provide oral health services to patients who are low income,
408.27 uninsured, have special needs, and are underserved;

408.28 (iv) have professional staff familiar with the cultural background of the clinic's patients;

408.29 (v) charge for services on a sliding fee scale designed to provide assistance to low-income
408.30 patients based on current poverty income guidelines and family size;

408.31 (vi) do not restrict access or services because of a patient's financial limitations or public
408.32 assistance status; and

409.1 (vii) have free care available as needed;

409.2 (2) federally qualified health centers, rural health clinics, and public health clinics;

409.3 (3) hospital-based dental clinics owned and operated by a city, county, or former state

409.4 hospital as defined in section 62Q.19, subdivision 1, paragraph (a), clause (4);

409.5 (4) a dental clinic or dental group owned and operated by a nonprofit corporation in

409.6 accordance with chapter 317A with more than 10,000 patient encounters per year with

409.7 patients who are uninsured or covered by medical assistance or MinnesotaCare;

409.8 (5) a dental clinic owned and operated by the University of Minnesota or the Minnesota

409.9 State Colleges and Universities system; and

409.10 (6) private practicing dentists if:

409.11 (i) the dentist's office is located within the seven-county metropolitan area and more

409.12 than 50 percent of the dentist's patient encounters per year are with patients who are uninsured

409.13 or covered by medical assistance or MinnesotaCare; or

409.14 (ii) the dentist's office is located outside the seven-county metropolitan area and more

409.15 than 25 percent of the dentist's patient encounters per year are with patients who are uninsured

409.16 or covered by medical assistance or MinnesotaCare.

409.17 Sec. 7. Minnesota Statutes 2018, section 256L.03, is amended by adding a subdivision to

409.18 read:

409.19 Subd. 7. Outpatient prescription drugs. Outpatient prescription drugs are covered

409.20 according to section 256L.30. This subdivision applies to all individuals enrolled in the

409.21 MinnesotaCare program.

409.22 EFFECTIVE DATE. This section is effective January 1, 2022.

409.23 Sec. 8. Minnesota Statutes 2018, section 256L.11, subdivision 7, is amended to read:

409.24 Subd. 7. Critical access dental providers. Effective for dental services provided to

409.25 MinnesotaCare enrollees on or after July 1, 2017, through December 31, 2021, the

409.26 commissioner shall increase payment rates to dentists and dental clinics deemed by the

409.27 commissioner to be critical access providers under section 256B.76, subdivision 4, by 20

409.28 percent above the payment rate that would otherwise be paid to the provider. The

409.29 commissioner shall pay the prepaid health plans under contract with the commissioner

409.30 amounts sufficient to reflect this rate increase. The prepaid health plan must pass this rate

410.1 increase to providers who have been identified by the commissioner as critical access dental
410.2 providers under section 256B.76, subdivision 4.

410.3 **Sec. 9. [256L.30] OUTPATIENT PRESCRIPTION DRUGS.**

410.4 Subdivision 1. Establishment of program. The commissioner shall administer and
410.5 oversee the outpatient prescription drug program for MinnesotaCare. The commissioner
410.6 shall not include the outpatient pharmacy benefit in a contract with a public or private entity.

410.7 Subd. 2. Covered outpatient prescription drugs. (a) In consultation with the Drug
410.8 Formulary Committee under section 256B.0625, subdivision 13d, the commissioner shall
410.9 establish an outpatient prescription drug formulary for MinnesotaCare that satisfies the
410.10 requirements for an essential health benefit under Code of Federal Regulations, title 45,
410.11 section 156.122. The commissioner may modify the formulary after consulting with the
410.12 Drug Formulary Committee and providing public notice and the opportunity for public
410.13 comment. The commissioner is exempt from the rulemaking requirements of chapter 14 to
410.14 establish the drug formulary, and section 14.386 does not apply. The commissioner shall
410.15 make the drug formulary available to the public on the agency website.

410.16 (b) The MinnesotaCare formulary must contain at least one drug in every United States
410.17 Pharmacopeia category and class or the same number of prescription drugs in each category
410.18 and class as the essential health benefit benchmark plan, whichever is greater.

410.19 (c) The commissioner may negotiate drug rebates or discounts directly with a drug
410.20 manufacturer to place a drug on the formulary. The commissioner may also negotiate drug
410.21 rebates, or discounts, with a drug manufacturer through a contract with a vendor.

410.22 (d) Prior authorization may be required by the commissioner before certain formulary
410.23 drugs are eligible for payment. The Drug Formulary Committee may recommend drugs for
410.24 prior authorization directly to the commissioner. The commissioner may also request that
410.25 the Drug Formulary Committee review a drug for prior authorization.

410.26 (e) Before the commissioner requires prior authorization for a drug:

410.27 (1) the commissioner must provide the Drug Formulary Committee with information
410.28 on the impact that placing the drug on prior authorization may have on the quality of patient
410.29 care and on program costs and information regarding whether the drug is subject to clinical
410.30 abuse or misuse if such data is available; and

410.31 (2) the Drug Formulary Committee must hold a public forum and receive public comment
410.32 for an additional 15 days from the date of the public forum.

411.1 (f) Notwithstanding paragraph (e), the commissioner may automatically require prior
411.2 authorization for a period not to exceed 180 days for any drug that is approved by the United
411.3 States Food and Drug Administration after July 1, 2019. The 180-day period begins no later
411.4 than the first day that a drug is available for shipment to pharmacies within the state. The
411.5 Drug Formulary Committee shall recommend to the commissioner general criteria to use
411.6 for determining prior authorization of the drugs, but the Drug Formulary Committee is not
411.7 required to review each individual drug.

411.8 (g) The commissioner may also require prior authorization before nonformulary drugs
411.9 are eligible for payment.

411.10 (h) Prior authorization requests must be processed in accordance with Code of Federal
411.11 Regulations, title 45, section 156.122.

411.12 Subd. 3. **Pharmacy provider participation.** (a) A pharmacy enrolled to dispense
411.13 prescription drugs to medical assistance enrollees under section 256B.0625 must participate
411.14 as a provider in the MinnesotaCare outpatient prescription drug program.

411.15 (b) A pharmacy that is enrolled to dispense prescription drugs to MinnesotaCare enrollees
411.16 is not permitted to refuse service to an enrollee unless:

411.17 (1) the pharmacy does not have a prescription drug in stock and cannot obtain the drug
411.18 in time to treat the enrollee's medical condition;

411.19 (2) the enrollee is unable or unwilling to pay the enrollee's co-payment at the time the
411.20 drug is dispensed;

411.21 (3) after performing drug utilization review, the pharmacist identifies the prescription
411.22 drug as being a therapeutic duplication, having a drug-disease contraindication, having a
411.23 drug-drug interaction, having been prescribed for the incorrect dosage or duration of
411.24 treatment, having a drug-allergy interaction, or having issues related to clinical abuse or
411.25 misuse by the enrollee;

411.26 (4) the prescription drug is not covered by MinnesotaCare; or

411.27 (5) dispensing the drug would violate a provision of chapter 151.

411.28 Subd. 4. **Covered outpatient prescription drug reimbursement rate.** (a) The basis
411.29 for determining the amount of payment shall be the lowest of the National Average Drug
411.30 Acquisition Cost; the maximum allowable cost established under section 256B.0625,
411.31 subdivision 13e, plus a fixed dispensing fee; or the usual and customary price. The fixed
411.32 dispensing fee shall be \$1.50 for covered outpatient prescription drugs.

412.1 (b) The basis for determining the amount of payment for a pharmacy that acquires drugs
412.2 through the federal 340B Drug Pricing Program shall be the lowest of (1) the National
412.3 Average Drug Acquisition Cost minus 30 percent; (2) the maximum allowable cost
412.4 established under section 256B.0625, subdivision 13e, minus 30 percent, plus a fixed
412.5 dispensing fee; or (3) the usual and customary price. The fixed dispensing fee shall be \$1.50
412.6 for covered outpatient prescription drugs.

412.7 (c) For purposes of this subdivision, the usual and customary price is the lowest price
412.8 charged by the provider to a patient who pays for the prescription by cash, check, or charge
412.9 account and includes the prices the pharmacy charges to customers enrolled in a prescription
412.10 savings club or prescription discount club administered by the pharmacy, pharmacy chain,
412.11 or contractor to the provider.

412.12 **EFFECTIVE DATE.** This section is effective January 1, 2022.

412.13 Sec. 10. **[256T.01] PURPOSE.**

412.14 (a) The legislature finds that the staggering growth in health care costs is having a
412.15 devastating effect on the health and cost of living of Minnesota residents. The legislature
412.16 further finds that the number of uninsured and underinsured residents is growing each year
412.17 and that the cost of health care coverage for our insured residents often far exceeds their
412.18 ability to pay.

412.19 (b) The legislature further finds that it must enact immediate and intensive cost
412.20 containment measures to limit the growth of health care expenditures, reform insurance
412.21 practices, and finance a plan that offers access to affordable health care for Minnesota
412.22 residents by capturing dollars now lost to inefficiencies in Minnesota's health care system.

412.23 (c) The legislature further finds that providing affordable access to health care is essential
412.24 to quality of life in Minnesota.

412.25 (d) It is, therefore, the intent of the legislature to establish the OneCare Buy-In to address
412.26 the immediate challenges of affordability and access related to prescription drugs and dental
412.27 care and to offer comprehensive coverage options that establish contingencies for failures
412.28 in the individual market.

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

412.30 Sec. 11. **[256T.02] DEFINITIONS.**

412.31 Subdivision 1. **Application.** For purposes of this chapter, the terms in this section have
412.32 the meanings given.

- 413.1 Subd. 2. **Commissioner.** "Commissioner" means the commissioner of human services.
- 413.2 Subd. 3. **Department.** "Department" means the Department of Human Services.
- 413.3 Subd. 4. **Essential health benefits.** "Essential health benefits" has the meaning given
413.4 in section 62Q.81, subdivision 4.
- 413.5 Subd. 5. **Individual market.** "Individual market" has the meaning given in section
413.6 62A.011, subdivision 5.
- 413.7 Subd. 6. **MNsure website.** "MNsure website" has the meaning given in section 62V.02,
413.8 subdivision 13.
- 413.9 **EFFECTIVE DATE.** This section is effective the day following final enactment.
- 413.10 **Sec. 12. [256T.03] ONECARE BUY-IN.**
- 413.11 Subdivision 1. **Establishment.** (a) The commissioner shall establish a program consistent
413.12 with this section to offer products developed for the OneCare Buy-In through the MNsure
413.13 website.
- 413.14 (b) The commissioner, in collaboration with the commissioner of commerce and the
413.15 MNsure Board, shall:
- 413.16 (1) establish a cost allocation methodology to reimburse MNsure operations in lieu of
413.17 the premium withhold for qualified health plans under section 62V.05;
- 413.18 (2) implement mechanisms to ensure the long-term financial sustainability of Minnesota's
413.19 public health care programs and mitigate any adverse financial impacts to the state and
413.20 MNsure. These mechanisms must minimize adverse selection, state financial risk and
413.21 contribution, and negative impacts to premiums in the individual and group health insurance
413.22 markets; and
- 413.23 (3) coordinate eligibility and coverage to ensure that persons, to the extent possible,
413.24 transitioning between medical assistance, MinnesotaCare, and the OneCare Buy-In have
413.25 continuity of care.
- 413.26 (c) The OneCare Buy-In shall be considered: (1) a public health care program for purposes
413.27 of chapter 62V; and (2) the MinnesotaCare program for purposes of requirements for health
413.28 maintenance organizations under section 62D.04, subdivision 5, and providers under section
413.29 256B.0644.
- 413.30 (d) The Department of Human Services is deemed to meet and receive certification and
413.31 authority under section 62D.03 and be in compliance with sections 62D.01 to 62D.30. The

414.1 commissioner has the authority to accept and expend all federal funds made available under
414.2 this chapter upon federal approval.

414.3 Subd. 2. Premium administration and payment. (a) The commissioner shall establish
414.4 annually a per-enrollee monthly premium rate. The commissioner shall publish the premium
414.5 rate by August 1 of each year.

414.6 (b) OneCare Buy-In premium administration shall be consistent with requirements under
414.7 the federal Affordable Care Act for qualified health plan premium administration. Premium
414.8 rates shall be established in accordance with section 62A.65, subdivision 3.

414.9 Subd. 3. Rates to providers. The commissioner shall establish rates for provider
414.10 payments that are targeted to the current rates established under chapter 256L, plus the
414.11 aggregate difference between those rates and Medicare rates. The aggregate must not consider
414.12 services that receive a Medicare encounter payment.

414.13 Subd. 4. Reserve requirements. A OneCare Buy-In reserve account is established in
414.14 the state treasury. Enrollee premiums collected under subdivision 2 shall be deposited into
414.15 the reserve account. The reserve account shall be used to cover expenditures related to
414.16 operation of the OneCare Buy-In, including the payment of claims and all other accrued
414.17 liabilities. No other account within the state treasury shall be used to finance the reserve
414.18 account except as otherwise specified in state law.

414.19 Subd. 5. Covered benefits. Each health plan established under this chapter must include
414.20 the essential health benefits package required under section 1302(a) of the Affordable Care
414.21 Act and as described in section 62Q.81; dental services described in section 256B.0625,
414.22 subdivision 9, paragraphs (b) and (c); and vision services described in Minnesota Rules,
414.23 part 9505.0277, and may include other services under section 256L.03, subdivision 1.

414.24 Subd. 6. Third-party administrator. (a) The commissioner may enter into a contract
414.25 with a third-party administrator to perform the operational management of the OneCare
414.26 Buy-In. Duties of the third-party administrator include but are not limited to the following:

414.27 (1) development and distribution of plan materials for potential enrollees;
414.28 (2) receipt and processing of electronic enrollment files sent from the state;
414.29 (3) creation and distribution of plan enrollee materials including identification cards,
414.30 certificates of coverage, plan formulary, provider directory, and premium billing statements;
414.31 (4) processing premium payments and sending termination notices for nonpayment to
414.32 enrollees and the state;

415.1 (5) payment and adjudication of claims;

415.2 (6) utilization management;

415.3 (7) coordination of benefits;

415.4 (8) grievance and appeals activities; and

415.5 (9) fraud, waste, and abuse prevention activities.

415.6 (b) Any solicitation of vendors to serve as the third-party administrator is subject to the

415.7 requirements under section 16C.06.

415.8 Subd. 7. **Eligibility.** (a) To be eligible for the OneCare Buy-In, a person must:

415.9 (1) be a resident of Minnesota; and

415.10 (2) not be eligible for government-sponsored programs as defined in United States Code,

415.11 title 26, section 5000A(f)(1)(A). For purposes of this subdivision, an applicant or enrollee

415.12 who is entitled to Medicare Part A or enrolled in Medicare Part B coverage under title XVIII

415.13 of the Social Security Act, United States Code, title 42, sections 1395c to 1395w-152, is

415.14 considered eligible for government-sponsored programs. An applicant or enrollee who is

415.15 entitled to premium-free Medicare Part A shall not refuse to apply for or enroll in Medicare

415.16 coverage to establish eligibility for the OneCare Buy-In.

415.17 (b) A person who is determined eligible for enrollment in a qualified health plan with

415.18 or without advance payments of the premium tax credit and with or without cost-sharing

415.19 reductions according to Code of Federal Regulations, title 45, section 155.305, paragraphs

415.20 (a), (f), and (g), is eligible to purchase and enroll in the OneCare Buy-In instead of purchasing

415.21 a qualified health plan as defined under section 62V.02.

415.22 Subd. 8. **Enrollment.** (a) A person may apply for the OneCare Buy-In during the annual

415.23 open and special enrollment periods established for MNsure as defined in Code of Federal

415.24 Regulations, title 45, sections 155.410 and 155.420 through the MNsure website.

415.25 (b) A person must annually reenroll for the OneCare Buy-In during open and special

415.26 enrollment periods.

415.27 Subd. 9. **Premium tax credits, cost-sharing reductions, and subsidies.** A person who

415.28 is eligible under this chapter, and whose income is less than or equal to 400 percent of the

415.29 federal poverty guidelines, may qualify for advance premium tax credits and cost-sharing

415.30 reductions under Code of Federal Regulations, title 45, section 155.305, paragraphs (a), (f),

415.31 and (g), to purchase a health plan established under this chapter.

416.1 **Subd. 10. Covered benefits and payment rate modifications.** The commissioner, after
416.2 providing public notice and an opportunity for public comment, may modify the covered
416.3 benefits and payment rates to carry out this chapter.

416.4 **Subd. 11. Request for federal authority.** The commissioner shall seek all necessary
416.5 federal waivers to establish the OneCare Buy-In under this chapter.

416.6 **EFFECTIVE DATE.** (a) Subdivisions 1 to 10 are effective January 1, 2023.

416.7 (b) Subdivision 11 is effective the day following final enactment.

416.8 Sec. 13. **[256T.04] ONECARE BUY-IN PRODUCTS.**

416.9 **Subdivision 1. Platinum product.** The commissioner of human services shall establish
416.10 a OneCare Buy-In coverage option that provides platinum level of coverage in accordance
416.11 with the Affordable Care Act and benefits that are actuarially equivalent to 90 percent of
416.12 the full actuarial value of the benefits provided under the OneCare Buy-In coverage option.
416.13 This product must be made available in all rating areas in the state.

416.14 **Subd. 2. Silver and gold products.** (a) If any rating area lacks an affordable or
416.15 comprehensive health care coverage option according to standards developed by the
416.16 commissioner of health, the following year the commissioner of human services shall offer
416.17 silver and gold products established under paragraph (b) in the rating area for a five-year
416.18 period. Notwithstanding section 62U.04, subdivision 11, the commissioner of health may
416.19 use data collected under section 62U.04, subdivisions 4 and 5, to monitor triggers in the
416.20 individual market under this chapter. Effective January 1, 2020, the commissioner of health
416.21 may require submission of additional data elements under section 62U.04, subdivisions 4
416.22 and 5, in a manner specified by the commissioner, to conduct the analysis necessary to
416.23 monitor the individual market under this chapter.

416.24 (b) The commissioner shall establish the following OneCare Buy-In coverage options:
416.25 one coverage option shall provide silver level of coverage in accordance with the Affordable
416.26 Care Act and benefits that are actuarially equivalent to 70 percent of the full actuarial value
416.27 of the benefits provided under the OneCare Buy-In coverage option, and one coverage
416.28 option shall provide gold level of coverage in accordance with the Affordable Care Act and
416.29 benefits that are actuarially equivalent to 80 percent of the full actuarial value of the benefits
416.30 provided under the OneCare Buy-In coverage option.

416.31 **Subd. 3. Qualified health plan rules.** (a) The coverage options developed under this
416.32 section are subject to the process under section 62K.06. The coverage options developed

417.1 under this section are deemed to meet requirements of chapters 62A, 62K, and 62V that
417.2 apply to qualified health plans.

417.3 (b) Notwithstanding any other law to the contrary, benefits under this section are
417.4 secondary to a plan of insurance or benefit program under which an eligible person may
417.5 have coverage. The commissioner shall use cost-avoidance techniques to coordinate any
417.6 other health coverage for eligible persons and identify eligible persons who may have
417.7 coverage or benefits under other plans of insurance.

417.8 (c) The Department of Human Services is not an insurance company for purposes of
417.9 this chapter.

417.10 Subd. 4. **Actuarial value.** Determination of the actuarial value of coverage options under
417.11 this section must be calculated in accordance with Code of Federal Regulations, title 45,
417.12 section 156.135.

417.13 **EFFECTIVE DATE.** This section is effective January 1, 2023.

417.14 Sec. 14. **[256T.30] OUTPATIENT PRESCRIPTION DRUGS.**

417.15 Subdivision 1. **Establishment of program.** The commissioner shall administer and
417.16 oversee the outpatient prescription drug program. The commissioner shall not include the
417.17 outpatient pharmacy benefit in a contract with a public or private entity.

417.18 Subd. 2. **Covered outpatient prescription drugs.** Outpatient prescription drugs are
417.19 covered in accordance with chapter 256L.

417.20 Subd. 3. **Pharmacy provider participation.** (a) A pharmacy enrolled to dispense
417.21 prescription drugs to medical assistance enrollees under section 256B.0625 must participate
417.22 as a provider in the outpatient prescription drug program under this section.

417.23 (b) A pharmacy that is enrolled to dispense prescription drugs under this section is not
417.24 permitted to refuse service to an enrollee unless:

417.25 (1) the pharmacy does not have a prescription drug in stock and cannot obtain the drug
417.26 in time to treat the enrollee's medical condition;

417.27 (2) the enrollee is unable or unwilling to pay the enrollee's co-payment at the time the
417.28 drug is dispensed;

417.29 (3) after performing drug utilization review, the pharmacist identifies the prescription
417.30 drug as being a therapeutic duplication, having a drug-disease contraindication, having a
417.31 drug-drug interaction, having been prescribed for the incorrect dosage or duration of

418.1 treatment, having a drug-allergy interaction, or having issues related to clinical abuse or
418.2 misuse by the enrollee;

418.3 (4) the prescription drug is not covered by the plan; or

418.4 (5) dispensing the drug would violate a provision of chapter 151.

418.5 Subd. 4. **Reimbursement rate.** The commissioner shall establish outpatient prescription
418.6 drug reimbursement rates according to chapter 256L.

418.7 **EFFECTIVE DATE.** This section is effective January 1, 2023.

418.8 Sec. 15. **DIRECTION TO COMMISSIONER; STATE-BASED RISK ADJUSTMENT**
ANALYSIS.

418.10 The commissioner of commerce, in consultation with the commissioner of health, shall
418.11 conduct a study on the design and implementation of a state-based risk adjustment program.
418.12 The commissioner shall report on the findings of the study and any recommendations to
418.13 the legislative committees with jurisdiction over the individual health insurance market by
418.14 February 15, 2021.

418.15 Sec. 16. **REPEALER.**

418.16 Minnesota Statutes 2018, section 256L.11, subdivision 6a, is repealed.

418.17 **EFFECTIVE DATE.** This section is effective January 1, 2022.

418.18 **ARTICLE 10**

418.19 **OPIOIDS**

418.20 Section 1. Minnesota Statutes 2018, section 151.01, is amended by adding a subdivision
418.21 to read:

418.22 Subd. 2b. **Chain pharmacy.** "Chain pharmacy" means any pharmacy that is part of a
418.23 group of ten or more establishments that (1) conduct business under the same business
418.24 name, or (2) operate under common ownership or management or pursuant to a franchise
418.25 agreement with the same franchisor.

419.1 Sec. 2. Minnesota Statutes 2018, section 151.01, is amended by adding a subdivision to
419.2 read:

419.3 Subd. 42. **Unit.** "Unit" means, with respect to a particular drug product, the individual
419.4 dosage form of the drug product that is most commonly prescribed to a patient, including
419.5 but not limited to tablet, capsule, patch, syringe, milliliter, or gram.

419.6 Sec. 3. Minnesota Statutes 2018, section 151.065, is amended by adding a subdivision to
419.7 read:

419.8 Subd. 3a. **Controlled substance registration fees.** (a) Initial and annual renewal
419.9 controlled substance registration fees are as follows:

419.10 (1) controlled substance drug manufacturer, large, \$75,000;

419.11 (2) controlled substance drug manufacturer, medium, \$5,000;

419.12 (3) controlled substance drug manufacturer, small, \$500;

419.13 (4) drug wholesaler distributing controlled substances, large, \$75,000;

419.14 (5) drug wholesaler distributing controlled substances, small, \$2,500;

419.15 (6) pharmacy dispensing controlled substances, other than hospital or chain pharmacy,
419.16 \$2,500;

419.17 (7) pharmacy other than a hospital, independent, \$500;

419.18 (8) pharmacy, hospital (50 or more beds), \$2,500;

419.19 (9) pharmacy, hospital (fewer than 50 beds), \$500;

419.20 (10) practitioner prescribing, administering, or dispensing controlled substances, \$125;

419.21 and

419.22 (11) controlled substances researcher, \$125.

419.23 (b) For the purposes of this subdivision:

419.24 (1) a controlled substance drug manufacturer shall be subject to the fee established under
419.25 paragraph (a), clause (1), if the data collected through the prescription monitoring program
419.26 established under section 152.126 indicates that 5,000,000 or more units of the manufacturer's
419.27 controlled substance products have been dispensed to residents of this state during the
419.28 previous calendar year;

419.29 (2) a controlled substance drug manufacturer shall be subject to the fee established under
419.30 paragraph (a), clause (2), if the data collected through the prescription monitoring program

420.1 established under section 152.126 indicates that more than 1,000,000 but less than 5,000,000
420.2 units of the manufacturer's controlled substance products have been dispensed to residents
420.3 of this state during the previous calendar year;

420.4 (3) a controlled substance drug manufacturer shall be subject to the fee established under
420.5 paragraph (a), clause (3), if the data collected through the prescription monitoring program
420.6 established under section 152.126 indicates that 1,000,000 or fewer units of the
420.7 manufacturer's controlled substance products have been dispensed to residents of this state
420.8 during the previous calendar year;

420.9 (4) a wholesaler of controlled substances shall be subject to the fee established under
420.10 paragraph (a), clause (4), if the data collected pursuant to section 152.10, subdivision 4,
420.11 indicates that the wholesaler has distributed 5,000,000 or more units of controlled substances
420.12 within or into this state; and

420.13 (5) a wholesaler of controlled substances shall be subject to the fee established under
420.14 paragraph (a), clause (5), if the data collected pursuant to section 152.10, subdivision 4,
420.15 indicates that the wholesaler has distributed less than 5,000,000 units of controlled substances
420.16 within or into this state.

420.17 Sec. 4. Minnesota Statutes 2018, section 151.252, subdivision 1, is amended to read:

420.18 Subdivision 1. **Requirements.** (a) No person shall act as a drug manufacturer without
420.19 first obtaining a license from the board and paying any applicable fee specified in section
420.20 151.065.

420.21 (b) In addition to the license required under paragraph (a), a manufacturer of a Schedule
420.22 II through IV opiate controlled substance must pay the applicable registration fee specified
420.23 in section 151.77, subdivision 3, by June 1 of each year, beginning June 1, 2020. In the
420.24 event of a change of ownership of the manufacturer, the new owner must pay the registration
420.25 fee specified under section 151.77, subdivision 3, that the original owner would have been
420.26 assessed had it retained ownership. The board may assess a late fee of ten percent per month
420.27 for every portion of a month that the registration fee is paid after the due date.

420.28 (b) (c) Application for a drug manufacturer license under this section shall be made in
420.29 a manner specified by the board.

420.30 (e) (d) No license shall be issued or renewed for a drug manufacturer unless the applicant
420.31 agrees to operate in a manner prescribed by federal and state law and according to Minnesota
420.32 Rules.

421.1 ~~(d)~~ (e) No license shall be issued or renewed for a drug manufacturer that is required to
421.2 be registered pursuant to United States Code, title 21, section 360, unless the applicant
421.3 supplies the board with proof of registration. The board may establish by rule the standards
421.4 for licensure of drug manufacturers that are not required to be registered under United States
421.5 Code, title 21, section 360.

421.6 ~~(e)~~ (f) No license shall be issued or renewed for a drug manufacturer that is required to
421.7 be licensed or registered by the state in which it is physically located unless the applicant
421.8 supplies the board with proof of licensure or registration. The board may establish, by rule,
421.9 standards for the licensure of a drug manufacturer that is not required to be licensed or
421.10 registered by the state in which it is physically located.

421.11 ~~(f)~~ (g) The board shall require a separate license for each facility located within the state
421.12 at which drug manufacturing occurs and for each facility located outside of the state at
421.13 which drugs that are shipped into the state are manufactured.

421.14 ~~(g)~~ (h) The board shall not issue an initial or renewed license for a drug manufacturing
421.15 facility unless the facility passes an inspection conducted by an authorized representative
421.16 of the board. In the case of a drug manufacturing facility located outside of the state, the
421.17 board may require the applicant to pay the cost of the inspection, in addition to the license
421.18 fee in section 151.065, unless the applicant furnishes the board with a report, issued by the
421.19 appropriate regulatory agency of the state in which the facility is located or by the United
421.20 States Food and Drug Administration, of an inspection that has occurred within the 24
421.21 months immediately preceding receipt of the license application by the board. The board
421.22 may deny licensure unless the applicant submits documentation satisfactory to the board
421.23 that any deficiencies noted in an inspection report have been corrected.

421.24 Sec. 5. Minnesota Statutes 2018, section 151.47, is amended by adding a subdivision to
421.25 read:

421.26 Subd. 1a. Controlled substance wholesale drug distributor requirements. In addition
421.27 to the license required under subdivision 1, a wholesale drug distributor distributing a
421.28 Schedule II through IV opiate controlled substance must pay the applicable registration fee
421.29 specified in section 151.77, subdivision 4, by June 1 of each year beginning June 1, 2020.
421.30 In the event of a change in ownership of the wholesale drug distributor, the new owner must
421.31 pay the registration fee specified in section 151.77, subdivision 4, that the original owner
421.32 would have been assessed had it retained ownership. The board may assess a late fee of ten
421.33 percent per month for every portion of a month that the registration fee is paid after the due
421.34 date.

422.1 **Sec. 6. [151.77] OPIATE PRODUCT REGISTRATION FEE.**

422.2 Subdivision 1. Definitions. For purposes of this section, the following terms have the
422.3 meanings given them:

422.4 (1) "manufacturer" means a manufacturer licensed under section 151.252 that is engaged
422.5 in the manufacturing of an opiate;

422.6 (2) "opiate" means any opiate-containing controlled substance listed in section 152.02,
422.7 subdivisions 3 to 5, that is distributed, delivered, sold, or dispensed into or within this state;
422.8 and

422.9 (3) "wholesaler" means a wholesale drug distributor who is licensed under section 151.47,
422.10 and is engaged in the wholesale drug distribution of an opiate.

422.11 Subd. 2. Reporting requirements. (a) By March 1 of each year, beginning March 1,
422.12 2020, each manufacturer and each wholesale drug distributor must report to the board every
422.13 sale, delivery, or other distribution within or into this state of any opiate that is made to any
422.14 practitioner, pharmacy, hospital, veterinary hospital, or other person who is permitted by
422.15 section 151.37 to possess controlled substances for administration or dispensing to patients
422.16 that occurred during the previous calendar year. Reporting must be in the automation of
422.17 reports and consolidated orders system format unless otherwise specified by the board. If
422.18 a manufacturer or wholesaler fails to provide information required under this paragraph on
422.19 a timely basis, the board may assess an administrative penalty of \$500 per day. This penalty
422.20 shall not be considered a form of disciplinary action.

422.21 (b) By March 1 of each year, beginning March 1, 2020, each owner of a pharmacy with
422.22 at least one location within this state must report to the board the intracompany delivery or
422.23 distribution into this state of any opiate, to the extent that those deliveries and distributions
422.24 are not reported to the board by a licensed wholesale drug distributor owned by, under
422.25 contract to, or otherwise operating on behalf of the owner of the pharmacy. Reporting must
422.26 be in the manner and format specified by the board for deliveries and distributions that
422.27 occurred during the previous calendar year. The report must include the name of the
422.28 manufacturer or wholesaler from which the owner of the pharmacy ultimately purchased
422.29 the opiate, and the amount and date that the purchases occurred.

422.30 Subd. 3. Determination of each manufacturer's registration fee. (a) The board shall
422.31 annually assess manufacturer registration fees that in an aggregate amount total \$12,000,000.
422.32 The board shall determine each manufacturer's annual registration fee that is prorated and
422.33 based on the manufacturer's percentage of the total number of units reported to the board
422.34 under subdivision 2.

423.1 (b) By April 1 of each year, beginning April 1, 2020, the board shall notify each
423.2 manufacturer of the annual amount of the manufacturer's registration fee to be paid by June
423.3 1, in accordance with section 151.252, subdivision 1, paragraph (b).

423.4 (c) In conjunction with the data reported under this section, and notwithstanding section
423.5 152.126, subdivision 6, the board may use the data reported under section 152.126,
423.6 subdivision 4, to determine the manufacturer registration fees required under this subdivision.

423.7 (d) A manufacturer may dispute the registration fee as determined by the board no later
423.8 than 30 days after the date of notification; however, the manufacturer must still remit the
423.9 fee as required by section 151.252, subdivision 1, paragraph (b). The dispute must be filed
423.10 with the board in the manner and using the forms specified by the board. A manufacturer
423.11 must submit, with the required forms, data satisfactory to the board that demonstrates that
423.12 the registration fee was incorrect. The board must make a decision concerning a dispute no
423.13 later than 60 days after receiving the required dispute forms. If the board determines that
423.14 the manufacturer has satisfactorily demonstrated that the original fee was incorrect, the
423.15 board must adjust the manufacturer's registration fee due the next year by the amount that
423.16 is in excess of the correct fee that should have been paid.

423.17 **Subd. 4. Determination of each wholesaler's registration fee.** (a) The board shall
423.18 annually assess wholesaler registration fees that in an aggregate amount total \$8,000,000.
423.19 The board shall determine each wholesaler's annual registration fee that is prorated and
423.20 based on the wholesaler's percentage of the total number of units reported to the board under
423.21 subdivision 2. This paragraph does not apply to a wholesaler if the wholesaler is also licensed
423.22 as a drug manufacturer under section 151.252.

423.23 (b) By April 1 of each year, beginning April 1, 2020, the board shall notify each
423.24 wholesaler of the annual amount of the wholesaler's registration fee to be paid by June 1,
423.25 in accordance with section 151.47, subdivision 1a.

423.26 (c) A wholesaler may dispute the registration fee as determined by the board no later
423.27 than 30 days after the date of notification. However, the wholesaler must still remit the fee
423.28 as required by section 151.47, subdivision 1a. The dispute must be filed with the board in
423.29 the manner and using the forms specified by the board. A wholesaler must submit, with the
423.30 required forms, data satisfactory to the board that demonstrates that the registration fee was
423.31 incorrect. The board must make a decision concerning a dispute no later than 60 days after
423.32 receiving the required dispute forms. If the board determines that the wholesaler has
423.33 satisfactorily demonstrated that the original fee was incorrect, the board must adjust the

424.1 wholesaler's registration fee due the next year by the amount that is in excess of the correct
424.2 fee that should have been paid.

424.3 Subd. 5. Report. (a) The Board of Pharmacy shall evaluate the registration fee on drug
424.4 manufacturers and wholesalers established under this section, and whether the fee has
424.5 impacted the prescribing practices for opiates by reducing the number of opiate prescriptions
424.6 issued during calendar years 2020, 2021, and 2022, to the extent the board has the ability
424.7 to effectively identify a correlation. Notwithstanding section 152.126, subdivision 6, the
424.8 board may access the data reported under section 152.126, subdivision 4, to conduct this
424.9 evaluation.

424.10 (b) The board shall submit the results of its evaluation to the chairs and ranking minority
424.11 members of the legislative committees with jurisdiction over health and human services
424.12 policy and finance by March 1, 2023.

424.13 Subd. 6. Legislative review. The legislature shall review the reports from the Opioid
424.14 Addiction Advisory Council under section 151.255, subdivision 1, paragraph (c), the report
424.15 from the Board of Pharmacy under subdivision 5, and any other relevant report or information
424.16 related to the opioid crisis in Minnesota, to make a determination about whether the opiate
424.17 product registration fee assessed under this section should continue beyond July 1, 2023.

424.18 Sec. 7. Minnesota Statutes 2018, section 152.01, is amended by adding a subdivision to
424.19 read:

424.20 Subd. 25. Practitioner. "Practitioner" has the meaning given in section 151.01,
424.21 subdivision 23.

424.22 Sec. 8. Minnesota Statutes 2018, section 152.10, is amended to read:

424.23 **152.10 SALES, PERSONS ELIGIBLE CONTROLLED SUBSTANCE**
424.24 **REGISTRATION.**

424.25 Subdivision 1. Generally. No person ~~other than a licensed pharmacist, assistant~~
424.26 ~~pharmacist or pharmacist intern under the supervision of a pharmacist~~ shall sell a stimulant
424.27 or depressant drug and then only as provided in sections 152.021 to 152.12 and 152.026.
424.28 controlled substance except (1) as provided in this chapter, and (2) when any registration
424.29 required under this section has been obtained and is active.

424.30 Subd. 2. Registration requirement. (a) A person must obtain a registration issued by
424.31 the Board of Pharmacy in order to:

425.1 (1) manufacture, distribute, prescribe, or dispense any controlled substance within the
425.2 state;

425.3 (2) propose to engage in the manufacture, distribution, prescription, or dispensing of
425.4 any controlled substance within the state;

425.5 (3) dispense, distribute, or propose to dispense or distribute any controlled substance
425.6 for use in the state by shipping, mailing, or otherwise delivering the controlled substance
425.7 from a location outside this state; or

425.8 (4) use or propose to use controlled substances in the course of a bona fide research
425.9 project.

425.10 (b) Persons registered by the Board of Pharmacy under this section to manufacture,
425.11 distribute, prescribe, dispense, store, or conduct research with controlled substances may
425.12 possess, manufacture, distribute, prescribe, dispense, store, or conduct research with the
425.13 controlled substances to the extent authorized by the registration and in conformity with
425.14 this section. Registered persons must also comply with any other statutes or rules applicable
425.15 to the manufacture, distribution, prescribing, dispensing, or storage of, or research with,
425.16 prescription drugs.

425.17 (c) Except as otherwise provided by law, the following persons and entities are not
425.18 required to register and may lawfully possess controlled substances under this chapter:

425.19 (1) an agent or employee of any registered manufacturer, registered drug wholesaler, or
425.20 registered pharmacy while acting in the course of employment only;

425.21 (2) a common carrier, or an employee of a common carrier, whose possession of a
425.22 controlled substance is in the usual course of the person's business or employment;

425.23 (3) a licensed hospital or other licensed institution where sick and injured persons are
425.24 cared for or treated, bona fide hospitals where animals are treated, or employees of a licensed
425.25 hospital or institution acting in the course of employment, except that (i) employees who
425.26 are licensed practitioners must be registered to the extent that they engage in the prescribing
425.27 of controlled substances, and (ii) hospital pharmacies licensed by the board must be
425.28 registered;

425.29 (4) a licensed or registered health care professional who acts as the authorized agent of
425.30 a practitioner and who administers controlled substances at the direction of the practitioner,
425.31 provided that the practitioner is authorized to prescribe controlled substances pursuant to
425.32 section 152.12;

426.1 (5) an analytical laboratory, or employee of an analytical laboratory when acting in the
426.2 course of employment, when conducting an anonymous analysis service and when the
426.3 analytical laboratory is registered by the federal Drug Enforcement Administration;

426.4 (6) a medical cannabis manufacturer registered under section 152.25;

426.5 (7) a person in possession of any controlled substance prescribed for that person pursuant
426.6 to section 152.12, subdivision 1, or obtained pursuant to the requirements of the medical
426.7 cannabis program established under this chapter; or

426.8 (8) the owner of an animal for which a controlled substance has been prescribed pursuant
426.9 to section 152.12, subdivision 2.

426.10 (d) Nothing in this section prohibits a person for whom a controlled substance has been
426.11 dispensed in accordance with a prescription issued pursuant to section 152.12 from
426.12 designating a family member, caregiver, or other individual to assist the person in obtaining
426.13 or administering the controlled substance, or disposing of the controlled substance pursuant
426.14 to section 152.105.

426.15 (e) A separate registration is required at each principal place of business or professional
426.16 practice where the applicant manufactures, distributes, prescribes, dispenses, or conducts
426.17 research with controlled substances. This paragraph does not apply to an office used by a
426.18 practitioner who is registered at another location, where controlled substances are prescribed
426.19 but neither administered nor otherwise dispensed as a regular part of the professional practice
426.20 of the practitioner at the office, and where no supplies of controlled substances are
426.21 maintained.

426.22 (f) The Board of Pharmacy, through its authorized representative, has the authority to
426.23 inspect the establishment of a registrant or applicant for registration. This authority is granted
426.24 for routine inspections and for the purpose of conducting investigations of complaints made
426.25 against registrants.

426.26 (g) The board may require a registrant to submit documents or written statements of fact
426.27 relevant to a registration that the board deems necessary to determine whether the registration
426.28 should be granted or denied. If the registrant fails to provide the documents or statements
426.29 within a reasonable time after being requested to do so, the registrant shall be deemed to
426.30 have waived the opportunity to present the documents or statements for consideration by
426.31 the board in granting or denying the registration.

427.1 (h) Failure to renew the controlled substance registration on a timely basis shall cause
427.2 the registration to be automatically forfeited. A forfeited registration may be reinstated
427.3 pursuant to section 151.065, subdivision 7.

427.4 Subd. 3. **Registration.** (a) The Board of Pharmacy shall register an applicant to
427.5 manufacture, dispense, prescribe, distribute, or conduct research with controlled substances
427.6 included in section 152.02, subdivisions 3 to 6, unless it determines that the issuance of that
427.7 registration would be inconsistent with the public interest. In determining the public interest,
427.8 the board shall consider the following factors:

427.9 (1) maintaining effective controls against diversion of controlled substances into other
427.10 than legitimate medical, scientific, or industrial channels;

427.11 (2) complying with applicable federal, state, and local law;

427.12 (3) whether the applicant has been convicted under any federal or state laws relating to
427.13 any controlled substance;

427.14 (4) past experience in the manufacture, distribution, or dispensing of controlled substances
427.15 or in research involving controlled substances, and the existence in the applicant's
427.16 establishment of effective controls against diversion;

427.17 (5) whether the applicant has furnished false or fraudulent material in any application
427.18 filed under this chapter;

427.19 (6) suspension or revocation of the applicant's federal registration to manufacture,
427.20 distribute, prescribe, dispense, or conduct research with controlled substances as authorized
427.21 by federal law; and

427.22 (7) any other factor relevant to and consistent with public health and safety.

427.23 (b) Registration under paragraph (a) does not entitle a registrant to manufacture, dispense,
427.24 prescribe, and distribute controlled substances included in section 152.02, subdivision 2.
427.25 Manufacturing, dispensing, prescribing, and distribution of controlled substances included
427.26 in section 152.02, subdivision 2, may only occur as part of a bona fide research project
427.27 pursuant to section 152.12, subdivision 3, or 152.21 and as allowed under federal law and
427.28 regulations. However, medical cannabis, as defined in section 152.22, subdivision 6, may
427.29 be produced and distributed as allowed under section 152.29.

427.30 (c) A practitioner must be registered under this section in order to dispense or prescribe
427.31 any controlled substances included in section 152.02, subdivisions 3 to 6.

428.1 **Subd. 4. Revocation and suspension of registration.** (a) A registration under this
428.2 section to manufacture, dispense, prescribe, distribute, or conduct research with a controlled
428.3 substance may be suspended or revoked by the Board of Pharmacy upon finding probable
428.4 cause that the registrant has:

428.5 (1) furnished false or fraudulent material information in any application filed under this
428.6 chapter;

428.7 (2) been convicted of a felony pursuant to any state or federal law relating to any
428.8 controlled substance;

428.9 (3) had the registrant's federal controlled substance registration to manufacture, distribute,
428.10 prescribe, dispense, or conduct research with controlled substances suspended or revoked;

428.11 (4) had the registrant's state license to practice the registrant's profession suspended or
428.12 revoked by the applicable health-related licensing board;

428.13 (5) had the registrant's state license to practice the registrant's profession placed on
428.14 conditional status by the applicable health-related licensing board when the conditions
428.15 prohibit the registrant from prescribing, administering, dispensing, or otherwise handling
428.16 controlled substances; or

428.17 (6) violated federal or state statutes or regulations related to the manufacture, distribution,
428.18 prescribing, dispensing, or research of a controlled substance in a manner that places the
428.19 public at imminent risk of serious harm.

428.20 (b) The Board of Pharmacy may limit revocation or suspension of a registration to the
428.21 particular controlled substance with respect to which grounds for revocation or suspension
428.22 exist.

428.23 **Subd. 5. Reporting.** On at least a quarterly basis, drug wholesalers must report to the
428.24 board all distributions, within or into the state, of all Schedule II controlled substance
428.25 products, and of all Schedule III controlled substance products that contain narcotics or
428.26 gamma hydroxybutyric acid. Reporting must be in the automation of reports and consolidated
428.27 orders system format unless otherwise specified by the board. This reporting shall also meet
428.28 any other requirement for reporting distribution data to the board found in this chapter or
428.29 in chapter 151.

428.30 Sec. 9. Minnesota Statutes 2018, section 152.11, subdivision 1, is amended to read:

428.31 **Subdivision 1. General prescription requirements for controlled substances.** (a) A
428.32 written prescription or an oral prescription reduced to writing, when issued for a controlled

429.1 substance in Schedule II, III, IV, or V, is void unless: (1) it is written in ink and contains
429.2 the name and address of the person for whose use it is intended; (2) it states the amount of
429.3 the controlled substance to be compounded or dispensed, with directions for its use; (3) if
429.4 a written prescription, it contains the handwritten signature of the prescriber, the prescriber's
429.5 address, ~~and federal registry number of the prescriber~~ and a designation of the branch of
429.6 the healing art pursued by the prescriber; and if an oral prescription, the name and address
429.7 of the prescriber and a designation of the prescriber's branch of the healing art; ~~and~~ (4) it
429.8 shows the date when signed by the prescriber, or the date of acceptance in the pharmacy if
429.9 an oral prescription; and (5) it includes the prescriber's current state and federal controlled
429.10 substance registration numbers.

429.11 (b) An electronic prescription for a controlled substance in Schedule II, III, IV, or V is
429.12 void unless: (1) it complies with the standards established pursuant to section 62J.497 and
429.13 with those portions of Code of Federal Regulations, title 21, parts 1300, 1304, 1306, and
429.14 1311, that pertain to electronic prescriptions; and (2) it includes the prescriber's current
429.15 state controlled substance registration number.

429.16 (c) A prescription for a controlled substance in Schedule II, III, IV, or V that is transmitted
429.17 by facsimile, either computer to facsimile machine or facsimile machine to facsimile machine,
429.18 is void unless: (1) it complies with the applicable requirements of Code of Federal
429.19 Regulations, title 21, part 1306; and (2) it includes the prescriber's current state controlled
429.20 substance registration number.

429.21 (d) Every licensed pharmacy that dispenses a controlled substance prescription shall
429.22 retain the original prescription in a file for a period of not less than two years, open to
429.23 inspection by any officer of the state, county, or municipal government whose duty it is to
429.24 aid and assist with the enforcement of this chapter. An original electronic or facsimile
429.25 prescription may be stored in an electronic database, provided that the database provides a
429.26 means by which original prescriptions can be retrieved, as transmitted to the pharmacy, for
429.27 a period of not less than two years.

429.28 (e) Every licensed pharmacy shall distinctly label the container in which a controlled
429.29 substance is dispensed with the directions contained in the prescription for the use of that
429.30 controlled substance.

429.31 Sec. 10. Minnesota Statutes 2018, section 152.11, subdivision 1a, is amended to read:

429.32 Subd. 1a. **Prescription requirements for Schedule II controlled substances.** (a) No
429.33 person may dispense a controlled substance included in Schedule II of section 152.02 without
429.34 a prescription issued by (1) a ~~doctor of medicine, a doctor of osteopathic medicine licensed~~

430.1 ~~to practice medicine, a doctor of dental surgery, a doctor of dental medicine, a doctor of~~
430.2 ~~pediatry, or a doctor of veterinary medicine, practitioner~~ lawfully licensed to prescribe in
430.3 this state, acting within the practitioner's scope of practice, and having a current federal
430.4 controlled substance registration number and a state controlled substance registration number
430.5 issued pursuant to section 152.10, or by (2) a practitioner licensed to prescribe controlled
430.6 substances by the state in which the prescription is issued, and having a current federal Drug
430.7 Enforcement Administration controlled substance registration number and, if required, a
430.8 controlled substance registration number issued by the other state.

430.9 (b) The prescription must either be printed or written in ink and contain the handwritten
430.10 signature of the prescriber or be transmitted electronically or by facsimile as permitted under
430.11 subdivision 1. Provided that in emergency situations, as authorized by federal law, such
430.12 drug may be dispensed upon oral prescription reduced promptly to writing and filed by the
430.13 pharmacist. Such prescriptions shall be retained in conformity with section 152.101. No
430.14 prescription for a Schedule II substance may be refilled.

430.15 Sec. 11. Minnesota Statutes 2018, section 152.11, subdivision 2, is amended to read:

430.16 Subd. 2. **Prescription requirements for Schedule III or IV controlled substances. (a)**
430.17 No person may dispense a controlled substance included in Schedule III or IV of section
430.18 152.02 without a prescription issued, as permitted under subdivision 1, by ~~(1) a doctor of~~
430.19 ~~medicine, a doctor of osteopathic medicine licensed to practice medicine, a doctor of dental~~
430.20 ~~surgery, a doctor of dental medicine, a doctor of podiatry, a doctor of optometry limited to~~
430.21 ~~Schedule IV, or a doctor of veterinary medicine, practitioner~~ lawfully licensed to prescribe
430.22 in this state, acting within the practitioner's scope of practice, and having a current federal
430.23 controlled substance registration number and a state controlled substance registration number
430.24 issued pursuant to section 152.10, or from (2) a practitioner licensed to prescribe controlled
430.25 substances by the state in which the prescription is issued, and having a current federal drug
430.26 enforcement administration controlled substance registration number and, if required, a
430.27 controlled substance registration number issued by the other state.

430.28 (b) Such prescription may not be dispensed or refilled except with the documented
430.29 consent of the prescriber, and in no event more than six months after the date on which such
430.30 prescription was issued and no such prescription may be refilled more than five times.

430.31 Sec. 12. Minnesota Statutes 2018, section 152.11, subdivision 2a, is amended to read:

430.32 Subd. 2a. **Federal and state registration number exemption.** A prescription need not
430.33 bear a federal drug enforcement administration registration number ~~that authorizes the~~

431.1 ~~prescriber to prescribe controlled substances or a state controlled substance registration~~
431.2 ~~number if the drug prescribed is not a controlled substance in Schedule II, III, IV, or V. No~~
431.3 ~~person shall impose a requirement inconsistent with this subdivision.~~

431.4 Sec. 13. Minnesota Statutes 2018, section 152.11, subdivision 2b, is amended to read:

431.5 Subd. 2b. **Restriction on release of federal and state registration number.** No person
431.6 or entity may offer for sale, sell, lease, or otherwise release a federal drug enforcement
431.7 administration registration number ~~or a state controlled substance registration number~~ for
431.8 any reason, except for drug enforcement purposes authorized by this chapter and the federal
431.9 controlled substances registration system. For purposes of this section, an entity includes a
431.10 state governmental agency or regulatory board, a health plan company as defined under
431.11 section 62Q.01, subdivision 4, a managed care organization as defined under section 62Q.01,
431.12 subdivision 5, or any other entity that maintains prescription data.

431.13 Sec. 14. Minnesota Statutes 2018, section 152.11, subdivision 2c, is amended to read:

431.14 Subd. 2c. **Restriction on use of federal and state registration number.** No entity may
431.15 use a federal drug enforcement administration registration number ~~or a state controlled~~
431.16 ~~substance registration number~~ to identify or monitor the prescribing practices of a prescriber
431.17 to whom that number has been assigned, except for drug enforcement purposes authorized
431.18 by this chapter and the federal controlled substances registration system. For purposes of
431.19 this section, an entity includes a health plan company as defined under section 62Q.01,
431.20 subdivision 4, a managed care organization as defined under section 62Q.01, subdivision
431.21 5, or any other entity that maintains prescription data.

431.22 Sec. 15. Minnesota Statutes 2018, section 152.12, subdivision 1, is amended to read:

431.23 **Subdivision 1. Prescribing, dispensing, administering controlled substances in**
431.24 **Schedules II through V.** A licensed ~~doctor of medicine~~, a ~~doctor of osteopathic medicine~~,
431.25 ~~fully licensed to practice medicine~~, a ~~doctor of dental surgery~~, a ~~doctor of dental medicine~~,
431.26 ~~a licensed doctor of podiatry~~, a ~~licensed advanced practice registered nurse~~, or a ~~licensed~~
431.27 ~~doctor of optometry limited to Schedules IV and V, and practitioner~~ in the course of
431.28 professional practice ~~only and within the practitioner's scope of practice~~, may prescribe,
431.29 administer, and dispense a controlled substance included in Schedules II through V of section
431.30 152.02, may cause the same to be administered by a nurse, an intern or an assistant under
431.31 the direction and supervision of the ~~doctor practitioner~~, and may cause a person who is an
431.32 appropriately certified and licensed health care professional to prescribe and administer the
431.33 same within the expressed legal scope of the person's practice as defined in Minnesota

432.1 **Statutes.** An individual who prescribes under this subdivision must be registered pursuant
432.2 to section 152.10 and must have a current federal controlled substance registration number.

432.3 Sec. 16. Minnesota Statutes 2018, section 152.12, subdivision 2, is amended to read:

432.4 **Subd. 2. Doctor of veterinary medicine.** A licensed doctor of veterinary medicine who
432.5 is registered pursuant to section 152.10 and who has a current federal controlled substance
432.6 registration number, in good faith, and in the course of professional practice only, and not
432.7 for use by a human being, may prescribe, administer, and dispense a controlled substance
432.8 included in Schedules II through V of section 152.02, and may cause the same to be
432.9 administered by an assistant under the direction and supervision of the doctor.

432.10 Sec. 17. Minnesota Statutes 2018, section 152.12, subdivision 3, is amended to read:

432.11 **Subd. 3. Research project use of controlled substances.** Any qualified person may
432.12 use controlled substances in the course of a bona fide research project but cannot administer
432.13 or dispense such drugs to human beings unless such drugs are prescribed, dispensed and
432.14 administered by a person lawfully authorized to do so. Every person who engages in research
432.15 involving the use of such substances shall apply annually for registration by must register
432.16 with the state Board of Pharmacy and shall pay any applicable fee specified in section
432.17 151.065, provided that such registration shall not be required if the person is covered by
432.18 and has complied with federal laws covering such research projects pursuant to section
432.19 152.10.

432.20 Sec. 18. Minnesota Statutes 2018, section 152.12, subdivision 4, is amended to read:

432.21 **Subd. 4. Sale of controlled substances not prohibited for certain persons and**
432.22 **entities.** (a) Provided that the registration requirements in section 152.10 are met, nothing
432.23 in this chapter shall prohibit the sale to, or the possession of, a controlled substance in
432.24 Schedule II, III, IV or V by: Registered licensed drug wholesalers, registered licensed
432.25 manufacturers, registered licensed pharmacies, or any licensed hospital or other licensed
432.26 institutions wherein sick and injured persons are cared for or treated, or bona fide hospitals
432.27 wherein animals are treated; or by licensed pharmacists, or licensed doctors of medicine,
432.28 doctors of osteopathic medicine duly licensed to practice medicine, licensed doctors of
432.29 dental surgery, licensed doctors of dental medicine, licensed doctors of podiatry, licensed
432.30 doctors of optometry limited to Schedules IV and V, or licensed doctors of veterinary
432.31 medicine when such practitioners use controlled substances acting within the course and
432.32 scope of their professional practice only.

433.1 (b) Provided that the registration requirements in section 152.10 are met, nothing in this
433.2 chapter shall prohibit the possession of a controlled substance in Schedule II, III, IV or V
433.3 by an employee or agent of a ~~registered licensed~~ drug wholesaler, ~~registered licensed~~
433.4 manufacturer, or ~~registered licensed~~ pharmacy, while acting in the course of employment;
433.5 by a patient of a licensed ~~doctor of medicine, a doctor of osteopathic medicine duly licensed~~
433.6 ~~to practice medicine, a licensed doctor of dental surgery, a licensed doctor of dental medicine,~~
433.7 ~~or a licensed doctor of optometry limited to Schedules IV and V practitioner;~~ or by the
433.8 owner of an animal for which a controlled substance has been prescribed by a licensed
433.9 doctor of veterinary medicine, when such controlled substances are prescribed and dispensed
433.10 according to law.

433.11 Sec. 19. Minnesota Statutes 2018, section 152.125, subdivision 2, is amended to read:

433.12 **Subd. 2. Prescription and administration of controlled substances for intractable**
433.13 **pain.** Notwithstanding any other provision of this chapter, a ~~physician~~ practitioner lawfully
433.14 licensed to prescribe controlled substances in this state and registered pursuant to section
433.15 152.10 may prescribe or administer a controlled substance in Schedules II to V of section
433.16 152.02 to an individual in the course of the ~~physician's~~ practitioner's treatment of the
433.17 individual for a diagnosed condition causing intractable pain. No ~~physician~~ practitioner
433.18 shall be subject to disciplinary action by the ~~Board of Medical Practice~~ a health-related
433.19 licensing board for appropriately prescribing or administering a controlled substance in
433.20 Schedules II to V of section 152.02 in the course of treatment of an individual for intractable
433.21 pain, provided the ~~physician~~ practitioner keeps accurate records of the purpose, use,
433.22 prescription, and disposal of controlled substances, writes accurate prescriptions, and
433.23 prescribes medications in conformance with the chapter 147 of law under which the
433.24 practitioner is licensed.

433.25 Sec. 20. Minnesota Statutes 2018, section 152.125, subdivision 3, is amended to read:

433.26 **Subd. 3. Limits on applicability.** This section does not apply to:

433.27 (1) a ~~physician's~~ practitioner's treatment of an individual for chemical dependency
433.28 resulting from the use of controlled substances in Schedules II to V of section 152.02;
433.29 (2) the prescription or administration of controlled substances in Schedules II to V of
433.30 section 152.02 to an individual whom the ~~physician~~ practitioner knows to be using the
433.31 controlled substances for nontherapeutic purposes;

434.1 (3) the prescription or administration of controlled substances in Schedules II to V of
434.2 section 152.02 for the purpose of terminating the life of an individual having intractable
434.3 pain; or

434.4 (4) the prescription or administration of a controlled substance in Schedules II to V of
434.5 section 152.02 that is not a controlled substance approved by the United States Food and
434.6 Drug Administration for pain relief.

434.7 Sec. 21. Minnesota Statutes 2018, section 152.125, subdivision 4, is amended to read:

434.8 Subd. 4. **Notice of risks.** Prior to treating an individual for intractable pain in accordance
434.9 with subdivision 2, a physician practitioner shall discuss with the individual the risks
434.10 associated with the controlled substances in Schedules II to V of section 152.02 to be
434.11 prescribed or administered in the course of the physician's practitioner's treatment of an
434.12 individual, and document the discussion in the individual's record.

434.13 Sec. 22. Minnesota Statutes 2018, section 245.4661, subdivision 9, is amended to read:

434.14 Subd. 9. **Services and programs.** (a) The following three distinct grant programs are
434.15 funded under this section:

434.16 (1) mental health crisis services;
434.17 (2) housing with supports for adults with serious mental illness; and
434.18 (3) projects for assistance in transitioning from homelessness (PATH program).

434.19 (b) In addition, the following are eligible for grant funds:

434.20 (1) community education and prevention;
434.21 (2) client outreach;
434.22 (3) early identification and intervention;
434.23 (4) adult outpatient diagnostic assessment and psychological testing;
434.24 (5) peer support services;
434.25 (6) community support program services (CSP);
434.26 (7) adult residential crisis stabilization;
434.27 (8) supported employment;
434.28 (9) assertive community treatment (ACT);
434.29 (10) housing subsidies;

- 435.1 (11) basic living, social skills, and community intervention;
- 435.2 (12) emergency response services;
- 435.3 (13) adult outpatient psychotherapy;
- 435.4 (14) adult outpatient medication management;
- 435.5 (15) adult mobile crisis services;
- 435.6 (16) adult day treatment;
- 435.7 (17) partial hospitalization;
- 435.8 (18) adult residential treatment;
- 435.9 (19) adult mental health targeted case management;
- 435.10 (20) intensive community rehabilitative services (ICRS); ~~and~~
- 435.11 (21) transportation; and
- 435.12 (22) traditional healing provided to American Indians.

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

435.14 Sec. 23. Minnesota Statutes 2018, section 254A.03, subdivision 3, is amended to read:

435.15 Subd. 3. **Rules for substance use disorder care.** (a) The commissioner of human
435.16 services shall establish by rule criteria to be used in determining the appropriate level of
435.17 chemical dependency care for each recipient of public assistance seeking treatment for
435.18 substance misuse or substance use disorder. Upon federal approval of a comprehensive
435.19 assessment as a Medicaid benefit, or on July 1, 2018, whichever is later, and notwithstanding
435.20 the criteria in Minnesota Rules, parts 9530.6600 to 9530.6655, an eligible vendor of
435.21 comprehensive assessments under section 254B.05 may determine and approve the
435.22 appropriate level of substance use disorder treatment for a recipient of public assistance.
435.23 The process for determining an individual's financial eligibility for the consolidated chemical
435.24 dependency treatment fund or determining an individual's enrollment in or eligibility for a
435.25 publicly subsidized health plan is not affected by the individual's choice to access a
435.26 comprehensive assessment for placement.

435.27 (b) The commissioner shall develop and implement a utilization review process for
435.28 publicly funded treatment placements to monitor and review the clinical appropriateness
435.29 and timeliness of all publicly funded placements in treatment.

436.1 (c) If a screen result is positive for alcohol or substance misuse, a brief screening for
436.2 alcohol or substance use disorder that is provided to a recipient of public assistance within
436.3 a primary care clinic, hospital, or other medical setting or school setting establishes medical
436.4 necessity and approval for an initial set of substance use disorder services identified in
436.5 section 254B.05, subdivision 5. The initial set of services approved for a recipient whose
436.6 screen result is positive may include four hours of individual or group substance use disorder
436.7 treatment, two hours of substance use disorder treatment coordination, or two hours of
436.8 substance use disorder peer support services provided by a qualified individual according
436.9 to chapter 245G. A recipient must obtain an assessment pursuant to paragraph (a) to be
436.10 approved for additional treatment services.

436.11 **EFFECTIVE DATE.** Contingent upon federal approval, this section is effective July
436.12 1, 2019. The commissioner of human services shall notify the revisor of statutes when
436.13 federal approval is obtained or denied.

436.14 Sec. 24. **[256.042] OPIOID STEWARDSHIP ADVISORY COUNCIL.**

436.15 Subdivision 1. **Establishment of the advisory council.** (a) The Opioid Stewardship
436.16 Advisory Council is established to develop and implement a comprehensive and effective
436.17 statewide effort to address the opioid addiction and overdose epidemic in Minnesota. The
436.18 council shall focus on:

436.19 (1) prevention and education, including public education and awareness for adults and
436.20 youth, prescriber education, the development and sustainability of opioid overdose prevention
436.21 and education programs, and providing financial support to local law enforcement agencies
436.22 for opiate antagonist programs;

436.23 (2) treatment, including statewide access to effective treatment and recovery services
436.24 that is aligned with Minnesota's model of care approach to promoting access to treatment
436.25 and recovery services. This includes ensuring that individuals throughout the state have
436.26 access to treatment and recovery services, including care coordination services; peer recovery
436.27 services; medication-assisted treatment and office-based opioid treatment; integrative and
436.28 multidisciplinary therapies; and culturally specific services; and

436.29 (3) innovation and capacity building, including development of evidence-based practices
436.30 and using research and evaluation to understand which policies and programs promote
436.31 efficient and effective prevention, treatment, and recovery results. This also includes ensuring
436.32 that there are qualified providers and a comprehensive set of treatment and recovery services
436.33 throughout the state.

437.1 (b) The council shall:

437.2 (1) review local, state, and federal initiatives and funding related to prevention and
437.3 education, treatment, and services for individuals and families experiencing and affected
437.4 by opioid abuse, and promoting innovation and capacity building to address the opioid
437.5 addiction and overdose epidemic;

437.6 (2) establish priorities to address the state's opioid addiction and overdose epidemic for
437.7 the purpose of allocating funds and consult with the commissioner of management and
437.8 budget and the commissioner of human services to determine whether proposals are for
437.9 evidence-based practices, promising practices, or theory-based practices and whether
437.10 proposals align with evidence-based practices for opioid use disorder and co-occurring
437.11 conditions according to the Substance Abuse and Mental Health Services Administration
437.12 and the American Society for Addiction Medicine;

437.13 (3) ensure that available funding under this section is allocated to align with existing
437.14 state and federal funding to achieve the greatest impact and ensure a coordinated state effort
437.15 to address the opioid addiction and overdose epidemic;

437.16 (4) develop criteria and procedures to be used in awarding grants and allocating available
437.17 funds from the opiate epidemic response account and select proposals to receive grant
437.18 funding. The council is encouraged to select proposals that are promising practices or
437.19 theory-based practices, in addition to evidence-based practices, to help identify new
437.20 approaches to effective prevention, treatment, and recovery; and

437.21 (5) in consultation with the commissioner of management and budget, and within
437.22 available appropriations, select from the awarded grants projects that include promising
437.23 practices or theory-based activities for which the commissioner of management and budget
437.24 shall conduct evaluations using experimental or quasi-experimental design. Grants awarded
437.25 to proposals that include promising practices or theory-based activities and that are selected
437.26 for an evaluation shall be administered to support the experimental or quasi-experimental
437.27 evaluation and require grantees to collect and report information that is needed to complete
437.28 the evaluation. The commissioner of management and budget, under section 15.08, may
437.29 obtain additional relevant data to support the experimental or quasi-experimental evaluation
437.30 studies.

437.31 **Subd. 2. Membership.** (a) The council shall consist of 19 members appointed by the
437.32 commissioner of human services, except as otherwise specified:

438.1 (1) two members of the house of representatives, one from the majority party appointed
438.2 by the speaker of the house and one from the minority party appointed by the minority
438.3 leader;

438.4 (2) two members of the senate, one from the majority party appointed by the senate
438.5 majority leader and one from the minority party appointed by the senate minority leader;

438.6 (3) one member appointed by the Board of Pharmacy;

438.7 (4) one member who is a physician appointed by the Minnesota chapter of the American
438.8 College of Emergency Physicians;

438.9 (5) one member representing opioid treatment programs or other medication-assisted
438.10 treatment programs;

438.11 (6) one member who is a physician appointed by the Minnesota Hospital Association;

438.12 (7) one member who is a physician appointed by the Minnesota Society of Addiction
438.13 Medicine;

438.14 (8) one member who is a pain psychologist;

438.15 (9) one member appointed by the Steve Rummler Hope Network;

438.16 (10) one member appointed by the Minnesota Ambulance Association;

438.17 (11) one member representing the Minnesota courts who is a judge or law enforcement
438.18 officer;

438.19 (12) two public members who are Minnesota residents and who have been impacted by
438.20 the opioid epidemic;

438.21 (13) two members representing an Indian tribe;

438.22 (14) the commissioner of human services or designee; and

438.23 (15) the commissioner of health or designee.

438.24 (b) The commissioner of human services shall coordinate appointments to provide
438.25 geographic diversity and shall ensure that at least one-half of the council members appointed
438.26 by the commissioner reside outside of the seven-county metropolitan area.

438.27 (c) The council is governed by section 15.059, except that members of the council who
438.28 are receiving compensation for the member's appointed role shall receive no compensation
438.29 other than reimbursement for expenses. Notwithstanding section 15.059, subdivision 6, the
438.30 council shall not expire.

439.1 (d) The chair shall convene the council at least quarterly, and may convene other meetings
439.2 as necessary. The chair shall convene meetings at different locations in the state to provide
439.3 geographic access, and shall ensure that at least one-half of the meetings are held at locations
439.4 outside of the seven-county metropolitan area.

439.5 (e) The commissioner of human services shall provide staff and administrative services
439.6 for the advisory council.

439.7 (f) The council is subject to chapter 13D.

439.8 Subd. 3. **Conflict of interest.** Advisory council members must disclose to the council
439.9 and recuse themselves from voting on any matter before the council if the member has a
439.10 conflict of interest. A conflict of interest means a financial association that has the potential
439.11 to bias or have the appearance of biasing a council member's decision related to the opiate
439.12 epidemic response grant decision process or other council activities under this section.

439.13 Subd. 4. **Council recommendations.** The council shall make recommendations on the
439.14 funds annually appropriated to the commissioner of human services from the opioid
439.15 stewardship fund to be awarded for the upcoming fiscal year.

439.16 Subd. 5. **Grants.** The commissioner of human services shall award grants within
439.17 appropriations from the opioid stewardship fund under section 256.043. The grants shall
439.18 be awarded based on recommendations from the advisory council that address the priorities
439.19 in subdivision 1, paragraph (a), clauses (1) to (3).

439.20 Subd. 6. **Reports.** (a) The commissioner, in consultation with the advisory council, shall
439.21 report annually to the chairs and ranking minority members of the legislative committees
439.22 with jurisdiction over health and human services policy and finance by March 1 of each
439.23 year beginning March 1, 2022, information about the individual projects that receive grants
439.24 and the overall role of the project in addressing the opioid addiction and overdose epidemic
439.25 in Minnesota. The report must describe the grantees and the activities implemented, along
439.26 with measurable outcomes as determined by the council in consultation with the
439.27 commissioner of human services and the commissioner of management and budget. At a
439.28 minimum, the report must include information about the number of individuals who received
439.29 information or treatment, the outcomes the individuals achieved, and demographic
439.30 information about the individuals participating in the project; an assessment of the progress
439.31 toward achieving statewide access to qualified providers and comprehensive treatment and
439.32 recovery services; and an update on the evaluation implemented by the commissioner of
439.33 management and budget for the promising practices and theory-based projects that receive
439.34 funding. Each report must also identify instances in which the commissioner did not follow

440.1 recommendations of the advisory council and the commissioner's rationale for not doing
440.2 so.

440.3 (b) The commissioner of management and budget, in consultation with the Opioid
440.4 Stewardship Advisory Council and the commissioner of human services, shall report to the
440.5 chairs and ranking minority members of the legislative committees with jurisdiction over
440.6 health and human services policy and finance when an evaluation study described in
440.7 subdivision 1, paragraph (b), clause (5), is complete on the promising practices or
440.8 theory-based projects that are selected for evaluation activities. The report shall include
440.9 demographic information; outcome information for the individuals in the program; the
440.10 results for the program in promoting recovery, employment, family reunification, and
440.11 reducing involvement with the criminal justice system; and other relevant outcomes
440.12 determined by the commissioner of management and budget that are specific to the projects
440.13 that are evaluated. The report shall include information about the ability of grant programs
440.14 to be scaled to achieve the statewide results that the grant project demonstrated.

440.15 Sec. 25. **[256.043] OPIOID STEWARDSHIP FUND.**

440.16 The opioid stewardship fund is established in the state treasury. The registration fees
440.17 assessed by the Board of Pharmacy under section 151.77 and the license fees identified in
440.18 section 151.065, subdivision 3a, shall be deposited into the fund. All interest earnings shall
440.19 be credited to the fund.

440.20 Sec. 26. **OPIOID STEWARDSHIP ADVISORY COUNCIL FIRST MEETING.**

440.21 The commissioner of human services shall convene the first meeting of the Opioid
440.22 Stewardship Advisory Council established under Minnesota Statutes, section 256.042, no
440.23 later than October 1, 2019. The members shall elect a chair at the first meeting.

440.24 **ARTICLE 11**

440.25 **HEALTH-RELATED LICENSING BOARDS**

440.26 Section 1. **[144A.39] FEES.**

440.27 Subdivision 1. Nonrefundable fees. All fees are nonrefundable.

440.28 Subd. 2. Amounts. (a) Fees may not exceed the following amounts but may be adjusted
440.29 lower by board direction and are for the exclusive use of the board as required to sustain
440.30 board operations. The maximum amounts of fees are:

440.31 (1) application for licensure, \$200;

- 441.1 (2) for a prospective applicant for a review of education and experience advisory to the
441.2 license application, \$100, to be applied to the fee for application for licensure if the latter
441.3 is submitted within one year of the request for review of education and experience;
- 441.4 (3) state examination, \$125;
- 441.5 (4) initial license, \$250 if issued between July 1 and December 31, \$100 if issued between
441.6 January 1 and June 30;
- 441.7 (5) acting administrator permit, \$400;
- 441.8 (6) renewal license, \$250;
- 441.9 (7) duplicate license, \$50;
- 441.10 (8) reinstatement fee, \$250;
- 441.11 (9) health services executive initial license, \$200;
- 441.12 (10) health services executive renewal license, \$200;
- 441.13 (11) reciprocity verification fee, \$50;
- 441.14 (12) second shared administrator assignment, \$250;
- 441.15 (13) continuing education fees:
- 441.16 (i) greater than 6 hours, \$50; and
- 441.17 (ii) 7 hours or more, \$75;
- 441.18 (14) education review, \$100;
- 441.19 (15) fee to a sponsor for review of individual continuing education seminars, institutes,
441.20 workshops, or home study courses:
- 441.21 (i) for less than seven clock hours, \$30; and
- 441.22 (ii) for seven or more clock hours, \$50;
- 441.23 (16) fee to a licensee for review of continuing education seminars, institutes, workshops,
441.24 or home study courses not previously approved for a sponsor and submitted with an
441.25 application for license renewal:
- 441.26 (i) for less than seven clock hours total, \$30; and
- 441.27 (ii) for seven or more clock hours total, \$50;
- 441.28 (17) late renewal fee, \$75;
- 441.29 (18) fee to a licensee for verification of licensure status and examination scores, \$30;

442.1 (19) registration as a registered continuing education sponsor, \$1,000; and
442.2 (20) mail labels, \$75.
442.3 (b) The revenue generated from the fees must be deposited in an account in the state
442.4 government special revenue fund.

442.5 Sec. 2. Minnesota Statutes 2018, section 147D.27, is amended by adding a subdivision to
442.6 read:

442.7 Subd. 5. Additional fees. (a) The following fees also apply:

442.8 (1) traditional midwifery annual registration fee, \$100;
442.9 (2) traditional midwifery application fee, \$100;
442.10 (3) traditional midwifery late fee, \$75;
442.11 (4) traditional midwifery inactive status, \$50;
442.12 (5) traditional midwifery temporary permit, \$75;
442.13 (6) traditional midwifery certification fee, \$25;
442.14 (7) duplicate license or registration fee, \$20;
442.15 (8) certification letter, \$25;
442.16 (9) education or training program approval fee, \$100; and
442.17 (10) report creation and generation, \$60 per hour billed in quarter-hour increments with
442.18 a quarter-hour minimum.

442.19 (b) The revenue generated from the fees must be deposited in an account in the state
442.20 government special revenue fund.

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

442.22 Sec. 3. Minnesota Statutes 2018, section 147E.40, subdivision 1, is amended to read:

442.23 Subdivision 1. **Fees.** (a) Fees are as follows:

442.24 (1) registration application fee, \$200;
442.25 (2) renewal fee, \$150;
442.26 (3) late fee, \$75;
442.27 (4) inactive status fee, \$50; and

443.1 (5) temporary permit fee, \$25;
443.2 (6) naturopathic doctor certification fee, \$25;
443.3 (7) naturopathic doctor duplicate license fee, \$20;
443.4 (8) naturopathic doctor emeritus registration fee, \$50;
443.5 (9) naturopathic doctor certification fee, \$25;
443.6 (10) duplicate license or registration fee, \$20;
443.7 (11) education or training program approval fee, \$100; and
443.8 (12) report creation and generation, \$60 per hour billed in quarter-hour increments with
443.9 a quarter-hour minimum.

443.10 (b) The revenue generated from the fees must be deposited in an account in the state
443.11 government special revenue fund.

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

443.13 Sec. 4. Minnesota Statutes 2018, section 147F.17, subdivision 1, is amended to read:

443.14 Subdivision 1. **Fees.** (a) Fees are as follows:

443.15 (1) license application fee, \$200;
443.16 (2) initial licensure and annual renewal, \$150; and
443.17 (3) late fee, \$75;
443.18 (4) genetic counselor certification fee, \$25;
443.19 (5) duplicate license fee, \$20;
443.20 (6) education or training program approval fee, \$100; and
443.21 (7) report creation and generation, \$60 per hour billed in quarter-hour increments with
443.22 a quarter-hour minimum.

443.23 (b) The revenue generated from the fees must be deposited in an account in the state
443.24 government special revenue fund.

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

444.1 Sec. 5. Minnesota Statutes 2018, section 148.59, is amended to read:

444.2 **148.59 LICENSE RENEWAL; LICENSE AND REGISTRATION FEES.**

444.3 A licensed optometrist shall pay to the state Board of Optometry a fee as set by the board
444.4 in order to renew a license as provided by board rule. No fees shall be refunded. Fees may
444.5 not exceed the following amounts but may be adjusted lower by board direction and are for
444.6 the exclusive use of the board:

- 444.7 (1) optometry licensure application, \$160;
- 444.8 (2) optometry annual licensure renewal, ~~\$135~~ \$200;
- 444.9 (3) optometry late penalty fee, \$75;
- 444.10 (4) annual license renewal card, \$10;
- 444.11 (5) continuing education provider application, \$45;
- 444.12 (6) emeritus registration, \$10;
- 444.13 (7) endorsement/reciprocity application, \$160;
- 444.14 (8) replacement of initial license, \$12; and
- 444.15 (9) license verification, \$50;
- 444.16 (10) state juris prudence examination, \$75; and
- 444.17 (11) miscellaneous labels and data retrieval, \$50.

444.18 Sec. 6. Minnesota Statutes 2018, section 148.6445, subdivision 1, is amended to read:

444.19 Subdivision 1. **Initial licensure fee.** The initial licensure fee for occupational therapists
444.20 is ~~\$145~~ \$185. The initial licensure fee for occupational therapy assistants is ~~\$80~~ \$105. The
444.21 ~~board shall prorate fees based on the number of quarters remaining in the biennial licensure~~
444.22 ~~period~~.

444.23 Sec. 7. Minnesota Statutes 2018, section 148.6445, subdivision 2, is amended to read:

444.24 Subd. 2. **Licensure renewal fee.** The biennial licensure renewal fee for occupational
444.25 therapists is ~~\$145~~ \$185. The biennial licensure renewal fee for occupational therapy assistants
444.26 is ~~\$80~~ \$105.

444.27 Sec. 8. Minnesota Statutes 2018, section 148.6445, subdivision 2a, is amended to read:

444.28 Subd. 2a. **Duplicate license fee.** The fee for a duplicate license is ~~\$25~~ \$30.

445.1 Sec. 9. Minnesota Statutes 2018, section 148.6445, subdivision 3, is amended to read:

445.2 Subd. 3. **Late fee.** The fee for late submission of a renewal application is \$25 \$50.

445.3 Sec. 10. Minnesota Statutes 2018, section 148.6445, subdivision 4, is amended to read:

445.4 Subd. 4. **Temporary licensure fee.** The fee for temporary licensure is \$50 \$75.

445.5 Sec. 11. Minnesota Statutes 2018, section 148.6445, subdivision 5, is amended to read:

445.6 Subd. 5. **Limited licensure fee.** The fee for limited licensure is \$96 \$100.

445.7 Sec. 12. Minnesota Statutes 2018, section 148.6445, subdivision 6, is amended to read:

445.8 Subd. 6. **Fee for course approval after lapse of licensure.** The fee for course approval

445.9 after lapse of licensure is \$96 \$100.

445.10 Sec. 13. Minnesota Statutes 2018, section 148.6445, subdivision 10, is amended to read:

445.11 Subd. 10. **Use of fees.** (a) All fees are nonrefundable. The board shall only use fees
445.12 collected under this section for the purposes of administering this chapter. The legislature
445.13 must not transfer money generated by these fees from the state government special revenue
445.14 fund to the general fund.

445.15 (b) Licensure fees are for the exclusive use of the board and shall be established by the

445.16 board not to exceed the nonrefundable amounts in this section.

445.17 Sec. 14. Minnesota Statutes 2018, section 148.7815, subdivision 1, is amended to read:

445.18 Subdivision 1. **Fees.** (a) The board shall establish fees as follows:

445.19 (1) application fee, \$50; and

445.20 (2) annual license fee, \$100;

445.21 (3) athletic trainer certification fee, \$25;

445.22 (4) athletic trainer duplicate license fee, \$20;

445.23 (5) naturopathic doctor certification fee, \$25;

445.24 (6) duplicate license or registration fee, \$20;

445.25 (7) education or training program approval fee, \$100;

445.26 (8) report creation and generation, \$60 per hour billed in quarter-hour increments with

445.27 a quarter-hour minimum; and

446.1 (9) examination administrative fee:

446.2 (i) half day, \$50; and

446.3 (ii) full day, \$80.

446.4 (b) The revenue generated from the fees must be deposited in an account in the state

446.5 government special revenue fund.

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

446.7 Sec. 15. **[148.981] FEES.**

446.8 Subdivision 1. Licensing fees. The nonrefundable fees for licensure shall be established

446.9 by the board, not to exceed the following amounts:

446.10 (1) application for admission to national standardized examination, \$150;

446.11 (2) application for professional responsibility examination, \$150;

446.12 (3) application for licensure as a licensed psychologist, \$500;

446.13 (4) renewal of license for a licensed psychologist, \$500;

446.14 (5) late renewal of license for a licensed psychologist, \$250;

446.15 (6) application for converting from master's to doctoral level licensure, \$150;

446.16 (7) application for guest licensure, \$150;

446.17 (8) certificate replacement fee, \$25;

446.18 (9) mailing and duplication fee, \$5;

446.19 (10) statute and rule book fee, \$10;

446.20 (11) verification fee, \$20; and

446.21 (12) fee for optional preapproval of postdoctoral supervision, \$50.

446.22 Subd. 2. **Continuing education sponsor fee.** A sponsor applying for approval of a

446.23 continuing education activity pursuant to Minnesota Rules, part 7200.3830, subpart 2, shall

446.24 submit with the application a fee to be established by the board, not to exceed \$80 for each

446.25 activity.

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

447.1 Sec. 16. Minnesota Statutes 2018, section 148E.180, is amended to read:

447.2 **148E.180 FEE AMOUNTS.**

447.3 Subdivision 1. **Application fees.** Nonrefundable application fees for licensure ~~are as~~
447.4 ~~follows may not exceed the following amounts but may be adjusted lower by board action:~~

447.5 (1) for a licensed social worker, ~~\$45~~ \$75;

447.6 (2) for a licensed graduate social worker, ~~\$45~~ \$75;

447.7 (3) for a licensed independent social worker, ~~\$45~~ \$75;

447.8 (4) for a licensed independent clinical social worker, ~~\$45~~ \$75;

447.9 (5) for a temporary license, \$50; and

447.10 (6) for a ~~license~~ license by endorsement, ~~\$85~~ \$115.

447.11 The fee for criminal background checks is the fee charged by the Bureau of Criminal
447.12 Apprehension. The criminal background check fee must be included with the application
447.13 fee as required according to section 148E.055.

447.14 Subd. 2. **License fees.** Nonrefundable license fees ~~are as follows may not exceed the~~
447.15 ~~following amounts but may be adjusted lower by board action:~~

447.16 (1) for a licensed social worker, ~~\$81~~ \$115;

447.17 (2) for a licensed graduate social worker, ~~\$144~~ \$210;

447.18 (3) for a licensed independent social worker, ~~\$216~~ \$305;

447.19 (4) for a licensed independent clinical social worker, ~~\$238.50~~ \$335;

447.20 (5) for an emeritus inactive license, ~~\$43.20~~ \$65;

447.21 (6) for an emeritus active license, one-half of the renewal fee specified in subdivision
447.22 3; and

447.23 (7) for a temporary leave fee, the same as the renewal fee specified in subdivision 3.

447.24 If the licensee's initial license term is less or more than 24 months, the required license
447.25 fees must be prorated proportionately.

447.26 Subd. 3. **Renewal fees.** Nonrefundable renewal fees for licensure ~~are as follows may~~
447.27 ~~not exceed the following amounts but may be adjusted lower by board action:~~

447.28 (1) for a licensed social worker, ~~\$81~~ \$115;

447.29 (2) for a licensed graduate social worker, ~~\$144~~ \$210;

448.1 (3) for a licensed independent social worker, ~~\$216~~ \$305; and

448.2 (4) for a licensed independent clinical social worker, ~~\$238.50~~ \$335.

448.3 Subd. 4. **Continuing education provider fees.** Continuing education provider fees are
448.4 as follows the following nonrefundable amounts:

448.5 (1) for a provider who offers programs totaling one to eight clock hours in a one-year
448.6 period according to section 148E.145, \$50;

448.7 (2) for a provider who offers programs totaling nine to 16 clock hours in a one-year
448.8 period according to section 148E.145, \$100;

448.9 (3) for a provider who offers programs totaling 17 to 32 clock hours in a one-year period
448.10 according to section 148E.145, \$200;

448.11 (4) for a provider who offers programs totaling 33 to 48 clock hours in a one-year period
448.12 according to section 148E.145, \$400; and

448.13 (5) for a provider who offers programs totaling 49 or more clock hours in a one-year
448.14 period according to section 148E.145, \$600.

448.15 Subd. 5. **Late fees.** Late fees are as follows the following nonrefundable amounts:

448.16 (1) renewal late fee, one-fourth of the renewal fee specified in subdivision 3;

448.17 (2) supervision plan late fee, \$40; and

448.18 (3) license late fee, \$100 plus the prorated share of the license fee specified in subdivision
448.19 2 for the number of months during which the individual practiced social work without a
448.20 license.

448.21 Subd. 6. **License cards and wall certificates.** (a) The nonrefundable fee for a license
448.22 card as specified in section 148E.095 is \$10.

448.23 (b) The nonrefundable fee for a license wall certificate as specified in section 148E.095
448.24 is \$30.

448.25 Subd. 7. **Reactivation fees.** Reactivation fees are as follows the following nonrefundable
448.26 amounts:

448.27 (1) reactivation from a temporary leave or emeritus status, the prorated share of the
448.28 renewal fee specified in subdivision 3; and

448.29 (2) reactivation of an expired license, 1-1/2 times the renewal fees specified in subdivision
448.30 3.

449.1 Sec. 17. Minnesota Statutes 2018, section 150A.06, is amended by adding a subdivision
449.2 to read:

449.3 **Subd. 10. Emeritus inactive license.** A person licensed to practice dentistry, dental
449.4 therapy, dental hygiene, or dental assisting pursuant to section 150A.05 or Minnesota Rules,
449.5 part 3100.8500, who retires from active practice in the state may apply to the board for
449.6 emeritus inactive licensure. An application for emeritus inactive licensure may be made on
449.7 the biennial licensing form or by petitioning the board, and the applicant must pay a onetime
449.8 application fee pursuant to section 150A.091, subdivision 19. In order to receive emeritus
449.9 inactive licensure, the applicant must be in compliance with board requirements and cannot
449.10 be the subject of current disciplinary action resulting in suspension, revocation,
449.11 disqualification, condition, or restriction of the licensee to practice dentistry, dental therapy,
449.12 dental hygiene, or dental assisting. An emeritus inactive license is not a license to practice,
449.13 but is a formal recognition of completion of a person's dental career in good standing.

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

449.15 Sec. 18. Minnesota Statutes 2018, section 150A.06, is amended by adding a subdivision
449.16 to read:

449.17 **Subd. 11. Emeritus active licensure.** (a) A person licensed to practice dentistry, dental
449.18 therapy, dental hygiene, or dental assisting may apply for an emeritus active license if the
449.19 person is retired from active practice, is in compliance with board requirements, and is not
449.20 the subject of current disciplinary action resulting in suspension, revocation, disqualification,
449.21 condition, or restriction of the license to practice dentistry, dental therapy, dental hygiene,
449.22 or dental assisting.

449.23 (b) An emeritus active licensee may engage only in the following types of practice:

449.24 (1) pro bono or volunteer dental practice;
449.25 (2) paid practice not to exceed 500 hours per calendar year for the exclusive purpose of
449.26 providing licensing supervision to meet the board's requirements; or
449.27 (3) paid consulting services not to exceed 500 hours per calendar year.

449.28 (c) An emeritus active licensee shall not hold out as a full licensee and may only hold
449.29 out as authorized to practice as described in this subdivision. The board may take disciplinary
449.30 or corrective action against an emeritus active licensee based on violations of applicable
449.31 law or board requirements.

450.1 (d) A person may apply for an emeritus active license by completing an application form
450.2 specified by the board and must pay the application fee pursuant to section 150A.091,
450.3 subdivision 20.

450.4 (e) If an emeritus active license is not renewed every two years, the license expires. The
450.5 renewal date is the same as the licensee's renewal date when the licensee was in active
450.6 practice. In order to renew an emeritus active license, the licensee must:

450.7 (1) complete an application form as specified by the board;
450.8 (2) pay the required renewal fee pursuant to section 150A.091, subdivision 20; and
450.9 (3) report at least 25 continuing education hours completed since the last renewal, which
450.10 must include:

450.11 (i) at least one hour in two different required CORE areas;
450.12 (ii) at least one hour of mandatory infection control;
450.13 (iii) for dentists and dental therapists, at least 15 hours of fundamental credits for dentists
450.14 and dental therapists, and for dental hygienists and dental assistants, at least seven hours of
450.15 fundamental credits; and
450.16 (iv) for dentists and dental therapists, no more than ten elective credits, and for dental
450.17 hygienists and dental assistants, no more than six elective credits.

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

450.19 Sec. 19. Minnesota Statutes 2018, section 150A.091, is amended by adding a subdivision
450.20 to read:

450.21 **Subd. 19. Emeritus inactive license.** An individual applying for emeritus inactive
450.22 licensure under section 150A.06, subdivision 10, must pay a onetime fee of \$50. There is
450.23 no renewal fee for an emeritus inactive license.

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

450.25 Sec. 20. Minnesota Statutes 2018, section 150A.091, is amended by adding a subdivision
450.26 to read:

450.27 **Subd. 20. Emeritus active license.** An individual applying for emeritus active licensure
450.28 under section 150A.06, subdivision 11, must pay a fee upon application and upon renewal
450.29 every two years. The fees for emeritus active license application and renewal are as follows:
450.30 dentist, \$212; dental therapist, \$100; dental hygienist, \$75; and dental assistant, \$55.

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

451.2 Sec. 21. Minnesota Statutes 2018, section 151.065, subdivision 1, is amended to read:

451.3 Subdivision 1. **Application fees.** Application fees for licensure and registration are as
451.4 follows:

451.5 (1) pharmacist licensed by examination, \$145 \$175;

451.6 (2) pharmacist licensed by reciprocity, \$240 \$275;

451.7 (3) pharmacy intern, \$37.50 \$50;

451.8 (4) pharmacy technician, \$37.50 \$50;

451.9 (5) pharmacy, \$225 \$260;

451.10 (6) drug wholesaler, legend drugs only, \$235 \$260;

451.11 (7) drug wholesaler, legend and nonlegend drugs, \$235 \$260;

451.12 (8) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, \$210 \$260;

451.13 (9) drug wholesaler, medical gases, \$175 \$260;

451.14 (10) drug wholesaler, also licensed as a pharmacy in Minnesota, \$150 \$260;

451.15 (11) drug manufacturer, legend drugs only, \$235 \$260;

451.16 (12) drug manufacturer, legend and nonlegend drugs, \$235 \$260;

451.17 (13) drug manufacturer, nonlegend or veterinary legend drugs, \$210 \$260;

451.18 (14) drug manufacturer, medical gases, \$185 \$260;

451.19 (15) drug manufacturer, also licensed as a pharmacy in Minnesota, \$150 \$260;

451.20 (16) medical gas distributor, \$110 \$260; and

451.21 (~~(17) controlled substance researcher, \$75; and~~

451.22 (~~(18)~~ (17) pharmacy professional corporation, \$125 \$150.

451.23 Sec. 22. Minnesota Statutes 2018, section 151.065, subdivision 2, is amended to read:

451.24 Subd. 2. **Original license fee.** The pharmacist original licensure fee, \$145 \$175.

451.25 Sec. 23. Minnesota Statutes 2018, section 151.065, subdivision 3, is amended to read:

451.26 Subd. 3. **Annual renewal fees.** Annual licensure and registration renewal fees are as
451.27 follows:

- 452.1 (1) pharmacist, \$145 \$175;
- 452.2 (2) pharmacy technician, \$37.50 \$50;
- 452.3 (3) pharmacy, \$225 \$260;
- 452.4 (4) drug wholesaler, legend drugs only, \$235 \$260;
- 452.5 (5) drug wholesaler, legend and nonlegend drugs, \$235 \$260;
- 452.6 (6) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, \$210 \$260;
- 452.7 (7) drug wholesaler, medical gases, \$185 \$260;
- 452.8 (8) drug wholesaler, also licensed as a pharmacy in Minnesota, \$150 \$260;
- 452.9 (9) drug manufacturer, legend drugs only, \$235 \$260;
- 452.10 (10) drug manufacturer, legend and nonlegend drugs, \$235 \$260;
- 452.11 (11) drug manufacturer, nonlegend, veterinary legend drugs, or both, \$210 \$260;
- 452.12 (12) drug manufacturer, medical gases, \$185 \$260;
- 452.13 (13) drug manufacturer, also licensed as a pharmacy in Minnesota, \$150 \$260;
- 452.14 (14) medical gas distributor, \$110 \$260; and
- 452.15 (15) controlled substance researcher, \$75; and
- 452.16 (16) (15) pharmacy professional corporation, \$75 \$100.

452.17 Sec. 24. Minnesota Statutes 2018, section 151.065, subdivision 6, is amended to read:

- 452.18 Subd. 6. **Reinstatement fees.** (a) A pharmacist who has allowed the pharmacist's license
452.19 to lapse may reinstate the license with board approval and upon payment of any fees and
452.20 late fees in arrears, up to a maximum of \$1,000.
- 452.21 (b) A pharmacy technician who has allowed the technician's registration to lapse may
452.22 reinstate the registration with board approval and upon payment of any fees and late fees
452.23 in arrears, up to a maximum of \$90.
- 452.24 (c) An owner of a pharmacy, a drug wholesaler, a drug manufacturer, or a medical gas
452.25 distributor who has allowed the license of the establishment to lapse may reinstate the license
452.26 with board approval and upon payment of any fees and late fees in arrears.
- 452.27 (d) A controlled substance researcher registrant who has allowed the researcher's a
452.28 registration issued pursuant to subdivision 4 to lapse may reinstate the registration with
452.29 board approval and upon payment of any fees and late fees in arrears.

453.1 (e) A pharmacist owner of a professional corporation who has allowed the corporation's
453.2 registration to lapse may reinstate the registration with board approval and upon payment
453.3 of any fees and late fees in arrears.

453.4 Sec. 25. REPEALER.

453.5 Minnesota Rules, parts 6400.6970; 7200.6100; and 7200.6105, are repealed.

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

ARTICLE 12

HEALTH DEPARTMENT

453.9 Section 1. Minnesota Statutes 2018, section 144.3831, subdivision 1, is amended to read:

453.10 Subdivision 1. **Fee setting.** The commissioner of health may assess an annual fee of
453.11 \$6.36 \$9.72 for every service connection to a public water supply that is owned or operated
453.12 by a home rule charter city, a statutory city, a city of the first class, or a town. The
453.13 commissioner of health may also assess an annual fee for every service connection served
453.14 by a water user district defined in section 110A.02.

453.15 **EFFECTIVE DATE.** This section is effective January 1, 2020.

453.16 Sec. 2. **[144.397] STATEWIDE TOBACCO CESSATION SERVICES.**

453.17 (a) The commissioner of health shall administer, or contract for the administration of,
453.18 statewide tobacco cessation services to assist Minnesotans who are seeking advice or services
453.19 to help them quit using tobacco products. The commissioner shall establish statewide public
453.20 awareness activities to inform the public of the availability of the services and encourage
453.21 the public to utilize the services because of the dangers and harm of tobacco use and
453.22 dependence.

453.23 (b) Services to be provided may include but are not limited to:

453.24 (1) telephone-based coaching and counseling;

453.25 (2) referrals;

453.26 (3) written materials mailed upon request;

453.27 (4) web-based texting or e-mail services; and

453.28 (5) free Food and Drug Administration-approved tobacco cessation medications.

454.1 (c) Services provided must be consistent with evidence-based best practices in tobacco
454.2 cessation services. Services provided must be coordinated with health plan company tobacco
454.3 prevention and cessation services that may be available to individuals depending on their
454.4 health coverage.

454.5 **Sec. 3. [145.9275] COMMUNITY-BASED OPIOID AND OTHER DRUG ABUSE**
454.6 **PREVENTION; PILOT GRANT PROGRAM.**

454.7 Subdivision 1. Community pilot prevention projects. To the extent funds are
454.8 appropriated for the purposes of this subdivision, the commissioner shall establish a grant
454.9 program to fund community opioid abuse prevention pilot grants to reduce emergency room
454.10 and other health care provider visits resulting from opioid use or abuse and to reduce rates
454.11 of opioid addiction in the community using the following six activities:

454.12 (1) establishing multidisciplinary controlled substance care teams that may consist of
454.13 physicians, pharmacists, social workers, nurse care coordinators, and mental health
454.14 professionals;

454.15 (2) delivering health care services and care coordination, through controlled substance
454.16 care teams, to reduce the inappropriate use of opioids by patients and rates of opioid
454.17 addiction;

454.18 (3) addressing any unmet social services needs that create barriers to managing pain
454.19 effectively and obtaining optimal health outcomes;

454.20 (4) providing prescriber and dispenser education and assistance to reduce the inappropriate
454.21 prescribing and dispensing of opioids;

454.22 (5) promoting the adoption of best practices related to opioid disposal and reducing
454.23 opportunities for illegal access to opioids; and

454.24 (6) engaging partners outside of the health care system, including schools, law
454.25 enforcement, and social services, to address root causes of opioid abuse and addiction at
454.26 the community level.

454.27 Subd. 2. Culture as health; preventing disparities. To the extent funds are appropriated
454.28 for the purposes of this subdivision, the commissioner shall establish a grant program to
454.29 fund organizations working directly with African Americans, urban American Indians, and
454.30 Minnesota's 11 Tribal Nations. For grants to Tribal Nations, the tribal governments shall
454.31 determine how to best use allocated funds to address and prevent substance use disorder
454.32 and overdoses within their communities.

455.1 Sec. 4. **[145.9285] COMMUNITY SOLUTIONS FOR HEALTHY CHILD**
455.2 **DEVELOPMENT GRANT PROGRAM.**

455.3 Subdivision 1. Establishment. The commissioner shall establish the community solutions
455.4 for healthy child development grant program. The purpose of the program is to:

455.5 (1) improve child development outcomes as related to the well-being of children of color
455.6 and American Indian children from prenatal to grade 3 and their families, including but not
455.7 limited to the goals outlined by the Department of Human Service's early childhood systems
455.8 reform effort: early learning; health and well-being; economic security; and safe, stable,
455.9 nurturing relationships and environments by funding community-based solutions for
455.10 challenges that are identified by the affected community;

455.11 (2) reduce racial disparities in children's health and development, from prenatal to grade
455.12 3; and

455.13 (3) promote racial and geographic equity.

455.14 Subd. 2. Commissioner's duties. The commissioner of health shall:

455.15 (1) develop a request for proposals for the healthy child development grant program in
455.16 consultation with the Community Solutions Advisory Council;
455.17 (2) provide outreach, technical assistance, and program development support to increase
455.18 capacity for new and existing service providers in order to better meet statewide needs,
455.19 particularly in greater Minnesota and areas where services to reduce health disparities have
455.20 not been established;

455.21 (3) review responses to requests for proposals, in consultation with the Community
455.22 Solutions Advisory Council, and award grants under this section;

455.23 (4) ensure communication with the ethnic councils, Minnesota Indian Affairs Council,
455.24 and the governor's early learning council on the request for proposal process;

455.25 (5) establish a transparent and objective accountability process, in consultation with the
455.26 Community Solutions Advisory Council, focused on outcomes that grantees agree to achieve;

455.27 (6) provide grantees with access to data to assist grantees in establishing and
455.28 implementing effective community-led solutions;

455.29 (7) maintain data on outcomes reported by grantees; and

455.30 (8) contract with an independent third-party entity to evaluate the success of the grant
455.31 program and to build the evidence base for effective community solutions in reducing health
455.32 disparities of children of color and American Indian children from prenatal to grade 3.

456.1 Subd. 3. Community Solutions Advisory Council; establishment; duties;

456.2 compensation. (a) No later than October 1, 2019, the commissioner shall convene a
456.3 12-member Community Solutions Advisory Council as follows:

456.4 (1) two members representing the African Heritage community;

456.5 (2) two members representing the Latino community;

456.6 (3) two members representing the Asian-Pacific Islander community;

456.7 (4) two members representing the American Indian community;

456.8 (5) two parents of children of color or that are American Indian with children under nine
456.9 years of age;

456.10 (6) one member with research or academic expertise in racial equity and healthy child
456.11 development; and

456.12 (7) one member representing an organization that advocates on behalf of communities
456.13 of color or American Indians.

456.14 (b) At least three of the 12 members of the advisory council must come from outside
456.15 the seven-county metropolitan area.

456.16 (c) The Community Solutions Advisory Council shall:

456.17 (1) advise the commissioner on the development of the request for proposals for
456.18 community solutions healthy child development grants. In advising the commissioner, the
456.19 council must consider how to build on the capacity of communities to promote child and
456.20 family well-being and address social determinants of healthy child development;

456.21 (2) review responses to requests for proposals and advise the commissioner on the
456.22 selection of grantees and grant awards;

456.23 (3) advise the commissioner on the establishment of a transparent and objective
456.24 accountability process focused on outcomes the grantees agree to achieve;

456.25 (4) advise the commissioner on ongoing oversight and necessary support in the
456.26 implementation of the program; and

456.27 (5) support the commissioner on other racial equity and early childhood grant efforts.

456.28 (d) Each advisory council member shall be compensated in accordance with section
456.29 15.059, subdivision 3.

456.30 Subd. 4. Eligible grantees. Organizations eligible to receive grant funding under this
456.31 section include:

457.1 (1) organizations or entities that work with communities of color and American Indian
457.2 communities;

457.3 (2) tribal nations and tribal organizations as defined in section 658P of the Child Care
457.4 and Development Block Grant Act of 1990; and

457.5 (3) organizations or entities focused on supporting healthy child development.

457.6 **Subd. 5. Strategic consideration and priority of proposals; eligible populations;**

457.7 **grant awards.** (a) The commissioner, in consultation with the Community Solutions
457.8 Advisory Council, shall develop a request for proposals for healthy child development
457.9 grants. In developing the proposals and awarding the grants, the commissioner shall consider
457.10 building on the capacity of communities to promote child and family well-being and address
457.11 social determinants of healthy child development. Proposals must focus on increasing racial
457.12 equity and healthy child development and reducing health disparities experienced by children
457.13 of color and American Indian children from prenatal to grade 3 and their families.

457.14 (b) In awarding the grants, the commissioner shall provide strategic consideration and
457.15 give priority to proposals from:

457.16 (1) organizations or entities led by people of color and serving communities of color;

457.17 (2) organizations or entities led by American Indians and serving American Indians,
457.18 including tribal nations and tribal organizations;

457.19 (3) organizations or entities with proposals focused on healthy development from prenatal
457.20 to age three;

457.21 (4) organizations or entities with proposals focusing on multigenerational solutions;

457.22 (5) organizations or entities located in or with proposals to serve communities located
457.23 in counties that are moderate to high risk according to the Wilder Research Risk and Reach
457.24 Report; and

457.25 (6) community-based organizations that have historically served communities of color
457.26 and American Indians and have not traditionally had access to state grant funding.

457.27 The advisory council may recommend additional strategic considerations and priorities to
457.28 the commissioner.

457.29 (c) The first round of grants must be awarded no later than April 15, 2020. Grants must
457.30 be awarded annually thereafter. Grants are awarded for a period of three years.

457.31 **Subd. 6. Geographic distribution of grants.** The commissioner and the advisory council
457.32 shall ensure that grant funds are prioritized and awarded to organizations and entities that

458.1 are within counties that have a higher proportion of people of color and American Indians
458.2 than the state average, to the extent possible.

458.3 Subd. 7. Report. Grantees must report grant program outcomes to the commissioner on
458.4 the forms and according to the timelines established by the commissioner.

458.5 Sec. 5. Minnesota Statutes 2018, section 152.22, subdivision 13, is amended to read:

458.6 Subd. 13. **Registry verification.** "Registry verification" means the verification provided
458.7 by the commissioner that a patient is enrolled in the registry program and that includes the
458.8 patient's name, registry number, and qualifying medical condition and, if applicable, the
458.9 name of the patient's registered designated caregiver or parent ~~or~~, legal guardian, or spouse.

458.10 Sec. 6. Minnesota Statutes 2018, section 152.25, subdivision 1c, is amended to read:

458.11 Subd. 1c. **Notice to patients.** Upon the revocation or nonrenewal of a manufacturer's
458.12 registration under subdivision 1a or implementation of an enforcement action under
458.13 subdivision 1b that may affect the ability of a registered patient, registered designated
458.14 caregiver, or a registered patient's parent ~~or~~, legal guardian, or spouse to obtain medical
458.15 cannabis from the manufacturer subject to the enforcement action, the commissioner shall
458.16 notify in writing each registered patient and the patient's registered designated caregiver or
458.17 registered patient's parent ~~or~~, legal guardian, or spouse about the outcome of the proceeding
458.18 and information regarding alternative registered manufacturers. This notice must be provided
458.19 two or more business days prior to the effective date of the revocation, nonrenewal, or other
458.20 enforcement action.

458.21 Sec. 7. Minnesota Statutes 2018, section 152.27, subdivision 3, is amended to read:

458.22 Subd. 3. **Patient application.** (a) The commissioner shall develop a patient application
458.23 for enrollment into the registry program. The application shall be available to the patient
458.24 and given to health care practitioners in the state who are eligible to serve as health care
458.25 practitioners. The application must include:

458.26 (1) the name, mailing address, and date of birth of the patient;

458.27 (2) the name, mailing address, and telephone number of the patient's health care
458.28 practitioner;

458.29 (3) the name, mailing address, and date of birth of the patient's designated caregiver, if
458.30 any, or the patient's parent ~~or~~, legal guardian, or spouse if the parent ~~or~~, legal guardian, or
458.31 spouse will be acting as a caregiver;

459.1 (4) a copy of the certification from the patient's health care practitioner that is dated
459.2 within 90 days prior to submitting the application which certifies that the patient has been
459.3 diagnosed with a qualifying medical condition and, if applicable, that, in the health care
459.4 practitioner's medical opinion, the patient is developmentally or physically disabled and,
459.5 as a result of that disability, the patient is unable to self-administer medication or acquire
459.6 medical cannabis from a distribution facility; and

459.7 (5) all other signed affidavits and enrollment forms required by the commissioner under
459.8 sections 152.22 to 152.37, including, but not limited to, the disclosure form required under
459.9 paragraph (c).

459.10 (b) The commissioner shall require a patient to resubmit a copy of the certification from
459.11 the patient's health care practitioner on a yearly basis and shall require that the recertification
459.12 be dated within 90 days of submission.

459.13 (c) The commissioner shall develop a disclosure form and require, as a condition of
459.14 enrollment, all patients to sign a copy of the disclosure. The disclosure must include:

459.15 (1) a statement that, notwithstanding any law to the contrary, the commissioner, or an
459.16 employee of any state agency, may not be held civilly or criminally liable for any injury,
459.17 loss of property, personal injury, or death caused by any act or omission while acting within
459.18 the scope of office or employment under sections 152.22 to 152.37; and

459.19 (2) the patient's acknowledgement acknowledgment that enrollment in the patient registry
459.20 program is conditional on the patient's agreement to meet all of the requirements of sections
459.21 152.22 to 152.37.

459.22 Sec. 8. Minnesota Statutes 2018, section 152.27, subdivision 4, is amended to read:

459.23 **Subd. 4. Registered designated caregiver.** (a) The commissioner shall register a
459.24 designated caregiver for a patient if the patient's health care practitioner has certified that
459.25 the patient, in the health care practitioner's medical opinion, is developmentally or physically
459.26 disabled and, as a result of that disability, the patient is unable to self-administer medication
459.27 or acquire medical cannabis from a distribution facility and the caregiver has agreed, in
459.28 writing, to be the patient's designated caregiver. As a condition of registration as a designated
459.29 caregiver, the commissioner shall require the person to:

459.30 (1) be at least 21 years of age;

459.31 (2) agree to only possess any medical cannabis for purposes of assisting the patient; and

460.1 (3) agree that if the application is approved, the person will not be a registered designated
460.2 caregiver for more than one patient, unless the patients reside in the same residence.

460.3 (b) The commissioner shall conduct a criminal background check on the designated
460.4 caregiver prior to registration to ensure that the person does not have a conviction for a
460.5 disqualifying felony offense. Any cost of the background check shall be paid by the person
460.6 seeking registration as a designated caregiver. A designated caregiver must have the criminal
460.7 background check renewed every two years.

460.8 Sec. 9. Minnesota Statutes 2018, section 152.27, subdivision 5, is amended to read:

460.9 **Subd. 5. Parents or, legal guardians, and spouses.** A parent or, legal guardian, or
460.10 spouse of a patient may act as the caregiver to the patient without having to register as a
460.11 designated caregiver. The parent or, legal guardian, or spouse shall follow all of the
460.12 requirements of parents and, legal guardians, and spouses listed in sections 152.22 to 152.37.
460.13 Nothing in sections 152.22 to 152.37 limits any legal authority a parent or, legal guardian,
460.14 or spouse may have for the patient under any other law.

460.15 Sec. 10. Minnesota Statutes 2018, section 152.27, subdivision 6, is amended to read:

460.16 **Subd. 6. Patient enrollment.** (a) After receipt of a patient's application, application fees,
460.17 and signed disclosure, the commissioner shall enroll the patient in the registry program and
460.18 issue the patient and patient's registered designated caregiver or parent or, legal guardian,
460.19 or spouse, if applicable, a registry verification. The commissioner shall approve or deny a
460.20 patient's application for participation in the registry program within 30 days after the
460.21 commissioner receives the patient's application and application fee. The commissioner may
460.22 approve applications up to 60 days after the receipt of a patient's application and application
460.23 fees until January 1, 2016. A patient's enrollment in the registry program shall only be
460.24 denied if the patient:

460.25 (1) does not have certification from a health care practitioner that the patient has been
460.26 diagnosed with a qualifying medical condition;

460.27 (2) has not signed and returned the disclosure form required under subdivision 3,
460.28 paragraph (c), to the commissioner;

460.29 (3) does not provide the information required;

460.30 (4) has previously been removed from the registry program for violations of section
460.31 152.30 or 152.33; or

460.32 (5) provides false information.

461.1 (b) The commissioner shall give written notice to a patient of the reason for denying
461.2 enrollment in the registry program.

461.3 (c) Denial of enrollment into the registry program is considered a final decision of the
461.4 commissioner and is subject to judicial review under the Administrative Procedure Act
461.5 pursuant to chapter 14.

461.6 (d) A patient's enrollment in the registry program may only be revoked upon the death
461.7 of the patient or if a patient violates a requirement under section 152.30 or 152.33.

461.8 (e) The commissioner shall develop a registry verification to provide to the patient, the
461.9 health care practitioner identified in the patient's application, and to the manufacturer. The
461.10 registry verification shall include:

461.11 (1) the patient's name and date of birth;

461.12 (2) the patient registry number assigned to the patient;

461.13 (3) the patient's qualifying medical condition as provided by the patient's health care
461.14 practitioner in the certification; and

461.15 (4) the name and date of birth of the patient's registered designated caregiver, if any, or
461.16 the name of the patient's parent ~~or~~, legal guardian, or spouse if the parent ~~or~~, legal guardian,
461.17 or spouse will be acting as a caregiver.

461.18 Sec. 11. Minnesota Statutes 2018, section 152.28, subdivision 1, is amended to read:

461.19 **Subdivision 1. Health care practitioner duties.** (a) Prior to a patient's enrollment in
461.20 the registry program, a health care practitioner shall:

461.21 (1) determine, in the health care practitioner's medical judgment, whether a patient suffers
461.22 from a qualifying medical condition, and, if so determined, provide the patient with a
461.23 certification of that diagnosis;

461.24 (2) determine whether a patient is developmentally or physically disabled and, as a result
461.25 of that disability, the patient is unable to self-administer medication or acquire medical
461.26 cannabis from a distribution facility, and, if so determined, include that determination on
461.27 the patient's certification of diagnosis;

461.28 (3) advise patients, registered designated caregivers, and parents ~~or~~, legal guardians, or
461.29 spouses who are acting as caregivers of the existence of any nonprofit patient support groups
461.30 or organizations;

462.1 (4) provide explanatory information from the commissioner to patients with qualifying
462.2 medical conditions, including disclosure to all patients about the experimental nature of
462.3 therapeutic use of medical cannabis; the possible risks, benefits, and side effects of the
462.4 proposed treatment; the application and other materials from the commissioner; and provide
462.5 patients with the Tennesseen warning as required by section 13.04, subdivision 2; and

462.6 (5) agree to continue treatment of the patient's qualifying medical condition and report
462.7 medical findings to the commissioner.

462.8 (b) Upon notification from the commissioner of the patient's enrollment in the registry
462.9 program, the health care practitioner shall:

462.10 (1) participate in the patient registry reporting system under the guidance and supervision
462.11 of the commissioner;

462.12 (2) report health records of the patient throughout the ongoing treatment of the patient
462.13 to the commissioner in a manner determined by the commissioner and in accordance with
462.14 subdivision 2;

462.15 (3) determine, on a yearly basis, if the patient continues to suffer from a qualifying
462.16 medical condition and, if so, issue the patient a new certification of that diagnosis; and

462.17 (4) otherwise comply with all requirements developed by the commissioner.

462.18 (c) Nothing in this section requires a health care practitioner to participate in the registry
462.19 program.

462.20 Sec. 12. Minnesota Statutes 2018, section 152.29, subdivision 3, is amended to read:

462.21 **Subd. 3. Manufacturer; distribution.** (a) A manufacturer shall require that employees
462.22 licensed as pharmacists pursuant to chapter 151 be the only employees to give final approval
462.23 for the distribution of medical cannabis to a patient.

462.24 (b) A manufacturer may dispense medical cannabis products, whether or not the products
462.25 have been manufactured by the manufacturer, but is not required to dispense medical cannabis
462.26 products.

462.27 (c) Prior to distribution of any medical cannabis, the manufacturer shall:

462.28 (1) verify that the manufacturer has received the registry verification from the
462.29 commissioner for that individual patient;

462.30 (2) verify that the person requesting the distribution of medical cannabis is the patient,
462.31 the patient's registered designated caregiver, or the patient's parent ~~or~~, legal guardian, or

463.1 spouse listed in the registry verification using the procedures described in section 152.11,
463.2 subdivision 2d;

463.3 (3) assign a tracking number to any medical cannabis distributed from the manufacturer;
463.4 (4) ensure that any employee of the manufacturer licensed as a pharmacist pursuant to
463.5 chapter 151 has consulted with the patient to determine the proper dosage for the individual
463.6 patient after reviewing the ranges of chemical compositions of the medical cannabis and
463.7 the ranges of proper dosages reported by the commissioner. For purposes of this clause, a
463.8 consultation may be conducted remotely using a videoconference, so long as the employee
463.9 providing the consultation is able to confirm the identity of the patient, the consultation
463.10 occurs while the patient is at a distribution facility, and the consultation adheres to patient
463.11 privacy requirements that apply to health care services delivered through telemedicine;

463.12 (5) properly package medical cannabis in compliance with the United States Poison
463.13 Prevention Packing Act regarding child-resistant packaging and exemptions for packaging
463.14 for elderly patients, and label distributed medical cannabis with a list of all active ingredients
463.15 and individually identifying information, including:

463.16 (i) the patient's name and date of birth;
463.17 (ii) the name and date of birth of the patient's registered designated caregiver or, if listed
463.18 on the registry verification, the name of the patient's parent ~~or~~, legal guardian, or spouse, if
463.19 applicable;

463.20 (iii) the patient's registry identification number;

463.21 (iv) the chemical composition of the medical cannabis; and

463.22 (v) the dosage; and

463.23 (6) ensure that the medical cannabis distributed contains a maximum of a 30-day supply
463.24 of the dosage determined for that patient.

463.25 (d) A manufacturer shall require any employee of the manufacturer who is transporting
463.26 medical cannabis or medical cannabis products to a distribution facility to carry identification
463.27 showing that the person is an employee of the manufacturer.

463.28 Sec. 13. Minnesota Statutes 2018, section 152.32, subdivision 2, is amended to read:

463.29 **Subd. 2. Criminal and civil protections.** (a) Subject to section 152.23, the following
463.30 are not violations under this chapter:

464.1 (1) use or possession of medical cannabis or medical cannabis products by a patient
464.2 enrolled in the registry program, or possession by a registered designated caregiver or the
464.3 parent ~~or, legal guardian, or spouse~~ of a patient if the parent ~~or, legal guardian, or spouse~~
464.4 is listed on the registry verification;

464.5 (2) possession, dosage determination, or sale of medical cannabis or medical cannabis
464.6 products by a medical cannabis manufacturer, employees of a manufacturer, a laboratory
464.7 conducting testing on medical cannabis, or employees of the laboratory; and

464.8 (3) possession of medical cannabis or medical cannabis products by any person while
464.9 carrying out the duties required under sections 152.22 to 152.37.

464.10 (b) Medical cannabis obtained and distributed pursuant to sections 152.22 to 152.37 and
464.11 associated property is not subject to forfeiture under sections 609.531 to 609.5316.

464.12 (c) The commissioner, the commissioner's staff, the commissioner's agents or contractors,
464.13 and any health care practitioner are not subject to any civil or disciplinary penalties by the
464.14 Board of Medical Practice, the Board of Nursing, or by any business, occupational, or
464.15 professional licensing board or entity, solely for the participation in the registry program
464.16 under sections 152.22 to 152.37. A pharmacist licensed under chapter 151 is not subject to
464.17 any civil or disciplinary penalties by the Board of Pharmacy when acting in accordance
464.18 with the provisions of sections 152.22 to 152.37. Nothing in this section affects a professional
464.19 licensing board from taking action in response to violations of any other section of law.

464.20 (d) Notwithstanding any law to the contrary, the commissioner, the governor of
464.21 Minnesota, or an employee of any state agency may not be held civilly or criminally liable
464.22 for any injury, loss of property, personal injury, or death caused by any act or omission
464.23 while acting within the scope of office or employment under sections 152.22 to 152.37.

464.24 (e) Federal, state, and local law enforcement authorities are prohibited from accessing
464.25 the patient registry under sections 152.22 to 152.37 except when acting pursuant to a valid
464.26 search warrant.

464.27 (f) Notwithstanding any law to the contrary, neither the commissioner nor a public
464.28 employee may release data or information about an individual contained in any report,
464.29 document, or registry created under sections 152.22 to 152.37 or any information obtained
464.30 about a patient participating in the program, except as provided in sections 152.22 to 152.37.

464.31 (g) No information contained in a report, document, or registry or obtained from a patient
464.32 under sections 152.22 to 152.37 may be admitted as evidence in a criminal proceeding

465.1 unless independently obtained or in connection with a proceeding involving a violation of
465.2 sections 152.22 to 152.37.

465.3 (h) Notwithstanding section 13.09, any person who violates paragraph (e) or (f) is guilty
465.4 of a gross misdemeanor.

465.5 (i) An attorney may not be subject to disciplinary action by the Minnesota Supreme
465.6 Court or professional responsibility board for providing legal assistance to prospective or
465.7 registered manufacturers or others related to activity that is no longer subject to criminal
465.8 penalties under state law pursuant to sections 152.22 to 152.37.

465.9 (j) Possession of a registry verification or application for enrollment in the program by
465.10 a person entitled to possess or apply for enrollment in the registry program does not constitute
465.11 probable cause or reasonable suspicion, nor shall it be used to support a search of the person
465.12 or property of the person possessing or applying for the registry verification, or otherwise
465.13 subject the person or property of the person to inspection by any governmental agency.

465.14 Sec. 14. Minnesota Statutes 2018, section 152.33, subdivision 1, is amended to read:

465.15 **Subdivision 1. Intentional diversion; criminal penalty.** In addition to any other
465.16 applicable penalty in law, a manufacturer or an agent of a manufacturer who intentionally
465.17 transfers medical cannabis to a person other than a patient, a registered designated caregiver
465.18 or, if listed on the registry verification, a parent ~~or~~, legal guardian, or spouse of a patient is
465.19 guilty of a felony punishable by imprisonment for not more than two years or by payment
465.20 of a fine of not more than \$3,000, or both. A person convicted under this subdivision may
465.21 not continue to be affiliated with the manufacturer and is disqualified from further
465.22 participation under sections 152.22 to 152.37.

465.23 Sec. 15. Minnesota Statutes 2018, section 152.33, subdivision 2, is amended to read:

465.24 **Subd. 2. Diversion by patient, registered designated caregiver, ~~or~~ parent, legal
465.25 guardian, or patient's spouse; criminal penalty.** In addition to any other applicable penalty
465.26 in law, a patient, registered designated caregiver or, if listed on the registry verification, a
465.27 parent ~~or~~, legal guardian, or spouse of a patient who intentionally sells or otherwise transfers
465.28 medical cannabis to a person other than a patient, designated registered caregiver or, if listed
465.29 on the registry verification, a parent ~~or~~, legal guardian, or spouse of a patient is guilty of a
465.30 felony punishable by imprisonment for not more than two years or by payment of a fine of
465.31 not more than \$3,000, or both.

466.1 Sec. 16. Minnesota Statutes 2018, section 214.25, subdivision 2, is amended to read:

466.2 Subd. 2. **Commissioner of health data.** ~~(a)~~ All data collected or maintained as part of
466.3 the commissioner of health's duties under Minnesota Statutes 2018, sections 214.19, 214.23,
466.4 and 214.24₂, shall be classified as investigative data under section 13.39, except that inactive
466.5 investigative data shall be classified as private data under section 13.02, subdivision 12, or
466.6 nonpublic data under section 13.02, subdivision 9, in the case of data not on individuals.

466.7 ~~(b) Notwithstanding section 13.05, subdivision 9, data addressed in this subdivision
466.8 shall not be disclosed except as provided in this subdivision or section 13.04; except that
466.9 the commissioner may disclose to the boards under section 214.23.~~

466.10 ~~(c) The commissioner may disclose data addressed under this subdivision as necessary:
466.11 to identify, establish, implement, and enforce a monitoring plan; to investigate a regulated
466.12 person; to alert persons who may be threatened by illness as evidenced by epidemiologic
466.13 data; to control or prevent the spread of HIV, HBV, or HCV disease; or to diminish an
466.14 imminent threat to the public health.~~

466.15 **EFFECTIVE DATE.** This section is effective on January 1, 2020, and no new cases
466.16 shall be investigated under this subdivision after June 1, 2019.

466.17 Sec. 17. **REVISOR INSTRUCTION.**

466.18 The revisor of statutes shall correct any internal cross-references to sections 214.17 to
466.19 214.25 that occur as a result of the repealed language and may make changes necessary to
466.20 correct punctuation, grammar, or structure of the remaining text and preserve its meaning.

466.21 Sec. 18. **REPEALER.**

466.22 Minnesota Statutes 2018, sections 214.17; 214.18; 214.19; 214.20; 214.21; 214.22;
466.23 214.23; and 214.24, are repealed on January 1, 2020, and no new cases shall be investigated
466.24 under these sections after June 1, 2019.

466.25 ARTICLE 13

466.26 ADULT PROTECTION

466.27 Section 1. **[256M.42] ADULT PROTECTION GRANT ALLOCATION.**

466.28 Subdivision 1. **Formula.** (a) The commissioner shall allocate state money appropriated
466.29 under this section to each county board and tribal government approved by the commissioner
466.30 to assume county agency duties for adult protective services or as a lead investigative agency

467.1 under section 626.557 on an annual basis in an amount determined according to the following
467.2 formula:

467.3 (1) 25 percent must be allocated on the basis of the number of reports of suspected
467.4 vulnerable adult maltreatment under sections 626.557 and 626.5572, when the county or
467.5 tribe is responsible as determined by the most recent data of the commissioner; and

467.6 (2) 75 percent must be allocated on the basis of the number of screened-in reports for
467.7 adult protective services or vulnerable adult maltreatment investigations under sections
467.8 626.557 and 626.5572, when the county or tribe is responsible as determined by the most
467.9 recent data of the commissioner.

467.10 (b) The commissioner is precluded from changing the formula under this subdivision
467.11 or recommending a change to the legislature without public review and input.

467.12 Subd. 2. **Payment.** The commissioner shall make allocations under subdivision 1 to
467.13 each county board or tribal government each year on or before July 10.

467.14 Subd. 3. **Prohibition on supplanting existing money.** Money received under this section
467.15 must be used for staffing for protection of vulnerable adults or to expand adult protective
467.16 services. Money must not be used to supplant current county or tribe expenditures for these
467.17 purposes.

467.18 **EFFECTIVE DATE.** This section is effective July 1, 2020.

ARTICLE 14

ASSISTED LIVING LICENSURE

467.21 Section 1. **[144I.01] DEFINITIONS.**

467.22 Subdivision 1. **Applicability.** For the purposes of this chapter, the definitions in this
467.23 section have the meanings given.

467.24 Subd. 2. **Activities of daily living.** "Activities of daily living" has the meaning given in
467.25 section 256B.0659, subdivision 1, paragraph (b).

467.26 Subd. 3. **Adult.** "Adult" means a natural person who has attained the age of 18 years.

467.27 Subd. 4. **Assisted living.** "Assisted living" means a licensed establishment that: (1)
467.28 provides sleeping accommodations to one or more adults; and (2) provides home care
467.29 services. For purposes of this chapter, assisted living does not include:

467.30 (i) emergency shelter, transitional housing, or any other residential units serving
467.31 exclusively or primarily homeless individuals, as defined under section 116L.361;

468.1 (ii) a housing with services establishment registered under section 144D.025;

468.2 (iii) a nursing home licensed under chapter 144A;

468.3 (iv) a hospital, certified boarding care, or supervised living facility licensed under sections

468.4 144.50 to 144.56;

468.5 (v) a lodging establishment licensed under chapter 157 and Minnesota Rules, parts

468.6 9520.0500 to 9520.0670, or under chapter 245D or 245G, except lodging establishments

468.7 that provide dementia care services;

468.8 (vi) a lodging establishment serving as a shelter for individuals fleeing domestic violence;

468.9 (vii) services and residential settings licensed under chapter 245A, including adult foster

468.10 care and services and settings governed under the standards in chapter 245D;

468.11 (viii) private homes where the residents own or rent the home and control all aspects of

468.12 the property and building;

468.13 (ix) a duly organized condominium, cooperative, and common interest community, or

468.14 owners' association of the condominium, cooperative, and common interest community

468.15 where at least 80 percent of the units that comprise the condominium, cooperative, or

468.16 common interest community are occupied by individuals who are the owners, members, or

468.17 shareholders of the units;

468.18 (x) temporary family health care dwellings as defined in sections 394.307 and 462.3593;

468.19 (xi) settings offering services conducted by and for the adherents of any recognized

468.20 church or religious denomination for its members through spiritual means or by prayer for

468.21 healing; or

468.22 (xii) housing financed pursuant to sections 462A.37 to 462A.375, units financed with

468.23 low-income housing tax credits pursuant to United States Code, title 26, section 42, and

468.24 units financed by the Minnesota Housing Finance Agency that are intended to serve

468.25 individuals with disabilities or individuals who are homeless.

468.26 **Subd. 5. Assisted living resident or resident.** "Assisted living resident" or "resident"

468.27 means a person who resides in a licensed assisted living that is subject to the requirements

468.28 of this chapter.

468.29 **Subd. 6. Commissioner.** "Commissioner" means the commissioner of health.

468.30 **Subd. 7. Controlling person.** (a) "Controlling person" means any public body,

468.31 governmental agency, business entity, officer, nursing home administrator, assisted living

468.32 administrator, or director whose responsibilities include the direction of the management

469.1 or policies of an assisted living. Controlling person also means any person who, directly or
469.2 indirectly, beneficially owns any interest in:

469.3 (1) any corporation, partnership, limited liability company, real estate investment trust
469.4 (REIT), or other business association that is a controlling person;

469.5 (2) the land on which the assisted living is located;

469.6 (3) the structure in which an assisted living is located;

469.7 (4) any mortgage, contract for deed, or other obligation secured in whole or in part by
469.8 the land or structure comprising the assisted living; or

469.9 (5) any lease or sublease of the land, structure, or facilities comprising the assisted living.

469.10 (b) For purposes of this chapter, controlling person does not include:

469.11 (1) a bank, savings bank, trust company, savings association, credit union, industrial
469.12 loan and thrift company, investment banking firm, or insurance company unless the entity
469.13 directly or through a subsidiary operates a nursing home;

469.14 (2) an individual state official or employee, or a member or employee of the governing
469.15 body of a political subdivision of the state that operates one or more assisted livings, unless
469.16 the individual is also an officer or director of a nursing home, receives any remuneration
469.17 from an assisted living, or owns any of the beneficial interests not excluded in this
469.18 subdivision;

469.19 (3) a natural person who is a member of a tax-exempt organization under section 290.05,
469.20 subdivision 2, unless the individual is also an officer or director of an assisted living, or
469.21 owns any of the beneficial interests not excluded in this subdivision; and

469.22 (4) a natural person who owns less than five percent of the outstanding common shares
469.23 of a corporation:

469.24 (i) whose securities are exempt by virtue of section 80A.45, clause (6); or

469.25 (ii) whose transactions are exempt by virtue of section 80A.46, clause (7).

469.26 Subd. 8. **Home care services.** "Home care services" means services as defined in section
469.27 144A.43, subdivision 3, and comprehensive PLUS services as defined in section 144I.02.

469.28 Subd. 9. **Licensee.** "Licensee" means a person or entity to whom the commissioner
469.29 issues an assisted living license and is a controlling person.

470.1 Subd. 10. Management agreement. "Management agreement" means a written, executed
470.2 agreement between a licensee and manager regarding the provision of certain services on
470.3 behalf of the licensee.

470.4 Subd. 11. Manager or operator. "Manager" or "operator" means an entity or person
470.5 possessing the right to exercise operational or management control over, or directly or
470.6 indirectly conduct, the day-to-day operation of an establishment.

470.7 Subd. 12. New construction. "New construction" means a new building, renovation,
470.8 modification, reconstruction, physical changes altering the use of occupancy, or an addition
470.9 to a building.

470.10 Subd. 13. Person-centered planning and service delivery. "Person-centered planning
470.11 and service delivery" means services as defined in section 245D.07, subdivision 1a, paragraph
470.12 (b).

470.13 Subd. 14. Supportive services. "Supportive services" means services that may be offered
470.14 or provided by an assisted living provider as part of the assisted living license and means
470.15 help with personal laundry, handling or assisting with personal funds of residents, or
470.16 arranging for medical services, health-related services, social services, housekeeping, central
470.17 dining, recreation, or transportation. Arranging for services does not include making referrals,
470.18 or contacting a service provider in an emergency.

470.19 Sec. 2. **[144I.02] ASSISTED LIVING LICENSE; APPLICABLE LAWS;**
470.20 **APPLICATION AND RENEWAL.**

470.21 Subdivision 1. License required. (a) Beginning July 1, 2021, no newly formed entity
470.22 may open, operate, maintain, advertise, or hold itself out as an assisted living in Minnesota
470.23 unless it is licensed under this chapter.

470.24 (b) Entities that operated as a housing with services establishment under chapter 144D
470.25 with an arranged home care provider licensed under section 144A.471, must convert to the
470.26 assisted living license beginning July 1, 2021, in compliance with the commissioner's process
470.27 so that all assisted living settings are licensed by July 1, 2022.

470.28 (c) After July 1, 2022, it shall be a criminal gross misdemeanor to open, operate, maintain,
470.29 advertise, or hold oneself out as an assisted living without a license pursuant to section
470.30 609.0341, subdivision 1.

470.31 (d) No person or business shall provide both housing combined with health services
470.32 without first obtaining an assisted living license from the commissioner.

471.1 Subd. 2. Licensure levels. (a) The levels in this subdivision are established for assisted
471.2 living licensure:

471.3 (b) Basic License - For assisted living facilities that provide basic home care services
471.4 as defined in section 144A.471, subdivision 6. In addition to the services defined in section
471.5 144A.471, basic license includes:

471.6 (1) assistance with activities of daily living such as bathing, dressing, grooming, eating,
471.7 transfers, mobility, positioning, and toileting; and assistance with instrumental activities of
471.8 daily living such as meal planning and preparation, paying bills, shopping, performing
471.9 household tasks, and communication by telephone or other media; and

471.10 (2) assisting with self-administered medications.

471.11 (c) Comprehensive License - For assisted living facilities that provide services as defined
471.12 in section 144A.471, subdivision 7.

471.13 (d) Comprehensive PLUS License - For assisted living facilities that provide both
471.14 comprehensive home care services and services in a secure or separate dementia care unit
471.15 or wing and complies with requirements in sections 144I.13 to 144I.18.

471.16 Subd. 3. Licensed home care provider requirements applicable to assisted living
471.17 licensing. The following sections apply to assisted living licensees in this chapter:

471.18 (1) section 144A.43, subdivisions 1d, 1e, 2a to 2e, 3, 3a, 7, 10 to 16, 18 to 25, 27 to 33,
471.19 35 to 38;

471.20 (2) section 144A.44, Home Care Bill of Rights, and section 144A.441, assisted living
471.21 bill of rights addendum;

471.22 (3) section 144A.45, subdivision 6, relating to tuberculosis prevention and control;

471.23 (4) section 144A.474, subdivisions 4 to 8, 11, and 12, relating to surveys, fines, and
471.24 reconsiderations;

471.25 (5) section 144A.475, relating to enforcement;

471.26 (6) section 144A.476, relating to background studies;

471.27 (7) section 144A.477, relating to medicare certified home health agencies;

471.28 (8) section 144A.478, relating to innovation variance;

471.29 (9) section 144A.479, relating to quality management, handling resident's finances and
471.30 property, reporting maltreatment, and employee records;

471.31 (10) section 144A.4791, relating to providers' responsibilities to clients;

- 472.1 (11) section 144A.4792, relating to medication management;
- 472.2 (12) section 144A.4793, relating to treatment and therapy management services;
- 472.3 (13) section 144A.4794, relating to client record requirements;
- 472.4 (14) section 144A.4795, relating to home care provider responsibilities regarding their
- 472.5 staff;
- 472.6 (15) section 144A.4796, relating to orientation and annual training requirements;
- 472.7 (16) section 144A.4797, relating to provision of services;
- 472.8 (17) section 144A.4798, relating to employee health status;
- 472.9 (18) section 144A.4799, relating to Department of Health licensed home care provider
- 472.10 advisory council;
- 472.11 (19) section 144A.484, relating to integrated licensure and home and community-based
- 472.12 services designation;
- 472.13 (20) sections 144D.065, 144D.066, and 144D.10, relating to dementia care training,
- 472.14 manager training, and commissioner enforcement;
- 472.15 (21) section 144D.07, relating to prohibition of restraints;
- 472.16 (22) section 144D.08, relating to uniform consumer information guide;
- 472.17 (23) section 144D.11, relating to emergency planning; and
- 472.18 (24) section 144D.051, subdivisions 3 to 6.
- 472.19 Subd. 4. **Provisional license.** (a) Beginning July 1, 2021, for new assisted living license
- 472.20 applicants, the commissioner shall issue a provisional license to each of the licensure levels
- 472.21 specified in subdivision 2 which is effective for up to one year from the license effective
- 472.22 date, except that a provisional license may be extended according to paragraph (d).
- 472.23 (b) During the provisional license period, the commissioner shall survey the provisional
- 472.24 licensee after the commissioner is notified or has evidence that the provisional licensee has
- 472.25 residents and is providing services.
- 472.26 (c) Within two days of beginning to provide services, the provisional licensee must
- 472.27 provide notice to the commissioner that it is serving residents by sending an e-mail to the
- 472.28 e-mail address provided by the commissioner. If the provisional licensee does not provide
- 472.29 assisted living services during the provisional license year period, then the provisional
- 472.30 license expires at the end of the period and the applicant must reapply for the provisional
- 472.31 assisted living license.

473.1 (d) If the provisional licensee notifies the commissioner that the licensee has residents
473.2 within 45 days prior to the provisional license expiration, the commissioner may extend the
473.3 provisional license for up to 60 days in order to allow the commissioner to complete the
473.4 on-site survey required under this section and follow-up survey visits.

473.5 (e) If the provisional licensee is in substantial compliance with the survey, the
473.6 commissioner shall issue an assisted living license. If the provisional licensee is not in
473.7 substantial compliance with the survey, the commissioner shall either: (1) not issue the
473.8 assisted living license and terminate the provisional license; or (2) extend the provisional
473.9 license for a period not to exceed 90 days and apply conditions, to the extension of the
473.10 provisional license. If the provisional licensee is not in substantial compliance with the
473.11 survey within the time period of the extension or if the provisional licensee does not satisfy
473.12 the license conditions, the commissioner may deny the license.

473.13 (f) If a provisional licensee whose assisted living license has been denied or extended
473.14 with conditions disagrees with the conclusions of the commissioner, then the provisional
473.15 licensee may request a reconsideration by the commissioner or commissioner's designee.
473.16 The reconsideration request process must be conducted internally by the commissioner or
473.17 designee, and chapter 14 does not apply.

473.18 (g) The provisional licensee requesting the reconsideration must make the request in
473.19 writing and must list and describe the reasons why the provisional licensee disagrees with
473.20 the decision to deny the assisted living license or the decision to extend the provisional
473.21 license with conditions.

473.22 (h) The reconsideration request and supporting documentation must be received by the
473.23 commissioner within 15 calendar days after the date the provisional license receives the
473.24 denial or provisional license with conditions.

473.25 (i) A provisional licensee whose license is denied is permitted to continue operating as
473.26 an assisted living during the period of time when:

- 473.27 (1) a reconsideration is in process;
- 473.28 (2) an extension of the provisional license and terms associated with it is in active
473.29 negotiation between the commissioner and the licensee and the commissioner confirms the
473.30 negotiation is active; or
- 473.31 (3) a transfer of residents to a new assisted living establishment is underway and not all
473.32 the residents have relocated.

- 474.1 Subd. 5. License applications. (a) Each application for an assisted living license,
474.2 including a provisional license, must include information sufficient to show that the applicant
474.3 meets the requirements of licensure, including:
- 474.4 (1) the business name and legal entity name of the operating entity, street address and
474.5 mailing address of the assisted living; the names, e-mail addresses, telephone numbers, and
474.6 mailing addresses of the owner or owners, direct and indirect, and managerial officials of
474.7 the assisted living; and if the owner or owners are not natural persons, identification of the
474.8 type of business entity of the owner or owners and the names, e-mail addresses, telephone
474.9 numbers of the officers and members of the governing body, or comparable persons for
474.10 partnerships, limited liability corporations, or other types of business organizations of the
474.11 owner or owners;
- 474.12 (2) the name and mailing address of the managing agent, whether through management
474.13 agreement or lease agreement, of the establishment, if different from the owner or owners,
474.14 and the name of the on-site administrator;
- 474.15 (3) the license fee in the amount specified in subdivision 11;
- 474.16 (4) the e-mail address, physical address, mailing address, and telephone number of the
474.17 principal administrative office;
- 474.18 (5) any state or federal court judgments, bankruptcy filings, tax liens, administrative
474.19 actions, or investigations by any state or federal government agency against the applicant
474.20 or the controlling person, or all persons involved in the management, operation, or control
474.21 of the assisted living occurring within the last ten years;
- 474.22 (6) documentation of compliance with the background study requirements of section
474.23 144A.476 for the owner, controlling person, and all persons involved in the management,
474.24 operation, or control of the assisted living establishment. Each application for a new license
474.25 must include documentation for the applicant and for each individual with five percent or
474.26 more direct or indirect ownership in the applicant;
- 474.27 (7) documentation of a background study as required by section 144.057 for any
474.28 individual seeking employment, paid or volunteer, with the assisted living establishment;
- 474.29 (8) evidence of workers' compensation coverage as required by sections 176.181 and
474.30 176.182;
- 474.31 (9) documentation of liability coverage, if the provider has it;

- 475.1 (10) documentation that identifies the manager or operator who is in charge of day-to-day
475.2 operations and attestation that the person has reviewed and understands the assisted living
475.3 provider regulations;
- 475.4 (11) documentation that the applicant has designated one or more owners, controlling
475.5 persons, or employees as an agent or agents, which shall not affect the legal responsibility
475.6 of any other owner or controlling person under this chapter;
- 475.7 (12) the signature of the controlling person on behalf of the assisted living applicant;
- 475.8 (13) documentation of whether the assisted living health or supportive services are
475.9 included in the monthly base rate to be paid by the resident;
- 475.10 (14) attestation that the applicant will comply with the prohibitions against deceptive
475.11 marketing and business practices required by section 144I.21;
- 475.12 (15) documentation showing that the applicant has at least one year's worth of capital
475.13 or revenue sufficient to operate the assisted living;
- 475.14 (16) verification that the applicant has the following policies and procedures in place so
475.15 that if a license is issued, the applicant will implement the policies and procedures and keep
475.16 them current:
- 475.17 (i) requirements in section 626.556, reporting of maltreatment of minors; and section
475.18 626.557, reporting of maltreatment of vulnerable adults;
- 475.19 (ii) conducting and handling background studies on employees;
- 475.20 (iii) orientation, training, and competency evaluations of assisted living staff, and a
475.21 process for evaluating staff performance;
- 475.22 (iv) handling complaints from residents, family members, or resident representatives
475.23 regarding staff or services provided by staff, the building, physical plant, or environment;
- 475.24 (v) conducting initial evaluation of residents' needs, move-in assessments, and the
475.25 providers' ability to provide those services, including the services the residents request;
- 475.26 (vi) conducting initial and ongoing resident evaluations and assessments from a
475.27 person-centered perspective, and how changes in a resident's condition are identified,
475.28 managed, and communicated to staff and other health care providers as appropriate;
- 475.29 (vii) orientation to and implementation of the home care client bill of rights in sections
475.30 144A.44 and 144A.4791 with assisted living addendum;
- 475.31 (viii) infection control practices;

- 476.1 (ix) reminders for medications, treatments, or exercises, if provided as services;
- 476.2 (x) conducting appropriate screenings, or documentation of prior screenings, to show
- 476.3 that staff are free of tuberculosis, consistent with current United States Centers for Disease
- 476.4 Control and Prevention standards;
- 476.5 (xi) procedures about ensuring resident rights to information about and appeals from
- 476.6 residency contracts and services terminations; and
- 476.7 (xii) policies and procedures for updating the staffing plan that ensures resident care
- 476.8 needs are met, including a description of what factors are necessary to meet resident care
- 476.9 needs and procedures for quality control reviews assessing the effectiveness of the staffing
- 476.10 plans;
- 476.11 (17) for comprehensive and comprehensive PLUS applicants, in addition to the
- 476.12 requirements in clause (16), the applicant must provide verification that the applicant has
- 476.13 policies and procedures in place so that if a license is issued, the applicant will implement
- 476.14 the policies and procedures and keep them current as required by section 144A.472,
- 476.15 subdivision 2;
- 476.16 (18) identification of financial interest of any individual, including stockholders who
- 476.17 have an incident of ownership in the applicant representing an interest of five percent or
- 476.18 more. For the purposes of this chapter, an individual with a five percent or more direct or
- 476.19 indirect ownership is presumed to have an effect on the operation of the facility with respect
- 476.20 to factors affecting the care or training provided;
- 476.21 (19) identification of any individual with a five percent or more direct or indirect
- 476.22 ownership that has ever been convicted of a crime associated with the operation of a
- 476.23 long-term care, community-based, or health care facility or agency under federal law or the
- 476.24 laws of any state;
- 476.25 (20) identification of all states where the applicant, or individual having a five percent
- 476.26 or more ownership, currently or previously has been licensed as owner or operator of a
- 476.27 long-term care, community-based, or health care facility or agency where its license or
- 476.28 federal certification has been denied, suspended, restricted, conditioned, or revoked under
- 476.29 a private or state-controlled receivership, or where these same actions are pending under
- 476.30 the laws of any state or federal authority; and
- 476.31 (21) any other information required by the commissioner.

477.1 (b) If the owner of the facility is a different entity from the operator or management
477.2 company of the facility, both the operator and the owner must complete an application for
477.3 licensure for review under the same application process. Only one license fee is required.

477.4 **Subd. 6. Transfers prohibited; changes in ownership.** Any assisted living license
477.5 issued by the commissioner may not be transferred to another party. Before acquiring
477.6 ownership of an assisted living provider business, a prospective applicant must apply for a
477.7 new license. A change of ownership is a transfer of operational control to a different business
477.8 entity and includes:

477.9 (1) transfer of the business to a different or new corporation;
477.10 (2) in the case of a partnership, the dissolution or termination of the partnership under
477.11 chapter 323A, with the business continuing by a successor partnership or other entity;
477.12 (3) relinquishment of control of the provider to another party, including to a contract
477.13 management firm that is not under the control of the owner of the business's assets;
477.14 (4) transfer of the business by a sole proprietor to another party or entity; or
477.15 (5) in the case of a privately held corporation, the change in ownership or control of 50
477.16 percent or more of the outstanding voting stock.

477.17 **Subd. 7. License renewal.** Except as provided in section 144A.475, a license that is not
477.18 a provisional license may be renewed for a period of one year if the licensee satisfies the
477.19 following:

477.20 (1) submits an application for renewal in the format provided by the commissioner at
477.21 least 60 days before expiration of the license;
477.22 (2) submits the renewal fee of \$8,000;
477.23 (3) submits the late fee pursuant to subdivision 11 if the renewal application is received
477.24 less than 30 days before the expiration date of the license;
477.25 (4) complies with sections 144A.43 to 144A.4798 and the provisions of this chapter;
477.26 (5) provides information sufficient to show that the applicant meets the requirements of
477.27 licensure, including items required under subdivision 5;
477.28 (6) provides verification that all policies under subdivision 5 are current;
477.29 (7) updates the information required by subdivision 5, paragraph (a), clause (18); and
477.30 (8) provides any other information deemed necessary by the commissioner.

478.1 **Subd. 8. Notification of changes of information.** The provisional licensee or licensee
478.2 shall notify the commissioner in writing prior to any financial or contractual change and
478.3 within 60 calendar days after any change in the information required in subdivision 5.

478.4 **Subd. 9. Actions on licenses.** (a) The commissioner shall consider an applicant's
478.5 performance history, in Minnesota and in other states, including repeat violations or rule
478.6 violations, before issuing a provisional license, license, or renewal license.

478.7 (b) An applicant must not have a history within the last five years in Minnesota or in
478.8 any other state of a license or certification involuntarily suspended or voluntarily terminated
478.9 during any enforcement process in a facility that provides care to children, the elderly or ill
478.10 individuals, or individuals with disabilities.

478.11 (c) Failure to provide accurate information or demonstrate required performance history
478.12 may result in the denial of a license.

478.13 (d) The commissioner may deny, revoke, suspend, restrict, or refuse to renew the license
478.14 or impose conditions if:

478.15 (1) the applicant fails to provide complete and accurate information on the application
478.16 and the commissioner concludes that the missing or corrected information is needed to
478.17 determine if a license shall be granted;

478.18 (2) the assisted living, knowingly or with reason to know, made a false statement of a
478.19 material fact in an application for the license or any data attached to the application, or in
478.20 any matter under investigation by the department;

478.21 (3) the assisted living refused to allow representatives or agents of the department to
478.22 inspect its books, records, and files, or any portion of the premises;

478.23 (4) willfully prevented, interfered with, or attempted to impede in any way: (i) the work
478.24 of any authorized representative of the department, the ombudsman for long-term care or
478.25 the ombudsman for mental health and developmental disabilities; or (ii) the duties of the
478.26 commissioner, local law enforcement, city or county attorneys, adult protection, county
478.27 case managers, or other local government personnel;

478.28 (5) the assisted living has been the subject of a substantiated maltreatment violation,
478.29 had level 2 widespread determination on a survey, had a level 3 or level 4 violation as
478.30 specified in section 144A.474, subdivision 11, or the assisted living engaged in conduct
478.31 that was detrimental to the health, welfare, or safety of the resident;

479.1 (6) the assisted living has a history of noncompliance with federal or state regulations
479.2 in providing care or services. The factors the commissioner may consider include but are
479.3 not limited to the gravity and frequency of the noncompliance; and

479.4 (7) the assisted living engages in conduct in section 144A.475, subdivision 1; or

479.5 (8) the assisted living violates any requirement in this chapter.

479.6 (e) For all new licensees after a change in ownership, the commissioner shall complete
479.7 a survey within six months after the new license is issued.

479.8 Subd. 10. Fees. (a) An initial applicant seeking assisted living licensure must submit
479.9 the following application fee to the commissioner along with a completed application:

479.10 (1) for a basic assisted living facility providing basic home care services, \$5,500;

479.11 (2) for a comprehensive assisted living facility providing comprehensive home care
479.12 services, \$9,500; and

479.13 (3) for a comprehensive PLUS assisted living facility providing comprehensive home
479.14 care services and dementia care, \$14,250.

479.15 (b) An assisted living filing a change of ownership as required under subdivision 6 must
479.16 submit the following application fee to the commissioner, along with the documentation
479.17 required for the change of ownership:

479.18 (1) for a basic assisted living, \$5,500;

479.19 (2) for a comprehensive assisted living, \$9,500; or

479.20 (3) for a comprehensive PLUS assisted living, \$10,000.

479.21 (c) The penalty for late submission of the renewal application before expiration of the
479.22 license is \$200. The penalty for practicing after expiration of the assisted living license and
479.23 before a renewal license is issued is \$250 per each day after expiration of the license until
479.24 the renewal license issuance date. The assisted living is still subject to the criminal gross
479.25 misdemeanor penalties for operating after license expiration.

479.26 (d) Fees collected under this section shall be deposited in the state treasury and credited
479.27 to the state government special revenue fund. All fees are nonrefundable.

479.28 (e) Fines collected under this subdivision shall be deposited in a dedicated special revenue
479.29 account. On an annual basis, the balance in the special revenue account shall be appropriated
479.30 to the commissioner to implement the recommendations of the advisory council established
479.31 in section 144A.4799.

480.1 Sec. 3. **[144I.03] ASSISTED LIVING LICENSES PRACTICE REQUIREMENTS.**

480.2 **Subdivision 1. Requirements.** All licensed assisted living shall:

480.3 (1) distribute to residents, families, and resident representatives and enforce the home
480.4 care bill of rights requirements in section 144A.44 and the assisted living bill of rights in
480.5 section 144A.441 except that the advance notice period for termination of housing and
480.6 services shall be no less than 30 days;

480.7 (2) provide health-related services in a manner that complies with applicable home care
480.8 licensure requirements in chapter 144A and the Nurse Practice Act in sections 148.171 to
480.9 148.285;

480.10 (3) utilize person-centered planning and service delivery process as defined in section
480.11 245D.07;

480.12 (4) have and maintain a system for delegation of health care activities to unlicensed
480.13 personnel by a registered nurse, including supervision and evaluation of the delegated
480.14 activities as required by applicable home care licensure requirements in chapter 144A and
480.15 the Nurse Practice Act in sections 148.171 to 148.285;

480.16 (5) have, maintain, and document a system to visually check on each assisted living
480.17 resident a minimum of once daily or more than once daily depending on the person-centered
480.18 care plan;

480.19 (6) provide a means for assisted living residents to request assistance for health and
480.20 safety needs 24 hours per day, seven days per week;

480.21 (7) have an on-site registered nurse or licensed practical nurse available 24 hours per
480.22 day, seven days per week, who is responsible for responding to the requests of assisted
480.23 living residents for assistance with health or safety needs, who shall be:

480.24 (i) awake;

480.25 (ii) located in the same building, in an attached building, or on a contiguous campus
480.26 with the housing with services establishment in order to respond within a reasonable amount
480.27 of time;

480.28 (iii) capable of communicating with assisted living residents; and

480.29 (iv) capable of providing either the assistance required or, if the person on-site is a
480.30 licensed practical nurse, have access to an on-call registered nurse;

480.31 (8) offer to provide or make available at least the following supportive services to assisted
480.32 living residents:

481.1 (i) at least two daily nutritious meals with snacks available seven days per week,
481.2 according to the recommended dietary allowances in the United States Department of
481.3 Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The
481.4 following apply:

481.5 (A) modified special diets that are appropriate to residents' needs and choices;
481.6 (B) menus prepared at least one week in advance, and made available to all residents.
481.7 The facility must encourage residents' involvement in menu planning. Meal substitutions
481.8 must be of similar nutritional value if a resident refuses a food that is served. Residents
481.9 must be informed in advance of menu changes;
481.10 (C) food must be prepared and served according to the Minnesota Food Code, Minnesota
481.11 Rules, chapter 4626; and

481.12 (D) the assisted living cannot require a resident to include and pay for meals in their
481.13 residency contract;

481.14 (ii) weekly housekeeping;
481.15 (iii) weekly laundry service;
481.16 (iv) upon the request of the resident, provide direct or reasonable assistance with arranging
481.17 for transportation to medical and social services appointments, shopping, and other recreation,
481.18 and provide the name of or other identifying information about the person or persons
481.19 responsible for providing this assistance;

481.20 (v) upon the request of the resident, provide reasonable assistance with accessing
481.21 community resources and social services available in the community, and provide the name
481.22 of or other identifying information about the person or persons responsible for providing
481.23 this assistance; and

481.24 (vi) have a daily program of social and recreational activities that are based upon
481.25 individual and group interests, physical, mental, and psychosocial needs, and that creates
481.26 opportunities for active participation in the community at large;

481.27 (9) make available to all prospective and current assisted living clients a copy of the
481.28 uniform consumer information guide required by section 144G.06;

481.29 (10) maintain a safe, clean, sanitary, functional, comfortable, and home-like physical
481.30 environment; and

481.31 (11) establish and maintain an infection control program.

481.32 Subd. 2. **Nursing assessment.** (a) A licensed assisted living shall:

482.1 (1) have the arranged home care provider conduct a nursing assessment by a registered
482.2 nurse of the physical and cognitive needs of the prospective resident and propose a temporary
482.3 service plan prior to the date on which a prospective resident executes a contract with an
482.4 assisted living establishment or the date on which a prospective resident moves in, whichever
482.5 is earlier. If necessitated by either the geographic distance between the prospective resident
482.6 and the provider, or urgent or unexpected circumstances exist, the assessment may be
482.7 conducted using telecommunication methods based on practice standards that meet the
482.8 individual resident's needs and reflect person-centered planning and service delivery; and

482.9 (2) inform the prospective resident of the availability of and contact information for
482.10 long-term care consultation services under section 256B.0911 prior to the date on which a
482.11 prospective resident executes a contract with a licensed assisted living establishment or the
482.12 date on which a prospective resident moves in, whichever is earlier.

482.13 (b) The arranged home care provider shall comply with applicable home care licensure
482.14 requirements in chapter 144A and the Nurse Practice Act in sections 148.171 to 148.285
482.15 with respect to conducting a nursing assessment prior to the delivery of nursing services
482.16 and the execution of a home care service plan or service agreement.

482.17 **Subd. 3. Services oversight and information.** The assisted living shall provide each
482.18 assisted living resident with identifying and contact information about the persons who can
482.19 assist with health care or supportive services being provided. The assisted living shall keep
482.20 each resident informed of changes in personnel referenced in this subdivision.

482.21 **Subd. 4. Governing body.** Every basic, comprehensive, and comprehensive PLUS
482.22 assisted living licensee shall have a governing body that assumes full legal responsibility
482.23 for determining, implementing, and monitoring policies governing the licensee's operation.

482.24 **Subd. 5. Administrator.** Every basic, comprehensive, and comprehensive PLUS assisted
482.25 living licensee shall have an administrator who is responsible for: (1) the day-to-day
482.26 management of both the housing and the services provided including the overall responsibility
482.27 for the medical services components for comprehensive and comprehensive PLUS; (2)
482.28 implementing the policies and procedures; and (3) leading the staff.

482.29 **Subd. 6. Clinical nurse supervision.** All comprehensive and comprehensive PLUS
482.30 licensees must have a clinical nurse supervisor who is a registered nurse licensed in
482.31 Minnesota.

482.32 **Subd. 7. Resident councils.** All basic, comprehensive, and comprehensive PLUS
482.33 licensees shall establish both a resident council whose members are residents living at that
482.34 location and a family or resident representative council. The licensee shall support the

483.1 council's establishment and provide meeting space; materials; any necessary equipment
483.2 such as computers, printers, and assistive listening devices for use with hearing aids;
483.3 microphones; and tables. The licensee shall offer a staff person to attend to take minutes
483.4 for the council. Resident council minutes are public data and must be available to all residents
483.5 in the assisted living. Family or resident representatives may attend resident councils if
483.6 invited by a resident on the council.

483.7 Subd. 8. **Resident grievances.** All basic, comprehensive, and comprehensive PLUS
483.8 licensees must post in a conspicuous place information about the assisted living's grievance
483.9 procedure, and the name, telephone number, and e-mail contact information for the
483.10 individuals who are responsible for handling resident grievances. The notice must also have
483.11 the contact information for the Minnesota Adult Abuse Reporting Center, the common entry
483.12 point, and the state and applicable regional Office of Ombudsman for Long-Term Care.

483.13 Subd. 9. **Reporting suspected crime and maltreatment.** An assisted living shall support
483.14 protection and safety through access to the state's systems for reporting suspected criminal
483.15 activity and suspected vulnerable adult maltreatment by:

483.16 (1) posting the 911 emergency number in common areas and near telephones provided
483.17 by the assisted living;

483.18 (2) posting information and the reporting number for the common entry point to report
483.19 suspected maltreatment of a vulnerable adult under section 626.557; and

483.20 (3) providing reasonable accommodations with information and notices in plain language.

483.21 Subd. 10. **Protecting resident rights.** An assisted living shall ensure that every resident
483.22 has access to consumer advocacy or legal services by:

483.23 (1) encouraging and assisting each resident to access these protection services;
483.24 (2) providing names and contact information, including telephone numbers and e-mail
483.25 addresses of at least three individuals or organizations that provide advocacy or legal services
483.26 to residents;

483.27 (3) providing the name and contact information for the Minnesota Office of Ombudsman
483.28 for Long-Term Care, including both the state and regional contact information;

483.29 (4) making every effort to assist residents in obtaining information on whether Medicare
483.30 or medical assistance will pay for services;

483.31 (5) making reasonable accommodations for people who have communication disabilities
483.32 and those who speak a language other than English; and

484.1 (6) providing all information and notices in plain language and in terms the residents
484.2 can understand.

484.3 Subd. 11. Protection-related rights. (a) In addition to the rights required in sections
484.4 144A.44 and 144A.441, the following rights must be provided to all assisted living residents.
484.5 The assisted living must promote and protect these rights for each resident by making
484.6 residents aware of these rights and ensuring staff are trained to support these rights:

484.7 (1) the right to furnish and decorate the resident's unit within the terms of the lease;

484.8 (2) the right to access food at any time;

484.9 (3) the right to choose visitors and the times of visits;

484.10 (4) the right to choose a roommate if sharing a unit;

484.11 (5) the right to personal privacy including the right to have and use a lockable door on
484.12 the resident's unit. The assisted living provider shall provide the locks on the resident's unit.

484.13 Only a staff member with a specific need to enter the unit shall have keys, and advance
484.14 notice must be given to the resident before entrance, when possible;

484.15 (6) the right to engage in chosen activities;

484.16 (7) the right to engage in community life;

484.17 (8) the right to control personal resources; and

484.18 (9) the right to individual autonomy, initiative, and independence in making life choices
484.19 including a daily schedule and with whom to interact.

484.20 (b) The resident's rights in paragraph (a), clauses (2), (3), and (5), may be restricted for
484.21 an individual resident only if determined necessary for health and safety reasons identified
484.22 by the assisted living provider through an initial assessment or reassessment, as defined
484.23 under section 144A.4791 and documented in the written service plan under section 144A.43.
484.24 Any restrictions of those rights for people served under sections 256B.0915 and 256B.49
484.25 must be documented by the case manager in the resident's coordinated service and support
484.26 plan (CSSP), as defined in sections 256B.0915, subdivision 6, and 256B.49, subdivision
484.27 15.

484.28 Subd. 12. Retaliation prohibited. (a) An assisted living must not retaliate by taking an
484.29 adverse action against a resident, resident representative, assisted living employee, or other
484.30 interested person who:

484.31 (1) files a complaint or grievance or asserts any rights on behalf of themselves or the
484.32 resident;

485.1 (2) submits a report to law enforcement, the common entry point, or any other agency,
485.2 whether voluntarily or due to a mandatory reporting requirement;

485.3 (3) advocates on behalf of the resident for services or enforcement of the resident's rights;
485.4 or

485.5 (4) enters into a contract with a home care provider, health professional, or pharmacy
485.6 of the person's own choice who is not the arranged or preferred provider associated with
485.7 the assisted living.

485.8 (b) For purposes of this section, "adverse action" means an action taken by the assisted
485.9 living and its agents, including but not limited to:

485.10 (1) discharging or transferring from the assisted living, or terminating services or the
485.11 residency contract;

485.12 (2) discharging from or terminating employment or demoting unless for good cause;

485.13 (3) suddenly establishing new fees or increasing fees or costs for services when the costs
485.14 are not also applied to all residents;

485.15 (4) restricting access to or use of amenities or services;

485.16 (5) infringing or violating any resident rights in the client bills of rights as required by
485.17 sections 144A.44 and 144A.441;

485.18 (6) communicating verbally or in writing to the assisted living employees or residents
485.19 and their families false information about any person who advocated on behalf of the resident;
485.20 and

485.21 (7) restricting or prohibiting access to the assisted living or to the resident, including
485.22 issuing a no trespass order under section 609.605.

485.23 Subd. 13. **Payment for services under disability waivers.** For new assisted living as
485.24 defined in section 144I.01, home and community-based services under section 256B.49 are
485.25 not available when the new assisted living setting is adjoined to, or on the same property
485.26 as, an institution as defined by the Federal Centers for Medicare and Medicaid Services in
485.27 Code of Federal Regulations, title 42, section 441.301(c).

485.28 **EFFECTIVE DATE.** This section is effective July 1, 2021.

485.29 Sec. 4. **[144I.04] MANAGEMENT AGREEMENTS; GENERAL REQUIREMENTS.**

485.30 Subdivision 1. **Notification.** (a) If the proposed or current licensee uses a manager, the
485.31 licensee must have a written management agreement that is consistent with this chapter.

486.1 (b) The proposed or current licensee must notify the commissioner of its use of a manager
486.2 upon:

- 486.3 (1) initial application for a license;
486.4 (2) retention of a manager following initial application;
486.5 (3) change of managers; and
486.6 (4) modification of an existing management agreement.

486.7 (c) The proposed or current licensee must provide to the commissioner a written
486.8 management agreement, including an organizational chart showing the relationship between
486.9 the proposed or current licensee, management company, and all related organizations.

486.10 (d) The written management agreement must be submitted:

- 486.11 (1) 60 days before:
486.12 (i) the initial licensure date;
486.13 (ii) the proposed change of ownership date; or
486.14 (iii) the effective date of the management agreement; or
486.15 (2) 30 days before the effective date of any amendment to an existing management
486.16 agreement.

486.17 (e) The proposed licensee or the current licensee must notify the residents and their
486.18 representatives 60 days before entering into a new management agreement.

486.19 (f) A proposed licensee must submit a management agreement attestation form, as
486.20 required by the assisted living application.

486.21 **Subd. 2. Management agreement; licensee.** (a) The licensee is responsible for:

- 486.22 (1) the daily operations and provisions of services in the assisted living;
486.23 (2) ensuring the assisted living is operated in a manner consistent with all applicable
486.24 laws and rules;
486.25 (3) ensuring the manager acts in conformance with the management agreement; and
486.26 (4) ensuring the manager does not present as, or give the appearance that the manager
486.27 is the licensee.

486.28 (b) The licensee must not give the manager responsibilities that are so extensive that the
486.29 licensee is relieved of daily responsibility for the daily operations and provision of services

487.1 in the assisted living facility. If the licensee does so, the commissioner must determine that
487.2 a change of ownership has occurred.

487.3 (c) The licensee and manager must act in accordance with the terms of the management
487.4 agreement. If the commissioner determines they are not, then the department may impose
487.5 enforcement remedies.

487.6 (d) The licensee may enter into a management agreement only if the management
487.7 agreement creates a principal/agent relationship between the licensee and manager.

487.8 Subd. 3. Terms of agreement. A management agreement at a minimum must:

487.9 (1) describe the responsibilities of the licensee and manager, including items, services,
487.10 and activities to be provided;

487.11 (2) require the licensee's governing body, board of directors, or similar authority to
487.12 appoint the administrator;

487.13 (3) provide for the maintenance and retention of all records in accordance with this
487.14 chapter and other applicable laws;

487.15 (4) allow unlimited access by the commissioner to documentation and records according
487.16 to applicable laws or regulations;

487.17 (5) require the manager to immediately send copies of inspections and notices of
487.18 noncompliance to the licensee;

487.19 (6) state that the licensee is responsible for reviewing, acknowledging, and signing all
487.20 assisted living initial and renewal license applications;

487.21 (7) state that the manager and licensee shall review the management agreement annually
487.22 and notify the commissioner of any change according to applicable regulations;

487.23 (8) acknowledge that the licensee is the party responsible for complying with all laws
487.24 and rules applicable to the assisted living;

487.25 (9) require the licensee to maintain ultimate responsibility over personnel issues relating
487.26 to the operation of the assisted living and care of the residents including but not limited to
487.27 staffing plans, hiring, and performance management of employees, orientation, and training;

487.28 (10) state the manager will not present as, or give the appearance that the manager is
487.29 the licensee; and

488.1 (11) state that a duly authorized manager may execute resident leases or agreements on
488.2 behalf of the licensee, but all such resident leases or agreements must be between the licensee
488.3 and the resident.

488.4 Subd. 4. Commissioner review. The commissioner may review a management agreement
488.5 at any time. Following the review, the department may require:

488.6 (1) the proposed or current licensee or manager to provide additional information or
488.7 clarification;

488.8 (2) any changes necessary to:

488.9 (i) bring the management agreement into compliance with this chapter; and

488.10 (ii) ensure that the licensee has not been relieved of the responsibility for the daily
488.11 operations of the assisted living; and

488.12 (3) the licensee to participate in monthly meetings and quarterly on-site visits to the
488.13 assisted living.

488.14 Subd. 5. Resident funds. (a) If the management agreement delegates day-to-day
488.15 management of resident funds to the manager, the licensee:

488.16 (1) retains all fiduciary and custodial responsibility for funds that have been deposited
488.17 with the assisted living by the resident;

488.18 (2) is directly accountable to the resident for such funds; and

488.19 (3) must ensure any party responsible for holding or managing residents' personal funds
488.20 is bonded or obtains insurance in sufficient amounts to specifically cover losses of resident
488.21 funds and provides proof of bond or insurance.

488.22 (b) If responsibilities for the day-to-day management of the resident funds are delegated
488.23 to the manager, the manager must:

488.24 (1) provide the licensee with a monthly accounting of the resident funds; and

488.25 (2) meet all legal requirements related to holding and accounting for resident funds.

488.26 Sec. 5. **[144I.05] MINIMUM SITE REQUIREMENTS AND FIRE SAFETY.**

488.27 Subdivision 1. Site requirements. (a) Effective July 1, 2019, the following items are
488.28 required:

488.29 (1) each assisted living must be located so that all residents are protected in their health,
488.30 comfort, and safety;

489.1 (2) public utilities must be available and working;

489.2 (3) inspected and approved water and septic systems are in place;

489.3 (4) the location of the assisted living is located no closer than 300 feet to the right-of-way

489.4 of a railroad mainline or to the property line of industrial sites that are hazardous to health;

489.5 (5) the location of the assisted living is not located within 85 feet of underground or 300

489.6 feet of aboveground storage tanks or warehouses containing flammable liquids;

489.7 (6) the location of the assisted living is publicly accessible to fire department services

489.8 and emergency medical services;

489.9 (7) the topography of the location of the assisted living provides good natural drainage

489.10 and is not subject to flooding;

489.11 (8) all-weather roads and walks are within the lot lines to the primary entrance and the

489.12 service entrance, including employees' and visitors' parking at the site;

489.13 (9) the primary entrance is accessible for persons with disabilities; and

489.14 (10) the location of the assisted living includes space for outdoor activities for residents.

489.15 (b) The assisted living must be in compliance with all applicable state and local laws,

489.16 regulation standards, ordinances, codes for fire safety, and building, accessibility, and zoning

489.17 requirements including ongoing obligations under the Americans with Disabilities Act and

489.18 the Minnesota Human Rights Act.

489.19 Subd. 2. **Fire protection.** (a) Effective July 1, 2019, each assisted living building must

489.20 have a comprehensive fire protection system that includes:

489.21 (1) protection throughout by an approved, supervised automatic sprinkler system

489.22 according to building code requirements established in Minnesota Rules, part 1305.0903,

489.23 or smoke detectors installed in each occupiable room and maintained in accordance with

489.24 NFPA 72; and

489.25 (2) portable fire extinguishers installed and tested in accordance with NFPA 10.

489.26 (b) Beginning July 1, 2019, fire drills must be conducted in accordance with the

489.27 residential board and care requirements in the Life Safety Code.

489.28 (c) After June 30, 2022, all new construction in an assisted living must meet the provisions

489.29 relevant to licensed assisted living in the most current edition of the Facility Guidelines

489.30 Institute's Guidelines for Design and Construction of Residential Health, Care and Support

490.1 Facilities and of adopted rules. In addition to the guidelines, assisted livings shall provide
490.2 the option of a bath in addition to a shower for all residents.

490.3 (d) For all new construction beginning July 1, 2022, the requirements in clauses (1) to
490.4 (7) must be provided to the commissioner:

490.5 (1) Architectural and engineering plans and specifications for new construction must be
490.6 prepared and signed by architects and engineers who are registered in Minnesota. Final
490.7 working drawings and specifications for proposed construction must be submitted to the
490.8 commissioner for review and approval.

490.9 (2) Preliminary plans must be drawn in scale, show basic dimensions, and indicate the
490.10 general layout and space arrangement of the proposed building or area and must include a
490.11 site plan when applicable. Plans must indicate assignments of rooms and areas, and must
490.12 show bed capacities and fixed equipment.

490.13 (3) Final architectural plans and specifications must include elevations and sections
490.14 throughout the building showing types of construction, and must indicate dimensions and
490.15 assignment of rooms and areas, room finishes, door types and hardware, elevations and
490.16 details of nurses' work areas, utility rooms, toilets and bathing areas, and large-scale layouts
490.17 of dietary and laundry areas. Plans must show the location of fixed equipment and sections
490.18 and details of elevators, chutes, and other conveying systems. Fire walls and smoke partitions
490.19 must be indicated. The roof plan must show all mechanical installations. The site plan must
490.20 indicate the proposed and existing buildings, topography, roadways, walks, and utility
490.21 service lines.

490.22 (4) Final mechanical and electrical plans and specifications must address the complete
490.23 layout and type of all installations, systems, and equipment to be provided. Heating plans
490.24 must include heating elements, piping, thermostatic controls, pumps, tanks, heat exchangers,
490.25 boilers, breeching, and accessories. Ventilation plans must include room air quantities,
490.26 ducts, fire and smoke dampers, exhaust fans, humidifiers, and air handling units. Plumbing
490.27 plans must include a fixtures and equipment fixture schedule; water supply and circulating
490.28 piping, pumps, tanks, riser diagrams, and building drains; the size, location, and elevation
490.29 of water and sewer services; and the building fire protection systems. Electrical plans must
490.30 include fixtures and equipment, receptacles, switches, power outlets, circuits, power and
490.31 light panels, transformers, and service feeders. Plans must show the location of nurse call
490.32 signals, cable lines, fire alarm stations, and detectors and emergency lighting.

490.33 (5) Unless construction is begun within one year after approval of the final working
490.34 drawing and specifications, the drawings must be resubmitted for review and approval. All

491.1 construction must be executed according to the approved final plans and specifications.

491.2 Subsequent construction changes must be made in accordance with the adopted requirements,

491.3 and must be reviewed by the commissioner before the changes are made.

491.4 (6) The commissioner must be notified within 30 days before completion of construction

491.5 so that the commissioner can make arrangements for a final inspection by the commissioner.

491.6 (7) At least one set of complete life safety plans including changes resulting from

491.7 remodeling or alterations must be kept on file in the assisted living.

491.8 (e) After July 1, 2022, all newly licensed buildings where assisted living services are

491.9 provided must ensure that 20 percent of the assisted living resident rooms are accessible

491.10 under the Minnesota Accessibility Code.

491.11 (f) An assisted living may request that the commissioner grant a variance or waiver from

491.12 the provisions of this section. A request for a waiver must be submitted to the commissioner

491.13 in writing. Each request must contain:

491.14 (1) the specific requirement for which the variance or waiver is requested;

491.15 (2) the reasons for the request;

491.16 (3) the alternative measures that will be taken if a variance or waiver is granted;

491.17 (4) the length of time for which the variance or waiver is requested; and

491.18 (5) other relevant information deemed necessary by the commissioner to properly evaluate

491.19 the request for the waiver.

491.20 (g) The decision to grant or deny a variance or waiver must be based on the

491.21 commissioner's evaluation of the following criteria:

491.22 (1) whether the waiver will adversely affect the health, treatment, comfort, safety, or

491.23 well-being of a patient;

491.24 (2) whether the alternative measures to be taken, if any, are equivalent to or superior to

491.25 those prescribed in this section; and

491.26 (3) whether compliance with any requirement would impose an undue burden upon the

491.27 applicant.

491.28 **Sec. 6. [144I.06] RESIDENCY CONTRACT REQUIREMENTS.**

491.29 Subdivision 1. Contract required. (a) No assisted living may operate in Minnesota

491.30 unless a written residency contract is executed between the assisted living licensee and each

492.1 resident or resident's representative and unless the assisted living complies with the terms
492.2 of the contract.

492.3 (b) No other lease or contract shall be in effect in addition to the residency contract.

492.4 Subd. 2. **Contents.** A residency contract, which must be titled as such, shall include the
492.5 following items:

492.6 (1) the name, street address, and mailing address of the assisted living;

492.7 (2) the name and mailing address of the owner or owners of the assisted living and if
492.8 the owner or owners are not a natural person, identification of the type of business entity
492.9 of the owner or owners;

492.10 (3) the name and mailing address of the managing agent through a management agreement
492.11 or lease agreement if different from the owner or owners;

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

492.14 (5) the name and contact information for 24 hours per day, seven days per week, for the
492.15 administrator, clinical nurse supervisor, registered nurse manager, governing body members,
492.16 and a statement that this information is subject to change and whenever there is a change,
492.17 the assisted living will notify each resident within one week of the change;

492.18 (6) a statement describing the registration and licensure status of the location and any
492.19 provider providing health-related or supportive services;

492.20 (7) the term period of the contract;

492.21 (8) a description of the services to be provided to the resident and the base rate to be
492.22 paid for the resident including a delineation of the portion of the base rate that constitutes
492.23 rent and a delineation of charges for each service included in the base rate;

492.24 (9) a description of any additional services, including home care services available for
492.25 additional fees from the assisted living directly or through arrangements with the assisted
492.26 living, and a schedule of fees charged for these services;

492.27 (10) a conspicuous notice informing the resident of policies concerning the conditions
492.28 under which the process for modifying the resident contract including whether a move to
492.29 a different room or sharing a room would be required in the event the resident can no longer
492.30 pay the service fees or rent;

492.31 (11) a description of the assisted living's policies related to medical assistance waivers
492.32 under sections 256B.0915 and 256B.092, including:

493.1 (i) whether the provider is enrolled with the Department of Human Services to provide
493.2 customized living services under medical assistance waivers;

493.3 (ii) whether there is a limit on the number of people residing at the assisted living who
493.4 can receive customized living services at any point in time. If so, the limit must be provided;

493.5 (iii) a statement explaining that medical assistance waivers provide payment for services,
493.6 but do not cover the cost of rent;

493.7 (iv) a statement explaining that residents may be eligible for assistance with rent through
493.8 the housing support program; and

493.9 (v) a description of the rent requirements for people who are eligible for medical
493.10 assistance waivers but who are not eligible for assistance through the housing support
493.11 program;

493.12 (12) a description of the assisted living's internal complaint process including the names
493.13 and contact information of staff who may receive complaints, plus the toll-free complaint
493.14 line for the Office of Ombudsman for Long-Term Care;

493.15 (13) billing and payment procedures and requirements;

493.16 (14) a statement regarding the freedom of choice a resident has to choose services from
493.17 providers they want and that there will be no additional fees imposed by the assisted living
493.18 for making those choices;

493.19 (15) the service agreement shall be attached to the residency contract when the service
493.20 agreement is completed.

493.21 Subd. 3. **Filing.** Residency contracts will be maintained by the assisted living in files
493.22 from the date of execution until three years after the contract is terminated. The contracts
493.23 and all associated documents will be available for on-site inspection by the commissioner
493.24 at any time. The documents shall be available for viewing or copies shall be made available
493.25 to the resident and resident's representative at any time.

493.26 Sec. 7. **[144I.07] RESIDENCY CONTRACT TERMINATION.**

493.27 Subdivision 1. **Limitations.** (a) An assisted living licensee may terminate a residency
493.28 contract only if:

493.29 (1) the resident has not paid the rent;

493.30 (2) the safety or health of other individuals in the assisted living is endangered;

493.31 (3) the assisted living licensee intends to cease operation; or

494.1 (4) the assisted living's license is being restricted by the commissioner of health or human
494.2 services.

494.3 A breach of a service agreement does not constitute a breach of a residency contract.

494.4 (b) Prior to terminating a residency contract, an assisted living licensee must provide a
494.5 resident with at least:

494.6 (1) 30 days' advance written notice of termination in cases of nonpayment of rent;

494.7 (2) 30 days' advance written notice of termination in cases of alleged breach of contract;

494.8 (3) 60 days' advance written notice of closure of the assisted living licensee unless the
494.9 closure is due to a commissioner license enforcement action pursuant to section 144I.02,
494.10 subdivision 9; and

494.11 (4) a comprehensive discharge plan.

494.12 (c) Notwithstanding paragraphs (a) and (b), an assisted living licensee may immediately
494.13 commence residency contract termination if:

494.14 (1) the alleged breach involves any of the acts listed in section 504B.171, subdivision
494.15 1;

494.16 (2) the assisted living resident holds over beyond the date to vacate mutually agreed
494.17 upon in writing by the resident and the assisted living licensee; or

494.18 (3) the assisted living resident holds over beyond the date provided by the resident to
494.19 the assisted living licensee in a notice of voluntary termination of the lease. The resident
494.20 retains their appeal rights pursuant to subdivision 3.

494.21 (d) Nothing in this section affects other rights and remedies available under chapter
494.22 504B.

494.23 Subd. 2. **Contents of notice.** (a) The notice required under subdivision 1 must include:

494.24 (1) a detailed explanation of the reason for the termination;

494.25 (2) the date termination will occur;

494.26 (3) an adequate and safe discharge location; and

494.27 (4) a statement that the recipient of the notice may contact the Office of Ombudsman
494.28 for Long-Term Care regarding the residency contract termination issues and the address
494.29 and telephone number of the Office of Ombudsman for Long-Term Care, the Office of
494.30 Administrative Hearings, and a protection and advocacy agency.

495.1 (b) The notice must also include the following statements:

495.2 (1) that the resident has a right to request a meeting with the assisted living licensee to
495.3 discuss and attempt to resolve the alleged breach to avoid termination;

495.4 (2) that the resident has a right to appeal the termination of the residency contract to the
495.5 Office of Administrative Hearings and the date and time by which the resident must submit
495.6 an appeal request;

495.7 (3) that the resident has a right to avoid termination of the residency contract by paying
495.8 the rent in full within ten days of receiving written notice of nonpayment; and

495.9 (4) that the resident has the right to cure the breach within 30 days of receiving written
495.10 notice of the breach.

495.11 Subd. 3. **Right to appeal termination of the residency contract.** (a) At any time prior
495.12 to the expiration of the notice period provided under subdivision 2, a resident may appeal
495.13 the termination by making a written request for a hearing to the Office of Administrative
495.14 Hearings, which must schedule the hearing no later than 14 days after receiving the appeal
495.15 request. In the case of an immediate notice of eviction, the resident has ten days to appeal
495.16 after receipt of the notice to appeal. The hearing must be held at the location where the
495.17 resident resides, unless it is impractical or the parties agree otherwise. The hearing is not a
495.18 formal evidentiary hearing. The hearing may be attended by telephone as allowed by the
495.19 administrative law judge. The hearing shall be limited to the amount of time necessary for
495.20 the participants to expeditiously present the facts about the proposed termination. The
495.21 administrative law judge shall issue a recommendation to the commissioner within ten
495.22 business days after the hearing. Attorney representation is not required at the hearing nor
495.23 does appearing without an attorney constitute the unauthorized practice of law.

495.24 (b) A resident who makes a timely appeal of a notice of residency contract termination
495.25 may not be evicted by the assisted living licensee until the Office of Administrative Hearings
495.26 makes a final determination on the appeal in favor of the assisted living licensee.

495.27 (c) The commissioner may direct the assisted living licensee to rescind the residency
495.28 contract termination or readmit the resident if:

495.29 (1) the residency contract termination was in violation of state or federal law;

495.30 (2) the resident cures the alleged breach of lease or pays the rent owed on or before the
495.31 date of the administrative hearing; or

495.32 (3) the discharge plan is in violation of state or federal law.

496.1 (d) The assisted living licensee must readmit the resident if the resident is hospitalized
496.2 for medical necessity before the resolution of the appeal.

496.3 (e) Residents are not required to request a meeting as provided in subdivision 2 prior to
496.4 submitting an appeal hearing request.

496.5 (f) Nothing in this section limits the rights of a resident or the resident's representative
496.6 to request or receive assistance from the Office of Ombudsman for Long-Term Care and a
496.7 protection and advocacy agency concerning the proposed residency contract termination.

496.8 **Subd. 4. Discharge plan and transfer of information to new residence.** (a) Sufficiently
496.9 in advance of discharging a resident, an assisted living licensee must prepare an adequate
496.10 discharge plan that:

496.11 (1) is based on the resident's discharge goals;

496.12 (2) includes in discharge planning the resident, the resident's case manager, and the
496.13 resident's representative, if any;

496.14 (3) contains a plan for appropriate and sufficient postdischarge care; and

496.15 (4) proposes a safe discharge location which does not include a private home where the
496.16 occupant is unwilling or unable to care for the resident, a homeless shelter, a hotel, or a
496.17 motel.

496.18 (b) An assisted living licensee may not discharge a resident if the resident will, upon
496.19 discharge, become homeless as defined in section 116L.361, subdivision 5.

496.20 (c) An assisted living licensee that proposes to discharge a resident must assist the
496.21 resident with applying for and locating a safe and adequate discharge location, including
496.22 coordinating with the county case manager, if any.

496.23 (d) Prior to discharge, an assisted living licensee must provide to the receiving facility
496.24 or setting all information known to the licensee related to the resident that is necessary to
496.25 ensure continuity of care and services including, at a minimum:

496.26 (1) the resident's full name, date of birth, and insurance information;

496.27 (2) the name, telephone number, and address of the resident's representative, if any;

496.28 (3) the resident's current documented diagnoses;

496.29 (4) the resident's known allergies;

496.30 (5) the name and telephone number of the resident's physician and the current physician
496.31 orders, if known;

497.1 (6) any and all medication administration records;
497.2 (7) the most recent resident assessment; and
497.3 (8) copies of health care directives, do not resuscitate orders, and any guardianship orders
497.4 or powers of attorney.

497.5 (e) For purposes of this subdivision, "discharge" means the involuntary relocation of a
497.6 resident due to a termination of a residency contract. If a residential contract is initiated by
497.7 the assisted living provider, it is considered a discharge.

497.8 **Subd. 5. Final accounting; return of money and property.** (a) Within 30 days of the
497.9 date of discharge, the assisted living licensee shall:

497.10 (1) provide to the resident or resident's representative a final statement of account;
497.11 (2) provide any refunds due; and
497.12 (3) return any money, property, or valuables held in trust or custody by the assisted
497.13 living licensee.

497.14 (b) As required by section 504B.178, an assisted living licensee may not collect a
497.15 nonrefundable security deposit unless it is applied to the first month's charges.

497.16 Sec. 8. **[144I.08] TERMINATION OF SERVICES; ARRANGED HOME CARE**
497.17 **PROVIDER.**

497.18 **Subdivision 1. Notice; permissible reason to terminate services.** (a) Except as provided
497.19 in paragraph (b), the assisted living must provide at least 30 days' notice prior to terminating
497.20 a service contract. Notwithstanding any other provision of law, the assisted living may
497.21 terminate services only if:

497.22 (1) the resident engages in conduct that interferes with the assisted living's ability to
497.23 carry out the terms of the service plan and cannot be cured by updating or changing the
497.24 terms of the service plan; or

497.25 (2) the resident fails to pay for services, provided the resident has not cured the breach
497.26 within 30 days of receiving written notice of nonpayment.

497.27 (b) Notwithstanding paragraph (a), the assisted living may terminate services with ten
497.28 days' notice if a doctor or treating physician documents that an emergency or a significant
497.29 change in the resident's condition has resulted in service needs that exceed the current service
497.30 plan and that cannot be safely met by the assisted living. In this situation, the assisted living

498.1 must assist the resident in obtaining services from a home care provider wherever the resident
498.2 chooses to receive the services.

498.3 (c) If the license of the assisted living is restricted by the commissioner, then the licensee
498.4 must follow the directions of the commissioner for ceasing services to residents and the
498.5 notice provisions in this subdivision may not apply.

498.6 Subd. 2. **Contents of service termination notice.** If an arranged home care provider
498.7 who is not Medicare certified terminates a service agreement or service plan with a resident
498.8 in an assisted living setting, the home care provider shall provide the resident and the legal
498.9 representative or resident representative, if any, with advance written notice of service
498.10 termination according to subdivision 1 that must include:

498.11 (1) the effective date of service termination;

498.12 (2) the reason for service termination;

498.13 (3) without extending the termination notice period, an affirmative offer to meet with
498.14 the resident or the resident's representative within five business days of the date of the
498.15 service termination notice to discuss the termination;

498.16 (4) contact information for other assisted living licensees in the geographic area of the
498.17 resident;

498.18 (5) a statement that the provider will participate in a coordinated transfer of care of the
498.19 client to another provider;

498.20 (6) a statement that the resident has a right to request a meeting with the arranged home
498.21 care provider to discuss and attempt to avoid the service termination;

498.22 (7) the name and contact information of a representative of the arranged home care
498.23 provider with whom the resident may discuss the notice of service termination;

498.24 (8) a copy of the home care bill of rights;

498.25 (9) a statement that the notice of service termination of home care services by the home
498.26 care provider does not constitute notice of termination of the lease of the assisted living;
498.27 and

498.28 (10) a statement that the recipient of the notice may contact the Office of Ombudsman
498.29 for Long-Term Care regarding the lease termination issues and a statement that the resident
498.30 has the right to appeal the service termination to the Office of Administrative Hearings and
498.31 provide the contact information for the Office of Administrative Hearings, including the
498.32 mailing address, fax number, e-mail address, and telephone number.

499.1 **Subd. 3. Right to appeal service termination.** (a) At any time prior to the expiration
499.2 of the notice period provided in subdivision 1, a resident may appeal the service termination
499.3 by making a written request for a hearing to the Office of Administrative Hearings. The
499.4 Office of Administrative Hearings must conduct the hearing no later than 14 days after the
499.5 office receives the appeal request from the resident. The hearing must be held in the place
499.6 where the resident resides unless it is impractical or the parties agree to a different place.
499.7 Attorney representation is not required at the hearing, nor does appearing without an attorney
499.8 constitute the unauthorized practice of law. The hearing is not a formal evidentiary hearing.
499.9 The hearing may also be attended by telephone as allowed by the administrative law judge.
499.10 The hearing shall be limited to the amount of time necessary for the participants to
499.11 expeditiously present the facts about the proposed termination. The administrative law judge
499.12 shall issue a recommendation to the commissioner within ten business days after the hearing.

499.13 (b) The arranged home care provider may not discontinue services to a resident who
499.14 timely appeals a notice of service termination until the Office of Administrative Hearings
499.15 has made a final determination on the appeal in favor of the assisted living licensee.

499.16 (c) Residents are not required to request a meeting under subdivision 1 prior to submitting
499.17 a request for an appeal hearing.

499.18 (d) The commissioner may direct the assisted living licensee to rescind the service
499.19 contract termination if the Office of Administrative Hearings decides that the proposed
499.20 termination was in violation of state or federal law.

499.21 (e) Nothing in this section limits the right of a resident or a resident's representative to
499.22 request or receive assistance from the Office of Ombudsman for Long-Term Care and a
499.23 protection and advocacy agency concerning the proposed service termination.

499.24 Sec. 9. **[144I.09] RELOCATIONS WITHIN ASSISTED LIVING LOCATION.**

499.25 Subdivision 1. **Notice required before relocation within location.** An assisted living
499.26 licensee must:

499.27 (1) notify a resident and the resident's representative, if any, at least 14 days prior to a
499.28 proposed nonemergency relocation to a different room at the same location; and
499.29 (2) obtain consent from the resident and the resident's representative, if any.

499.30 A resident must be allowed to stay in the resident's room or reasonable modifications
499.31 must be made to another room to accommodate the resident.

500.1 Subd. 2. **Evaluation.** An assisted living licensee shall evaluate the resident's individual
500.2 needs before deciding whether the room the resident will be moved to fits the resident's
500.3 psychological, cognitive, and health care needs, including the accessibility of the bathroom.

500.4 Subd. 3. **Restriction on relocation.** A person who has been a private-pay resident for
500.5 at least one year and resides in a private room, and whose payments subsequently will be
500.6 made under the medical assistance program, may not be relocated to a shared room without
500.7 the consent of the resident or the resident's representative, if any.

500.8 Sec. 10. **[144I.10] COMMISSIONER OVERSIGHT AND AUTHORITY.**

500.9 (a) The commissioner shall license, survey, and monitor without advance notice assisted
500.10 living licensees in accordance with this chapter.

500.11 (b) The commissioner shall survey assisted living licensees on a frequency of once per
500.12 year.

500.13 (c) After July 1, 2022, the commissioner shall provide blueprint review for all new
500.14 assisted living construction and must approve the plans before construction is commenced.

500.15 (d) The commissioner shall provide on-site reviews of the construction to ensure that
500.16 all physical plant standards are met before the assisted living license is complete.

500.17 Sec. 11. **[144I.11] EXPEDITED RULEMAKING AUTHORIZED.**

500.18 (a) The commissioner shall adopt rules for all assisted living licenses that promote
500.19 person-centered planning and service and optimal quality of life, and that ensure resident
500.20 rights are protected, resident choice is allowed, and public health and safety is ensured.

500.21 (b) On July 1, 2019, the commissioner shall begin expedited rulemaking using the process
500.22 in section 14.389, except that the rulemaking process is exempt from section 14.389,
500.23 subdivision 5.

500.24 (c) The commissioner shall adopt rules that include but are not limited to the following:

500.25 (1) building design, physical plant standards, environmental health and safety minimum
500.26 standards from the most recent version of the Facility Guide Institute's Guidelines for Design
500.27 and Construction of Residential Health, Care, and Support Facilities, including appendices;

500.28 (2) staffing minimums and ratios for each level of licensure to best protect the health
500.29 and safety of residents no matter their vulnerability;

500.30 (3) require provider notices and disclosures to residents and their families;

- 501.1 (4) training prerequisites and ongoing training for administrators and caregiving staff;
- 501.2 (5) minimum requirements for move-in assessments and ongoing assessments and
- 501.3 practice standards in sections 144A.43 to 144A.47;
- 501.4 (6) requirements for licensees to ensure minimum nutrition and dietary standards required
- 501.5 by section 144I.03 are provided;
- 501.6 (7) requirements for supportive services provided by assisted living licensees;
- 501.7 (8) identifying personnel in assisted living providers aside from those already required
- 501.8 to obtain background studies as required in sections 144.057, 144.0572, 144A.476, and
- 501.9 144I.02 who need to obtain background studies and establish a process for obtaining those
- 501.10 results;
- 501.11 (9) procedures for discharge planning and ensuring resident appeal rights;
- 501.12 (10) procedures for ensuring that licensees establish resident and family councils;
- 501.13 (11) content requirements for all license or provisional license applications;
- 501.14 (12) requirements that support for assisted living providers to comply with home and
- 501.15 community-based requirements in Code of Federal Regulations, title 42, section 441.301(c);
- 501.16 (13) core dementia care requirements and training in all levels of licensure;
- 501.17 (14) requirements for a comprehensive PLUS license in terms of training, care standards,
- 501.18 noticing changes of condition, assessments, and health care; and
- 501.19 (15) preadmission criteria, initial assessments, and continuing assessments.
- 501.20 (d) The commissioner shall publish the proposed rules by December 31, 2019, and shall
- 501.21 publish final rules by December 31, 2020.

501.22 Sec. 12. **TRANSITION PERIOD.**

- 501.23 (a) From July 1, 2019, to June 30, 2020, the commissioner shall engage in the expedited
- 501.24 rulemaking process.
- 501.25 (b) From July 1, 2020, to June 30, 2021, the commissioner shall hire staff, develop forms,
- 501.26 and communicate with stakeholders about the new assisted living licensing.
- 501.27 (c) From July 1, 2021, to June 30, 2022, all existing housing with services establishments
- 501.28 with arranged home care providers must convert their registration and license to an assisted
- 501.29 living license.

502.1 (d) After June 30, 2021, all new assisted living providers must be licensed by the
502.2 commissioner.

502.3 (e) Beginning July 1, 2022, all assisted living providers must have a license issued by
502.4 the commissioner.

502.5 Sec. 13. **RESIDENT QUALITY OF CARE AND OUTCOMES IMPROVEMENT**
502.6 **TASK FORCE.**

502.7 The commissioner shall establish an expert task force to examine and make
502.8 recommendations, on an ongoing basis, on how to apply proven safety and quality
502.9 improvement practices and infrastructure to settings and providers that provide long-term
502.10 services and supports. The task force shall include representation from nonprofit
502.11 Minnesota-based organizations dedicated to patient safety and innovation in health care
502.12 safety and quality, Department of Health staff with expertise in issues related to safety and
502.13 adverse health events, consumer organizations, direct care providers or their representatives,
502.14 organizations representing long-term care providers and home care providers in Minnesota,
502.15 national patient safety experts, and other experts in the safety and quality improvement
502.16 field. The task force shall have at least two public members who are either home care
502.17 recipients in an assisted living setting or have family members living in assisted living
502.18 settings, either past or present. The task force shall periodically provide recommendations
502.19 to the commissioner and the legislature on changes needed to promote safety and quality
502.20 improvement practices in long-term care settings and with long-term care providers. The
502.21 membership shall be voluntary except that public members can be reimbursed under the
502.22 provisions of Minnesota Statutes, section 15.059, subdivision 3. The task force will meet
502.23 no fewer than four times per year. The task force must be established by July 1, 2020.

502.24 Sec. 14. **REPEALER.**

502.25 Minnesota Statutes 2018, sections 144G.01; 144G.02; 144G.03; 144G.04; 144G.05; and
502.26 144G.06, are repealed effective July 1, 2021.

502.27 **ARTICLE 15**
502.28 **DEMENTIA CARE SERVICES FOR COMPREHENSIVE PLUS LICENSEES**

502.29 Section 1. **[144I.12] DEFINITIONS.**

502.30 (a) For purposes of sections 144I.13 to 144I.18, the definitions in this section apply.

503.1 (b) "Advertise" means to make publicly and generally known, usually by printed notice,
503.2 broadcast, verbal marketing, website, or electronic communication.

503.3 (c) "Alzheimer's disease" means a type of dementia that gradually destroys an individual's
503.4 memory and ability to learn, reason, make judgments, communicate, and carry out daily
503.5 activities.

503.6 (d) "Applicant" means the person, persons, or entity, required to complete an application
503.7 for a comprehensive PLUS license. Applicant includes a sole proprietor, each partner in a
503.8 partnership, and each member in a limited liability company, corporation, or entity that
503.9 owns the assisted living facility. Applicant also includes the sole proprietor, each partner
503.10 in a partnership, and each member in a limited liability company, corporation, or entity that
503.11 operates the assisted living facility on behalf of the facility business owner.

503.12 (e) "Comprehensive PLUS" means the license described in section 144I.02, subdivision
503.13 2.

503.14 (f) "Dementia" means the loss of intellectual function of sufficient severity that interferes
503.15 with an individual's daily functioning. Dementia affects an individual's memory and ability
503.16 to think, reason, speak, and move. Symptoms may also include changes in personality,
503.17 mood, and behavior. Irreversible dementias include but are not limited to:

503.18 (1) Alzheimer's disease;

503.19 (2) vascular dementia;

503.20 (3) Lewy body dementia;

503.21 (4) frontal-temporal lobe dementia;

503.22 (5) alcohol dementia;

503.23 (6) Huntington's disease; and

503.24 (7) Creutzfeldt-Jakob disease.

503.25 (g) "Dementia care unit" means a special care unit in a designated, separate area for
503.26 individuals with Alzheimer's disease or other dementia that is locked, segregated, or secured
503.27 to prevent or limit access by a resident outside the designated or separated area.

503.28 (h) "Dementia trained staff" means an employee that has completed the minimum training
503.29 requirements and has demonstrated knowledge and understanding in supporting individuals
503.30 with dementia.

504.1 (i) "Direct care staff" means a person employed by the assisted living facility whose
504.2 primary responsibility is to provide personal care services to residents. These personal care
504.3 services may include:

- 504.4 (1) medication administration;
504.5 (2) resident-focused activities;
504.6 (3) assistance with activities of daily living;
504.7 (4) supervision and support of residents; and
504.8 (5) serving meals, but not meal preparation.

504.9 (j) "Disclosure statement" means the written information the assisted living facility is
504.10 required to provide to consumers to enhance the understanding of comprehensive PLUS
504.11 services, costs, and operations.

504.12 (k) "Emergency situation" means a disruption to normal care and services caused by an
504.13 unforeseen event beyond the control of the licensee whether natural, technological, or
504.14 manmade where staff that are trained as required by adopted rules are not available.

504.15 (l) "Preservice training" means training that must be completed before staff takes
504.16 responsibility for their job duties.

504.17 (m) "Resident" means an individual with dementia.

504.18 **Sec. 2. [144I.13] APPLICATION FOR COMPREHENSIVE PLUS LICENSE.**

504.19 Subdivision 1. **Comprehensive PLUS license required.** A licensed assisted living
504.20 establishment that offers or provides care to residents with dementia in a dementia care unit
504.21 must obtain a comprehensive PLUS license.

504.22 Subd. 2. **Application.** The applicant seeking a comprehensive PLUS license must submit
504.23 to the commissioner a completed license application 60 days prior to receiving an initial
504.24 license, the expiration of the current PLUS license, or a change in ownership.

504.25 Subd. 3. **Contents of application.** The applicant must also include the following with
504.26 the initial application and fee:

- 504.27 (1) comprehensive PLUS uniform disclosure statement;
504.28 (2) employee training curricula;
504.29 (3) policies and procedures;
504.30 (4) floor plan;

505.1 (5) residency or admission agreement;
505.2 (6) copy of the service or care planning tool; and
505.3 (7) copies of brochures or advertisements that are used to advertise the facility and the
505.4 facility's services.

505.5 **Subd. 4. Demonstrated capacity.** (a) The applicant must have the ability to provide
505.6 services in a manner that is consistent with the requirements of this chapter.

505.7 (b) The commissioner shall consider the following criteria, including but not limited to:

505.8 (1) the experience of the applicant in managing residents with dementia or previous
505.9 long-term care experience; and

505.10 (2) the compliance history of the applicant in the operation of any care facility licensed,
505.11 certified, or registered under federal or state laws.

505.12 (c) If the applicant does not have experience in managing residents with dementia, the
505.13 applicant must employ a consultant or management company for at least the first year of
505.14 operation. The consultant or management company must have experience in dementia care
505.15 operations and must be approved by the commissioner. The applicant must implement the
505.16 recommendations of the consultant or management company or present an acceptable plan
505.17 to the commissioner to address the consultant's identified concerns.

505.18 (d) The commissioner shall conduct an on-site inspection prior to the issuance of a
505.19 comprehensive PLUS license to ensure compliance with the physical plant requirements.

505.20 (e) The label "Comprehensive PLUS" shall be identified on the license.

505.21 **Subd. 5. Relinquishing comprehensive PLUS license.** The licensee must notify the
505.22 commissioner in writing at least 60 days prior to the voluntary relinquishment of the
505.23 comprehensive PLUS license. For voluntary relinquishment, the facility must:

505.24 (1) give all residents and their designated representatives 45-day notice. The notice must
505.25 include:

505.26 (i) the proposed effective date of the relinquishment;

505.27 (ii) changes in staffing;

505.28 (iii) changes in services including the elimination or addition of services; and

505.29 (iv) staff training that must occur when the relinquishment becomes effective;

505.30 (2) submit a transitional plan to the commissioner demonstrating how the current residents
505.31 shall be evaluated and assessed to reside in other housing settings that are not an assisted

506.1 living facility with a comprehensive PLUS license, that are physically unsecured, or that
506.2 would require move-out or transfer to other settings;

506.3 (3) change service or care plans as appropriate to address any needs the residents may
506.4 have with the transition;

506.5 (4) notify the commissioner when the relinquishment process has been completed; and

506.6 (5) revise advertising materials and disclosure information to remove any reference that
506.7 the facility is an assisted living establishment with a comprehensive PLUS license.

506.8 **Sec. 3. [144I.14] ADVERTISING OF COMPREHENSIVE PLUS LICENSE.**

506.9 Subdivision 1. General. An applicant may not advertise as having a comprehensive
506.10 PLUS license until the applicant has obtained a comprehensive PLUS license from the
506.11 commissioner. A prospective assisted living establishment seeking a comprehensive PLUS
506.12 license may advertise that they have submitted an application for a license to the
506.13 commissioner.

506.14 Subd. 2. Advertising comprehensive PLUS license. An assisted living establishment
506.15 with a comprehensive PLUS license may advertise that it has a comprehensive PLUS license.
506.16 However, the advertising materials may not imply or state that the commissioner recommends
506.17 or supports a specific assisted living establishment with a comprehensive PLUS license.

506.18 Subd. 3. Truth in advertising. All advertising material must be truthful and must not
506.19 include or use misleading information about the type or status of home care license connected
506.20 to any housing with services establishment, including an assisted living establishment with
506.21 a comprehensive PLUS license.

506.22 Subd. 4. Notice of false advertising. Upon the determination that a housing with services
506.23 establishment inaccurately implies or advertises that they have a comprehensive PLUS
506.24 license, the commissioner shall send a notice to the licensee to cease the advertising
506.25 immediately. Failure to comply may result in a civil penalty as outlined in section 144I.21.

506.26 **Sec. 4. [144I.15] RESPONSIBILITIES OF ADMINISTRATION FOR**
506.27 **COMPREHENSIVE PLUS LICENSEES.**

506.28 Subdivision 1. General. The comprehensive PLUS licensee is responsible for the care
506.29 and housing of the persons with dementia and the provision of person-centered care that
506.30 promotes each resident's dignity, independence, and comfort. This includes the supervision,
506.31 training, and overall conduct of the staff.

507.1 **Subd. 2. Additional requirements.** (a) The comprehensive PLUS licensee must follow
507.2 the comprehensive assisted living license requirements in section 144I.02, home care
507.3 licensing under chapter 144A, and the criteria in this section.

507.4 (b) The administrator of the assisted living establishment with a comprehensive PLUS
507.5 license must complete and document that at least ten hours of the required annual continuing
507.6 educational requirements relate to the care of individuals with dementia. Continuing education
507.7 credits must be obtained through commissioner-approved sources that may include college
507.8 courses, preceptor credits, self-directed activities, course instructor credits, corporate training,
507.9 in-service training, professional association training, web-based training, correspondence
507.10 courses, telecourses, seminars, and workshops.

507.11 (c) The comprehensive PLUS licensee must provide a uniform disclosure statement
507.12 designated by the commissioner to each person who requests information that explains the
507.13 services, costs, and operations for a resident at an assisted living establishment with a
507.14 comprehensive PLUS license.

507.15 **Subd. 3. Policies.** In addition to the policies and procedures required in the licensing of
507.16 home care services in chapter 144A, the comprehensive PLUS licensee must develop and
507.17 implement policies and procedures that address the:

507.18 (1) philosophy of how services are provided based upon the assisted living licensee's
507.19 values, mission, and promotion of person-centered care and how the philosophy shall be
507.20 implemented;

507.21 (2) evaluation of behavioral symptoms and design of supports for intervention plans;
507.22 (3) wandering and egress prevention that provides detailed instructions to staff in the
507.23 event a resident elopes;

507.24 (4) assessment of residents for the use and effects of medications, including psychotropic
507.25 medications;

507.26 (5) use of supportive devices with restraining qualities;

507.27 (6) staffing plan to ensure that residents' needs are met including a quality control system
507.28 that periodically reviews how well the staffing plan is working;

507.29 (7) staff training specific to dementia care;

507.30 (8) description of life enrichment programs and how activities are implemented;

507.31 (9) description of family support programs and efforts to keep the family engaged;

508.1 (10) limiting the use of public address and intercom systems for emergencies and
508.2 evacuation drills only;

508.3 (11) transportation coordination and assistance to and from outside medical appointments;
508.4 and

508.5 (12) safekeeping of resident's possessions.

508.6 The policies and procedures must be provided to residents and the resident's representative
508.7 at the time of move-in.

508.8 Sec. 5. **[144I.16] STAFFING AND STAFF TRAINING FOR COMPREHENSIVE**
508.9 **PLUS LICENSEES.**

508.10 Subdivision 1. General. (a) The comprehensive PLUS licensee must provide residents
508.11 with dementia-trained staff who have been instructed in the person-centered care approach.
508.12 All direct care and other community staff assigned to care for dementia residents must be
508.13 specially trained to work with residents with Alzheimer's disease and other dementias.

508.14 (b) Only staff trained as specified in subdivisions 2 and 3 shall be assigned to care for
508.15 dementia residents.

508.16 (c) Staffing levels must be sufficient to meet the scheduled and unscheduled needs of
508.17 residents. Staffing levels during nighttime hours shall be based on the sleep patterns and
508.18 needs of residents.

508.19 (d) In an emergency situation when trained staff are not available to provide services,
508.20 the assisted living facility may assign staff who have not completed the required training.
508.21 The particular emergency situation must be documented and must address:

- 508.22 (1) the nature of the emergency;
508.23 (2) how long the emergency lasted; and
508.24 (3) the names and positions of staff that provided coverage.

508.25 Subd. 2. Staffing requirements. A comprehensive PLUS licensee must ensure that staff
508.26 who provide support to residents with dementia have a basic understanding and fundamental
508.27 knowledge of the residents' emotional and unique health care needs using person-centered
508.28 planning delivery. Direct care dementia-trained staff and other staff must be trained on the
508.29 topics identified during the expedited rulemaking process. These requirements are in addition
508.30 to the licensing requirements for training.

509.1 **Subd. 3. Supervising staff training.** Persons providing or overseeing staff training must
509.2 have experience and knowledge in the care of individuals with dementia.

509.3 **Subd. 4. Preservice and in-service training.** Preservice and in-service training may
509.4 include various methods of instruction, such as classroom style, web-based training, video,
509.5 or one-to-one training. The dementia care unit must have a method for determining and
509.6 documenting each staff person's knowledge and understanding of the training provided. All
509.7 training must be documented.

509.8 **Sec. 6. [144I.17] SERVICES FOR RESIDENTS WITH DEMENTIA.**

509.9 **Subdivision 1. Move-in assessment.** (a) At the time of move-in, dementia-trained staff
509.10 must make reasonable attempts to identify the customary routines of each resident and the
509.11 resident's preferences in how services may be delivered. Minimum services to be provided
509.12 include:

509.13 (1) assistance with activities of daily living that address the needs of each resident with
509.14 dementia due to cognitive or physical limitations. These services must meet or be in addition
509.15 to the requirements in the licensing rules for the facility. Services must be provided in a
509.16 person-centered manner that promotes resident choice, dignity, and sustains the resident's
509.17 abilities;

509.18 (2) health care services provided according to the licensing statutes and rules of the
509.19 facility;

509.20 (3) a daily meal program for nutrition and hydration must be provided and available
509.21 throughout each resident's waking hours. The individualized nutritional plan for each resident
509.22 must be documented in the resident's service or care plan. In addition, the assisted living
509.23 must:

509.24 (i) provide visual contrast between plates, eating utensils, and the table to maximize the
509.25 independence of each resident; and

509.26 (ii) provide adaptive eating utensils for those residents who have been evaluated as
509.27 needing them to maintain their eating skills; and

509.28 (4) meaningful activities that promote or help sustain the physical and emotional
509.29 well-being of residents. The activities must be person-directed and available during residents'
509.30 waking hours.

509.31 (b) Each resident must be evaluated for activities according to the licensing rules
509.32 governing assisted living. In addition, the evaluation must address the following:

- 510.1 (1) past and current interests;
- 510.2 (2) current abilities and skills;
- 510.3 (3) emotional and social needs and patterns;
- 510.4 (4) physical abilities and limitations;
- 510.5 (5) adaptations necessary for the resident to participate; and
- 510.6 (6) identification of activities for behavioral interventions.
- 510.7 (c) An individualized activity plan must be developed for each resident based on their
- 510.8 activity evaluation. The plan must reflect the resident's activity preferences and needs.
- 510.9 (d) A selection of daily structured and non-structured activities must be provided and
- 510.10 included on the resident's activity service or care plan as appropriate. Daily activity options
- 510.11 based on resident evaluation may include but are not limited to:
- 510.12 (1) occupation or chore related tasks;
- 510.13 (2) scheduled and planned events such as entertainment or outings;
- 510.14 (3) spontaneous activities for enjoyment or those that may help defuse a behavior;
- 510.15 (4) one-to-one activities that encourage positive relationships between residents and
- 510.16 staff such as telling a life story, reminiscing, or playing music;
- 510.17 (5) spiritual, creative, and intellectual activities;
- 510.18 (6) sensory stimulation activities;
- 510.19 (7) physical activities that enhance or maintain a resident's ability to ambulate or move;
- 510.20 and
- 510.21 (8) outdoor activities.
- 510.22 (e) Behavioral symptoms that negatively impact the resident and others in the assisted
- 510.23 living must be evaluated and included on the service or care plan. The staff must initiate
- 510.24 and coordinate outside consultation or acute care when indicated.
- 510.25 (f) Support must be offered to family and other significant relationships on a regularly
- 510.26 scheduled basis but not less than quarterly. Examples in which support may be provided
- 510.27 include support groups, community gatherings, social events, or meetings that address the
- 510.28 needs of individual residents or their family or significant relationships.
- 510.29 (g) Access to secured outdoor space and walkways that allow residents to enter and
- 510.30 return without staff assistance must be provided.

511.1 Sec. 7. **[144I.18] PHYSICAL DESIGN, ENVIRONMENT, AND SAFETY OF**
511.2 **DEMENTIA CARE UNITS.**

511.3 Subdivision 1. Life safety code. A comprehensive PLUS licensee must comply with
511.4 the most current edition of NFPA.101, life safety code, health care chapter.

511.5 Subd. 2. Comprehensive PLUS and dementia care units located on ground
511.6 level. Dementia care units must be located on the ground level of the building to ensure
511.7 access to outdoor space and safe evacuation.

511.8 Subd. 3. Secure outdoor recreation area. The assisted living establishment with a
511.9 comprehensive PLUS license must provide:

511.10 (1) outdoor recreation space that is a minimum of 600 square feet or 15 square feet per
511.11 resident, whichever is greater, and is exclusive of normal walkways and landscaping. The
511.12 space must have a minimum dimension of 15 feet in any direction;

511.13 (2) fences surrounding the perimeter of the outdoor recreation area must be no less than
511.14 six feet in height, constructed to reduce the risk of resident elopement, and maintained in
511.15 functional condition;

511.16 (3) walkways must meet applicable federal, state, and accessibility codes. Walkway
511.17 surfaces must be of a medium to dark reflectance value to prevent glare from reflected
511.18 sunlight;

511.19 (4) outdoor furniture must be of a sufficient weight, stability, and design, and be
511.20 maintained to prevent resident injury or prevent aid in elopement; and

511.21 (5) doors to the outdoor recreation area may be locked during nighttime hours or during
511.22 severe weather per facility policy.

511.23 Subd. 4. Common areas in dementia care unit. (a) Common areas must include the
511.24 following requirements:

511.25 (1) freedom of movement for the residents to common areas and to the resident's personal
511.26 spaces;

511.27 (2) a multipurpose room for dining, group and individual activities, and family visits
511.28 that complies with the facility licensing requirements for common space;

511.29 (3) comfortable seating;

511.30 (4) safe corridors and passageways through the common areas that are free of objects
511.31 that may cause falls; and

512.1 (5) windows or skylights that are at least as large as 12 percent of the square footage of
512.2 the common area.

512.3 (b) A public address or intercom system is not required, however if one exists it must
512.4 be used within the dementia care unit only for emergencies.

512.5 Subd. 5. Resident rooms in dementia care unit. (a) Residents may not be locked out
512.6 of or inside of their rooms at any time.

512.7 (b) Residents must be encouraged to decorate and furnish their rooms with personal
512.8 items and furnishings based on the resident's needs, preferences, and appropriateness.

512.9 (c) The dementia care unit must individually identify residents' rooms to assist residents
512.10 in recognizing their room.

ARTICLE 16

DECEPTIVE MARKETING AND BUSINESS PRACTICES

512.13 **Section 1. [144I.20] DEFINITIONS.**

512.14 Subdivision 1. **Applicability.** For the purposes of this section and section 144I.21, the
512.15 definitions in this section have the meanings given.

512.16 Subd. 2. **Facility.** "Facility" means a facility that is licensed as a nursing home under
512.17 chapter 144A or a boarding care home under sections 144.50 to 144.56; a registered housing
512.18 with services establishment under chapter 144D; the licensed home care provider providing
512.19 services in a housing with services establishment; or an assisted living licensed under this
512.20 chapter.

512.21 Subd. 3. **Resident representative.** "Resident representative" means a court-appointed
512.22 guardian, health care agent under section 145C.01, subdivision 2, or person chosen by the
512.23 resident and identified in the resident's records on file with the facility.

512.24 **Sec. 2. [144I.21] DECEPTIVE MARKETING AND BUSINESS PRACTICES.**

512.25 (a) Facilities are prohibited from engaging in deceptive marketing and business practices
512.26 as follows:

512.27 (1) making any false, fraudulent, deceptive, or misleading statements in marketing,
512.28 advertising, or other oral or written description or representation of cares or services, whether
512.29 in oral, written, or electronic form;

512.30 (2) arranging for or providing health or supportive care services that are substantially
512.31 different from or more expensive than those offered, promised, marketed, or advertised;

513.1 (3) failing to deliver any health or supportive care or services the provider or facility
513.2 promised or represented that the facility was able to provide;

513.3 (4) failing to inform the resident in writing of any limitations to services available prior
513.4 to executing a contract for a service plan or lease agreement;

513.5 (5) discharging or terminating the lease or services of a resident following a required
513.6 period of private pay when the next form of payment will be from the medical assistance
513.7 waivers under sections 256B.0915 and 256B.49 after the licensee has promised to continue
513.8 the same services after private pay ceases;

513.9 (6) discharging or terminating the lease or services of a resident following a required
513.10 period of private pay when the next form of payment will be from the medical assistance
513.11 elderly waiver program after the licensee has promised to continue the same services after
513.12 private pay ceases;

513.13 (7) failing to disclose and clearly explain the purpose of any nonrefundable fee prior to
513.14 executing a contract for the service plan or lease;

513.15 (8) advertising or representing orally or in writing that the licensee has a special care
513.16 unit, such as for dementia or memory care, without complying with training and disclosure
513.17 requirements under sections 144D.065 and 325F.72 and any other applicable law; and

513.18 (9) misstating or falsely asserting statutory requirements as being the cause of a business
513.19 decision.

513.20 (b) A violation of this section shall result in no less than a level 2 fine, but may result
513.21 in a level 3 or level 4 fine if, as a result of the deceptive marketing and business practices,
513.22 the resulting harm was equal to or greater than that described in section 144A.47, subdivision
513.23 11.

513.24 (c) The commissioner may suspend, refuse to renew, or revoke a license or provisional
513.25 license for a repeated violation of this section.

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

ARTICLE 17

HOUSING WITH SERVICES CONFORMING CHANGES

513.29 Section 1. Minnesota Statutes 2018, section 144D.01, subdivision 4, is amended to read:

513.30 Subd. 4. **Housing with services establishment or establishment.** (a) "Housing with
513.31 services establishment" or "establishment" means:

- 514.1 (1) an establishment providing sleeping accommodations to one or more adult residents,
514.2 at least 80 percent of which are 55 years of age or older, and offering or providing, for a
514.3 fee, ~~one or more regularly scheduled health related services or~~ two or more regularly
514.4 scheduled supportive services, whether offered or provided directly by the establishment
514.5 or by another entity arranged for by the establishment; or
- 514.6 (2) an establishment that registers under section 144D.025.
- 514.7 (b) Housing with services establishment does not include:
- 514.8 (1) a nursing home licensed under chapter 144A;
- 514.9 (2) a hospital, certified boarding care home, or supervised living facility licensed under
514.10 sections 144.50 to 144.56;
- 514.11 (3) a board and lodging establishment licensed under chapter 157 and Minnesota Rules,
514.12 parts 9520.0500 to 9520.0670, or under chapter 245D or 245G;
- 514.13 (4) an assisted living licensed under chapter 144I;
- 514.14 ~~(4)~~(5) a board and lodging establishment which serves as a shelter for battered women
514.15 or other similar purpose;
- 514.16 ~~(5)~~(6) a family adult foster care home licensed by the Department of Human Services;
- 514.17 ~~(6)~~(7) private homes in which the residents are related by kinship, law, or affinity with
514.18 the providers of services;
- 514.19 ~~(7)~~(8) residential settings for persons with developmental disabilities in which the
514.20 services are licensed under chapter 245D;
- 514.21 ~~(8)~~(9) a home-sharing arrangement such as when an elderly or disabled person or
514.22 single-parent family makes lodging in a private residence available to another person in
514.23 exchange for services or rent, or both;
- 514.24 ~~(9)~~(10) a duly organized condominium, cooperative, common interest community, or
514.25 owners' association of the foregoing where at least 80 percent of the units that comprise the
514.26 condominium, cooperative, or common interest community are occupied by individuals
514.27 who are the owners, members, or shareholders of the units;
- 514.28 ~~(10)~~(11) services for persons with developmental disabilities that are provided under a
514.29 license under chapter 245D; or
- 514.30 ~~(11)~~(12) a temporary family health care dwelling as defined in sections 394.307 and
514.31 462.3593.

515.1 **EFFECTIVE DATE.** This section is effective July 1, 2022.

515.2 Sec. 2. Minnesota Statutes 2018, section 144D.015, is amended to read:

515.3 **144D.015 DEFINITION FOR PURPOSES OF LONG-TERM CARE INSURANCE.**

515.4 For purposes of consistency with terminology commonly used in long-term care insurance
515.5 policies and notwithstanding chapter 144G, a housing with services establishment that is
515.6 registered under section 144D.03 and that holds, or makes arrangements with an individual
515.7 or entity that holds any type of home care license and all other licenses, permits, registrations,
515.8 or other governmental approvals legally required for delivery of the services the establishment
515.9 offers or provides to its residents, constitutes an "assisted living facility" or "assisted living
515.10 residence." A housing with services that provides home care services must be licensed as
515.11 an assisted living pursuant to chapter 144I.

515.12 **EFFECTIVE DATE.** This section is effective July 1, 2022.

515.13 Sec. 3. Minnesota Statutes 2018, section 144D.04, subdivision 2, is amended to read:

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

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

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

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

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

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

515.28 (6) the term of the contract;

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

- 516.1 (8) a description of any additional services, ~~including home care services~~, available for
516.2 an additional fee from the establishment directly or through arrangements with the
516.3 establishment, and a schedule of fees charged for these services;
- 516.4 (9) a conspicuous notice informing the tenant of the policy concerning the conditions
516.5 under which and the process through which the contract may be modified, amended, or
516.6 terminated, including whether a move to a different room or sharing a room would be
516.7 required in the event that the tenant can no longer pay the current rent;
- 516.8 (10) a description of the establishment's complaint resolution process available to residents
516.9 including the toll-free complaint line for the Office of Ombudsman for Long-Term Care;
- 516.10 (11) the resident's designated representative, if any;
- 516.11 (12) the establishment's referral procedures if the contract is terminated;
- 516.12 (13) requirements of residency used by the establishment to determine who may reside
516.13 or continue to reside in the housing with services establishment;
- 516.14 (14) billing and payment procedures and requirements;
- 516.15 (15) a statement regarding the ability of a resident to receive services from service
516.16 providers with whom the establishment does not have an arrangement;
- 516.17 (16) a statement regarding the availability of public funds for payment for residence or
516.18 services in the establishment; and
- 516.19 (17) a statement regarding the availability of and contact information for long-term care
516.20 consultation services under section 256B.0911 in the county in which the establishment is
516.21 located.

516.22 **EFFECTIVE DATE.** This section is effective July 1, 2022.

516.23 Sec. 4. **REPEALER.**

516.24 Minnesota Statutes 2018, sections 144D.01, subdivisions 2a, 3a, and 6; 144D.04,
516.25 subdivision 2a; 144D.045; 144D.06; 144D.09; and 144D.10, are repealed effective July 1,
516.26 2022.

517.1

ARTICLE 18

517.2

HOME CARE CHANGES

517.3 Section 1. Minnesota Statutes 2018, section 144A.43, subdivision 6, is amended to read:

517.4 Subd. 6. **License.** "License" means a basic or comprehensive home care license issued
517.5 by the commissioner to a home care provider and effective July 1, 2022, providing services
517.6 outside of assisted living settings licensed under chapter 144I.517.7 Sec. 2. **[144A.431] APPLICABILITY OF HOME CARE STATUTES TO ASSISTED**517.8 **LIVING LICENSE REQUIREMENTS IN CHAPTER 144I.**517.9 The provisions in sections 144A.43 to 144A.47 apply to assisted living license
517.10 requirements pursuant to section 144I.02. Assisted living license requirements in chapter
517.11 144I are effective starting July 1, 2021, for all new assisted living licensees and when home
517.12 care licensees have converted their home care license to the assisted living license between
517.13 July 1, 2021, and June 30, 2022.

517.14 Sec. 3. Minnesota Statutes 2018, section 144A.44, subdivision 1, is amended to read:

517.15 Subdivision 1. **Statement of rights.** (a) A person client or resident who receives home
517.16 care services in the community or in an assisted living licensed under chapter 144I has these
517.17 rights:517.18 (1) ~~the right to receive written information, in plain language, about rights before~~
517.19 receiving services, including what to do if rights are violated;517.20 (2) ~~the right to receive care and services according to a suitable and up-to-date plan, and~~
517.21 ~~subject to accepted health care, medical or nursing standards and person-centered care,~~ to
517.22 take an active part in developing, modifying, and evaluating the plan and services;517.23 (3) ~~the right to be told before receiving services the type and disciplines of staff who~~
517.24 will be providing the services, the frequency of visits proposed to be furnished, other choices
517.25 that are available for addressing home care needs, and the potential consequences of refusing
517.26 these services;517.27 (4) ~~the right to be told in advance of any recommended changes by the provider in the~~
517.28 service plan and to take an active part in any decisions about changes to the service plan;517.29 (5) ~~the right to refuse services or treatment;~~517.30 (6) ~~the right to know, before receiving services or during the initial visit, any limits to~~
517.31 the services available from a home care provider;

- 518.1 (7) ~~the right to~~ be told before services are initiated what the provider charges for the
518.2 services; to what extent payment may be expected from health insurance, public programs,
518.3 or other sources, if known; and what charges the client may be responsible for paying;
- 518.4 (8) ~~the right to~~ know that there may be other services available in the community,
518.5 including other home care services and providers, and to know where to find information
518.6 about these services;
- 518.7 (9) ~~the right to~~ choose freely among available providers and to change providers after
518.8 services have begun, within the limits of health insurance, long-term care insurance, medical
518.9 assistance, ~~or~~ other health programs, or public programs;
- 518.10 (10) ~~the right to~~ have personal, financial, and medical information kept private, and to
518.11 be advised of the provider's policies and procedures regarding disclosure of such information;
- 518.12 (11) ~~the right to~~ access the client's own records and written information from those
518.13 records in accordance with sections 144.291 to 144.298;
- 518.14 (12) ~~the right to~~ be served by people who are properly trained and competent to perform
518.15 their duties;
- 518.16 (13) ~~the right to~~ be treated with courtesy and respect, and to have the client's property
518.17 treated with respect;
- 518.18 (14) ~~the right to~~ be free from physical and verbal abuse, neglect, financial exploitation,
518.19 and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment
518.20 of Minors Act;
- 518.21 (15) ~~the right to~~ reasonable, advance notice of changes in services or charges;
- 518.22 (16) ~~the right to~~ know the provider's reason for termination of services;
- 518.23 (17) ~~the right to~~ at least ten 30 days' advance notice of the termination of a service or
518.24 housing by a provider, except in cases where:
- 518.25 (i) the client engages in conduct that significantly alters the terms of the service plan
518.26 with the home care provider;
- 518.27 (ii) the client, person who lives with the client, or others create an abusive or unsafe
518.28 work environment for the person providing home care services; or
- 518.29 (iii) an emergency or a significant change in the client's condition has resulted in service
518.30 needs that exceed the current service plan and that cannot be safely met by the home care
518.31 provider;

519.1 (18) ~~the right to~~ a coordinated transfer when there will be a change in the provider of
519.2 services;

519.3 (19) ~~the right to complain to staff and others of the client's choice about services that~~
519.4 are provided, or fail to be provided, and the lack of courtesy or respect to the client or the
519.5 client's property ~~and the right to recommend changes in policies and services, free from~~
519.6 ~~retaliation including the threat of termination of services;~~

519.7 (20) ~~the right to know how to contact an individual associated with the home care provider~~
519.8 who is responsible for handling problems and to have the home care provider investigate
519.9 and attempt to resolve the grievance or complaint;

519.10 (21) ~~the right to know the name and address of the state or county agency to contact for~~
519.11 additional information or assistance; ~~and~~

519.12 (22) ~~the right to assert these rights personally, or have them asserted by the client's~~
519.13 representative or by anyone on behalf of the client, without retaliation;_

519.14 (23) internet service at the client's own expense, unless it is provided by the provider;
519.15 and

519.16 (24) place an electronic monitoring device in the client's or resident's space in compliance
519.17 with state requirements.

519.18 (b) When providers violate the rights in this section, they are subject to the fines and
519.19 license actions in sections 144A.474, subdivision 11, and 144A.475.

519.20 (c) Providers must do all of the following:

519.21 (1) encourage and assist in the fullest possible exercise of these rights;

519.22 (2) provide the names and telephone numbers of individuals and organizations that
519.23 provide advocacy and legal services for clients and residents seeking to assert their rights;

519.24 (3) make every effort to assist clients or residents in obtaining information regarding
519.25 whether Medicare, medical assistance, other health programs, or public programs will pay
519.26 for services;

519.27 (4) make reasonable accommodations for people who have communication disabilities,
519.28 or those who speak a language other than English; and

519.29 (5) provide all information and notices in plain language and in terms the client or
519.30 resident can understand.

520.1 Sec. 4. Minnesota Statutes 2018, section 144A.44, subdivision 2, is amended to read:

520.2 Subd. 2. **Interpretation and enforcement of rights.** These rights are established for
520.3 the benefit of clients or residents who receive home care services. All home care providers,
520.4 including those exempted under section 144A.471, must comply with this section. The
520.5 commissioner shall enforce this section and the home care bill of rights requirement against
520.6 home care providers exempt from licensure in the same manner as for licensees. A home
520.7 care provider may not request or require a client to surrender any of these rights as a condition
520.8 of receiving services. This statement of rights does not replace or diminish other rights and
520.9 liberties that may exist relative to clients receiving home care services, persons providing
520.10 home care services, or providers licensed under sections 144A.43 to 144A.482.

520.11 Sec. 5. Minnesota Statutes 2018, section 144A.441, is amended to read:

520.12 **144A.441 ASSISTED LIVING BILL OF RIGHTS ADDENDUM.**

520.13 Assisted living clients residents, as defined in section 144G.01, subdivision 3 144I.01,
520.14 shall be provided with the home care bill of rights required by section 144A.44, except that
520.15 the home care bill of rights provided to these clients residents must include the following
520.16 provision in place of the provision in section 144A.44, subdivision 1, paragraph (a), clause
520.17 (17):

520.18 "(17) the right to reasonable, advance notice of changes in services or charges, including
520.19 at least 30 days' advance notice of the termination of a service or housing by a provider,
520.20 except in cases where:

520.21 (i) the recipient of services engages in conduct that alters the conditions of employment
520.22 as specified in the employment contract between the home care provider and the individual
520.23 providing home care services, or creates an abusive or unsafe work environment for the
520.24 individual providing home care services;

520.25 (ii) an emergency for the informal caregiver or a significant change in the recipient's
520.26 condition has resulted in service needs that exceed the current service provider agreement
520.27 and that cannot be safely met by the home care provider; or

520.28 (iii) the provider has not received payment for services, for which at least ten days'
520.29 advance notice of the termination of a service shall be provided."

521.1 Sec. 6. Minnesota Statutes 2018, section 144A.442, is amended to read:

521.2 **144A.442 ASSISTED LIVING CLIENTS RESIDENTS; SERVICE**

521.3 **TERMINATION.**

521.4 (a) If an arranged home care provider, as defined in section 144D.01, subdivision 2a,
521.5 who is not also Medicare certified terminates a service agreement or service plan with an
521.6 assisted living client, as defined in section 144G.01, subdivision 3, the home care provider
521.7 shall provide the assisted living client and the legal or designated representatives of the
521.8 client, if any, with a written notice of termination which includes the following information:

521.9 (1) the effective date of termination;

521.10 (2) the reason for termination;

521.11 (3) without extending the termination notice period, an affirmative offer to meet with
521.12 the assisted living client or client representatives within no more than five business days of
521.13 the date of the termination notice to discuss the termination;

521.14 (4) contact information for a reasonable number of other home care providers in the
521.15 geographic area of the assisted living client, as required by section 144A.4791, subdivision
521.16 10;

521.17 (5) a statement that the provider will participate in a coordinated transfer of the care of
521.18 the client to another provider or caregiver, as required by section 144A.44, subdivision 1,
521.19 clause (18);

521.20 (6) the name and contact information of a representative of the home care provider with
521.21 whom the client may discuss the notice of termination;

521.22 (7) a copy of the home care bill of rights; and

521.23 (8) a statement that the notice of termination of home care services by the home care
521.24 provider does not constitute notice of termination of the housing with services contract with
521.25 a housing with services establishment.

521.26 (b) Effective July 1, 2021, all assisted living settings must comply with the provisions
521.27 in chapter 144I relating to termination of services and housing.

521.28 Sec. 7. Minnesota Statutes 2018, section 144A.471, subdivision 1, is amended to read:

521.29 Subdivision 1. **License required.** (a) A home care provider may not open, operate,
521.30 manage, conduct, maintain, or advertise itself as a home care provider or provide home care

522.1 services in Minnesota without a temporary or current home care provider license issued by
522.2 the commissioner of health.

522.3 (b) Effective July 1, 2021, all assisted living providers licensed pursuant to chapter 144I
522.4 shall comply with this chapter for the provision of basic and comprehensive home care
522.5 services.

522.6 Sec. 8. Minnesota Statutes 2018, section 144A.471, subdivision 5, is amended to read:

522.7 Subd. 5. **Basic and comprehensive levels of licensure.** (a) An applicant seeking to
522.8 become a home care provider must apply for either a basic or comprehensive home care
522.9 license.

522.10 (b) Effective July 1, 2021, all home care providers who also provide housing, must apply
522.11 for an assisted living license pursuant to chapter 144I according to the process set out by
522.12 the commissioner. Home care providers providing services in the community without
522.13 providing housing must apply for a license under this chapter.

522.14 Sec. 9. Minnesota Statutes 2018, section 144A.471, subdivision 9, is amended to read:

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

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

522.19 (i) determination of whether a client needs home care services, or assisting a client in
522.20 determining what services are needed;

522.21 (ii) referral of clients to a home care provider;

522.22 (iii) administration of payments for home care services; or

522.23 (iv) administration of a health care home established under section 256B.0751;

522.24 (2) an individual who is not an employee of a licensed home care provider if the
522.25 individual:

522.26 (i) only provides services as an independent contractor to one or more licensed home
522.27 care providers;

522.28 (ii) provides no services under direct agreements or contracts with clients; and

522.29 (iii) is contractually bound to perform services in compliance with the contracting home
522.30 care provider's policies and service plans;

- 523.1 (3) a business that provides staff to home care providers, such as a temporary employment
523.2 agency, if the business:
- 523.3 (i) only provides staff under contract to licensed or exempt providers;
- 523.4 (ii) provides no services under direct agreements with clients; and
- 523.5 (iii) is contractually bound to perform services under the contracting home care provider's
523.6 direction and supervision;
- 523.7 (4) any home care services conducted by and for the adherents of any recognized church
523.8 or religious denomination for its members through spiritual means, or by prayer for healing;
- 523.9 (5) an individual who only provides home care services to a relative;
- 523.10 (6) an individual not connected with a home care provider that provides assistance with
523.11 basic home care needs if the assistance is provided primarily as a contribution and not as a
523.12 business;
- 523.13 (7) an individual not connected with a home care provider that shares housing with and
523.14 provides primarily housekeeping or homemaking services to an elderly or disabled person
523.15 in return for free or reduced-cost housing;
- 523.16 (8) an individual or provider providing home-delivered meal services;
- 523.17 (9) an individual providing senior companion services and other older American volunteer
523.18 programs (OAVP) established under the Domestic Volunteer Service Act of 1973, United
523.19 States Code, title 42, chapter 66;
- 523.20 ~~(10) an employee of a nursing home or home care provider licensed under this chapter
523.21 or an employee of a boarding care home licensed under sections 144.50 to 144.56 when
523.22 responding to occasional emergency calls from individuals residing in a residential setting
523.23 that is attached to or located on property contiguous to the nursing home, boarding care
523.24 home, or location where home care services are also provided;~~
- 523.25 ~~(11) an employee of a nursing home or home care provider licensed under this chapter
523.26 or an employee of a boarding care home licensed under sections 144.50 to 144.56 when
523.27 providing occasional minor services free of charge to individuals residing in a residential
523.28 setting that is attached to or located on property contiguous to the nursing home, boarding
523.29 care home, or location where home care services are also provided;~~
- 523.30 (12) a member of a professional corporation organized under chapter 319B that does
523.31 not regularly offer or provide home care services as defined in section 144A.43, subdivision
523.32 3;

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

524.6 (14) an individual or agency that provides medical supplies or durable medical equipment,
524.7 except when the provision of supplies or equipment is accompanied by a home care service;

524.8 (15) a physician licensed under chapter 147;

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

524.11 (17) a business that only provides services that are primarily instructional and not medical
524.12 services or health-related support services;

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

524.15 (19) an individual or business licensed as hospice as defined in sections 144A.75 to
524.16 144A.755 who is not providing home care services independent of hospice service;

524.17 (20) activities conducted by the commissioner of health or a community health board
524.18 as defined in section 145A.02, subdivision 5, including communicable disease investigations
524.19 or testing; or

524.20 (21) administering or monitoring a prescribed therapy necessary to control or prevent a
524.21 communicable disease, or the monitoring of an individual's compliance with a health directive
524.22 as defined in section 144A.4172, subdivision 6.

524.23 **EFFECTIVE DATE.** The amendments to clauses (10) and (11) are effective July 1,
524.24 2021.

524.25 Sec. 10. Minnesota Statutes 2018, section 144A.472, subdivision 7, is amended to read:

524.26 Subd. 7. **Fees; application, change of ownership, and renewal.** (a) An initial applicant
524.27 seeking temporary home care licensure must submit the following application fee to the
524.28 commissioner along with a completed application:

524.29 (1) for a basic home care provider, \$2,100; or

524.30 (2) for a comprehensive home care provider, \$4,200.

525.1 (b) A home care provider who is filing a change of ownership as required under
 525.2 subdivision 5 must submit the following application fee to the commissioner, along with
 525.3 the documentation required for the change of ownership:

- 525.4 (1) for a basic home care provider, \$2,100; or
 525.5 (2) for a comprehensive home care provider, \$4,200.

525.6 (c) For the period ending June 30, 2018, a home care provider who is seeking to renew
 525.7 the provider's license shall pay a fee to the commissioner based on revenues derived from
 525.8 the provision of home care services during the calendar year prior to the year in which the
 525.9 application is submitted, according to the following schedule:

525.10 **License Renewal Fee**

Provider Annual Revenue	Fee
525.12 greater than \$1,500,000	\$6,625
525.13 greater than \$1,275,000 and no more than 525.14 \$1,500,000	\$5,797
525.15 greater than \$1,100,000 and no more than 525.16 \$1,275,000	\$4,969
525.17 greater than \$950,000 and no more than 525.18 \$1,100,000	\$4,141
525.19 greater than \$850,000 and no more than \$950,000	\$3,727
525.20 greater than \$750,000 and no more than \$850,000	\$3,313
525.21 greater than \$650,000 and no more than \$750,000	\$2,898
525.22 greater than \$550,000 and no more than \$650,000	\$2,485
525.23 greater than \$450,000 and no more than \$550,000	\$2,070
525.24 greater than \$350,000 and no more than \$450,000	\$1,656
525.25 greater than \$250,000 and no more than \$350,000	\$1,242
525.26 greater than \$100,000 and no more than \$250,000	\$828
525.27 greater than \$50,000 and no more than \$100,000	\$500
525.28 greater than \$25,000 and no more than \$50,000	\$400
525.29 no more than \$25,000	\$200

525.30 (d) For the period between July 1, 2018, and June 30, 2020, a home care provider who
 525.31 is seeking to renew the provider's license shall pay a fee to the commissioner in an amount
 525.32 that is ten percent higher than the applicable fee in paragraph (c). A home care provider's
 525.33 fee shall be based on revenues derived from the provision of home care services during the
 525.34 calendar year prior to the year in which the application is submitted.

525.35 (e) Beginning July 1, 2020, a home care provider who is seeking to renew the provider's
 525.36 license shall pay a fee to the commissioner based on revenues derived from the provision

526.1 of home care services during the calendar year prior to the year in which the application is
 526.2 submitted, according to the following schedule:

526.3 **License Renewal Fee**

526.4 Provider Annual Revenue	526.4 Fee
526.5 greater than \$1,500,000	\$7,651
526.6 greater than \$1,275,000 and no more than 526.7 \$1,500,000	\$6,695
526.8 greater than \$1,100,000 and no more than 526.9 \$1,275,000	\$5,739
526.10 greater than \$950,000 and no more than 526.11 \$1,100,000	\$4,783
526.12 greater than \$850,000 and no more than \$950,000	\$4,304
526.13 greater than \$750,000 and no more than \$850,000	\$3,826
526.14 greater than \$650,000 and no more than \$750,000	\$3,347
526.15 greater than \$550,000 and no more than \$650,000	\$2,870
526.16 greater than \$450,000 and no more than \$550,000	\$2,391
526.17 greater than \$350,000 and no more than \$450,000	\$1,913
526.18 greater than \$250,000 and no more than \$350,000	\$1,434
526.19 greater than \$100,000 and no more than \$250,000	\$957
526.20 greater than \$50,000 and no more than \$100,000	\$577
526.21 greater than \$25,000 and no more than \$50,000	\$462
526.22 no more than \$25,000	\$231

526.23 (f) If requested, the home care provider shall provide the commissioner information to
 526.24 verify the provider's annual revenues or other information as needed, including copies of
 526.25 documents submitted to the Department of Revenue.

526.26 (g) At each annual renewal, a home care provider may elect to pay the highest renewal
 526.27 fee for its license category, and not provide annual revenue information to the commissioner.

526.28 (h) A temporary license or license applicant, or temporary licensee or licensee that
 526.29 knowingly provides the commissioner incorrect revenue amounts for the purpose of paying
 526.30 a lower license fee, shall be subject to a civil penalty in the amount of double the fee the
 526.31 provider should have paid.

526.32 (i) The fee for failure to comply with the notification requirements in section 144A.473,
 526.33 subdivision 2, paragraph (c), is \$1,000.

526.34 (j) Fees and penalties collected under this section shall be deposited in the state
 526.35 treasury and credited to the state government special revenue fund. All fees are
 526.36 nonrefundable. Fees collected under paragraphs (c), (d), and (e) are nonrefundable even if

527.1 received before July 1, 2017, for temporary licenses or licenses being issued effective July
527.2 1, 2017, or later.

527.3 (k) Fines collected under this subdivision shall be deposited in a dedicated special revenue
527.4 account. On an annual basis, the balance in the special revenue account will be appropriated
527.5 to the commissioner to implement the recommendations of the advisory council established
527.6 in section 144A.4799. Fines collected in state fiscal years 2018 and 2019 shall be deposited
527.7 in the dedicated special revenue account as described in this section.

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

527.9 Sec. 11. Minnesota Statutes 2018, section 144A.474, subdivision 9, is amended to read:

527.10 Subd. 9. **Follow-up surveys.** For providers that have Level 3 or Level 4 violations under
527.11 subdivision 11, or any violations determined to be widespread, the department shall conduct
527.12 a follow-up survey within 90 calendar days of the survey. When conducting a follow-up
527.13 survey, the surveyor will focus on whether the previous violations have been corrected and
527.14 may also address any new violations that are observed while evaluating the corrections that
527.15 have been made. ~~If a new violation is identified on a follow-up survey, no fine will be~~
527.16 ~~imposed unless it is not corrected on the next follow-up survey.~~

527.17 Sec. 12. Minnesota Statutes 2018, section 144A.474, subdivision 11, is amended to read:

527.18 Subd. 11. **Fines.** (a) Fines and enforcement actions under this subdivision may be assessed
527.19 based on the level and scope of the violations described in paragraph ~~(e)~~ (b) and imposed
527.20 immediately with no opportunity to correct the violation first as follows:

527.21 (1) Level 1, no fines or enforcement;

527.22 (2) Level 2, ~~fines ranging from \$0 to a fine of \$500 per violation~~, in addition to any of
527.23 the enforcement mechanisms authorized in section 144A.475 for widespread violations;

527.24 (3) Level 3, ~~fines ranging from \$500 to \$1,000 a fine of \$3,000 per incident plus \$100~~
527.25 ~~for each resident affected by the violation~~, in addition to any of the enforcement mechanisms
527.26 authorized in section 144A.475; and

527.27 (4) Level 4, ~~fines ranging from \$1,000 to a fine of \$5,000 per incident plus \$200 for~~
527.28 ~~each resident affected by the violation~~, in addition to any of the enforcement mechanisms
527.29 authorized in section 144A.475; and

527.30 (5) for maltreatment violations as defined in section 626.557 including abuse, neglect,
527.31 financial exploitation, and drug diversion, that are determined against the provider, an

528.1 immediate fine shall be imposed of \$5,000 per incident plus \$200 for each resident affected
528.2 by the violation; and

528.3 (6) the fines in clauses (1) to (4) are increased and immediate fine imposition is authorized
528.4 for both surveys and investigations conducted.

528.5 (b) Correction orders for violations are categorized by both level and scope and fines
528.6 shall be assessed as follows:

528.7 (1) level of violation:

528.8 (i) Level 1 is a violation that has no potential to cause more than a minimal impact on
528.9 the client and does not affect health or safety;

528.10 (ii) Level 2 is a violation that did not harm a client's health or safety but had the potential
528.11 to have harmed a client's health or safety, but was not likely to cause serious injury,
528.12 impairment, or death;

528.13 (iii) Level 3 is a violation that harmed a client's health or safety, not including serious
528.14 injury, impairment, or death, or a violation that has the potential to lead to serious injury,
528.15 impairment, or death; and

528.16 (iv) Level 4 is a violation that results in serious injury, impairment, or death;

528.17 (2) scope of violation:

528.18 (i) isolated, when one or a limited number of clients are affected or one or a limited
528.19 number of staff are involved or the situation has occurred only occasionally;

528.20 (ii) pattern, when more than a limited number of clients are affected, more than a limited
528.21 number of staff are involved, or the situation has occurred repeatedly but is not found to be
528.22 pervasive; and

528.23 (iii) widespread, when problems are pervasive or represent a systemic failure that has
528.24 affected or has the potential to affect a large portion or all of the clients.

528.25 (c) If the commissioner finds that the applicant or a home care provider ~~required to be~~
528.26 ~~licensed under sections 144A.43 to 144A.482~~ has not corrected violations by the date
528.27 specified in the correction order or conditional license resulting from a survey or complaint
528.28 investigation, the commissioner ~~may impose a fine. A~~ shall provide a notice of
528.29 noncompliance with a correction order ~~must be mailed by e-mail~~ to the applicant's or
528.30 provider's last known e-mail address. The noncompliance notice must list the violations not
528.31 corrected.

529.1 (d) For every violation identified by the commissioner, the commissioner shall issue an
529.2 immediate fine pursuant to paragraph (a), clause (6). The license holder must still correct
529.3 the violation in the time specified. The issuance of an immediate fine can occur in addition
529.4 to any enforcement mechanism authorized under section 144A.475. The immediate fine
529.5 may be appealed as allowed under this subdivision.

529.6 (e) The license holder must pay the fines assessed on or before the payment date
529.7 specified. If the license holder fails to fully comply with the order, the commissioner may
529.8 issue a second fine or suspend the license until the license holder complies by paying the
529.9 fine. A timely appeal shall stay payment of the fine until the commissioner issues a final
529.10 order.

529.11 (f) A license holder shall promptly notify the commissioner in writing when a violation
529.12 specified in the order is corrected. If upon reinspection the commissioner determines that
529.13 a violation has not been corrected as indicated by the order, the commissioner may issue a
529.14 second fine. The commissioner shall notify the license holder by mail to the last known
529.15 address in the licensing record that a second fine has been assessed. The license holder may
529.16 appeal the second fine as provided under this subdivision.

529.17 (g) A home care provider that has been assessed a fine under this subdivision has a
529.18 right to a reconsideration or a hearing under this section and chapter 14.

529.19 (h) When a fine has been assessed, the license holder may not avoid payment by
529.20 closing, selling, or otherwise transferring the licensed program to a third party. In such an
529.21 event, the license holder shall be liable for payment of the fine.

529.22 (i) In addition to any fine imposed under this section, the commissioner may assess
529.23 a penalty amount based on costs related to an investigation that results in a final order
529.24 assessing a fine or other enforcement action authorized by this chapter.

529.25 (j) Fines collected under this subdivision shall be deposited in ~~the state government~~
529.26 a dedicated special revenue fund and credited to an account separate from the revenue
529.27 ~~collected under section 144A.472. Subject to an appropriation by the legislature, the revenue~~
529.28 ~~from the fines collected must be used by the commissioner for special projects to improve~~
529.29 ~~home care in Minnesota as recommended by~~ account. On an annual basis, the balance in
529.30 the special revenue account shall be appropriated to the commissioner to implement the
529.31 recommendations of the advisory council established in section 144A.4799. Fines collected
529.32 in state fiscal years 2018 and 2019 shall be deposited in the dedicated special revenue
529.33 account as described in this section.

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

530.1 Sec. 13. Minnesota Statutes 2018, section 144A.475, subdivision 3b, is amended to read:

530.2 Subd. 3b. **Expedited hearing.** (a) Within five business days of receipt of the license
530.3 holder's timely appeal of a temporary suspension or issuance of a conditional license, the
530.4 commissioner shall request assignment of an administrative law judge. The request must
530.5 include a proposed date, time, and place of a hearing. A hearing must be conducted by an
530.6 administrative law judge pursuant to Minnesota Rules, parts 1400.8505 to 1400.8612, within
530.7 30 calendar days of the request for assignment, unless an extension is requested by either
530.8 party and granted by the administrative law judge for good cause. The commissioner shall
530.9 issue a notice of hearing by certified mail or personal service at least ten business days
530.10 before the hearing. Certified mail to the last known address is sufficient. The scope of the
530.11 hearing shall be limited solely to the issue of whether the temporary suspension or issuance
530.12 of a conditional license should remain in effect and whether there is sufficient evidence to
530.13 conclude that the licensee's actions or failure to comply with applicable laws are level 3 or
530.14 4 violations as defined in section 144A.474, subdivision 11, paragraph (b), or that there
530.15 were violations that posed an imminent risk of harm to the health and safety of persons in
530.16 the provider's care.

530.17 (b) The administrative law judge shall issue findings of fact, conclusions, and a
530.18 recommendation within ten business days from the date of hearing. The parties shall have
530.19 ten calendar days to submit exceptions to the administrative law judge's report. The record
530.20 shall close at the end of the ten-day period for submission of exceptions. The commissioner's
530.21 final order shall be issued within ten business days from the close of the record. When an
530.22 appeal of a temporary immediate suspension or conditional license is withdrawn or dismissed,
530.23 the commissioner shall issue a final order affirming the temporary immediate suspension
530.24 or conditional license within ten calendar days of the commissioner's receipt of the
530.25 withdrawal or dismissal. The license holder is prohibited from operation during the temporary
530.26 suspension period.

530.27 (c) When the final order under paragraph (b) affirms an immediate suspension, and a
530.28 final licensing sanction is issued under subdivisions 1 and 2 and the licensee appeals that
530.29 sanction, the licensee is prohibited from operation pending a final commissioner's order
530.30 after the contested case hearing conducted under chapter 14.

530.31 (d) A licensee whose license is temporarily suspended must comply with the requirements
530.32 for notification and transfer of clients in subdivision 5. These requirements remain if an
530.33 appeal is requested.

531.1 Sec. 14. Minnesota Statutes 2018, section 144A.475, subdivision 5, is amended to read:

531.2 Subd. 5. **Plan required.** (a) The process of suspending or revoking, or refusing to renew
531.3 a license must include a plan for transferring affected clients' care to other providers
531.4 by the home care provider, which will be monitored by the commissioner. Within three
531.5 business calendar days of being notified of the final revocation, refusal to renew, or
531.6 suspension action, the home care provider shall provide the commissioner, the lead agencies
531.7 as defined in section 256B.0911, county adult protection and case managers, and the
531.8 ombudsman for long-term care with the following information:

531.9 (1) a list of all clients, including full names and all contact information on file;
531.10 (2) a list of each client's representative or emergency contact person, including full names
531.11 and all contact information on file;
531.12 (3) the location or current residence of each client;
531.13 (4) the payor sources for each client, including payor source identification numbers; and
531.14 (5) for each client, a copy of the client's service plan, and a list of the types of services
531.15 being provided.

531.16 (b) The revocation, refusal to renew, or suspension notification requirement is satisfied
531.17 by mailing the notice to the address in the license record. The home care provider shall
531.18 cooperate with the commissioner and the lead agencies, county adult protection and county
531.19 managers, and the ombudsman for long term care during the process of transferring care of
531.20 clients to qualified providers. Within three business calendar days of being notified of the
531.21 final revocation, refusal to renew, or suspension action, the home care provider must notify
531.22 and disclose to each of the home care provider's clients, or the client's representative or
531.23 emergency contact persons, that the commissioner is taking action against the home care
531.24 provider's license by providing a copy of the revocation, refusal to renew, or suspension
531.25 notice issued by the commissioner. If the provider does not comply with the disclosure
531.26 requirements in this section, the commissioner, lead agencies, county adult protection and
531.27 county managers and ombudsman for long-term care shall notify the clients, client
531.28 representatives, or emergency contact persons, about the action being taken. The revocation,
531.29 refusal to renew, or suspension notice is public data except for any private data contained
531.30 therein.

531.31 (c) A home care provider subject to this subdivision may continue operating during the
531.32 period of time home care clients are being transferred to other providers.

532.1 Sec. 15. Minnesota Statutes 2018, section 144A.476, subdivision 1, is amended to read:

532.2 **Subdivision 1. Prior criminal convictions; owner and managerial officials.** (a) Before
532.3 the commissioner issues a temporary license, issues a license as a result of an approved
532.4 change in ownership, or renews a license, an owner or managerial official is required to
532.5 complete a background study under section 144.057. No person may be involved in the
532.6 management, operation, or control of a home care provider if the person has been disqualified
532.7 under chapter 245C. If an individual is disqualified under section 144.057 or chapter 245C,
532.8 the individual may request reconsideration of the disqualification. If the individual requests
532.9 reconsideration and the commissioner sets aside or rescinds the disqualification, the individual
532.10 is eligible to be involved in the management, operation, or control of the provider. If an
532.11 individual has a disqualification under section 245C.15, subdivision 1, and the disqualification
532.12 is affirmed, the individual's disqualification is barred from a set aside, and the individual
532.13 must not be involved in the management, operation, or control of the provider.

532.14 (b) For purposes of this section, owners of a home care provider subject to the background
532.15 check requirement are those individuals whose ownership interest provides sufficient
532.16 authority or control to affect or change decisions related to the operation of the home care
532.17 provider. An owner includes a sole proprietor, a general partner, or any other individual
532.18 whose individual ownership interest can affect the management and direction of the policies
532.19 of the home care provider.

532.20 (c) For the purposes of this section, managerial officials subject to the background check
532.21 requirement are individuals who provide direct contact as defined in section 245C.02,
532.22 subdivision 11, or individuals who have the responsibility for the ongoing management or
532.23 direction of the policies, services, or employees of the home care provider. Data collected
532.24 under this subdivision shall be classified as private data on individuals under section 13.02,
532.25 subdivision 12.

532.26 (d) The department shall not issue any license if the applicant or owner or managerial
532.27 official has been unsuccessful in having a background study disqualification set aside under
532.28 section 144.057 and chapter 245C; if the owner or managerial official, as an owner or
532.29 managerial official of another home care provider, was substantially responsible for the
532.30 other home care provider's failure to substantially comply with sections 144A.43 to
532.31 144A.482; or if an owner that has ceased doing business, either individually or as an owner
532.32 of a home care provider, was issued a correction order for failing to assist clients in violation
532.33 of this chapter.

533.1 (e) Effective July 1, 2021, this section applies to controlling persons as defined in section
533.2 144I.01.

533.3 Sec. 16. Minnesota Statutes 2018, section 144A.4791, subdivision 10, is amended to read:

533.4 **Subd. 10. Termination of service plan.** (a) If a home care provider terminates a service
533.5 plan with a client, and the client continues to need home care services, the home care provider
533.6 shall provide the client and the client's representative, if any, with a 30-day written notice
533.7 of termination which includes the following information:

533.8 (1) the effective date of termination;

533.9 (2) the reason for termination;

533.10 (3) a list of known licensed home care providers in the client's immediate geographic
533.11 area;

533.12 (4) a statement that the home care provider will participate in a coordinated transfer of
533.13 care of the client to another home care provider, health care provider, or caregiver, as
533.14 required by the home care bill of rights, section 144A.44, subdivision 1, clause (17);

533.15 (5) the name and contact information of a person employed by the home care provider
533.16 with whom the client may discuss the notice of termination; and

533.17 (6) if applicable, a statement that the notice of termination of home care services does
533.18 not constitute notice of termination of the housing with services contract with a housing
533.19 with services establishment.

533.20 (b) When the home care provider voluntarily discontinues services to all clients, the
533.21 home care provider must notify the commissioner, lead agencies, and ombudsman for
533.22 long-term care about its clients and comply with the requirements in this subdivision.

533.23 Sec. 17. Minnesota Statutes 2018, section 144A.4799, is amended to read:

533.24 **144A.4799 DEPARTMENT OF HEALTH LICENSED HOME CARE AND**
533.25 **ASSISTED LIVING PROVIDER ADVISORY COUNCIL.**

533.26 Subdivision 1. **Membership.** The commissioner of health shall appoint eight persons
533.27 to a home care and assisted living program advisory council consisting of the following:

533.28 (1) three public members as defined in section 214.02 who shall be either persons who
533.29 are currently receiving home care services or, persons who have received home care within
533.30 five years of the application date, persons who have family members receiving home care

534.1 services, or persons who have family members who have received home care services within
534.2 five years of the application date;

534.3 (2) three Minnesota home care licensees representing basic and comprehensive levels
534.4 of licensure who may be a managerial official, an administrator, a supervising registered
534.5 nurse, or an unlicensed personnel performing home care tasks;

534.6 (3) one member representing the Minnesota Board of Nursing; ~~and~~

534.7 (4) one member representing the office of ombudsman for long-term care;:

534.8 (5) beginning July 1, 2021, three members representing providers who are eligible to
534.9 be assisted living licensees pursuant to chapter 144I; and

534.10 (6) beginning July 1, 2021, a member of a county health and human services or county
534.11 adult protection office.

534.12 Subd. 2. **Organizations and meetings.** The advisory council shall be organized and
534.13 administered under section 15.059 with per diems and costs paid within the limits of available
534.14 appropriations. Meetings will be held quarterly and hosted by the department. Subcommittees
534.15 may be developed as necessary by the commissioner. Advisory council meetings are subject
534.16 to the Open Meeting Law under chapter 13D.

534.17 Subd. 3. **Duties.** (a) At the commissioner's request, the advisory council shall provide
534.18 advice regarding regulations of Department of Health licensed home care providers in this
534.19 chapter, including advice on the following:

534.20 (1) community standards for home care practices and assisted living settings;

534.21 (2) enforcement of licensing standards and whether certain disciplinary actions are
534.22 appropriate;

534.23 (3) ways of distributing information to licensees and consumers of home care;

534.24 (4) training standards;

534.25 (5) identifying emerging issues and opportunities in ~~the home care field, including and~~
534.26 assisted living;

534.27 (6) identifying the use of technology in home and telehealth capabilities;

534.28 ~~(6)~~ (7) allowable home care licensing modifications and exemptions, including a method
534.29 for an integrated license with an existing license for rural licensed nursing homes to provide
534.30 limited home care services in an adjacent independent living apartment building owned by
534.31 the licensed nursing home; ~~and~~

535.1 ~~(7)~~(8) recommendations for studies using the data in section 62U.04, subdivision 4,
535.2 including but not limited to studies concerning costs related to dementia and chronic disease
535.3 among an elderly population over 60 and additional long-term care costs, as described in
535.4 section 62U.10, subdivision 6.; and

535.5 (9) the single unified assisted living resident bill of rights to be used by July 1, 2021,
535.6 for all new assisted living licensees and by assisted living licensees for the benefit of the
535.7 assisted living residents.

535.8 (b) The advisory council shall perform other duties as directed by the commissioner.

535.9 (c) The advisory council shall annually ~~review the balance of the account in the state~~
535.10 ~~government special revenue fund described in section 144A.474, subdivision 11, paragraph~~
535.11 ~~(i), and make annual recommendations by January 15 directly to the chairs and ranking~~
535.12 ~~minority members of the legislative committees with jurisdiction over health and human~~
535.13 ~~services regarding appropriations~~ to the commissioner for the purposes in section 144A.474,
535.14 subdivision 11, paragraph (i). The recommendations shall address ways the commissioner
535.15 ~~may improve protection of the public under existing statutes and laws and include but are~~
535.16 ~~not limited to projects that create and administer training of licensees and their employees~~
535.17 ~~to improve residents lives, supporting ways that licensees can improve and enhance quality~~
535.18 ~~care, ways to provide technical assistance to licensees to improve compliance; information~~
535.19 ~~technology and data projects that analyze and communicate information about trends of~~
535.20 ~~violations or lead to ways of improving resident care; communications strategies to licensees~~
535.21 ~~and the public; and other projects or pilots that benefit residents, families, and the public.~~

535.22 Sec. 18. **REPEALER.**

535.23 Minnesota Statutes 2018, section 144A.472, subdivision 4, is repealed.

ARTICLE 19

HUMAN SERVICES FORECAST ADJUSTMENTS

535.26 Section 1. **DEPARTMENT OF HUMAN SERVICES FORECAST ADJUSTMENT.**

535.27 The dollar amounts shown in the columns marked "Appropriations" are added to or, if
535.28 shown in parentheses, are subtracted from the appropriations in Laws 2017, First Special
535.29 Session chapter 6, article 18, from the general fund, or any other fund named, to the
535.30 commissioner of human services for the purposes specified in this article, to be available
535.31 for the fiscal year indicated for each purpose. The figure "2019" used in this article means
535.32 that the appropriations listed are available for the fiscal year ending June 30, 2019.

537.1	(j) Consolidated Chemical Dependency	
537.2	Treatment Fund (CCDTF) Entitlement	<u>(17,872,000)</u>
537.3	<u>Subd. 3. Technical Activities</u>	<u>(402,000)</u>
537.4	<u>This appropriation is from the federal TANF</u>	
537.5	<u>fund.</u>	

537.6 Sec. 3. **EFFECTIVE DATE.**

537.7 Sections 1 and 2 are effective the day following final enactment.

ARTICLE 20

APPROPRIATIONS

537.10 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 "2020" and "2021" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2020, or June 30, 2021, respectively. "The first year" is fiscal year 2020. "The second year" is fiscal year 2021. "The biennium" is fiscal years 2020 and 2021.

APPROPRIATIONS

537.19 Available for the Year

Ending June 30

537.21 **2020** **2021**

537.21 **2020** **2021**

537.21 2020 2021

537.22 Sec. 2. **COMMISSIONER OF HUMAN**
537.23 **SERVICES**

537.24 Subdivision 1. Total Appropriation \$ 8,258,513,000 \$ 8,377,920,000

Appropriations by Fund

	<u>2020</u>	<u>2021</u>
537.26		
537.27 <u>General</u>	<u>7,442,146,000</u>	<u>7,531,758,000</u>
537.28 <u>State Government</u>		
537.29 <u>Special Revenue</u>	<u>5,575,000</u>	<u>5,566,000</u>
537.30 <u>Health Care Access</u>	<u>527,628,000</u>	<u>551,705,000</u>
537.31 <u>Federal TANF</u>	<u>274,650,000</u>	<u>276,245,000</u>

538.1	<u>Lottery Prize</u>	<u>1,896,000</u>	<u>1,896,000</u>
538.2	<u>Opioid Stewardship</u>	<u>6,618,000</u>	<u>10,750,000</u>

538.3 The amounts that may be spent for each
538.4 purpose are specified in the following
538.5 subdivisions.

538.6 **Subd. 2. TANF Maintenance of Effort**

538.7 **(a) Nonfederal Expenditures.** The
538.8 commissioner shall ensure that sufficient
538.9 qualified nonfederal expenditures are made
538.10 each year to meet the state's maintenance of
538.11 effort (MOE) requirements of the TANF block
538.12 grant specified under Code of Federal
538.13 Regulations, title 45, section 263.1. In order
538.14 to meet these basic TANF/MOE requirements,
538.15 the commissioner may report as TANF/MOE
538.16 expenditures only nonfederal money expended
538.17 for allowable activities listed in the following
538.18 clauses:

538.19 (1) MFIP cash, diversionary work program,
538.20 and food assistance benefits under Minnesota
538.21 Statutes, chapter 256J;
538.22 (2) the child care assistance programs under
538.23 Minnesota Statutes, sections 119B.03 and
538.24 119B.05, and county child care administrative
538.25 costs under Minnesota Statutes, section
538.26 119B.15;

538.27 (3) state and county MFIP administrative costs
538.28 under Minnesota Statutes, chapters 256J and
538.29 256K;
538.30 (4) state, county, and tribal MFIP employment
538.31 services under Minnesota Statutes, chapters
538.32 256J and 256K;
538.33 (5) expenditures made on behalf of legal
538.34 noncitizen MFIP recipients who qualify for

539.1 the MinnesotaCare program under Minnesota

539.2 Statutes, chapter 256L;

539.3 (6) qualifying working family credit

539.4 expenditures under Minnesota Statutes, section

539.5 290.0671;

539.6 (7) qualifying Minnesota education credit

539.7 expenditures under Minnesota Statutes, section

539.8 290.0674; and

539.9 (8) qualifying Head Start expenditures under

539.10 Minnesota Statutes, section 119A.50.

539.11 **(b) Nonfederal Expenditures; Reporting.**

539.12 For the activities listed in paragraph (a),

539.13 clauses (2) to (8), the commissioner may

539.14 report only expenditures that are excluded

539.15 from the definition of assistance under Code

539.16 of Federal Regulations, title 45, section

539.17 260.31.

539.18 **(c) Certain Expenditures Required.** The

539.19 commissioner shall ensure that the MOE used

539.20 by the commissioner of management and

539.21 budget for the February and November

539.22 forecasts required under Minnesota Statutes,

539.23 section 16A.103, contains expenditures under

539.24 paragraph (a), clause (1), equal to at least 16

539.25 percent of the total required under Code of

539.26 Federal Regulations, title 45, section 263.1.

539.27 **(d) Limitation; Exceptions.** The

539.28 commissioner must not claim an amount of

539.29 TANF/MOE in excess of the 75 percent

539.30 standard in Code of Federal Regulations, title

539.31 45, section 263.1(a)(2), except:

539.32 (1) to the extent necessary to meet the 80

539.33 percent standard under Code of Federal

539.34 Regulations, title 45, section 263.1(a)(1), if it

540.1 is determined by the commissioner that the
540.2 state will not meet the TANF work
540.3 participation target rate for the current year;
540.4 (2) to provide any additional amounts under
540.5 Code of Federal Regulations, title 45, section
540.6 264.5, that relate to replacement of TANF
540.7 funds due to the operation of TANF penalties;
540.8 and
540.9 (3) to provide any additional amounts that may
540.10 contribute to avoiding or reducing TANF work
540.11 participation penalties through the operation
540.12 of the excess MOE provisions of Code of
540.13 Federal Regulations, title 45, section 261.43
540.14 (a)(2).

540.15 **(e) Supplemental Expenditures.** For the
540.16 purposes of paragraph (d), the commissioner
540.17 may supplement the MOE claim with working
540.18 family credit expenditures or other qualified
540.19 expenditures to the extent such expenditures
540.20 are otherwise available after considering the
540.21 expenditures allowed in this subdivision.

540.22 **(f) Reduction of Appropriations; Exception.**
540.23 The requirement in Minnesota Statutes, section
540.24 256.011, subdivision 3, that federal grants or
540.25 aids secured or obtained under that subdivision
540.26 be used to reduce any direct appropriations
540.27 provided by law, does not apply if the grants
540.28 or aids are federal TANF funds.

540.29 **(g) IT Appropriations Generally.** This
540.30 appropriation includes funds for information
540.31 technology projects, services, and support.
540.32 Notwithstanding Minnesota Statutes, section
540.33 16E.0466, funding for information technology
540.34 project costs shall be incorporated into the

541.1 service level agreement and paid to the Office
541.2 of MN.IT Services by the Department of
541.3 Human Services under the rates and
541.4 mechanism specified in that agreement.

541.5 **(h) Receipts for Systems Project.**

541.6 Appropriations and federal receipts for
541.7 information systems projects for MAXIS,
541.8 PRISM, MMIS, ISDS, METS, and SSIS must
541.9 be deposited in the state systems account
541.10 authorized in Minnesota Statutes, section
541.11 256.014. Money appropriated for computer
541.12 projects approved by the commissioner of the
541.13 Office of MN.IT Services, funded by the
541.14 legislature, and approved by the commissioner
541.15 of management and budget may be transferred
541.16 from one project to another and from
541.17 development to operations as the
541.18 commissioner of human services considers
541.19 necessary. Any unexpended balance in the
541.20 appropriation for these projects does not
541.21 cancel and is available for ongoing
541.22 development and operations.

541.23 **(i) Federal SNAP Education and Training**

541.24 Grants. Federal funds available during fiscal
541.25 years 2020 and 2021 for Supplemental
541.26 Nutrition Assistance Program Education and
541.27 Training and SNAP Quality Control
541.28 Performance Bonus grants are appropriated
541.29 to the commissioner of human services for the
541.30 purposes allowable under the terms of the
541.31 federal award. This paragraph is effective the
541.32 day following final enactment.

542.1 **Subd. 3. Working Family Credit as TANF/MOE.**

542.2 The commissioner may claim as TANF/MOE

542.3 up to \$6,707,000 per year of working family

542.4 credit expenditures in each fiscal year.

542.5 **Subd. 4. Central Office; Operations**

542.6 Appropriations by Fund

542.7 <u>General</u>	<u>153,377,000</u>	<u>151,082,000</u>
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542.8 <u>State Government</u>		
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542.9 <u>Special Revenue</u>	<u>5,450,000</u>	<u>5,441,000</u>
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542.10 <u>Health Care Access</u>	<u>20,709,000</u>	<u>22,459,000</u>
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542.11 <u>Federal TANF</u>	<u>100,000</u>	<u>100,000</u>
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542.12 **(a) Administrative Recovery; Set-Aside.** The

542.13 commissioner may invoice local entities

542.14 through the SWIFT accounting system as an

542.15 alternative means to recover the actual cost of

542.16 administering the following provisions:

542.17 (1) Minnesota Statutes, section 125A.744,

542.18 subdivision 3;

542.19 (2) Minnesota Statutes, section 245.495,

542.20 paragraph (b);

542.21 (3) Minnesota Statutes, section 256B.0625,

542.22 subdivision 20, paragraph (k);

542.23 (4) Minnesota Statutes, section 256B.0924,

542.24 subdivision 6, paragraph (g);

542.25 (5) Minnesota Statutes, section 256B.0945,

542.26 subdivision 4, paragraph (d); and

542.27 (6) Minnesota Statutes, section 256F.10,

542.28 subdivision 6, paragraph (b).

542.29 **(b) Base Level Adjustment.** The general fund

542.30 base is \$143,583,000 in fiscal year 2022 and

542.31 \$146,013,000 in fiscal year 2023. The health

542.32 care access fund base is \$20,709,000 in fiscal

542.33 year 2023. The state government special

543.1 revenue fund base is \$5,442,000 in fiscal year
 543.2 2023.

543.3 **Subd. 5. Central Office; Children and Families**

543.4 **Appropriations by Fund**

543.5 <u>General</u>	<u>13,353,000</u>	<u>14,204,000</u>
543.6 <u>Federal TANF</u>	<u>2,582,000</u>	<u>2,582,000</u>

543.7 **(a) Financial Institution Data Match and**
 543.8 **Payment of Fees.** The commissioner is
 543.9 authorized to allocate up to \$310,000 each
 543.10 year in fiscal year 2020 and fiscal year 2021
 543.11 from the systems special revenue account to
 543.12 make payments to financial institutions in
 543.13 exchange for performing data matches
 543.14 between account information held by financial
 543.15 institutions and the public authority's database
 543.16 of child support obligors as authorized by
 543.17 Minnesota Statutes, section 13B.06,
 543.18 subdivision 7.

543.19 **(b) Base Level Adjustment.** The general fund
 543.20 base is \$14,440,000 in fiscal year 2022 and
 543.21 \$14,693,000 in fiscal year 2023.

543.22 **Subd. 6. Central Office; Health Care**

543.23 **Appropriations by Fund**

543.24 <u>General</u>	<u>22,612,000</u>	<u>23,633,000</u>
543.25 <u>Health Care Access</u>	<u>25,358,000</u>	<u>25,056,000</u>

543.26 **(a) Nonemergency Medical Transportation**
 543.27 **Program Audits.** \$557,000 in fiscal year 2020
 543.28 and \$1,119,000 in fiscal year 2021 are from
 543.29 the general fund to conduct audits of the
 543.30 nonemergency medical transportation
 543.31 program.

543.32 **(b) Base Level Adjustment.** The general fund
 543.33 base is \$26,780,000 in fiscal year 2022 and
 543.34 \$29,180,000 in fiscal year 2023. The health

544.1 care access fund base is \$26,340,000 in fiscal
 544.2 year 2022 and \$27,088,000 in fiscal year 2023.

544.3 **Subd. 7. Central Office; Continuing Care for**
 544.4 **Older Adults**

544.5 **Appropriations by Fund**

544.6 <u>General</u>	<u>20,330,000</u>	<u>17,991,000</u>
544.7 <u>State Government</u>		
544.8 <u>Special Revenue</u>	<u>125,000</u>	<u>125,000</u>

544.9 **Base Level Adjustment.** The general fund
 544.10 base is \$20,486,000 in fiscal year 2022 and
 544.11 \$18,006,000 in fiscal year 2023.

544.12 **Subd. 8. Central Office; Community Supports**

544.13 **Appropriations by Fund**

544.14 <u>General</u>	<u>35,081,000</u>	<u>34,979,000</u>
544.15 <u>Lottery Prize</u>	<u>163,000</u>	<u>163,000</u>
544.16 <u>Opioid Stewardship</u>	<u>218,000</u>	<u>350,000</u>

544.17 **(a) Assisted Living Survey.** Beginning in
 544.18 fiscal year 2020, \$2,500,000 is appropriated
 544.19 in the even numbered year of each biennium
 544.20 to fund a resident experience survey and
 544.21 family survey for all housing with services
 544.22 sites. This paragraph does not expire.

544.23 **(b) Information and Assistance Grant**

544.24 **Transfer.** \$1,000,000 in fiscal year 2020 and
 544.25 \$1,000,000 in fiscal year 2021 are transferred
 544.26 to the Continuing Care for Older Adults
 544.27 administration from the Aging and Adult
 544.28 Services grants for developing the Home and
 544.29 Community Based Report Card for assisted
 544.30 living. This transfer is ongoing.

544.31 **(c) Certified Community Behavioral Health**

544.32 **Center (CCBHC) Expansion.** \$310,000 in
 544.33 fiscal year 2020 and \$285,000 in fiscal year
 544.34 2021 are from the general fund to support
 544.35 CCBHC expansion.

545.1 **(d) Base Level Adjustment.** The general fund
 545.2 base is \$34,434,000 in fiscal year 2022 and
 545.3 \$34,134,000 in fiscal year 2023. The opioid
 545.4 stewardship fund base is \$336,000 in fiscal
 545.5 year 2022 and \$336,000 in fiscal year 2023.

545.6 **Subd. 9. Forecasted Programs; MFIP/DWP**

545.7 **Appropriations by Fund**

545.8 <u>General</u>	<u>93,888,000</u>	<u>112,508,000</u>
545.9 <u>Federal TANF</u>	<u>78,135,000</u>	<u>79,404,000</u>

545.10 **MFIP Rate Increase.** Effective February 1,
 545.11 2020, the amount of the MFIP cash assistance
 545.12 portion of the transitional standard is increased
 545.13 \$100 per month per household. This increase
 545.14 shall be reflected in the MFIP cash assistance
 545.15 portion of the transitional standard published
 545.16 annually by the Department of Human
 545.17 Services. This paragraph does not expire.

545.18 **Subd. 10. Forecasted Programs; MFIP Child**
 545.19 **Care Assistance**

109,270,000 123,202,000

545.20 **Subd. 11. Forecasted Programs; General**
 545.21 **Assistance**

50,563,000 51,200,000

545.22 **(a) General Assistance Standard.** The
 545.23 commissioner shall set the monthly standard
 545.24 of assistance for general assistance units
 545.25 consisting of an adult recipient who is
 545.26 childless and unmarried or living apart from
 545.27 parents or a legal guardian at \$203. The
 545.28 commissioner may reduce this amount
 545.29 according to Laws 1997, chapter 85, article 3,
 545.30 section 54.

545.31 **(b) Emergency General Assistance Limit.**

545.32 The amount appropriated for emergency
 545.33 general assistance is limited to no more than
 545.34 \$6,729,812 in fiscal year 2020 and \$6,729,812
 545.35 in fiscal year 2021. Funds to counties shall be

546.1 allocated by the commissioner using the
 546.2 allocation method under Minnesota Statutes,
 546.3 section 256D.06.

546.4 <u>Subd. 12. Forecasted Programs; Minnesota</u>		
546.5 <u>Supplemental Aid</u>	<u>41,834,000</u>	<u>45,866,000</u>

546.6 <u>Subd. 13. Forecasted Programs; Housing</u>		
546.7 <u>Support</u>	<u>169,757,000</u>	<u>173,586,000</u>

546.8 <u>Subd. 14. Forecasted Programs; Northstar Care</u>		
546.9 <u>for Children</u>	<u>86,921,000</u>	<u>94,528,000</u>

546.10 <u>Subd. 15. Forecasted Programs; MinnesotaCare</u>		
	<u>26,772,000</u>	<u>29,526,000</u>

546.11 **(a) Generally.** This appropriation is from the
 546.12 health care access fund.

546.13 **(b) OneCare Buy-In Option.** The fiscal year
 546.14 2023 base for MinnesotaCare is increased by
 546.15 \$112,000,000 to serve as a reserve for the
 546.16 Department of Human Services to
 546.17 operationalize the OneCare Buy-In Option
 546.18 under Minnesota Statutes, chapter 256T. This
 546.19 is a onetime increase.

546.20 **Subd. 16. Forecasted Programs; Medical**

546.21 **Assistance**

546.22 Appropriations by Fund

546.23 <u>General</u>	<u>5,664,289,000</u>	<u>5,682,365,000</u>
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546.24 <u>Health Care Access</u>	<u>450,574,000</u>	<u>470,449,000</u>
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546.25 **Behavioral Health Services.** \$1,000,000 in
 546.26 fiscal year 2020 and \$1,000,000 in fiscal year
 546.27 2021 are for behavioral health services
 546.28 provided by hospitals identified under
 546.29 Minnesota Statutes, section 256.969,
 546.30 subdivision 2b, paragraph (a), clause (4). The
 546.31 increase in payments shall be made by
 546.32 increasing the adjustment under Minnesota
 546.33 Statutes, section 256.969, subdivision 2b,
 546.34 paragraph (e), clause (2).

547.1	<u>Subd. 17. Forecasted Programs; Alternative Care</u>		
547.2		<u>45,243,000</u>	<u>45,245,000</u>
547.3	<u>Alternative Care Transfer.</u> Any money		
547.4	<u>allocated to the alternative care program that</u>		
547.5	<u>is not spent for the purposes indicated does</u>		
547.6	<u>not cancel but must be transferred to the</u>		
547.7	<u>medical assistance account.</u>		
547.8	<u>Subd. 18. Forecasted Programs; Chemical Dependency Treatment Fund</u>		
547.9		<u>156,941,000</u>	<u>158,166,000</u>
547.10	<u>Subd. 19. Grant Programs; Support Services Grants</u>		
547.11			
547.12	<u>Appropriations by Fund</u>		
547.13	<u>General</u>	<u>8,715,000</u>	<u>8,715,000</u>
547.14	<u>Federal TANF</u>	<u>96,213,000</u>	<u>96,311,000</u>
547.15	<u>Subd. 20. Grant Programs; Basic Sliding Fee Child Care Assistance Grants</u>		
547.16		<u>63,227,000</u>	<u>74,847,000</u>
547.17	<u>(a) Basic Sliding Fee Waiting List</u>		
547.18	<u>Allocation.</u> Notwithstanding Minnesota		
547.19	<u>Statutes, section 119B.03, \$8,676,000 in fiscal</u>		
547.20	<u>year 2020 and \$17,701,000 in fiscal year 2021</u>		
547.21	<u>are to reduce the basic sliding fee program</u>		
547.22	<u>waiting list as follows:</u>		
547.23	<u>(1) the calendar year 2020 allocation shall be</u>		
547.24	<u>increased to serve families on the waiting list.</u>		
547.25	<u>To receive funds appropriated for this purpose,</u>		
547.26	<u>a county must have a waiting list in the most</u>		
547.27	<u>recent published waiting list month;</u>		
547.28	<u>(2) funds shall be distributed proportionately</u>		
547.29	<u>based on the average of the most recent six</u>		
547.30	<u>months of published waiting lists to counties</u>		
547.31	<u>that meet the criteria in clause (1);</u>		
547.32	<u>(3) allocations in calendar years 2021 and</u>		
547.33	<u>beyond shall be calculated using the allocation</u>		
547.34	<u>formula in Minnesota Statutes, section</u>		
547.35	<u>119B.03; and</u>		

548.1 (4) the guaranteed floor for calendar year 2021
 548.2 shall be based on the revised calendar year
 548.3 2020 allocation.

548.4 **(b) Base Level Adjustment.** The general fund
 548.5 base is \$87,802,000 in fiscal year 2022 and
 548.6 \$95,282,000 in fiscal year 2023.

548.7 <u>Subd. 21. Grant Programs; Child Care</u>		
548.8 <u>Development Grants</u>	<u>1,737,000</u>	<u>1,737,000</u>

548.9 <u>Subd. 22. Grant Programs; Child Support</u>		
548.10 <u>Enforcement Grants</u>	<u>50,000</u>	<u>50,000</u>

548.11 <u>Subd. 23. Grant Programs; Children's Services</u>		
548.12 <u>Grants</u>		

548.13 <u>Appropriations by Fund</u>		
548.14 <u>General</u>	<u>40,857,000</u>	<u>45,345,000</u>
548.15 <u>Federal TANF</u>	<u>140,000</u>	<u>140,000</u>

548.16 **(a) Title IV-E Adoption Assistance.** (1) The
 548.17 commissioner shall allocate funds from the
 548.18 Title IV-E reimbursement to the state from
 548.19 the Fostering Connections to Success and
 548.20 Increasing Adoptions Act for adoptive, foster,
 548.21 and kinship families as required in Minnesota
 548.22 Statutes, section 256N.261.

548.23 (2) Additional federal reimbursement to the
 548.24 state as a result of the Fostering Connections
 548.25 to Success and Increasing Adoptions Act's
 548.26 expanded eligibility for title IV-E adoption
 548.27 assistance is for postadoption, foster care,
 548.28 adoption, and kinship services, including a
 548.29 parent-to-parent support network.

548.30 **(b) Base Level Adjustment.** The general fund
 548.31 base is \$48,283,000 in fiscal year 2022 and
 548.32 \$47,998,000 in fiscal year 2023.

548.33 <u>Subd. 24. Grant Programs; Children and</u>		
548.34 <u>Community Service Grants</u>	<u>59,201,000</u>	<u>59,701,000</u>

549.1	(a) Adult Protection Grants. \$1,000,000 in			
549.2	<u>fiscal year 2020 and \$1,500,000 in fiscal year</u>			
549.3	<u>2021 are for grant funding for adult abuse</u>			
549.4	<u>maltreatment investigations and adult</u>			
549.5	<u>protective services to counties and tribes as</u>			
549.6	<u>allocated and specified under Minnesota</u>			
549.7	<u>Statutes, section 256M.42.</u>			
549.8	(b) Base Level Adjustment. The general fund			
549.9	<u>base is \$60,251,000 in fiscal year 2022 and</u>			
549.10	<u>\$60,856,000 in fiscal year 2023.</u>			
549.11	Subd. 25. Grant Programs; Children and			
549.12	Economic Support Grants	<u>22,065,000</u>	<u>22,065,000</u>	
549.13	Minnesota Food Assistance Program.			
549.14	<u>Unexpended funds for the Minnesota food</u>			
549.15	<u>assistance program for fiscal year 2020 do not</u>			
549.16	<u>cancel but are available for this purpose in</u>			
549.17	<u>fiscal year 2021.</u>			
549.18	Subd. 26. Grant Programs; Health Care Grants			
549.19	Appropriations by Fund			
549.20	General	<u>3,711,000</u>	<u>3,711,000</u>	
549.21	Health Care Access	<u>3,465,000</u>	<u>3,465,000</u>	
549.22	Subd. 27. Grant Programs; Other Long-Term			
549.23	Care Grants	<u>1,925,000</u>	<u>1,925,000</u>	
549.24	Subd. 28. Grant Programs; Aging and Adult			
549.25	Services Grants	<u>31,811,000</u>	<u>31,995,000</u>	
549.26	Subd. 29. Grant Programs; Deaf and			
549.27	Hard-of-Hearing Grants	<u>2,886,000</u>	<u>2,886,000</u>	
549.28	Subd. 30. Grant Programs; Disabilities Grants	<u>22,231,000</u>	<u>22,944,000</u>	
549.29	(a) Training of Direct Support Services			
549.30	Providers. \$375,000 in fiscal year 2020 and			
549.31	\$375,000 in fiscal year 2021 are for stipends			
549.32	to pay for training of individual providers of			
549.33	direct support services as defined in Minnesota			
549.34	Statutes, section 256B.0711, subdivision 1.			
549.35	This training is available to individual			

550.1 providers who have completed designated
550.2 voluntary trainings made available through
550.3 the State Service Employees International
550.4 Union Healthcare Minnesota Committee. This
550.5 is a onetime appropriation. This appropriation
550.6 is available only if the labor agreement
550.7 between the state of Minnesota and the Service
550.8 Employees International Union Healthcare
550.9 Minnesota under Minnesota Statutes, section
550.10 179A.54, is approved under Minnesota
550.11 Statutes, section 3.855.

550.12 **(b) Training for New Worker Orientation.**
550.13 \$125,000 in fiscal year 2020 and \$125,000 in
550.14 fiscal year 2021 are for new worker orientation
550.15 training and is allocated to the Minnesota State
550.16 Service Employees International Union
550.17 Healthcare Minnesota Committee. This is a
550.18 onetime appropriation. This appropriation is
550.19 available only if the labor agreement between
550.20 the state of Minnesota and the Service
550.21 Employees International Union Healthcare
550.22 Minnesota under Minnesota Statutes, section
550.23 179A.54, is approved under Minnesota
550.24 Statutes, section 3.855.

550.25 **(c) Benefits Planning Grants.** \$600,000 in
550.26 fiscal year 2020 and \$600,000 in fiscal year
550.27 2021 are to provide grant funding to the
550.28 Disability Hub for benefits planning to people
550.29 with disabilities.

550.30 **(d) Regional Support for Person-Centered**
550.31 **Practices Grants.** \$374,000 in fiscal year
550.32 2020 and \$486,000 in fiscal year 2021 are to
550.33 extend and expand regional capacity for
550.34 person-centered planning. This grant funding
550.35 must be allocated to regional cohorts for

551.1 training, coaching, and mentoring for
 551.2 person-centered and collaborative safety
 551.3 practices benefiting people with disabilities,
 551.4 and employees, organizations, and
 551.5 communities serving people with disabilities.

551.6 **(e) Disability Hub for Families Grants.**

551.7 \$100,000 in fiscal year 2020 and \$200,000 in
 551.8 fiscal year 2021 are for grants to connect
 551.9 families through innovation grants, life
 551.10 planning tools, and website information as
 551.11 they support a child or family member with
 551.12 disabilities.

551.13 **(f) Electronic Visit Verification.** \$500,000
 551.14 in fiscal year 2021 is for grants to providers
 551.15 who use a different vendor than the contract
 551.16 with the State of Minnesota for electronic visit
 551.17 verification.

551.18 **(g) Base Level Adjustment.** The general fund
 551.19 base is \$22,556,000 in fiscal year 2022 and
 551.20 \$22,168,000 in fiscal year 2023.

551.21 **Subd. 31. Grant Programs; Housing Support**
 551.22 **Grants**

10,264,000 11,364,000

551.23 **Subd. 32. Grant Programs; Adult Mental Health**
 551.24 **Grants**

551.25 Appropriations by Fund

551.26 <u>General</u>	<u>78,708,000</u>	<u>78,377,000</u>
551.27 <u>Health Care Access</u>	<u>750,000</u>	<u>750,000</u>
551.28 <u>Opioid Stewardship</u>	<u>6,400,000</u>	<u>10,400,000</u>

551.29 **(a) Certified Community Behavioral Health**
 551.30 **Center (CCBHC) Expansion.** \$200,000 in
 551.31 fiscal year 2021 is from the general fund for
 551.32 grants for planning, staff training, and other
 551.33 quality improvements that are required to
 551.34 comply with federal CCBHC criteria for three
 551.35 expansion sites.

552.1 (b) Traditional Healing. \$2,400,000 in fiscal
 552.2 year 2020 and \$2,400,000 in fiscal year 2021
 552.3 are from the opioid stewardship fund
 552.4 appropriation to provide grant funding to
 552.5 Tribal Nations and five urban Indian
 552.6 communities for traditional healing practices
 552.7 to American Indians and increase the capacity
 552.8 of culturally specific providers in the
 552.9 behavioral health workforce.

552.10 (c) Opioid Stewardship Fee Distribution to
 552.11 Counties and Tribes. \$4,000,000 in fiscal
 552.12 year 2020 and \$4,000,000 in fiscal year 2021
 552.13 are from the opioid stewardship fund for
 552.14 allocation to county and tribal social service
 552.15 agencies by a formula determined by the
 552.16 commissioner of human services in
 552.17 consultation with counties and tribes.

552.18 (d) Opioid Stewardship Fund Initiatives.
 552.19 \$4,000,000 in fiscal year 2021 is from the
 552.20 opioid stewardship fund for initiatives related
 552.21 to prevention, education, treatment, and
 552.22 services that promote innovation and capacity
 552.23 building to address the opioid addiction and
 552.24 overdose epidemic.

552.25 (e) Base Level Adjustment. The general fund
 552.26 base is \$78,277,000 in fiscal year 2022 and
 552.27 \$78,177,000 in fiscal year 2023.

552.28 Subd. 33. Grant Programs; Child Mental Health
 552.29 Grants

25,726,000 25,726,000

552.30 (a) Children's Intensive Services Reform.
 552.31 \$400,000 in fiscal year 2020 and \$400,000 in
 552.32 fiscal year 2021 are appropriated from the
 552.33 general fund for start-up grants to prospective
 552.34 psychiatric residential treatment facility sites
 552.35 for administrative expenses, consulting

553.1 services, Health Insurance Portability and
553.2 Accountability Act of 1996 (HIPAA)
553.3 compliance, therapeutic resources including
553.4 evidence-based, culturally appropriate
553.5 curriculums, and training programs for staff
553.6 and clients as well as allowable physical
553.7 renovations to the property.

553.8 **(b) Base Level Adjustment.** The general fund
553.9 base is \$26,226,000 in fiscal year 2022 and
553.10 \$26,226,000 in fiscal year 2023.

553.11 **Subd. 34. Grant Programs; Chemical**
553.12 **Dependency Treatment Support Grants**

553.13 Appropriations by Fund

553.14	<u>General</u>	<u>2,136,000</u>	<u>2,136,000</u>
553.15	<u>Lottery Prize</u>	<u>1,733,000</u>	<u>1,733,000</u>

553.16 **Problem Gambling.** \$225,000 in fiscal year
553.17 2020 and \$225,000 in fiscal year 2021 are
553.18 from the lottery prize fund for a grant to the
553.19 state affiliate recognized by the National
553.20 Council on Problem Gambling. The affiliate
553.21 must provide services to increase public
553.22 awareness of problem gambling, education,
553.23 and training for individuals and organizations
553.24 providing effective treatment services to
553.25 problem gamblers and their families, and
553.26 research related to problem gambling.

553.27 **Subd. 35. Direct Care and Treatment -**
553.28 **Generally**

553.29 **(a) Transfer Authority.** Money appropriated
553.30 to budget activities under this subdivision and
553.31 subdivisions 36, 37, 38, and 39 may be
553.32 transferred between budget activities and
553.33 between years of the biennium with the
553.34 approval of the commissioner of management
553.35 and budget.

554.1 **(b) State Operated Services Account.** Any
 554.2 balance remaining in the state operated
 554.3 services account at the end of fiscal year 2019
 554.4 shall be transferred to the general fund.

554.5 **Subd. 36. Direct Care and Treatment - Mental**
 554.6 **Health and Substance Abuse**

129,186,000 130,543,000

554.7 **(a) Transfer Authority.** Money previously
 554.8 appropriated to support the continued
 554.9 operations of the Community Addiction
 554.10 Enterprise (C.A.R.E.) program may be
 554.11 transferred to the enterprise fund for C.A.R.E.

554.12 **(b) Base Level Adjustment.** The general fund
 554.13 base is \$130,539,000 in fiscal year 2022 and
 554.14 \$130,539,000 in fiscal year 2023.

554.15 **Subd. 37. Direct Care and Treatment -**
 554.16 **Community-Based Services**

16,630,000 17,177,000

554.17 **(a) Transfer Authority.** Money previously
 554.18 appropriated to support the continued
 554.19 operations of the Minnesota State Operated
 554.20 Community Services (MSOCS) program may
 554.21 be transferred to the enterprise fund for
 554.22 MSOCS.

554.23 **(b) MSOCS Operating Adjustment.**
 554.24 \$1,594,000 in fiscal year 2020 and \$3,729,000
 554.25 in fiscal year 2021 are from the general fund
 554.26 for the Minnesota State Operated Community
 554.27 Services program. The commissioner shall
 554.28 transfer \$1,594,000 in fiscal year 2020 and
 554.29 \$3,729,000 in fiscal year 2021 to the enterprise
 554.30 fund for MSOCS.

554.31 **(c) Base Level Adjustment.** The general fund
 554.32 base is \$17,176,000 in fiscal year 2022 and
 554.33 \$17,176,000 in fiscal year 2023.

554.34 **Subd. 38. Direct Care and Treatment - Forensic**
 554.35 **Services**

112,126,000 115,342,000

555.1	<u>Base Level Adjustment.</u> The general fund			
555.2	<u>base is \$115,944,000 in fiscal year 2022 and</u>			
555.3	<u>\$115,944,000 in fiscal year 2023.</u>			
555.4	<u>Subd. 39. Direct Care and Treatment - Sex Offender Program</u>	<u>97,243,000</u>		<u>98,689,000</u>
555.6	<u>(a) Transfer Authority.</u> Money appropriated			
555.7	<u>for the Minnesota sex offender program may</u>			
555.8	<u>be transferred between fiscal years of the</u>			
555.9	<u>biennium with the approval of the</u>			
555.10	<u>commissioner of management and budget.</u>			
555.11	<u>(b) Base Level Adjustment.</u> The general fund			
555.12	<u>base is \$99,234,000 in fiscal year 2022 and</u>			
555.13	<u>\$99,234,000 in fiscal year 2023.</u>			
555.14	<u>Subd. 40. Direct Care and Treatment - Operations</u>	<u>48,252,000</u>		<u>47,838,000</u>
555.16	<u>Base Level Adjustment.</u> The general fund			
555.17	<u>base is \$47,837,000 in fiscal year 2022 and</u>			
555.18	<u>\$47,837,000 in fiscal year 2023.</u>			
555.19	<u>Subd. 41. Technical Activities</u>	<u>97,381,000</u>		<u>97,708,000</u>
555.20	<u>(a) Generally.</u> This appropriation is from the			
555.21	<u>federal TANF fund.</u>			
555.22	<u>(b) Base Level Adjustment.</u> The TANF fund			
555.23	<u>base is \$97,760,000 in fiscal year 2022 and</u>			
555.24	<u>\$97,820,000 in fiscal year 2023.</u>			
555.25	<u>Sec. 3. COMMISSIONER OF HEALTH</u>			
555.26	<u>Subdivision 1. Total Appropriation</u>	<u>\$</u>	<u>253,084,000</u>	<u>\$</u>
555.27				<u>260,743,000</u>
555.28		<u>Appropriations by Fund</u>		
555.29		<u>2020</u>	<u>2021</u>	
555.30	<u>General</u>	<u>138,199,000</u>	<u>141,258,000</u>	
555.31	<u>State Government</u>			
555.32	<u>Special Revenue</u>	<u>59,662,000</u>	<u>61,914,000</u>	
555.32	<u>Health Care Access</u>	<u>37,510,000</u>	<u>36,607,000</u>	

556.1	<u>Federal TANF</u>	<u>11,713,000</u>	<u>11,713,000</u>
556.2	<u>Opioid Stewardship</u>		
556.3	<u>Fund</u>	<u>6,000,000</u>	<u>9,251,000</u>

556.4 The amounts that may be spent for each
 556.5 purpose are specified in the following
 556.6 subdivisions.

556.7 **Subd. 2. Health Improvement**

556.8 **Appropriations by Fund**

556.9	<u>General</u>	<u>98,345,000</u>	<u>97,775,000</u>
556.10	<u>State Government</u>		
556.11	<u>Special Revenue</u>	<u>7,232,000</u>	<u>7,162,000</u>
556.12	<u>Health Care Access</u>	<u>37,510,000</u>	<u>36,607,000</u>

556.13 Federal TANF 11,713,000 11,713,000

556.14 (a) TANF Appropriations. (1) \$3,579,000
 556.15 of the TANF fund each year is for home
 556.16 visiting and nutritional services listed under
 556.17 Minnesota Statutes, section 145.882,
 556.18 subdivision 7, clauses (6) and (7). Funds must
 556.19 be distributed to community health boards
 556.20 according to Minnesota Statutes, section
 556.21 145A.131, subdivision 1;

556.22 (2) \$2,000,000 of the TANF fund each year
 556.23 is for decreasing racial and ethnic disparities
 556.24 in infant mortality rates under Minnesota
 556.25 Statutes, section 145.928, subdivision 7;

556.26 (3) \$4,978,000 of the TANF fund each year
 556.27 is for the family home visiting grant program
 556.28 according to Minnesota Statutes, section
 556.29 145A.17. \$4,000,000 of the funding must be
 556.30 distributed to community health boards
 556.31 according to Minnesota Statutes, section
 556.32 145A.131, subdivision 1. \$978,000 of the
 556.33 funding must be distributed to tribal
 556.34 governments according to Minnesota Statutes,
 556.35 section 145A.14, subdivision 2a;

557.1 (4) \$1,156,000 of the TANF fund each year
557.2 is for family planning grants under Minnesota
557.3 Statutes, section 145.925; and
557.4 (5) The commissioner may use up to 6.23
557.5 percent of the funds appropriated each year to
557.6 conduct the ongoing evaluations required
557.7 under Minnesota Statutes, section 145A.17,
557.8 subdivision 7, and training and technical
557.9 assistance as required under Minnesota
557.10 Statutes, section 145A.17, subdivisions 4 and
557.11 5.

557.12 (b) TANF Carryforward. Any unexpended
557.13 balance of the TANF appropriation in the first
557.14 year of the biennium does not cancel but is
557.15 available for the second year.

557.16 **(c) Opioid and Other Drug Abuse**

557.17 Prevention. \$6,000,000 in fiscal year 2020
557.18 and \$9,251,000 in fiscal year 2021 are
557.19 appropriated from the opioid stewardship fund
557.20 to the commissioner of health to support a
557.21 comprehensive, community-based opioid and
557.22 other drug abuse prevention program. The
557.23 commissioner may use up to 19 percent in
557.24 fiscal year 2020 and up to 14 percent in fiscal
557.25 year 2021 for administration. The remaining
557.26 funds are allocated as follows:

557.27 (1) \$1,000,000 each fiscal year is for grants
557.28 to regional emergency medical services and
557.29 law enforcement agencies and organizations
557.30 to purchase opioid antagonists, including
557.31 Narcan or Naloxone, and to train first
557.32 responders across Minnesota;

557.33 (2) \$1,000,000 in fiscal year 2020 and
557.34 \$2,000,000 in fiscal year 2021 are for

558.1 community grants authorized in Minnesota
558.2 Statutes, section 145.9275, subdivision 1;
558.3 (3) \$2,000,000 in fiscal year 2020 and
558.4 \$4,000,000 in fiscal year 2021 are for tribal
558.5 government grants in Minnesota Statutes,
558.6 section 145.9275, subdivision 2; and
558.7 (4) \$875,000 in fiscal year 2020 and
558.8 \$1,000,000 in fiscal year 2021 are for
558.9 overdose fatality review grants across
558.10 Minnesota.

558.11 **(d) Comprehensive Suicide Prevention.**
558.12 \$3,929,000 each fiscal year from the general
558.13 fund appropriations is to support a
558.14 comprehensive, community-based suicide
558.15 prevention strategy. The funds are allocated
558.16 as follows:
558.17 (1) \$1,291,000 each fiscal year is for
558.18 community-based suicide prevention grants
558.19 authorized in Minnesota Statutes, section
558.20 145.56, subdivision 2. Specific emphasis must
558.21 be placed on those communities with the
558.22 greatest disparities;
558.23 (2) \$913,000 each fiscal year is to support
558.24 evidence-based training for educators and
558.25 school staff and purchase suicide prevention
558.26 curriculum for student use statewide, as
558.27 authorized in Minnesota Statutes, section
558.28 145.56, subdivision 2;
558.29 (3) \$205,000 each fiscal year is to implement
558.30 the Zero Suicide framework with up to 20
558.31 behavioral and health care organizations each
558.32 year to treat individuals at risk for suicide and
558.33 support those individuals across systems of
558.34 care upon discharge;

559.1 (4) \$1,322,000 each fiscal year is to develop
559.2 and fund a Minnesota-based network of
559.3 National Suicide Prevention Lifeline,
559.4 providing statewide coverage;

559.5 (5) \$198,000 each fiscal year is to conduct
559.6 suicide fatality reviews to identify the scope
559.7 of the suicide problem, identify high-risk
559.8 groups, set priority prevention activities, and
559.9 monitor the effects of suicide prevention
559.10 programs; and

559.11 (6) the commissioner may retain up to 22.4
559.12 percent of the appropriation under this
559.13 subdivision to administer the comprehensive
559.14 suicide prevention strategy.

559.15 **(e) Statewide Tobacco Cessation.** \$1,663,000
559.16 in fiscal year 2020 and \$2,878,000 in fiscal
559.17 year 2021 are from the general fund to the
559.18 commissioner of health for statewide tobacco
559.19 cessation services under Minnesota Statutes,
559.20 section 144.397.

559.21 **(f) Health Care Access Survey.** \$450,000 in
559.22 fiscal year 2020 is from the health care access
559.23 fund for the commissioner to continue and
559.24 improve the Minnesota Health Care Access
559.25 Survey. This appropriation is added to the
559.26 department's base budget for even-numbered
559.27 fiscal years.

559.28 **(g) Community Solutions for Healthy Child**
Development Grant Program. \$2,000,000
559.29 in fiscal year 2020 is for the community
559.30 solutions for healthy child development grant
559.31 program to promote health and racial equity
559.32 for young children and their families under
559.33 Minnesota Statutes, section 145.9285. The

560.1 commissioner may use up to 23.5 percent of
560.2 the total appropriation for administration. This
560.3 is a onetime appropriation and is available
560.4 until June 30, 2023.

560.5 **(h) Base Level Adjustments.** The health care
560.6 access fund base is \$37,657,000 in fiscal year
560.7 2022 and \$36,607,000 in fiscal year 2023.

560.8 **Subd. 3. Health Protection**

560.9 **Appropriations by Fund**

560.10 <u>General</u>	<u>28,904,000</u>	<u>32,421,000</u>
560.11 <u>State Government</u>		
560.12 <u>Special Revenue</u>	<u>52,430,000</u>	<u>54,752,000</u>

560.13 **(a) Vulnerable Adults Program**

560.14 **Improvements.** \$7,438,000 in fiscal year 2020
560.15 and \$4,302,000 in fiscal year 2021 are from
560.16 the general fund for the commissioner to
560.17 continue necessary current operations
560.18 improvements to the regulatory activities,
560.19 systems, analysis, reporting, and
560.20 communications that contribute to the health,
560.21 safety, care quality, and abuse prevention for
560.22 vulnerable adults in Minnesota. \$1,103,000 in
560.23 fiscal year 2020 and \$1,103,000 in fiscal year
560.24 2021 are from the state government special
560.25 revenue fund to improve the frequency of
560.26 home care provider inspections. The state
560.27 government special revenue appropriations
560.28 under this paragraph are onetime
560.29 appropriations.

560.30 **(b) Vulnerable Adults Regulatory Reform.**
560.31 \$2,432,000 in fiscal year 2020 and \$8,114,000
560.32 in fiscal year 2021 are from the general fund
560.33 for the commissioner to establish the assisted
560.34 living licensure under Minnesota Statutes,
560.35 section 144I.01. This is a onetime

561.1 appropriation. The commissioner shall transfer
 561.2 fine revenue previously deposited to the state
 561.3 government special revenue fund under
 561.4 Minnesota Statutes, section 144A.474,
 561.5 subdivision 11, which is estimated to be
 561.6 \$632,000, to a dedicated account in the state
 561.7 treasury.

561.8 **(c) Laboratory Equipment.** \$840,000 in
 561.9 fiscal year 2020 and \$655,000 in fiscal year
 561.10 2021 are from the general fund for the
 561.11 commissioner to purchase equipment for the
 561.12 public health laboratory. These appropriations
 561.13 are onetime appropriations and available until
 561.14 June 30, 2023.

561.15 **(d) Provider Network Adequacy Reviews.**
 561.16 \$231,000 in fiscal year 2020 and \$231,000 in
 561.17 fiscal year 2021 are from the general fund for
 561.18 health plan product reviews and licensing of
 561.19 health maintenance organizations. The
 561.20 \$77,000 annual transfer from the state
 561.21 government special revenue fund to the
 561.22 general fund required by Laws 2008, chapter
 561.23 364, section 17, paragraph (b), shall end in
 561.24 fiscal year 2019.

561.25 **(e) Base Level Adjustment.** The general fund
 561.26 base is \$25,150,000 in fiscal year 2022 and
 561.27 \$24,719,000 in fiscal year 2023. The state
 561.28 government special revenue fund base is
 561.29 \$67,107,000 in fiscal year 2022 and
 561.30 \$67,067,000 in fiscal year 2023.

561.31	Subd. 4. Health Operations	10,950,000	11,062,000
561.32	Sec. 4. HEALTH-RELATED BOARDS		
561.33	Subdivision 1. Total Appropriation	\$ 26,498,000	\$ 25,888,000

562.1	<u>This appropriation is from the state</u>		
562.2	<u>government special revenue fund unless</u>		
562.3	<u>specified otherwise. The amounts that may be</u>		
562.4	<u>spent for each purpose are specified in the</u>		
562.5	<u>following subdivisions.</u>		
562.6	<u>Subd. 2. Board of Chiropractic Examiners</u>	<u>629,000</u>	<u>641,000</u>
562.7	<u>Subd. 3. Board of Dentistry</u>	<u>1,503,000</u>	<u>1,450,000</u>
562.8	<u>Subd. 4. Board of Dietetics and Nutrition</u>		
562.9	<u>Practice</u>	<u>147,000</u>	<u>149,000</u>
562.10	<u>Subd. 5. Board of Marriage and Family Therapy</u>	<u>384,000</u>	<u>389,000</u>
562.11	<u>Base Level Adjustment. The base is \$384,000</u>		
562.12	<u>in fiscal year 2022 and \$384,000 in fiscal year</u>		
562.13	<u>2023.</u>		
562.14	<u>Subd. 6. Board of Medical Practice</u>	<u>6,013,000</u>	<u>5,996,000</u>
562.15	<u>(a) Health Professional Services Program.</u>		
562.16	<u>This appropriation includes \$1,023,000 in</u>		
562.17	<u>fiscal year 2020 and \$1,002,000 in fiscal year</u>		
562.18	<u>2021 for the health professional services</u>		
562.19	<u>program.</u>		
562.20	<u>(b) Base Level Adjustment. The base is</u>		
562.21	<u>\$5,912,000 in fiscal year 2022 and \$5,868,000</u>		
562.22	<u>in fiscal year 2023.</u>		
562.23	<u>Subd. 7. Board of Nursing</u>	<u>4,993,000</u>	<u>4,993,000</u>
562.24	<u>Subd. 8. Board of Nursing Home Administrators</u>	<u>3,733,000</u>	<u>3,201,000</u>
562.25	<u>(a) Administrative Services Unit - Operating</u>		
562.26	<u>Costs. Of this appropriation, \$3,445,000 in</u>		
562.27	<u>fiscal year 2020 and \$2,910,000 in fiscal year</u>		
562.28	<u>2021 are for operating costs of the</u>		
562.29	<u>administrative services unit. The</u>		
562.30	<u>administrative services unit may receive and</u>		
562.31	<u>expend reimbursements for services it</u>		
562.32	<u>performs for other agencies.</u>		

563.1 **(b) Administrative Services Unit - Volunteer**

563.2 **Health Care Provider Program.** Of this
563.3 appropriation, \$150,000 in fiscal year 2020
563.4 and \$150,000 in fiscal year 2021 are to pay
563.5 for medical professional liability coverage
563.6 required under Minnesota Statutes, section
563.7 214.40.

563.8 **(c) Administrative Services Unit -**

563.9 **Retirement Costs.** Of this appropriation,
563.10 \$558,000 in fiscal year 2020 is a onetime
563.11 appropriation to the administrative services
563.12 unit to pay for the retirement costs of
563.13 health-related board employees. This funding
563.14 may be transferred to the health board
563.15 incurring retirement costs. Any board that has
563.16 an unexpended balance for an amount
563.17 transferred under this paragraph shall transfer
563.18 the unexpended amount to the administrative
563.19 services unit. These funds are available either
563.20 year of the biennium.

563.21 **(d) Administrative Services Unit - Contested**

563.22 **Cases and Other Legal Proceedings.** Of this
563.23 appropriation, \$200,000 in fiscal year 2020
563.24 and \$200,000 in fiscal year 2021 are for costs
563.25 of contested case hearings and other
563.26 unanticipated costs of legal proceedings
563.27 involving health-related boards funded under
563.28 this section. Upon certification by a
563.29 health-related board to the administrative
563.30 services unit that costs will be incurred and
563.31 that there is insufficient money available to
563.32 pay for the costs out of money currently
563.33 available to that board, the administrative
563.34 services unit is authorized to transfer money
563.35 from this appropriation to the board for

564.1 payment of those costs with the approval of
 564.2 the commissioner of management and budget.
 564.3 The commissioner of management and budget
 564.4 must require any board that has an unexpended
 564.5 balance for an amount transferred under this
 564.6 paragraph to transfer the unexpended amount
 564.7 to the administrative services unit to be
 564.8 deposited in the state government special
 564.9 revenue fund.

564.10	<u>Subd. 9. Board of Optometry</u>	<u>200,000</u>	<u>201,000</u>
564.11	<u>Subd. 10. Board of Pharmacy</u>	<u>3,599,000</u>	<u>3,629,000</u>
564.12	<u>\$1,643,000 in fiscal year 2020 and \$1,285,000</u>		
564.13	<u>in fiscal year 2021 are from the opioid</u>		
564.14	<u>stewardship fund.</u>		
564.15	<u>Subd. 11. Board of Physical Therapy</u>	<u>547,000</u>	<u>549,000</u>
564.16	<u>Subd. 12. Board of Podiatric Medicine</u>	<u>199,000</u>	<u>199,000</u>
564.17	<u>Subd. 13. Board of Psychology</u>	<u>1,357,000</u>	<u>1,395,000</u>
564.18	<u>Base Level Adjustment. The base is</u>		
564.19	<u>\$1,355,000 in fiscal year 2022 and \$1,355,000</u>		
564.20	<u>in fiscal year 2023.</u>		
564.21	<u>Subd. 14. Board of Social Work</u>	<u>1,437,000</u>	<u>1,404,000</u>
564.22	<u>Subd. 15. Board of Veterinary Medicine</u>	<u>345,000</u>	<u>353,000</u>
564.23	<u>Subd. 16. Board of Behavioral Health and</u>		
564.24	<u>Therapy</u>	<u>937,000</u>	<u>858,000</u>
564.25	<u>Base Level Adjustment. The base is \$833,000</u>		
564.26	<u>in fiscal year 2022 and \$833,000 in fiscal year</u>		
564.27	<u>2023.</u>		
564.28	<u>Subd. 17. Board of Occupational Therapy</u>		
564.29	<u>Practice</u>	<u>450,000</u>	<u>456,000</u>
564.30	<u>Sec. 5. EMERGENCY MEDICAL SERVICES</u>		
564.31	<u>REGULATORY BOARD</u>	<u>\$</u>	<u>3,747,000</u>
564.32	<u>(a) Cooper/Sams Volunteer Ambulance</u>	<u>\$</u>	<u>3,809,000</u>
564.33	<u>Program. \$950,000 in fiscal year 2020 and</u>		

565.1 \$950,000 in fiscal year 2021 are for the
565.2 Cooper/Sams volunteer ambulance program
565.3 under Minnesota Statutes, section 144E.40.
565.4 (1) Of this amount, \$861,000 in fiscal year
565.5 2020 and \$861,000 in fiscal year 2021 are for
565.6 the ambulance service personnel longevity
565.7 award and incentive program under Minnesota
565.8 Statutes, section 144E.40.

565.9 (2) Of this amount, \$89,000 in fiscal year 2020
565.10 and \$89,000 in fiscal year 2021 are for the
565.11 operations of the ambulance service personnel
565.12 longevity award and incentive program under
565.13 Minnesota Statutes, section 144E.40.

565.14 (b) EMSRB Operations. \$1,851,000 in fiscal
565.15 year 2020 and \$1,913,000 in fiscal year 2021
565.16 are for board operations. The base for this
565.17 program is \$1,880,000 in fiscal year 2022 and
565.18 \$1,880,000 in fiscal year 2023.

565.19 (c) Regional Grants. \$585,000 in fiscal year
565.20 2020 and \$585,000 in fiscal year 2021 are for
565.21 regional emergency medical services
565.22 programs, to be distributed equally to the eight
565.23 emergency medical service regions under
565.24 Minnesota Statutes, section 144E.52.

565.25 (d) Ambulance Training Grant. \$585,000
565.26 in fiscal year 2020 and \$585,000 in fiscal year
565.27 2021 are for training grants under Minnesota
565.28 Statutes, section 144E.35.

565.29 (e) Base Level Adjustment. The base is
565.30 \$3,776,000 in fiscal year 2022 and \$3,776,000
565.31 in fiscal year 2023.

565.32 Sec. 6. **COUNCIL ON DISABILITY** \$ **1,014,000** **\$ 1,006,000**

566.1 Sec. 7. **OMBUDSMAN FOR MENTAL**
 566.2 **HEALTH AND DEVELOPMENTAL**
 566.3 **DISABILITIES** \$ 2,438,000 \$ 2,438,000

566.4 **Department of Psychiatry Monitoring.**

566.5 \$100,000 in fiscal year 2020 and \$100,000 in
 566.6 fiscal year 2021 are for monitoring the
 566.7 Department of Psychiatry at the University of
 566.8 Minnesota.

566.9 Sec. 8. **OMBUDSPERSONS FOR FAMILIES** \$ 714,000 \$ 723,000

566.10 Sec. 9. Laws 2017, First Special Session chapter 6, article 18, section 2, subdivision 1, is
 566.11 amended to read:

566.12 \$ 7,654,331,000
 566.13 Subdivision 1. **Total Appropriation** \$ 7,548,395,000 \$ 7,654,596,000

566.14 Appropriations by Fund

	2018	2019
566.16		6,880,153,000
566.17 General	6,819,523,000	<u>6,880,418,000</u>
566.18 State Government		
566.19 Special Revenue	4,274,000	4,274,000
566.20 Health Care Access	446,453,000	501,104,000
566.21 Federal TANF	276,249,000	266,904,000
566.22 Lottery Prize	1,896,000	1,896,000

566.23 The amounts that may be spent for each
 566.24 purpose are specified in the following
 566.25 subdivisions.

566.26 **EFFECTIVE DATE.** This section is effective April 1, 2019.

566.27 Sec. 10. Laws 2017, First Special Session chapter 6, article 18, section 2, subdivision 3,
 566.28 is amended to read:

566.29 Subd. 3. **Central Office; Operations**

566.30 Appropriations by Fund

566.31		121,009,000
566.32 General	136,778,000	<u>121,024,000</u>
566.33 State Government		
566.34 Special Revenue	4,149,000	4,149,000

567.1 Health Care Access 21,019,000 21,019,000
567.2 Federal TANF 100,000 100,000

567.3 **(a) Administrative Recovery; Set-Aside.** The
567.4 commissioner may invoice local entities
567.5 through the SWIFT accounting system as an
567.6 alternative means to recover the actual cost of
567.7 administering the following provisions:

567.8 (1) Minnesota Statutes, section 125A.744,
567.9 subdivision 3;

567.10 (2) Minnesota Statutes, section 245.495,
567.11 paragraph (b);

567.12 (3) Minnesota Statutes, section 256B.0625,
567.13 subdivision 20, paragraph (k);

567.14 (4) Minnesota Statutes, section 256B.0924,
567.15 subdivision 6, paragraph (g);

567.16 (5) Minnesota Statutes, section 256B.0945,
567.17 subdivision 4, paragraph (d); and

567.18 (6) Minnesota Statutes, section 256F.10,
567.19 subdivision 6, paragraph (b).

567.20 **(b) Transfer to Office of Legislative**

567.21 **Auditor.** \$600,000 in fiscal year 2018 and
567.22 \$600,000 in fiscal year 2019 are for transfer
567.23 to the Office of the Legislative Auditor for
567.24 audit activities under Minnesota Statutes,
567.25 section 3.972, subdivision 2b.

567.26 **(c) Base Level Adjustment.** The general fund
567.27 base is \$133,378,000 in fiscal year 2020 and
567.28 \$133,418,000 in fiscal year 2021.

567.29 **EFFECTIVE DATE.** This section is effective April 1, 2019.

567.30 Sec. 11. Laws 2017, First Special Session chapter 6, article 18, section 2, subdivision 5,
567.31 is amended to read:

567.32 **Subd. 5. Central Office; Health Care**

568.1	Appropriations by Fund		
568.2			<u>21,249,000</u>
568.3	General	20,719,000	<u>21,336,000</u>
568.4	Health Care Access	23,697,000	23,804,000

568.5 (a) Integrated Health Partnership Health

568.6 **Information Exchange.** \$125,000 in fiscal
568.7 year 2018 and \$250,000 in fiscal year 2019

568.8 are from the general fund to contract with

568.9 state-certified health information exchange

568.10 vendors to support providers participating in

568.11 an integrated health partnership under

568.12 Minnesota Statutes, section 256B.075

568.13 connect enrollees with community support

568.14 and social services and improve collaboration

568 15 among participating and authorized providers

568.16 (b) Transfer to Legislative Auditor. 153,000

568.17 in fiscal year 2018 and \$153,000 in fiscal year

568.18 2019 are from the general fund for transfer to

568.19 the Office of the Legislative Auditor for the

568.20 auditor to establish and maintain a team of

568.21 auditors with the training and experience

568.22 necessary to fulfill the requirements in

^{568.23} Minnesota Statutes, section 3.972, subdivision

568.24 2a

568.25 (c) **Base Level Adjustment.** The general fund

568.26 base is \$21,257,000 in fiscal year 2020 and

568.27 \$21,302,000 in fiscal year 2021.

568.28 **EFFECTIVE DATE.** This section is effective April 1, 2019.

568.29 Sec. 12. Laws 2017, First Special Session chapter 6, article 18, section 2, subdivision 15,
568.30 is amended to read:

**568.31 Subd. 15. Forecasted Programs; Medical
568.32 Assistance**

570.1 complex needs, training stipends, and training
570.2 for direct support workers and for
570.3 implementation of the registry as outlined in
570.4 the collective bargaining agreement.

570.5 (3) Notwithstanding Minnesota Statutes,
570.6 sections 3.855, 179A.22, subdivision 4, and
570.7 179A.54, subdivision 5, upon approval of a
570.8 negotiated collective bargaining agreement by
570.9 the SEIU and the commissioner of
570.10 management and budget, the commissioner
570.11 of human services is authorized to implement
570.12 the negotiated collective bargaining
570.13 agreement.

570.14 **EFFECTIVE DATE.** This section is effective April 1, 2019.

570.15 Sec. 13. **TRANSFER; OPIOID STEWARDSHIP FUND.**

570.16 In fiscal year 2020, the commissioner of management and budget shall transfer
570.17 \$13,000,000 from the health care access fund to the opioid stewardship fund. This is a
570.18 onetime transfer.

570.19 Sec. 14. **TRANSFERS; HUMAN SERVICES.**

570.20 Subdivision 1. **Grants.** The commissioner of human services, with the approval of the
570.21 commissioner of management and budget, may transfer unencumbered appropriation balances
570.22 for the biennium ending June 30, 2021, within fiscal years among the MFIP, general
570.23 assistance, medical assistance, MinnesotaCare, MFIP child care assistance under Minnesota
570.24 Statutes, section 119B.05, Minnesota supplemental aid program, group residential housing
570.25 program, the entitlement portion of Northstar Care for Children under Minnesota Statutes,
570.26 chapter 256N, and the entitlement portion of the chemical dependency consolidated treatment
570.27 fund, and between fiscal years of the biennium. The commissioner shall inform the chairs
570.28 and ranking minority members of the senate Health and Human Services Finance Division
570.29 and the house of representatives Health and Human Services Finance Committee quarterly
570.30 about transfers made under this subdivision.

570.31 Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative money
570.32 may be transferred within the Departments of Health and Human Services as the
570.33 commissioners consider necessary, with the advance approval of the commissioner of

571.1 management and budget. The commissioner shall inform the chairs and ranking minority
571.2 members of the senate Health and Human Services Finance Division and the house of
571.3 representatives Health and Human Services Finance Committee quarterly about transfers
571.4 made under this subdivision.

571.5 Sec. 15. **INDIRECT COSTS NOT TO FUND PROGRAMS.**

571.6 The commissioners of health and human services shall not use indirect cost allocations
571.7 to pay for the operational costs of any program for which they are responsible.

571.8 Sec. 16. **EXPIRATION OF UNCODIFIED LANGUAGE.**

571.9 All uncodified language contained in this article expires on June 30, 2021, unless a
571.10 different expiration date is explicit.

571.11 Sec. 17. **EFFECTIVE DATE.**

571.12 This article is effective July 1, 2019, unless a different effective date is specified.

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.

144A.071 MORATORIUM ON CERTIFICATION OF NURSING HOME BEDS.

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 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 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 first day of the month of January or July, whichever date occurs first following both the completion of the construction upgrades in the consolidation plan and the complete 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 housing support under chapter 256I;

(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 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

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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 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.

144A.472 HOME CARE PROVIDER LICENSE; APPLICATION AND RENEWAL.

Subd. 4. **Multiple units.** Multiple units or branches of a licensee must be separately licensed if the commissioner determines that the units cannot adequately share supervision and administration of services from the main office.

144D.01 DEFINITIONS.

Subd. 2a. **Arranged home care provider.** "Arranged home care provider" means a home care provider licensed under chapter 144A that provides services to some or all of the residents of a housing with services establishment and that is either the establishment itself or another entity with which the establishment has an arrangement.

Subd. 3a. **Direct-care staff.** "Direct-care staff" means staff and employees who provide home care services listed in section 144A.471, subdivisions 6 and 7.

Subd. 6. **Health-related services.** "Health-related services" include professional nursing services, home health aide tasks, or the central storage of medication for residents.

144D.04 HOUSING WITH SERVICES CONTRACTS.

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

(b) The contract must include a statement:

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

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

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

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

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

144D.045 INFORMATION CONCERNING ARRANGED HOME CARE PROVIDERS.

If a housing with services establishment has one or more arranged home care providers, the establishment shall arrange to have that arranged home care provider deliver the following information in writing to a prospective resident, prior to the date on which the prospective resident executes a contract with the establishment or the prospective resident's move-in date, whichever is earlier:

- (1) the name, mailing address, and telephone number of the arranged home care provider;
- (2) the name and mailing address of at least one natural person who is authorized to accept service of process on behalf of the entity described in clause (1);
- (3) a description of the process through which a home care service agreement or service plan between a resident and the arranged home care provider, if any, may be modified, amended, or terminated;
- (4) the arranged home care provider's billing and payment procedures and requirements; and
- (5) any limits to the services available from the arranged provider.

144D.06 OTHER LAWS.

In addition to registration under this chapter, a housing with services establishment must comply with chapter 504B and the provisions of section 325F.72, and shall obtain and maintain all other licenses, permits, registrations, or other governmental approvals required of it. A housing with services establishment is not required to obtain a lodging license under chapter 157 and related rules.

144D.09 TERMINATION OF LEASE.

The housing with services establishment shall include with notice of termination of lease information about how to contact the ombudsman for long-term care, including the address and telephone number along with a statement of how to request problem-solving assistance.

144D.10 MANAGER REQUIREMENTS.

(a) The person primarily responsible for oversight and management of a housing with services establishment, as designated by the owner of the housing with services establishment, must obtain at least 30 hours of continuing education every two years of employment as the manager in topics relevant to the operations of the housing with services establishment and the needs of its tenants. Continuing education earned to maintain a professional license, such as nursing home administrator license, nursing license, social worker license, and real estate license, can be used to complete this requirement.

(b) For managers of establishments identified in section 325F.72, this continuing education must include at least eight hours of documented training on the topics identified in section 144D.065, paragraph (b), within 160 working hours of hire, and two hours of training on these topics for each 12 months of employment thereafter.

(c) For managers of establishments not covered by section 325F.72, but who provide assisted living services under chapter 144G, this continuing education must include at least four hours of documented training on the topics identified in section 144D.065, paragraph (b), within 160 working hours of hire, and two hours of training on these topics for each 12 months of employment thereafter.

(d) A statement verifying compliance with the continuing education requirement must be included in the housing with services establishment's annual registration to the commissioner of health. The establishment must maintain records for at least three years demonstrating that the person primarily responsible for oversight and management of the establishment has attended educational programs as required by this section.

(e) New managers may satisfy the initial dementia training requirements by producing written proof of previously completed required training within the past 18 months.

(f) This section does not apply to an establishment registered under section 144D.025 serving the homeless.

144G.01 DEFINITIONS.

Subdivision 1. Scope; other definitions. For purposes of sections 144G.01 to 144G.05, the following definitions apply. In addition, the definitions provided in section 144D.01 also apply to sections 144G.01 to 144G.05.

Subd. 2. Assisted living. "Assisted living" means a service or package of services advertised, marketed, or otherwise described, offered, or promoted using the phrase "assisted living" either alone or in combination with other words, whether orally or in writing, and which is subject to the requirements of this chapter.

Subd. 3. Assisted living client; client. "Assisted living client" or "client" means a housing with services resident who receives assisted living that is subject to the requirements of this chapter.

Subd. 4. Commissioner. "Commissioner" means the commissioner of health.

144G.02 ASSISTED LIVING; PROTECTED TITLE; REGULATORY FUNCTION.

Subdivision 1. Protected title; restriction on use. No person or entity may use the phrase "assisted living," whether alone or in combination with other words and whether orally or in writing, to advertise, market, or otherwise describe, offer, or promote itself, or any housing, service, service package, or program that it provides within this state, unless the person or entity is a housing with services establishment that meets the requirements of this chapter, or is a person or entity that provides some or all components of assisted living that meet the requirements of this chapter. A person or entity entitled to use the phrase "assisted living" shall use the phrase only in the context of its participation in assisted living that meets the requirements of this chapter. A housing with services establishment offering or providing assisted living that is not made available to residents in all of its housing units shall identify the number or location of the units in which assisted living is available, and may not use the term "assisted living" in the name of the establishment registered with the commissioner under chapter 144D, or in the name the establishment uses to identify itself to residents or the public.

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.

144G.03 ASSISTED LIVING REQUIREMENTS.

Subdivision 1. Verification in annual registration. A registered housing with services establishment using the phrase "assisted living," pursuant to section 144G.02, subdivision 1, shall verify to the commissioner in its annual registration pursuant to chapter 144D that the establishment is complying with sections 144G.01 to 144G.05, as applicable.

Subd. 2. Minimum requirements for assisted living. (a) Assisted living shall be provided or made available only to individuals residing in a registered housing with services establishment. Except as expressly stated in this chapter, a person or entity offering assisted living may define the available services and may offer assisted living to all or some of the residents of a housing with services establishment. The services that comprise assisted living may be provided or made available directly by a housing with services establishment or by persons or entities with which the housing with services establishment has made arrangements.

(b) A person or entity entitled to use the phrase "assisted living," according to section 144G.02, subdivision 1, shall do so only with respect to a housing with services establishment, or a service,

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service package, or program available within a housing with services establishment that, at a minimum:

(1) provides or makes available health-related services under a home care license. At a minimum, health-related services must include:

(i) assistance with self-administration of medication, medication management, or medication administration as defined in section 144A.43; and

(ii) assistance with at least three of the following seven activities of daily living: bathing, dressing, grooming, eating, transferring, continence care, and toileting.

All health-related services shall be provided in a manner that complies with applicable home care licensure requirements in chapter 144A and sections 148.171 to 148.285;

(2) provides necessary assessments of the physical and cognitive needs of assisted living clients by a registered nurse, as required by applicable home care licensure requirements in chapter 144A and sections 148.171 to 148.285;

(3) has and maintains a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by applicable home care licensure requirements in chapter 144A and sections 148.171 to 148.285;

(4) provides staff access to an on-call registered nurse 24 hours per day, seven days per week;

(5) has and maintains a system to check on each assisted living client at least daily;

(6) provides a means for assisted living clients to request assistance for health and safety needs 24 hours per day, seven days per week, from the establishment or a person or entity with which the establishment has made arrangements;

(7) has a person or persons available 24 hours per day, seven days per week, who is responsible for responding to the requests of assisted living clients for assistance with health or safety needs, who shall be:

(i) awake;

(ii) located in the same building, in an attached building, or on a contiguous campus with the housing with services establishment in order to respond within a reasonable amount of time;

(iii) capable of communicating with assisted living clients;

(iv) capable of recognizing the need for assistance;

(v) capable of providing either the assistance required or summoning the appropriate assistance; and

(vi) capable of following directions;

(8) offers to provide or make available at least the following supportive services to assisted living clients:

(i) two meals per day;

(ii) weekly housekeeping;

(iii) weekly laundry service;

(iv) upon the request of the client, reasonable assistance with arranging for transportation to medical and social services appointments, and the name of or other identifying information about the person or persons responsible for providing this assistance;

(v) upon the request of the client, reasonable assistance with accessing community resources and social services available in the community, and the name of or other identifying information about the person or persons responsible for providing this assistance; and

(vi) periodic opportunities for socialization; and

(9) makes available to all prospective and current assisted living clients information consistent with the uniform format and the required components adopted by the commissioner under section 144G.06. This information must be made available beginning no later than six months after the commissioner makes the uniform format and required components available to providers according to section 144G.06.

Subd. 3. Exemption from awake-staff requirement. A housing with services establishment that offers or provides assisted living is exempt from the requirement in subdivision 2, paragraph (b), clause (7), item (i), that the person or persons available and responsible for responding to requests for assistance must be awake, if the establishment meets the following requirements:

- (1) the establishment has a maximum capacity to serve 12 or fewer assisted living clients;
- (2) the person or persons available and responsible for responding to requests for assistance are physically present within the housing with services establishment in which the assisted living clients reside;
- (3) the establishment has a system in place that is compatible with the health, safety, and welfare of the establishment's assisted living clients;
- (4) the establishment's housing with services contract, as required by section 144D.04, includes a statement disclosing the establishment's qualification for, and intention to rely upon, this exemption;
- (5) the establishment files with the commissioner, for purposes of public information but not review or approval by the commissioner, a statement describing how the establishment meets the conditions in clauses (1) to (4), and makes a copy of this statement available to actual and prospective assisted living clients; and
- (6) the establishment indicates on its housing with services registration, under section 144D.02 or 144D.03, as applicable, that it qualifies for and intends to rely upon the exemption under this subdivision.

Subd. 4. Nursing assessment. (a) A housing with services establishment offering or providing assisted living shall:

- (1) offer to have the arranged home care provider conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a service plan prior to the date on which a prospective resident executes a contract with a housing with services establishment or the date on which a prospective resident moves in, whichever is earlier; and
 - (2) inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a housing with services establishment or the date on which a prospective resident moves in, whichever is earlier.
- (b) An arranged home care provider is not obligated to conduct a nursing assessment by a registered nurse when requested by a prospective resident if either the geographic distance between the prospective resident and the provider, or urgent or unexpected circumstances, do not permit the assessment to be conducted prior to the date on which the prospective resident executes a contract or moves in, whichever is earlier. When such circumstances occur, the arranged home care provider shall offer to conduct a telephone conference whenever reasonably possible.
- (c) The arranged home care provider shall comply with applicable home care licensure requirements in chapter 144A and sections 148.171 to 148.285, with respect to the provision of a nursing assessment prior to the delivery of nursing services and the execution of a home care service plan or service agreement.

Subd. 5. Assistance with arranged home care provider. The housing with services establishment shall provide each assisted living client with identifying information about a person or persons reasonably available to assist the client with concerns the client may have with respect to the services provided by the arranged home care provider. The establishment shall keep each assisted living client reasonably informed of any changes in the personnel referenced in this subdivision. Upon request of the assisted living client, such personnel or designee shall provide reasonable assistance to the assisted living client in addressing concerns regarding services provided by the arranged home care provider.

Subd. 6. Termination of housing with services contract. If a housing with services establishment terminates a housing with services contract with an assisted living client, the establishment shall provide the assisted living client, and the legal or designated representative of the assisted living client, if any, with a written notice of termination which includes the following information:

- (1) the effective date of termination;
- (2) the section of the contract that authorizes the termination;

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(3) without extending the termination notice period, an affirmative offer to meet with the assisted living client and, if applicable, client representatives, within no more than five business days of the date of the termination notice to discuss the termination;

(4) an explanation that:

(i) the assisted living client must vacate the apartment, along with all personal possessions, on or before the effective date of termination;

(ii) failure to vacate the apartment by the date of termination may result in the filing of an eviction action in court by the establishment, and that the assisted living client may present a defense, if any, to the court at that time; and

(iii) the assisted living client may seek legal counsel in connection with the notice of termination;

(5) a statement that, with respect to the notice of termination, reasonable accommodation is available for the disability of the assisted living client, if any; and

(6) the name and contact information of the representative of the establishment with whom the assisted living client or client representatives may discuss the notice of termination.

144G.04 RESERVATION OF RIGHTS.

Subdivision 1. Use of services. Nothing in this chapter requires an assisted living client to utilize any service provided or made available in assisted living.

Subd. 2. Housing with services contracts. Nothing in this chapter requires a housing with services establishment to execute or refrain from terminating a housing with services contract with a prospective or current resident who is unable or unwilling to meet the requirements of residency, with or without assistance.

Subd. 3. Provision of services. Nothing in this chapter requires the arranged home care provider to offer or continue to provide services under a service agreement or service plan to a prospective or current resident of the establishment whose needs cannot be met by the arranged home care provider.

Subd. 4. Altering operations; service packages. Nothing in this chapter requires a housing with services establishment or arranged home care provider offering assisted living to fundamentally alter the nature of the operations of the establishment or the provider in order to accommodate the request or need for facilities or services by any assisted living client, or to refrain from requiring, as a condition of residency, that an assisted living client pay for a package of assisted living services even if the client does not choose to utilize all or some of the services in the package.

144G.05 REIMBURSEMENT UNDER ASSISTED LIVING SERVICE PACKAGES.

Notwithstanding the provisions of this chapter, the requirements for the elderly waiver program's assisted living payment rates under section 256B.0915, subdivision 3e, shall continue to be effective and providers who do not meet the requirements of this chapter may continue to receive payment under section 256B.0915, subdivision 3e, as long as they continue to meet the definitions and standards for assisted living and assisted living plus set forth in the federally approved Elderly Home and Community Based Services Waiver Program (Control Number 0025.91). Providers of assisted living for the community access for disability inclusion (CADI) and Brain Injury (BI) waivers shall continue to receive payment as long as they continue to meet the definitions and standards for assisted living and assisted living plus set forth in the federally approved CADI and BI waiver plans.

144G.06 UNIFORM CONSUMER INFORMATION GUIDE.

The commissioner shall adopt a uniform format for the guide to be used by individual providers, and the required components of materials to be used by providers to inform assisted living clients of their legal rights, and shall make the uniform format and the required components available to assisted living providers.

214.17 HIV, HBV, AND HCV PREVENTION PROGRAM; PURPOSE AND SCOPE.

Sections 214.17 to 214.25 are intended to promote the health and safety of patients and regulated persons by reducing the risk of infection in the provision of health care.

214.18 DEFINITIONS.

Subdivision 1. **Board.** "Board" means the Boards of Dentistry, Medical Practice, Nursing, and Podiatric Medicine. For purposes of sections 214.19, subdivisions 4 and 5; 214.20, paragraph (1); and 214.24, board also includes the Board of Chiropractic Examiners.

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of health.

Subd. 3. **HBV.** "HBV" means the hepatitis B virus with the e antigen present in the most recent blood test.

Subd. 3a. **HCV.** "HCV" means the hepatitis C virus.

Subd. 4. **HIV.** "HIV" means the human immunodeficiency virus.

Subd. 5. **Regulated person.** "Regulated person" means a licensed dental hygienist, dentist, physician, nurse who is currently registered as a registered nurse or licensed practical nurse, podiatrist, a registered dental assistant, a physician assistant, and for purposes of sections 214.19, subdivisions 4 and 5; 214.20, paragraph (a); and 214.24, a chiropractor.

214.19 REPORTING OBLIGATIONS.

Subdivision 1. **Permission to report.** A person with actual knowledge that a regulated person has been diagnosed as infected with HIV, HBV, or HCV may file a report with the commissioner.

Subd. 2. **Self-reporting.** A regulated person who is diagnosed as infected with HIV, HBV, or HCV shall report that information to the commissioner promptly, and as soon as medically necessary for disease control purposes but no more than 30 days after learning of the diagnosis or 30 days after becoming licensed or registered by the state.

Subd. 3. **Mandatory reporting.** A person or institution required to report HIV, HBV, or HCV status to the commissioner under Minnesota Rules, parts 4605.7030, subparts 1 to 4 and 6, and 4605.7040, shall, at the same time, notify the commissioner if the person or institution knows that the reported person is a regulated person.

Subd. 4. **Infection control reporting.** A regulated person shall, within ten days, report to the appropriate board personal knowledge of a serious failure or a pattern of failure by another regulated person to comply with accepted and prevailing infection control procedures related to the prevention of HIV, HBV, and HCV transmission. In lieu of reporting to the board, the regulated person may make the report to a designated official of the hospital, nursing home, clinic, or other institution or agency where the failure to comply with accepted and prevailing infection control procedures occurred. The designated official shall report to the appropriate board within 30 days of receiving a report under this subdivision. The report shall include specific information about the response by the institution or agency to the report. A regulated person shall not be discharged or discriminated against for filing a complaint in good faith under this subdivision.

Subd. 5. **Immunity.** A person is immune from civil liability or criminal prosecution for submitting a report in good faith to the commissioner or to a board under this section.

214.20 GROUNDS FOR DISCIPLINARY OR RESTRICTIVE ACTION.

A board may refuse to grant a license or registration or may impose disciplinary or restrictive action against a regulated person who:

(1) fails to follow accepted and prevailing infection control procedures, including a failure to conform to current recommendations of the Centers for Disease Control for preventing the transmission of HIV, HBV, and HCV, or fails to comply with infection control rules promulgated by the board. Injury to a patient need not be established;

(2) fails to comply with any requirement of sections 214.17 to 214.24; or

(3) fails to comply with any monitoring or reporting requirement.

214.21 TEMPORARY SUSPENSION.

The board may, without hearing, temporarily suspend the right to practice of a regulated person if the board finds that the regulated person has refused to submit to or comply with monitoring under section 214.23. The suspension shall take effect upon written notice to the regulated person specifying the statute or rule violated. The suspension shall remain in effect until the board issues a final order based on a stipulation or after a hearing. At the time the board issues the suspension notice, the board shall schedule a disciplinary hearing to be held under chapter 14. The regulated

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person shall be provided with at least 20 days' notice of a hearing held under this section. The hearing shall be scheduled to begin no later than 30 days after the issuance of the suspension order.

214.22 NOTICE; ACTION.

If the board has reasonable grounds to believe a regulated person infected with HIV, HBV, or HCV has done or omitted doing any act that would be grounds for disciplinary action under section 214.20, the board may take action after giving notice three business days before the action, or a lesser time if deemed necessary by the board. The board may:

- (1) temporarily suspend the regulated person's right to practice under section 214.21;
- (2) require the regulated person to appear personally at a conference with representatives of the board and to provide information relating to the regulated person's health or professional practice; and
- (3) take any other lesser action deemed necessary by the board for the protection of the public.

214.23 MONITORING.

Subdivision 1. **Commissioner of health.** The board shall enter into a contract with the commissioner to perform the functions in subdivisions 2 and 3. The contract shall provide that:

- (1) unless requested to do otherwise by a regulated person, a board shall refer all regulated persons infected with HIV, HBV, or HCV to the commissioner;
- (2) the commissioner may choose to refer any regulated person who is infected with HIV, HBV, or HCV as well as all information related thereto to the person's board at any time for any reason, including but not limited to: the degree of cooperation and compliance by the regulated person; the inability to secure information or the medical records of the regulated person; or when the facts may present other possible violations of the regulated persons practices act. Upon request of the regulated person who is infected with HIV, HBV, or HCV the commissioner shall refer the regulated person and all information related thereto to the person's board. Once the commissioner has referred a regulated person to a board, the board may not thereafter submit it to the commissioner to establish a monitoring plan unless the commissioner of health consents in writing;
- (3) a board shall not take action on grounds relating solely to the HIV, HBV, or HCV status of a regulated person until after referral by the commissioner; and
- (4) notwithstanding sections 13.39 and 13.41 and chapters 147, 147A, 148, 150A, 153, and 214, a board shall forward to the commissioner any information on a regulated person who is infected with HIV, HBV, or HCV that the Department of Health requests.

Subd. 2. **Monitoring plan.** After receiving a report that a regulated person is infected with HIV, HBV, or HCV, the board or the commissioner acting on behalf of the board shall evaluate the past and current professional practice of the regulated person to determine whether there has been a violation under section 214.20. After evaluation of the regulated person's past and current professional practice, the board or the commissioner, acting on behalf of the board, shall establish a monitoring plan for the regulated person. The monitoring plan may:

- (1) address the scope of a regulated person's professional practice when the board or the commissioner, acting on behalf of the board, determines that the practice constitutes an identifiable risk of transmission of HIV, HBV, or HCV from the regulated person to the patient;
- (2) include the submission of regular reports at a frequency determined by the board or the commissioner, acting on behalf of the board, regarding the regulated person's health status; and
- (3) include any other provisions deemed reasonable by the board or the commissioner of health, acting on behalf of the board.

The board or commissioner, acting on behalf of the board, may enter into agreements with qualified persons to perform monitoring on its behalf. The regulated person shall comply with any monitoring plan established under this subdivision.

Subd. 3. **Expert review panel.** The board or the commissioner acting on behalf of the board may appoint an expert review panel to assist in the performance of the responsibilities under this section. In consultations with the expert review panel, the commissioner or board shall, to the extent possible, protect the identity of the regulated person. When an expert review panel is appointed, it must contain at least one member appointed by the commissioner and one professional member appointed by the board. The panel shall provide expert assistance to the board, or to the commissioner

acting on behalf of the board, in the subjects of infectious diseases, epidemiology, practice techniques used by regulated persons, and other subjects determined by the board or by the commissioner acting on behalf of the board. Members of the expert review panel are subject to those provisions of chapter 13 that restrict the commissioner or the board under Laws 1992, chapter 559, article 1.

Subd. 4. Immunity. Members of the board or the commissioner acting on behalf of the board, and persons who participate on an expert review panel or who assist the board or the commissioner in monitoring the practice of a regulated person, are immune from civil liability or criminal prosecution for any actions, transactions, or publications made in good faith and in execution of, or relating to, their duties under sections 214.17 to 214.24, except that no immunity shall be available for persons who have knowingly violated any provision of chapter 13.

214.24 INSPECTION OF PRACTICE.

Subdivision 1. Authority. The board is authorized to conduct inspections of the clinical practice of a regulated person to determine whether the regulated person is following accepted and prevailing infection control procedures. The board shall provide at least three business days' notice to the clinical practice prior to the inspection. The clinical practice of a regulated person includes any location where the regulated person practices that is not an institution licensed and subject to inspection by the commissioner of health. During the course of inspections the privacy and confidentiality of patients and regulated persons shall be maintained. The board may require on license renewal forms that regulated persons inform the board of all locations where they practice.

Subd. 2. Access; records. An inspector from the board shall have access, during reasonable business hours for purposes of inspection, to all areas of the practice setting where patient care is rendered or drugs or instruments are held that come into contact with a patient. An inspector is authorized to interview employees and regulated persons in the performance of an inspection, to observe infection control procedures, test equipment used to sterilize instruments, and to review and copy all relevant records, excluding patient health records. In performing these responsibilities, inspectors shall make reasonable efforts to respect and preserve patient privacy and the privacy of the regulated person. Boards are authorized to conduct joint inspections and to share information obtained under this section. The boards shall contract with the commissioner to perform the duties under this subdivision.

Subd. 3. Board action. If accepted and prevailing infection control techniques are not being followed, the board may educate the regulated person or take other actions. The board and the inspector shall maintain patient confidentiality in any action resulting from the inspection.

Subd. 4. Rulemaking. A board is authorized to adopt rules setting standards for infection control procedures. Boards shall engage in joint rulemaking. Boards must seek and consider the advice of the commissioner of health before adopting rules. No inspections shall be conducted under this section until after infection control rules have been adopted. Each board is authorized to provide educational information and training to regulated persons regarding infection control. All regulated persons who are employers shall make infection control rules available to employees who engage in functions related to infection control.

245.462 DEFINITIONS.

Subd. 4a. Clinical supervision. "Clinical supervision" means the oversight responsibility for individual treatment plans and individual mental health service delivery, including that provided by the case manager. Clinical supervision must be accomplished by full or part-time employment of or contracts with mental health professionals. Clinical supervision must be documented by the mental health professional cosigning individual treatment plans and by entries in the client's record regarding supervisory activities.

245E.06 ADMINISTRATIVE SANCTIONS.

Subd. 2. Written notice of department sanction; sanction 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;

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- (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.

(e) Notwithstanding section 245E.03, subdivision 4, the effective date of the proposed sanction 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 shall be delayed pending the final outcome of the appeal. Implementation of a proposed sanction following the resolution of a timely appeal may be postponed if, in the opinion of the department, the delay of sanction 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.

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.

246.18 DISPOSAL OF FUNDS.

Subd. 8. State-operated services account. (a) The state-operated services account is established in the special revenue fund. Revenue generated by new state-operated services listed under this section established after July 1, 2010, that are not enterprise activities must be deposited into the state-operated services account, unless otherwise specified in law:

- (1) intensive residential treatment services;
- (2) foster care services; and
- (3) psychiatric extensive recovery treatment services.

(b) Funds deposited in the state-operated services account are appropriated to the commissioner of human services for the purposes of:

- (1) providing services needed to transition individuals from institutional settings within state-operated services to the community when those services have no other adequate funding source; and
- (2) funding the operation of the intensive residential treatment service program in Willmar.

Subd. 9. Transfers. The commissioner may transfer state mental health grant funds to the account in subdivision 8 for noncovered allowable costs of a provider certified and licensed under section 256B.0622 and operating under section 246.014.

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.

252.431 SUPPORTED EMPLOYMENT SERVICES; DEPARTMENTAL DUTIES; COORDINATION.

The commissioners of employment and economic development, human services, and education shall ensure that supported employment services provided as part of a comprehensive service system will:

- (1) provide the necessary supports to assist persons with severe disabilities to obtain and maintain employment in normalized work settings available to the general work force that:
 - (i) maximize community and social integration; and
 - (ii) provide job opportunities that meet the individual's career potential and interests;
- (2) allow persons with severe disabilities to actively participate in the planning and delivery of community-based employment services at the individual, local, and state level; and
- (3) be coordinated among the Departments of Human Services, Employment and Economic Development, and Education to:
 - (i) promote the most efficient and effective funding;
 - (ii) avoid duplication of services; and
 - (iii) improve access and transition to employability services.

The commissioners of employment and economic development, human services, and education shall report to the legislature by January 1993 on the steps taken to implement this section.

252.451 BUSINESS AGREEMENTS; SUPPORT AND SUPERVISION OF PERSONS WITH DISABILITIES.

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

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(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.

254B.03 RESPONSIBILITY TO PROVIDE CHEMICAL DEPENDENCY TREATMENT.

Subd. 4a. Division of costs for medical assistance services. Notwithstanding subdivision 4, for chemical dependency services provided on or after October 1, 2008, and reimbursed by medical assistance, the county share is 30 percent of the nonfederal share.

256B.0615 MENTAL HEALTH CERTIFIED PEER SPECIALIST.

Subd. 2. Establishment. The commissioner of human services shall establish a certified peer specialist program model, which:

- (1) provides nonclinical peer support counseling by certified peer specialists;
- (2) provides a part of a wraparound continuum of services in conjunction with other community mental health services;
- (3) is individualized to the consumer; and
- (4) promotes socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.

Subd. 4. Peer support specialist program providers. The commissioner shall develop a process to certify peer support specialist programs, in accordance with the federal guidelines, in order for the program to bill for reimbursable services. Peer support programs may be freestanding or within existing mental health community provider centers.

Subd. 5. Certified peer specialist training and certification. The commissioner of human services shall develop a training and certification process for certified peer specialists, who must be at least 21 years of age. The candidates must have had a primary diagnosis of mental illness, be a current or former consumer of mental health services, and must demonstrate leadership and advocacy skills and a strong dedication to recovery. The training curriculum must teach participating consumers specific skills relevant to providing peer support to other consumers. In addition to initial training and certification, the commissioner shall develop ongoing continuing educational workshops on pertinent issues related to peer support counseling.

256B.0616 MENTAL HEALTH CERTIFIED FAMILY PEER SPECIALIST.

Subd. 2. **Establishment.** The commissioner of human services shall establish a certified family peer specialists program model which:

- (1) provides nonclinical family peer support counseling, building on the strengths of families and helping them achieve desired outcomes;
- (2) collaborates with others providing care or support to the family;
- (3) provides nonadversarial advocacy;
- (4) promotes the individual family culture in the treatment milieu;
- (5) links parents to other parents in the community;
- (6) offers support and encouragement;
- (7) assists parents in developing coping mechanisms and problem-solving skills;
- (8) promotes resiliency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services;
- (9) establishes and provides peer-led parent support groups; and
- (10) increases the child's ability to function better within the child's home, school, and community by educating parents on community resources, assisting with problem solving, and educating parents on mental illnesses.

Subd. 4. **Peer support specialist program providers.** The commissioner shall develop a process to certify family peer support specialist programs, in accordance with the federal guidelines, in order for the program to bill for reimbursable services. Family peer support programs must operate within an existing mental health community provider or center.

Subd. 5. **Certified family peer specialist training and certification.** The commissioner shall develop a training and certification process for certified family peer specialists who must be at least 21 years of age. The candidates must have raised or be currently raising a child with a mental illness, have had experience navigating the children's mental health system, and must demonstrate leadership and advocacy skills and a strong dedication to family-driven and family-focused services. The training curriculum must teach participating family peer specialists specific skills relevant to providing peer support to other parents. In addition to initial training and certification, the commissioner shall develop ongoing continuing educational workshops on pertinent issues related to family peer support counseling.

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.0705 PERSONAL CARE ASSISTANCE SERVICES; MANDATED SERVICE VERIFICATION.

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

(b) "Personal care assistance services" or "PCA services" means services provided according to section 256B.0659.

(c) "Personal care assistant" or "PCA" has the meaning given in section 256B.0659, subdivision 1.

(d) "Service verification" means a random, unscheduled telephone call made for the purpose of verifying that the individual personal care assistant is present at the location where personal care assistance services are being provided and is providing services as scheduled.

Subd. 2. **Verification schedule.** An agency that submits claims for reimbursement for PCA services under this chapter must develop and implement administrative policies and procedures by which the agency verifies the services provided by a PCA. For each service recipient, the agency must conduct at least one service verification every 90 days. If more than one PCA provides services to a single service recipient, the agency must conduct a service verification for each PCA providing services before conducting a service verification for a PCA whose services were previously verified by the agency. Service verification must occur on an ongoing basis while the agency provides PCA services to the recipient. During service verification, the agency must speak with both the PCA and the service recipient or recipient's authorized representative. Only qualified professional service verifications are eligible for reimbursement. An agency may substitute a visit by a qualified professional that is eligible for reimbursement under section 256B.0659, subdivision 14 or 19.

Subd. 3. **Documentation of verification.** An agency must fully document service verifications in a legible manner and must maintain the documentation on site for at least five years from the date of documentation. For each service verification, documentation must include:

(1) the names and signatures of the service recipient or recipient's authorized representative, the PCA and any other agency staff present with the PCA during the service verification, and the staff person conducting the service verification; and

(2) the start and end time, day, month, and year of the service verification, and the corresponding PCA time sheet.

Subd. 4. **Variance.** The Office of Inspector General at the Department of Human Services may grant a variance to the service verification requirements in this section if an agency uses an electronic monitoring system or other methods that verify a PCA is present at the location where services are provided and is providing services according to the prescribed schedule. A decision to grant or deny a variance request is final and not subject to appeal under chapter 14.

256B.0943 CHILDREN'S THERAPEUTIC SERVICES AND SUPPORTS.

Subd. 10. **Service authorization.** Children's therapeutic services and supports are subject to authorization criteria and standards published by the commissioner according to section 256B.0625, subdivision 25.

256B.0944 CHILDREN'S MENTAL HEALTH CRISIS RESPONSE SERVICES.

Subd. 10. **Client record.** The provider must maintain a file for each client that complies with the requirements under section 256B.0943, subdivision 11, and contains the following information:

(1) individual crisis treatment plans signed by the recipient, mental health professional, and mental health practitioner who developed the crisis treatment plan, or if the recipient refused to sign the plan, the date and reason stated by the recipient for not signing the plan;

(2) signed release of information forms;

(3) recipient health information and current medications;

(4) emergency contacts for the recipient;

(5) case records that document the date of service, place of service delivery, signature of the person providing the service, and the nature, extent, and units of service. Direct or telephone contact with the recipient's family or others should be documented;

(6) required clinical supervision by mental health professionals;

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- (7) summary of the recipient's case reviews by staff; and
- (8) any written information by the recipient that the recipient wants in the file.

256B.0946 INTENSIVE TREATMENT IN FOSTER CARE.

Subd. 5. **Service authorization.** The commissioner will administer authorizations for services under this section in compliance with section 256B.0625, subdivision 25.

256B.0947 INTENSIVE REHABILITATIVE MENTAL HEALTH SERVICES.

Subd. 9. **Service authorization.** The commissioner shall publish prior authorization criteria and standards to be used for intensive nonresidential rehabilitative mental health services, as provided in section 256B.0625, subdivision 25.

256B.431 RATE DETERMINATION.

Subd. 3a. **Property-related costs after July 1, 1985.** (a) For rate years beginning on or after July 1, 1985, the commissioner, by permanent rule, shall reimburse nursing facility providers that are vendors in the medical assistance program for the rental use of real estate and depreciable equipment. "Real estate" means land improvements, buildings, and attached fixtures used directly for resident care. "Depreciable equipment" means the standard movable resident care equipment and support service equipment generally used in long-term care facilities.

(b) In developing the method for determining payment rates for the rental use of nursing facilities, the commissioner shall consider factors designed to:

- (1) simplify the administrative procedures for determining payment rates for property-related costs;
- (2) minimize discretionary or appealable decisions;
- (3) eliminate any incentives to sell nursing facilities;
- (4) recognize legitimate costs of preserving and replacing property;
- (5) recognize the existing costs of outstanding indebtedness allowable under the statutes and rules in effect on May 1, 1983;
- (6) address the current value of, if used directly for patient care, land improvements, buildings, attached fixtures, and equipment;
- (7) establish an investment per bed limitation;
- (8) reward efficient management of capital assets;
- (9) provide equitable treatment of facilities;
- (10) consider a variable rate; and
- (11) phase-in implementation of the rental reimbursement method.

(c) For rate years beginning on or after July 1, 1987, a nursing facility which has reduced licensed bed capacity after January 1, 1986, shall be allowed to:

- (1) aggregate the applicable investment per bed limits based on the number of beds licensed prior to the reduction; and
- (2) establish capacity days for each rate year following the licensure reduction based on the number of beds licensed on the previous April 1 if the commissioner is notified of the change by April 4. The notification must include a copy of the delicensure request that has been submitted to the commissioner of health.

(d) For rate years beginning on or after July 1, 1989, the interest expense that results from a refinancing of a nursing facility's demand call loan, when the loan that must be refinanced was incurred before May 22, 1983, is an allowable interest expense if:

- (1) the demand call loan or any part of it was in the form of a loan that was callable at the demand of the lender;
- (2) the demand call loan or any part of it was called by the lender through no fault of the nursing facility;

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- (3) the demand call loan or any part of it was made by a government agency operating under a statutory or regulatory loan program;
- (4) the refinanced debt does not exceed the sum of the allowable remaining balance of the demand call loan at the time of payment on the demand call loan and refinancing costs;
- (5) the term of the refinanced debt does not exceed the remaining term of the demand call loan, had the debt not been subject to an on-call payment demand; and
- (6) the refinanced debt is not a debt between related organizations as defined in Minnesota Rules, part 9549.0020, subpart 38.

Subd. 3f. Property costs after July 1, 1988. (a) For the rate year beginning July 1, 1988, the replacement-cost-new per bed limit must be \$32,571 per licensed bed in multiple bedrooms and \$48,857 per licensed bed in a single bedroom. For the rate year beginning July 1, 1989, the replacement-cost-new per bed limit for a single bedroom must be \$49,907 adjusted according to Minnesota Rules, part 9549.0060, subpart 4, item A, subitem (1). Beginning January 1, 1990, the replacement-cost-new per bed limits must be adjusted annually as specified in Minnesota Rules, part 9549.0060, subpart 4, item A, subitem (1). Beginning January 1, 1991, the replacement-cost-new per bed limits will be adjusted annually as specified in Minnesota Rules, part 9549.0060, subpart 4, item A, subitem (1), except that the index utilized will be the Bureau of Economic Analysis: Price Indexes for Private Fixed Investments in Structures; Special Care.

(b) For the rate year beginning July 1, 1988, the commissioner shall increase the rental factor as established in Minnesota Rules, part 9549.0060, subpart 8, item A, by 6.2 percent rounded to the nearest 100th percent for the purpose of reimbursing nursing facilities for soft costs and entrepreneurial profits not included in the cost valuation services used by the state's contracted appraisers. For rate years beginning on or after July 1, 1989, the rental factor is the amount determined under this paragraph for the rate year beginning July 1, 1988.

(c) For rate years beginning on or after July 1, 1988, in order to determine property-related payment rates under Minnesota Rules, part 9549.0060, for all nursing facilities except those whose average length of stay in a skilled level of care within a nursing facility is 180 days or less, the commissioner shall use 95 percent of capacity days. For a nursing facility whose average length of stay in a skilled level of care within a nursing facility is 180 days or less, the commissioner shall use the greater of resident days or 80 percent of capacity days but in no event shall the divisor exceed 95 percent of capacity days.

(d) For rate years beginning on July 1, 1988, and July 1, 1989, the commissioner shall add ten cents per resident per day to each nursing facility's property-related payment rate. The ten-cent property-related payment rate increase is not cumulative from rate year to rate year. For the rate year beginning July 1, 1990, the commissioner shall increase each nursing facility's equipment allowance as established in Minnesota Rules, part 9549.0060, subpart 10, by ten cents per resident per day. For rate years beginning on or after July 1, 1991, the adjusted equipment allowance must be adjusted annually for inflation as in Minnesota Rules, part 9549.0060, subpart 10, item E. For the rate period beginning October 1, 1992, the equipment allowance for each nursing facility shall be increased by 28 percent. For rate years beginning after June 30, 1993, the allowance must be adjusted annually for inflation.

(e) For rate years beginning on or after July 1, 1990, Minnesota Rules, part 9549.0060, subpart 5, item E, shall not apply to outstanding related organization debt incurred prior to May 23, 1983, provided that the debt was an allowable debt under Minnesota Rules, parts 9510.0010 to 9510.0480, the debt is subject to repayment through annual principal payments, and the nursing facility demonstrates to the commissioner's satisfaction that the interest rate on the debt was less than market interest rates for similar arm's-length transactions at the time the debt was incurred. If the debt was incurred due to a sale between family members, the nursing facility must also demonstrate that the seller no longer participates in the management or operation of the nursing facility. Debts meeting the conditions of this paragraph are subject to all other provisions of Minnesota Rules, parts 9549.0010 to 9549.0080.

(f) For rate years beginning on or after July 1, 1990, a nursing facility with operating lease costs incurred for the nursing facility's buildings shall receive its building capital allowance computed in accordance with Minnesota Rules, part 9549.0060, subpart 8. If an operating lease provides that the lessee's rent is adjusted to recognize improvements made by the lessor and related debt, the costs for capital improvements and related debt shall be allowed in the computation of the lessee's building capital allowance, provided that reimbursement for these costs under an operating lease shall not exceed the rate otherwise paid.

Subd. 3g. Property costs after July 1, 1990, for certain facilities. (a) For rate years beginning on or after July 1, 1990, nursing facilities that, on or after January 1, 1976, but prior to January 1, 1987, were newly licensed after new construction, or increased their licensed beds by a minimum of 35 percent through new construction, and whose building capital allowance is less than their allowable annual principal and interest on allowable debt prior to the application of the replacement-cost-new per bed limit and whose remaining weighted average debt amortization schedule as of January 1, 1988, exceeded 15 years, must receive a property-related payment rate equal to the greater of their rental per diem or their annual allowable principal and allowable interest without application of the replacement-cost-new per bed limit, divided by their capacity days as determined under Minnesota Rules, part 9549.0060, subpart 11, as modified by subdivision 3f, paragraph (c), for the preceding reporting year, plus their equipment allowance. A nursing facility that is eligible for a property-related payment rate under this subdivision and whose property-related payment rate in a subsequent rate year is its rental per diem must continue to have its property-related payment rates established for all future rate years based on the rental reimbursement method in Minnesota Rules, part 9549.0060.

The commissioner may require the nursing facility to apply for refinancing as a condition of receiving special rate treatment under this subdivision.

(b) If a nursing facility is eligible for a property-related payment rate under this subdivision, and the nursing facility's debt is refinanced after October 1, 1988, the provisions in paragraphs (1) to (7) also apply to the property-related payment rate for rate years beginning on or after July 1, 1990.

(1) A nursing facility's refinancing must not include debts with balloon payments.

(2) If the issuance costs, including issuance costs on the debt refinanced, are financed as part of the refinancing, the historical cost of capital assets limit in Minnesota Rules, part 9549.0060, subpart 5, item A, subitem (6), includes issuance costs that do not exceed seven percent of the debt refinanced, plus the related issuance costs. For purposes of this paragraph, issuance costs means the fees charged by the underwriter, issuer, attorneys, bond raters, appraisers, and trustees, and includes the cost of printing, title insurance, registration tax, and a feasibility study for the refinancing of a nursing facility's debt. Issuance costs do not include bond premiums or discounts when bonds are sold at other than their par value, points, or a bond reserve fund. To the extent otherwise allowed under this paragraph, the straight-line amortization of the refinancing issuance costs is not an allowable cost.

(3) The annual principal and interest expense payments and any required annual municipal fees on the nursing facility's refinancing replace those of the refinanced debt and, together with annual principal and interest payments on other allowable debts, are allowable costs subject to the limitation on historical cost of capital assets plus issuance costs as limited in paragraph (2), if any.

(4) If the nursing facility's refinancing includes zero coupon bonds, the commissioner shall establish a monthly debt service payment schedule based on an annuity that will produce an amount equal to the zero coupon bonds at maturity. The term and interest rate is the term and interest rate of the zero coupon bonds. Any refinancing to repay the zero coupon bonds is not an allowable cost.

(5) The annual amount of annuity payments is added to the nursing facility's allowable annual principal and interest payment computed in paragraph (3).

(6) The property-related payment rate is equal to the amount in paragraph (5), divided by the nursing facility's capacity days as determined under Minnesota Rules, part 9549.0060, subpart 11, as modified by subdivision 3f, paragraph (c), for the preceding reporting year plus an equipment allowance.

(7) Except as provided in this subdivision, the provisions of Minnesota Rules, part 9549.0060 apply.

Subd. 3i. Property costs for the rate year beginning July 1, 1990. Notwithstanding Minnesota Rules, part 9549.0060, subpart 13, item H, the commissioner shall determine property-related payment rates for nursing facilities for the rate year beginning July 1, 1990, as follows:

(a) The property-related payment rate for a nursing facility that qualifies under subdivision 3g is the greater of the rate determined under that subdivision or the rate determined under paragraph (c), (d), or (e), whichever is applicable.

(b) Nursing facilities shall be grouped according to the type of property-related payment rate the commissioner determined for the rate year beginning July 1, 1989. A nursing facility whose

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property-related payment rate was determined under Minnesota Rules, part 9549.0060, subpart 13, item A (full rental reimbursement), shall be considered group A. A nursing facility whose property-related payment rate was determined under Minnesota Rules, part 9549.0060, subpart 13, item B (phase-down to full rental reimbursement), shall be considered group B. A nursing facility whose property-related payment rate was determined under Minnesota Rules, part 9549.0060, subpart 13, item C or D (phase-up to full rental reimbursement), shall be considered group C.

(c) For the rate year beginning July 1, 1990, a group A nursing facility shall receive its property-related payment rate determined under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section.

(d) For the rate year beginning July 1, 1990, a Group B nursing facility shall receive the greater of 87 percent of the property-related payment rate in effect on July 1, 1989; or the rental per diem rate determined under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section in effect on July 1, 1990; or the sum of 100 percent of the nursing facility's allowable principal and interest expense, plus its equipment allowance multiplied by the resident days for the reporting year ending September 30, 1989, divided by the nursing facility's capacity days as determined under Minnesota Rules, part 9549.0060, subpart 11, as modified by subdivision 3f, paragraph (c); except that the nursing facility's property-related payment rate must not exceed its property-related payment rate in effect on July 1, 1989.

(e) For the rate year beginning July 1, 1990, a group C nursing facility shall receive its property-related payment rate determined under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section, except the rate must not exceed the lesser of its property-related payment rate determined for the rate year beginning July 1, 1989, multiplied by 116 percent or its rental per diem rate determined effective July 1, 1990.

(f) The property-related payment rate for a nursing facility that qualifies for a rate adjustment under Minnesota Rules, part 9549.0060, subpart 13, item G (special reappraisals), shall have the property-related payment rate determined in paragraphs (a) to (e) adjusted according to the provisions in that rule.

(g) Except as provided in subdivision 4, paragraph (f), and subdivision 11, a nursing facility that has a change in ownership or a reorganization of provider entity is subject to the provisions of Minnesota Rules, part 9549.0060, subpart 13, item F.

Subd. 13. Hold-harmless property-related rates. (a) Terms used in subdivisions 13 to 21 shall be as defined in Minnesota Rules, parts 9549.0010 to 9549.0080, and this section.

(b) Except as provided in this subdivision, for rate periods beginning on October 1, 1992, and for rate years beginning after June 30, 1993, the property-related rate for a nursing facility shall be the greater of \$4 or the property-related payment rate in effect on September 30, 1992. In addition, the incremental increase in the nursing facility's rental rate will be determined under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section.

(c) Notwithstanding Minnesota Rules, part 9549.0060, subpart 13, item F, a nursing facility that has a sale permitted under subdivision 14 after June 30, 1992, shall receive the property-related payment rate in effect at the time of the sale or reorganization. For rate periods beginning after October 1, 1992, and for rate years beginning after June 30, 1993, a nursing facility shall receive, in addition to its property-related payment rate in effect at the time of the sale, the incremental increase allowed under subdivision 14.

(d) For rate years beginning after June 30, 1993, the property-related rate for a nursing facility licensed after July 1, 1989, after relocating its beds from a separate nursing home to a building formerly used as a hospital and sold during the cost reporting year ending September 30, 1991, shall be its property-related rate prior to the sale in addition to the incremental increases provided under this section effective on October 1, 1992, of 29 cents per day, and any incremental increases after October 1, 1992, calculated by using its rental rate under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section, recognizing the current appraised value of the facility at the new location, and including as allowable debt otherwise allowable debt incurred to remodel the facility in the new location prior to the relocation of beds.

Subd. 15. Capital repair and replacement cost reporting and rate calculation. For rate years beginning after June 30, 1993, a nursing facility's capital repair and replacement payment rate shall be established annually as provided in paragraphs (a) to (e).

(a) Notwithstanding Minnesota Rules, part 9549.0060, subpart 12, the costs of any of the following items not included in the equity incentive computations under subdivision 16 or reported

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as a capital asset addition under subdivision 18, paragraph (b), including cash payment for equity investment and principal and interest expense for debt financing, must be reported in the capital repair and replacement cost category:

- (1) wall coverings;
- (2) paint;
- (3) floor coverings;
- (4) window coverings;
- (5) roof repair; and
- (6) window repair or replacement.

(b) Notwithstanding Minnesota Rules, part 9549.0060, subpart 12, the repair or replacement of a capital asset not included in the equity incentive computations under subdivision 16 or reported as a capital asset addition under subdivision 18, paragraph (b), must be reported under this subdivision when the cost of the item exceeds \$500, or in the plant operations and maintenance cost category when the cost of the item is equal to or less than \$500.

(c) To compute the capital repair and replacement payment rate, the allowable annual repair and replacement costs for the reporting year must be divided by actual resident days for the reporting year. The annual allowable capital repair and replacement costs shall not exceed \$150 per licensed bed. The excess of the allowed capital repair and replacement costs over the capital repair and replacement limit shall be a cost carryover to succeeding cost reporting periods, except that sale of a facility, under subdivision 14, shall terminate the carryover of all costs except those incurred in the most recent cost reporting year. The termination of the carryover shall have effect on the capital repair and replacement rate on the same date as provided in subdivision 14, paragraph (f), for the sale. For rate years beginning after June 30, 1994, the capital repair and replacement limit shall be subject to the index provided in subdivision 3f, paragraph (a). For purposes of this subdivision, the number of licensed beds shall be the number used to calculate the nursing facility's capacity days. The capital repair and replacement rate must be added to the nursing facility's total payment rate.

(d) Capital repair and replacement costs under this subdivision shall not be counted as either care-related or other operating costs, nor subject to care-related or other operating limits.

(e) If costs otherwise allowable under this subdivision are incurred as the result of 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 these assets exceeds the lesser of \$150,000 or ten percent of the nursing facility's appraised value, these costs must be claimed under subdivision 16 or 17, as appropriate.

Subd. 17. Special provisions for moratorium exceptions. Notwithstanding Minnesota Rules, part 9549.0060, subpart 3, for rate periods beginning on October 1, 1992, and for rate years beginning after June 30, 1993, a nursing facility that (1) has completed a construction project approved under section 144A.071, subdivision 4a, clause (m); (2) has completed a construction project approved under section 144A.071, subdivision 4a, and effective after June 30, 1995; (3) has completed a construction project approved under section 144A.071, subdivision 4c; or (4) has completed a renovation, replacement, or upgrading project approved under the moratorium exception process in section 144A.073 shall be reimbursed for costs directly identified to that project as provided in subdivision 16 and subdivisions 17 to 17f.

Subd. 17a. Allowable interest expense. (a) Notwithstanding Minnesota Rules, part 9549.0060, subparts 5, item A, subitems (1) and (3), and 7, item D, allowable interest expense on debt shall include:

- (1) interest expense on debt related to the cost of purchasing or replacing depreciable equipment, excluding vehicles, not to exceed ten percent of the total historical cost of the project; and
- (2) interest expense on debt related to financing or refinancing costs, including costs related to points, loan origination fees, financing charges, legal fees, and title searches; and issuance costs including bond discounts, bond counsel, underwriter's counsel, corporate counsel, printing, and financial forecasts. Allowable debt related to items in this clause shall not exceed seven percent of the total historical cost of the project. To the extent these costs are financed, the straight-line amortization of the costs in this clause is not an allowable cost; and

(3) interest on debt incurred for the establishment of a debt reserve fund, net of the interest earned on the debt reserve fund.

(b) Debt incurred for costs under paragraph (a) is not subject to Minnesota Rules, part 9549.0060, subpart 5, item A, subitem (5) or (6).

Subd. 17c. Replacement-costs-new per bed limit. Notwithstanding subdivision 3f, paragraph (a), for rate periods beginning on October 1, 1992, and for rate years beginning after June 30, 1993, the replacement-costs-new per bed limit to be used in Minnesota Rules, part 9549.0060, subpart 4, item B, for a nursing facility that has completed a renovation, replacement, or upgrading project that has been approved under the moratorium exception process in section 144A.073, or that has completed an addition to or replacement of buildings, attached fixtures, or land improvements for which the total historical cost exceeds the lesser of \$150,000 or ten percent of the most recent appraised value, must be \$47,500 per licensed bed in multiple-bed rooms and \$71,250 per licensed bed in a single-bed room. These amounts must be adjusted annually as specified in subdivision 3f, paragraph (a), beginning January 1, 1993.

Subd. 17d. Determination of rental per diem for total replacement projects. (a) For purposes of this subdivision, a total replacement means the complete replacement of the nursing facility's physical plant through the construction of a new physical plant, the transfer of the nursing facility's license from one physical plant location to another, or a new building addition to relocate beds from three- and four-bed wards. For total replacement projects completed on or after July 1, 1992, the commissioner shall compute the incremental change in the nursing facility's rental per diem, for rate years beginning on or after July 1, 1995, by replacing its appraised value, including the historical capital asset costs, and the capital debt and interest costs with the new nursing facility's allowable capital asset costs and the related allowable capital debt and interest costs. If the new nursing facility has decreased its licensed capacity, the aggregate investment per bed limit in subdivision 3a, paragraph (c), shall apply.

(b) If the new nursing facility has retained a portion of the original physical plant for nursing facility usage, then a portion of the appraised value prior to the replacement must be retained and included in the calculation of the incremental change in the nursing facility's rental per diem. For purposes of this subdivision, the original nursing facility means the nursing facility prior to the total replacement project. The portion of the appraised value to be retained shall be calculated according to clauses (1) to (3):

(1) The numerator of the allocation ratio shall be the square footage of the area in the original physical plant which is being retained for nursing facility usage.

(2) The denominator of the allocation ratio shall be the total square footage of the original nursing facility physical plant.

(3) Each component of the nursing facility's allowable appraised value prior to the total replacement project shall be multiplied by the allocation ratio developed by dividing clause (1) by clause (2).

(c) In the case of either type of total replacement as authorized under section 144A.071 or 144A.073, the provisions of subdivisions 17 to 17f shall also apply.

(d) For purposes of the moratorium exception authorized under section 144A.071, subdivision 4a, paragraph (s), if the total replacement involves the renovation and use of an existing health care facility physical plant, the new allowable capital asset costs and related debt and interest costs shall include first the allowable capital asset costs and related debt and interest costs of the renovation, to which shall be added the allowable capital asset costs of the existing physical plant prior to the renovation, and if reported by the facility, the related allowable capital debt and interest costs.

Subd. 17e. Replacement-costs-new per bed limit effective October 1, 2007. Notwithstanding Minnesota Rules, part 9549.0060, subpart 11, item C, subitem (2), for a total replacement, as defined in subdivision 17d, authorized under section 144A.071 or 144A.073 after July 1, 1999, any building project that is a relocation, renovation, upgrading, or conversion completed on or after July 1, 2001, or any building project eligible for reimbursement under section 256B.434, subdivision 4f, the replacement-costs-new per bed limit shall be \$74,280 per licensed bed in multiple-bed rooms, \$92,850 per licensed bed in semiprivate rooms with a fixed partition separating the resident beds, and \$111,420 per licensed bed in single rooms. Minnesota Rules, part 9549.0060, subpart 11, item C, subitem (2), does not apply. These amounts must be adjusted annually as specified in subdivision 3f, paragraph (a), beginning January 1, 2000. These amounts must be increased annually as specified in subdivision 3f, paragraph (a), beginning October 1, 2012.

Subd. 18. Updating appraisals, additions, and replacements. (a) Notwithstanding Minnesota Rules, part 9549.0060, subparts 1 to 3, the appraised value, routine updating of the appraised value, and special reappraisals are subject to this subdivision.

For all rate years after June 30, 1993, the commissioner shall no longer conduct any appraisals under Minnesota Rules, part 9549.0060, for the purpose of determining property-related payment rates.

(b) Notwithstanding Minnesota Rules, part 9549.0060, subpart 2, for rate years beginning after June 30, 1993, the commissioner shall routinely update the appraised value of each nursing facility by adding the cost of capital asset acquisitions to its allowable appraised value.

The commissioner shall also annually index each nursing facility's allowable appraised value by the inflation index referenced in subdivision 3f, paragraph (a), for the purpose of computing the nursing facility's annual rental rate. In annually adjusting the nursing facility's appraised value, the commissioner must not include the historical cost of capital assets acquired during the reporting year in the nursing facility's appraised value.

In addition, the nursing facility's appraised value must be reduced by the historical cost of capital asset disposals or applicable credits such as public grants and insurance proceeds. Capital asset additions and disposals must be reported on the nursing facility's annual cost report in the reporting year of acquisition or disposal. The incremental increase in the nursing facility's rental rate resulting from this annual adjustment as determined under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section shall be added to the nursing facility's property-related payment rate for the rate year following the reporting year.

Subd. 21. Indexing thresholds. Beginning January 1, 1993, and each January 1 thereafter, the commissioner shall annually update the dollar thresholds in subdivisions 15, paragraph (e), 16, and 17, and in section 144A.071, subdivisions 2 and 4a, clauses (b) and (e), by the inflation index referenced in subdivision 3f, paragraph (a).

Subd. 22. Changes to nursing facility reimbursement. In the determination of incremental increases in the nursing facility's rental rate as required in subdivisions 14 to 21, except for a refinancing permitted under subdivision 19, the commissioner must adjust the nursing facility's property-related payment rate for both incremental increases and decreases in recomputations of its rental rate.

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 first following the date on 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 or chapter 256R, a nursing facility reimbursed under that section or chapter that 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 or chapter 256R 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

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payment rate increase shall be effective the first day of the month of January or July, whichever occurs first following the date on 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 or chapter 256R, a nursing facility reimbursed under that section or chapter that 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 first following the date on which the delicensure of the beds becomes effective.

(e) For nursing facilities reimbursed under this section, section 256B.434, or chapter 256R, 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, section 256B.434, or chapter 256R, 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 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.

Subd. 45. Rate adjustments for some moratorium exception projects. Notwithstanding any other law to the contrary, money available for moratorium exception projects under section 144A.073, subdivisions 2 and 11, shall be used to fund the incremental rate increases resulting from this section for any nursing facility with a moratorium exception project approved under section 144A.073, and completed after August 30, 2010, where the replacement-costs-new limits under subdivision 17e were higher at any time after project approval than at the time of project completion. The commissioner shall calculate the property rate increase for these facilities using the highest set of limits; however, any rate increase under this section shall not be effective until on or after the effective date of this section, contingent upon federal approval. No property rate decrease shall result from this section.

256B.434 ALTERNATIVE PAYMENT DEMONSTRATION PROJECT.

Subd. 4. Alternate rates for nursing facilities. Effective for the rate years beginning on and after January 1, 2019, a nursing facility's property payment rate for the second and subsequent years of a facility's contract under this section are the previous rate year's property payment rate plus an inflation adjustment. 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 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.

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

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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).

Subd. 4i. Construction project rate adjustments for certain nursing facilities. (a) This subdivision applies to nursing facilities with at least 120 active beds as of January 1, 2015, that have projects approved in 2015 under the nursing facility moratorium exception process in section 144A.073. When each facility's moratorium exception construction project is completed, the facility must receive the rate adjustment allowed under subdivision 4f. In addition to that rate adjustment, facilities with at least 120 active beds, but not more than 149 active beds, as of January 1, 2015, must have their construction project rate adjustment increased by an additional \$4; and facilities with at least 150 active beds, but not more than 160 active beds, as of January 1, 2015, must have their construction project rate adjustment increased by an additional \$12.50.

(b) Notwithstanding any other law to the contrary, money available under section 144A.073, subdivision 11, after the completion of the moratorium exception approval process in 2015 under section 144A.073, subdivision 3, shall be used to reduce the fiscal impact to the medical assistance budget for the increases allowed in this subdivision.

Subd. 4j. Construction project rate increase for certain nursing facilities. (a) This subdivision applies to nursing facilities:

- (1) located in Ramsey County;
- (2) with at least 130 active beds as of September 30, 2017;
- (3) with a portion of beds dually certified for Medicare and Medicaid and a portion of beds certified for Medicaid only; and
- (4) with debt service payments that are not being covered by the existing property payment rate on September 30, 2017.

(b) The commissioner shall increase the property rate of each facility meeting the qualifications of this subdivision by \$7.55.

(c) Notwithstanding any other law to the contrary, money available under section 144A.073, subdivision 15, after the completion of the 2018 moratorium exception approval process under section 144A.073, subdivision 3, shall be used to pay the medical assistance cost for the property rate increase in this subdivision.

256L.11 PROVIDER PAYMENT.

Subd. 6a. Dental providers. Effective for dental services provided to MinnesotaCare enrollees on or after January 1, 2018, the commissioner shall increase payment rates to dental providers by 54 percent. Payments made to prepaid health plans under section 256L.12 shall reflect the payment increase described in this subdivision. The prepaid health plans under contract with the commissioner shall provide payments to dental providers that are at least equal to a rate that includes the payment rate specified in this subdivision, and if applicable to the provider, the rates described under subdivision 7.

256R.36 HOLD HARMLESS.

No nursing facility's operating payment rate, plus its employer health insurance costs portion of the external fixed costs payment rate, will be less than its prior system operating cost payment rate.

256R.40 NURSING FACILITY VOLUNTARY CLOSURE; ALTERNATIVES.

Subdivision 1. Definitions. (a) The definitions in this subdivision apply to this section.

(b) "Closure" means the cessation of operations of a nursing facility and delicensure and decertification of all beds within the facility.

(c) "Closure plan" means a plan to close a nursing facility and reallocate a portion of the resulting savings to provide planned closure rate adjustments at other facilities.

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(d) "Commencement of closure" means the date on which residents and designated representatives are notified of a planned closure as provided in section 144A.161, subdivision 5a, as part of an approved closure plan.

(e) "Completion of closure" means the date on which the final resident of the nursing facility designated for closure in an approved closure plan is discharged from the facility or the date that beds from a partial closure are delicensed and decertified.

(f) "Partial closure" means the delicensure and decertification of a portion of the beds within the facility.

(g) "Planned closure rate adjustment" means an increase in a nursing facility's operating rates resulting from a planned closure or a planned partial closure of another facility.

Subd. 2. Applications for planned closure rate. (a) To be considered for approval of a planned closure, an application must include:

(1) a description of the proposed closure plan, which must include identification of the facility or facilities to receive a planned closure rate adjustment;

(2) the proposed timetable for any proposed closure, including the proposed dates for announcement to residents, commencement of closure, and completion of closure;

(3) if available, the proposed relocation plan for current residents of any facility designated for closure. If a relocation plan is not available, the application must include a statement agreeing to develop a relocation plan designed to comply with section 144A.161;

(4) a description of the relationship between the nursing facility that is proposed for closure and the nursing facility or facilities proposed to receive the planned closure rate adjustment. If these facilities are not under common ownership, copies of any contracts, purchase agreements, or other documents establishing a relationship or proposed relationship must be provided; and

(5) documentation, in a format approved by the commissioner, that all the nursing facilities receiving a planned closure rate adjustment under the plan have accepted joint and several liability for recovery of overpayments under section 256B.0641, subdivision 2, for the facilities designated for closure under the plan.

(b) The application must also address the criteria listed in subdivision 3.

Subd. 3. Criteria for review of application. In reviewing and approving closure proposals, the commissioner shall consider, but not be limited to, the following criteria:

(1) improved quality of care and quality of life for consumers;

(2) closure of a nursing facility that has a poor physical plant;

(3) the existence of excess nursing facility beds, measured in terms of beds per thousand persons aged 85 or older. The excess must be measured in reference to:

(i) the county in which the facility is located. A facility in a county that is in the lowest quartile of counties with reference to beds per thousand persons aged 85 or older is not in an area of excess capacity;

(ii) the county and all contiguous counties;

(iii) the region in which the facility is located; or

(iv) the facility's service area. The facility shall indicate in its application the service area it believes is appropriate for this measurement;

(4) low-occupancy rates, provided that the unoccupied beds are not the result of a personnel shortage. In analyzing occupancy rates, the commissioner shall examine waiting lists in the applicant facility and at facilities in the surrounding area, as determined under clause (3);

(5) evidence of coordination between the community planning process and the facility application. If the planning group does not support a level of nursing facility closures that the commissioner considers to be reasonable, the commissioner may approve a planned closure proposal without its support;

(6) proposed usage of funds available from a planned closure rate adjustment for care-related purposes;

- (7) innovative use planned for the closed facility's physical plant;
- (8) evidence that the proposal serves the interests of the state; and
- (9) evidence of other factors that affect the viability of the facility, including excessive nursing pool costs.

Subd. 4. Review and approval of applications. (a) The commissioner, in consultation with the commissioner of health, shall approve or deny an application within 30 days after receiving it. The commissioner may appoint an advisory review panel composed of representatives of counties, consumers, and providers to review proposals and provide comments and recommendations to the committee. The commissioners of human services and health shall provide staff and technical assistance to the committee for the review and analysis of proposals.

(b) Approval of a planned closure expires 18 months after approval by the commissioner unless commencement of closure has begun.

(c) The commissioner may change any provision of the application to which the applicant, the regional planning group, and the commissioner agree.

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.

Subd. 6. Assignment of closure rate to another facility. A facility or facilities reimbursed under this chapter with a closure plan approved by the commissioner under subdivision 4 may assign a planned closure rate adjustment to another facility or facilities that are not closing or in the case of a partial closure, to the facility undertaking the partial closure. A facility may also elect to have a planned closure rate adjustment shared equally by the five nursing facilities with the lowest total operating payment rates in the state development region designated under section 462.385, in which the facility that is closing is located. The planned closure rate adjustment must be calculated under subdivision 5. Facilities that delicense beds without a closure plan, or whose closure plan is not approved by the commissioner, are not eligible to assign a planned closure rate adjustment under subdivision 5, unless they: (1) are delicensing five or fewer beds, or less than six percent of their total licensed bed capacity, whichever is greater; (2) are located in a county in the top three quartiles of beds per 1,000 persons aged 65 or older; and (3) have not delicensed beds in the prior three months. Facilities meeting these criteria are eligible to assign the amount calculated under subdivision 5 to themselves. If a facility is delicensing the greater of six or more beds, or six percent or more of its total licensed bed capacity, and does not have an approved closure plan or is not eligible for the adjustment under subdivision 5, the commissioner shall calculate the amount the facility would have been eligible to assign under subdivision 5, and shall use this amount to

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provide equal rate adjustments to the five nursing facilities with the lowest total operating payment rates in the state development region designated under section 462.385, in which the facility that delicensed beds is located.

Subd. 7. Other rate adjustments. Facilities receiving planned closure rate adjustments remain eligible for any applicable rate adjustments provided under this chapter.

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 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 month of January or July, whichever occurs first 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).

Laws 2010, First Special Session chapter 1, article 25, section 3, subdivision 10

Sec. 3. COMMISSIONER OF HUMAN SERVICES

Subd. 10. State-Operated Services

Obsolete Laundry Depreciation Account.

\$669,000, or the balance, whichever is greater,
must be transferred from the state-operated
services laundry depreciation account in the
special revenue fund and deposited into the
general fund by June 30, 2010. This paragraph is
effective the day following final enactment.

Operating Budget Reductions. No operating
budget reductions enacted in Laws 2010, chapter
200, or in this act shall be allocated to
state-operated services.

Prohibition on Transferring Funds. The
commissioner shall not transfer mental health
grants to state-operated services without specific
legislative approval. Notwithstanding any contrary
provision in this article, this paragraph shall not
expire.

(a) Adult Mental Health Services

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6,888,000

Base Adjustment. The general fund base is
decreased by \$12,286,000 in fiscal year 2012 and
\$12,394,000 in fiscal year 2013.

Appropriation Requirements. (a) The general
fund appropriation to the commissioner includes
funding for the following:

(1) to a community collaborative to begin
providing crisis center services in the Mankato
area that are comparable to the crisis services
provided prior to the closure of the Mankato Crisis
Center. The commissioner shall recruit former
employees of the Mankato Crisis Center who were
recently laid off to staff the new crisis services.
The commissioner shall obtain legislative approval
prior to discontinuing this funding;

(2) to maintain the building in Eveleth that
currently houses community transition services
and to establish a psychiatric intensive therapeutic
foster home as an enterprise activity. The
commissioner shall request a waiver amendment
to allow CADI funding for psychiatric intensive
therapeutic foster care services provided in the
same location and building as the community
transition services. If the federal government does
not approve the waiver amendment, the
commissioner shall continue to pay the lease for
the building out of the state-operated services
budget until the commissioner of administration
subleases the space or until the lease expires, and
shall establish the psychiatric intensive therapeutic
foster home at a different site. The commissioner
shall make diligent efforts to sublease the space;

(3) to convert the community behavioral health
hospitals in Wadena and Willmar to facilities that

provide more suitable services based on the needs of the community, which may include, but are not limited to, psychiatric extensive recovery treatment services. The commissioner may also establish other community-based services in the Willmar and Wadena areas that deliver the appropriate level of care in response to the express needs of the communities. The services established under this provision must be staffed by state employees.

(4) to continue the operation of the dental clinics in Brainerd, Cambridge, Faribault, Fergus Falls, and Willmar at the same level of care and staffing that was in effect on March 1, 2010. The commissioner shall not proceed with the planned closure of the dental clinics, and shall not discontinue services or downsize any of the state-operated dental clinics without specific legislative approval. The commissioner shall continue to bill for services provided to obtain medical assistance critical access dental payments and cost-based payment rates as provided in Minnesota Statutes, section 256B.76, subdivision 2, and shall bill for services provided three months retroactively from the date of this act. This appropriation is onetime;

(5) to convert the Minnesota Neurorehabilitation Hospital in Brainerd to a neurocognitive psychiatric extensive recovery treatment service; and

(6) to convert the Minnesota extended treatment options (METO) program to the following community-based services provided by state employees: (i) psychiatric extensive recovery treatment services; (ii) intensive transitional foster homes as enterprise activities; and (iii) other community-based support services. The provisions under Minnesota Statutes, section 252.025, subdivision 7, are applicable to the METO services established under this clause. Notwithstanding Minnesota Statutes, section 246.18, subdivision 8, any revenue lost to the general fund by the conversion of METO to new services must be replaced by revenue from the new services to offset the lost revenue to the general fund until June 30, 2013. Any revenue generated in excess of this amount shall be deposited into the special revenue fund under Minnesota Statutes, section 246.18, subdivision 8.

(b) The commissioner shall not move beds from the Anoka-Metro Regional Treatment Center to the psychiatric nursing facility at St. Peter without specific legislative approval.

(c) The commissioner shall implement changes, including the following, to save a minimum of \$6,006,000 beginning in fiscal year 2011, and report to the legislature the specific initiatives implemented and the savings allocated to each one, including:

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(1) maximizing budget savings through strategic employee staffing; and

(2) identifying and implementing cost reductions in cooperation with state-operated services employees.

Base level funding is reduced by \$6,006,000 effective fiscal year 2011.

(d) The commissioner shall seek certification or approval from the federal government for the new services under paragraph (a) that are eligible for federal financial participation and deposit the revenue associated with these new services in the account established under Minnesota Statutes, section 246.18, subdivision 8, unless otherwise specified.

(e) Notwithstanding any contrary provision in this article, this rider shall not expire.

(b) Minnesota Sex Offender Services

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(145,000)

Sex Offender Services. Base level funding for Minnesota sex offender services is reduced by \$418,000 in fiscal year 2012 and \$419,000 in fiscal year 2013 for the 50-bed sex offender treatment program within the Moose Lake correctional facility in which Department of Human Services staff from Minnesota sex offender services provide clinical treatment to incarcerated offenders. This reduction shall become part of the base for the Department of Human Services.

Interagency Agreements. The commissioner of human services may enter into interagency agreements with the commissioner of corrections to continue sex offender treatment and chemical dependency treatment on a cost-sharing basis, in which each department pays 50 percent of the costs of these services.

Base Adjustment. The general fund base is increased by \$418,000 in fiscal year 2012 and \$419,000 in fiscal year 2013.

2960.3030 CAPACITY LIMITS.

Subp. 3. **Exceptions to capacity limits.** A variance may be granted to allow up to eight foster children in addition to the license holder's own children if the conditions in items A to E are met:

- A. placement is necessary to keep a sibling group together, to keep a child in the child's home community, or is necessary because the foster child was formerly living in the home and it would be in the child's best interest to be placed there again;
- B. there is no risk of harm to the children currently in the home;
- C. the structural characteristics of the home, including sleeping space, can accommodate the additional foster children;
- D. the home remains in compliance with applicable zoning, health, fire, and building codes; and
- E. the statement of intended use states the conditions for the exception to capacity limits and explains how the license holder will maintain a ratio of adults to children which ensures the safety and appropriate supervision of all the children in the foster home.

A foster home licensed by the Department of Corrections need not meet the requirement in item A.

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.

6400.6970 FEES.

Subpart 1. **Payment types and nonrefundability.** The fees imposed in this part shall be paid by cash, personal check, bank draft, cashier's check, or money order made payable to the Board of Examiners for Nursing Home Administrators. All fees are nonrefundable.

Subp. 2. **Amounts.** The amount of fees may be set by the board with the approval of the Department of Management and Budget up to the limits provided in this part depending upon the total amount required to sustain board operations under Minnesota Statutes, section 16A.1285, subdivision 2. Information about fees in effect at any time is available from the board office. The maximum amounts of fees are:

- A. application for licensure, \$150;
- B. for a prospective applicant for a review of education and experience advisory to the license application, \$50, to be applied to the fee for application for licensure if the latter is submitted within one year of the request for review of education and experience;
- C. state examination, \$75;
- D. initial license, \$200 if issued between July 1 and December 31, \$100 if issued between January 1 and June 30;

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- E. acting administrator permit, \$250;
- F. renewal license, \$200;
- G. duplicate license, \$10;
- H. fee to a sponsor for review of individual continuing education seminars, institutes, workshops, or home study courses:
 - (1) for less than seven clock hours, \$30; and
 - (2) for seven or more clock hours, \$50;
- I. fee to a licensee for review of continuing education seminars, institutes, workshops, or home study courses not previously approved for a sponsor and submitted with an application for license renewal:
 - (1) for less than seven clock hours total, \$30; and
 - (2) for seven or more clock hours total, \$50;
- J. late renewal fee, \$50;
- K. fee to a licensee for verification of licensure status and examination scores, \$30; and
- L. registration as a registered continuing education sponsor, \$1,000.

7200.6100 FEES.

The nonrefundable fees for licensure payable to the board are as follows:

- A. application for admission to national standardized examination, \$150;
- B. application for professional responsibility examination, \$150;
- C. application for licensure as a licensed psychologist, \$500;
- D. renewal of license for a licensed psychologist, \$500;
- E. late renewal of license for a licensed psychologist, \$250;
- F. application for converting from master's to doctoral level licensure, \$150; and
- G. application for guest licensure, \$150.

7200.6105 CONTINUING EDUCATION SPONSOR FEE.

A sponsor applying for approval of a continuing education activity pursuant to part 7200.3830, subpart 2, shall submit with the application a fee of \$80 for each activity.

9502.0425 PHYSICAL ENVIRONMENT.

Subp. 4. **Means of escape.** From each room of the residence used by children, there must be two means of escape. One means of escape must be a stairway or door leading to the floor of exit discharge. The other must be a door or window leading directly outside. The window must be openable without special knowledge. It must have a clear opening of not less than 5.7 square feet and have a minimum clear opening dimension of 20 inches wide and 24 inches high. The window must be within 48 inches from the floor.

Subp. 16. **Extinguishers.** A portable, operational, multipurpose, dry chemical fire extinguisher with a minimum 2 A 10 BC rating must be maintained in the kitchen and cooking areas of the residence at all times. All caregivers shall know how to use the fire extinguisher.

Subp. 17. **Smoke detection systems.** Smoke detectors that have been listed by the Underwriter Laboratory must be properly installed and maintained on all levels.

9503.0155 FACILITY.

Subp. 8. **Telephone; posted numbers.** A telephone that is not coin operated must be located within the center. A list of emergency numbers must be posted next to the telephone. If a 911 emergency number is not available, the numbers listed must be those of the local fire department, police department, emergency transportation, and poison control center.

9505.0370 DEFINITIONS.

Subpart 1. **Scope.** For parts 9505.0370 to 9505.0372, the following terms have the meanings given them.

Subp. 2. **Adult day treatment.** "Adult day treatment" or "adult day treatment program" means a structured program of treatment and care.

Subp. 3. **Child.** "Child" means a person under 18 years of age.

Subp. 4. **Client.** "Client" means an eligible recipient who is determined to have or who is being assessed for a mental illness as specified in part 9505.0371.

Subp. 5. **Clinical summary.** "Clinical summary" means a written description of a clinician's formulation of the cause of the client's mental health symptoms, the client's prognosis, and the likely consequences of the symptoms; how the client meets the criteria for the diagnosis by describing the client's symptoms, the duration of symptoms, and functional impairment; an analysis of the client's other symptoms, strengths, relationships, life situations, cultural influences, and health concerns and their potential interaction with the diagnosis and formulation of the client's mental health condition; and alternative diagnoses that were considered and ruled out.

Subp. 6. **Clinical supervision.** "Clinical supervision" means the documented time a clinical supervisor and supervisee spend together to discuss the supervisee's work, to review individual client cases, and for the supervisee's professional development. It includes the documented oversight and supervision responsibility for planning, implementation, and evaluation of services for a client's mental health treatment.

Subp. 7. **Clinical supervisor.** "Clinical supervisor" means the mental health professional who is responsible for clinical supervision.

Subp. 8. **Cultural competence or culturally competent.** "Cultural competence" or "culturally competent" means the mental health provider's:

A. awareness of the provider's own cultural background, and the related assumptions, values, biases, and preferences that influence assessment and intervention processes;

B. ability and will to respond to the unique needs of an individual client that arise from the client's culture;

C. ability to utilize the client's culture as a resource and as a means to optimize mental health care; and

D. willingness to seek educational, consultative, and learning experiences to expand knowledge of and increase effectiveness with culturally diverse populations.

Subp. 9. **Cultural influences.** "Cultural influences" means historical, geographical, and familial factors that affect assessment and intervention processes. Cultural influences that are relevant to the client may include the client's:

A. racial or ethnic self-identification;

B. experience of cultural bias as a stressor;

C. immigration history and status;

D. level of acculturation;

- E. time orientation;
- F. social orientation;
- G. verbal communication style;
- H. locus of control;
- I. spiritual beliefs; and
- J. health beliefs and the endorsement of or engagement in culturally specific healing practices.

Subp. 10. **Culture.** "Culture" means the distinct ways of living and understanding the world that are used by a group of people and are transmitted from one generation to another or adopted by an individual.

Subp. 11. **Diagnostic assessment.** "Diagnostic assessment" means a written assessment that documents a clinical and functional face-to-face evaluation of the client's mental health, including the nature, severity and impact of behavioral difficulties, functional impairment, and subjective distress of the client, and identifies the client's strengths and resources.

Subp. 12. **Dialectical behavior therapy.** "Dialectical behavior therapy" means an evidence-based treatment approach provided in an intensive outpatient treatment program using a combination of individualized rehabilitative and psychotherapeutic interventions. A dialectical behavior therapy program is certified by the commissioner and involves the following service components: individual dialectical behavior therapy, group skills training, telephone coaching, and team consultation meetings.

Subp. 13. **Explanation of findings.** "Explanation of findings" means the explanation of a client's diagnostic assessment, psychological testing, treatment program, and consultation with culturally informed mental health consultants as required under parts 9520.0900 to 9520.0926, or other accumulated data and recommendations to the client, client's family, primary caregiver, or other responsible persons.

Subp. 14. **Family.** "Family" means a person who is identified by the client or the client's parent or guardian as being important to the client's mental health treatment. Family may include, but is not limited to, parents, children, spouse, committed partners, former spouses, persons related by blood or adoption, or persons who are presently residing together as a family unit.

Subp. 15. **Individual treatment plan.** "Individual treatment plan" means a written plan that outlines and defines the course of treatment. It delineates the goals, measurable objectives, target dates for achieving specific goals, main participants in treatment process, and recommended services that are based on the client's diagnostic assessment and other meaningful data that are needed to aid the client's recovery and enhance resiliency.

Subp. 16. **Medication management.** "Medication management" means a service that determines the need for or effectiveness of the medication prescribed for the treatment of a client's symptoms of a mental illness.

Subp. 17. **Mental health practitioner.** "Mental health practitioner" means a person who is qualified according to part 9505.0371, subpart 5, items B and C, and provides mental health services to a client with a mental illness under the clinical supervision of a mental health professional.

Subp. 18. **Mental health professional.** "Mental health professional" means a person who is enrolled to provide medical assistance services and is qualified according to part 9505.0371, subpart 5, item A.

Subp. 19. **Mental health telemedicine.** "Mental health telemedicine" has the meaning given in Minnesota Statutes, section 256B.0625, subdivision 46.

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Subp. 20. Mental illness. "Mental illness" has the meaning given in Minnesota Statutes, section 245.462, subdivision 20. "Mental illness" includes "emotional disturbance" as defined in Minnesota Statutes, section 245.4871, subdivision 15.

Subp. 21. Multidisciplinary staff. "Multidisciplinary staff" means a group of individuals from diverse disciplines who come together to provide services to clients under part 9505.0372, subparts 8, 9, and 10.

Subp. 22. Neuropsychological assessment. "Neuropsychological assessment" means a specialized clinical assessment of the client's underlying cognitive abilities related to thinking, reasoning, and judgment that is conducted by a qualified neuropsychologist.

Subp. 23. Neuropsychological testing. "Neuropsychological testing" means administering standardized tests and measures designed to evaluate the client's ability to attend to, process, interpret, comprehend, communicate, learn and recall information; and use problem-solving and judgment.

Subp. 24. Partial hospitalization program. "Partial hospitalization program" means a provider's time-limited, structured program of psychotherapy and other therapeutic services, as defined in United States Code, title 42, chapter 7, subchapter XVIII, part E, section 1395x, (ff), that is provided in an outpatient hospital facility or community mental health center that meets Medicare requirements to provide partial hospitalization services.

Subp. 25. Primary caregiver. "Primary caregiver" means a person, other than the facility staff, who has primary legal responsibility for providing the client with food, clothing, shelter, direction, guidance, and nurturance.

Subp. 26. Psychological testing. "Psychological testing" means the use of tests or other psychometric instruments to determine the status of the recipient's mental, intellectual, and emotional functioning.

Subp. 27. Psychotherapy. "Psychotherapy" means treatment of a client with mental illness that applies the most appropriate psychological, psychiatric, psychosocial, or interpersonal method that conforms to prevailing community standards of professional practice to meet the mental health needs of the client.

Subp. 28. Supervisee. "Supervisee" means an individual who requires clinical supervision because the individual does not meet mental health professional standards in part 9505.0371, subpart 5, item A.

**9505.0371 MEDICAL ASSISTANCE COVERAGE REQUIREMENTS FOR
OUTPATIENT MENTAL HEALTH SERVICES.**

Subpart 1. Purpose. This part describes the requirements that outpatient mental health services must meet to receive medical assistance reimbursement.

Subp. 2. Client eligibility for mental health services. The following requirements apply to mental health services:

A. The provider must use a diagnostic assessment as specified in part 9505.0372 to determine a client's eligibility for mental health services under this part, except:

(1) prior to completion of a client's initial diagnostic assessment, a client is eligible for:

(a) one explanation of findings;

(b) one psychological testing; and

(c) either one individual psychotherapy session, one family psychotherapy session, or one group psychotherapy session; and

(2) for a client who is not currently receiving mental health services covered by medical assistance, a crisis assessment as specified in Minnesota Statutes, section

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256B.0624 or 256B.0944, conducted in the past 60 days may be used to allow up to ten sessions of mental health services within a 12-month period.

B. A brief diagnostic assessment must meet the requirements of part 9505.0372, subpart 1, item D, and:

(1) may be used to allow up to ten sessions of mental health services as specified in part 9505.0372 within a 12-month period before a standard or extended diagnostic assessment is required when the client is:

(a) a new client; or

(b) an existing client who has had fewer than ten sessions of psychotherapy in the previous 12 months and is projected to need fewer than ten sessions of psychotherapy in the next 12 months, or who only needs medication management; and

(2) may be used for a subsequent annual assessment, if based upon the client's treatment history and the provider's clinical judgment, the client will need ten or fewer sessions of mental health services in the upcoming 12-month period; and

(3) must not be used for:

(a) a client or client's family who requires a language interpreter to participate in the assessment unless the client meets the requirements of subitem (1), unit (b), or (2); or

(b) more than ten sessions of mental health services in a 12-month period.

If, after completion of ten sessions of mental health services, the mental health professional determines the need for additional sessions, a standard assessment or extended assessment must be completed.

C. For a child, a new standard or extended diagnostic assessment must be completed:

(1) when the child does not meet the criteria for a brief diagnostic assessment;

(2) at least annually following the initial diagnostic assessment, if:

(a) additional services are needed; and

(b) the child does not meet criteria for brief assessment;

(3) when the child's mental health condition has changed markedly since the child's most recent diagnostic assessment; or

(4) when the child's current mental health condition does not meet criteria of the child's current diagnosis.

D. For an adult, a new standard diagnostic assessment or extended diagnostic assessment must be completed:

(1) when the adult does not meet the criteria for a brief diagnostic assessment or an adult diagnostic assessment update;

(2) at least every three years following the initial diagnostic assessment for an adult who receives mental health services;

(3) when the adult's mental health condition has changed markedly since the adult's most recent diagnostic assessment; or

(4) when the adult's current mental health condition does not meet criteria of the current diagnosis.

E. An adult diagnostic assessment update must be completed at least annually unless a new standard or extended diagnostic assessment is performed. An adult diagnostic assessment update must include an update of the most recent standard or extended diagnostic

assessment and any recent adult diagnostic assessment updates that have occurred since the last standard or extended diagnostic assessment.

Subp. 3. Authorization for mental health services. Mental health services under this part are subject to authorization criteria and standards published by the commissioner according to Minnesota Statutes, section 256B.0625, subdivision 25.

Subp. 4. Clinical supervision.

A. Clinical supervision must be based on each supervisee's written supervision plan and must:

- (1) promote professional knowledge, skills, and values development;
- (2) model ethical standards of practice;
- (3) promote cultural competency by:
 - (a) developing the supervisee's knowledge of cultural norms of behavior for individual clients and generally for the clients served by the supervisee regarding the client's cultural influences, age, class, gender, sexual orientation, literacy, and mental or physical disability;
 - (b) addressing how the supervisor's and supervisee's own cultures and privileges affect service delivery;
 - (c) developing the supervisee's ability to assess their own cultural competence and to identify when consultation or referral of the client to another provider is needed; and
 - (d) emphasizing the supervisee's commitment to maintaining cultural competence as an ongoing process;
- (4) recognize that the client's family has knowledge about the client and will continue to play a role in the client's life and encourage participation among the client, client's family, and providers as treatment is planned and implemented; and
- (5) monitor, evaluate, and document the supervisee's performance of assessment, treatment planning, and service delivery.

B. Clinical supervision must be conducted by a qualified supervisor using individual or group supervision. Individual or group face-to-face supervision may be conducted via electronic communications that utilize interactive telecommunications equipment that includes at a minimum audio and video equipment for two-way, real-time, interactive communication between the supervisor and supervisee, and meet the equipment and connection standards of part 9505.0370, subpart 19.

(1) Individual supervision means one or more designated clinical supervisors and one supervisee.

(2) Group supervision means one clinical supervisor and two to six supervisees in face-to-face supervision.

C. The supervision plan must be developed by the supervisor and the supervisee. The plan must be reviewed and updated at least annually. For new staff the plan must be completed and implemented within 30 days of the new staff person's employment. The supervision plan must include:

- (1) the name and qualifications of the supervisee and the name of the agency in which the supervisee is being supervised;
- (2) the name, licensure, and qualifications of the supervisor;
- (3) the number of hours of individual and group supervision to be completed by the supervisee including whether supervision will be in person or by some other method approved by the commissioner;

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(4) the policy and method that the supervisee must use to contact the clinical supervisor during service provision to a supervisee;

(5) procedures that the supervisee must use to respond to client emergencies; and

(6) authorized scope of practices, including:

- (a) description of the supervisee's service responsibilities;
- (b) description of client population; and
- (c) treatment methods and modalities.

D. Clinical supervision must be recorded in the supervisee's supervision record. The documentation must include:

- (1) date and duration of supervision;
- (2) identification of supervision type as individual or group supervision;
- (3) name of the clinical supervisor;
- (4) subsequent actions that the supervisee must take; and
- (5) date and signature of the clinical supervisor.

E. Clinical supervision pertinent to client treatment changes must be recorded by a case notation in the client record after supervision occurs.

Subp. 5. Qualified providers. Medical assistance covers mental health services according to part 9505.0372 when the services are provided by mental health professionals or mental health practitioners qualified under this subpart.

A. A mental health professional must be qualified in one of the following ways:

(1) in clinical social work, a person must be licensed as an independent clinical social worker by the Minnesota Board of Social Work under Minnesota Statutes, chapter 148D until August 1, 2011, and thereafter under Minnesota Statutes, chapter 148E;

(2) in psychology, a person licensed by the Minnesota Board of Psychology under Minnesota Statutes, sections 148.88 to 148.98, who has stated to the board competencies in the diagnosis and treatment of mental illness;

(3) in psychiatry, a physician licensed under Minnesota Statutes, chapter 147, who is certified by the American Board of Psychiatry and Neurology or is eligible for board certification;

(4) in marriage and family therapy, a person licensed as a marriage and family therapist by the Minnesota Board of Marriage and Family Therapy under Minnesota Statutes, sections 148B.29 to 148B.39, and defined in parts 5300.0100 to 5300.0350;

(5) in professional counseling, a person licensed as a professional clinical counselor by the Minnesota Board of Behavioral Health and Therapy under Minnesota Statutes, section 148B.5301;

(6) a tribally approved mental health care professional, who meets the standards in Minnesota Statutes, section 256B.02, subdivision 7, paragraphs (b) and (c), and who is serving a federally recognized Indian tribe; or

(7) in psychiatric nursing, a registered nurse who is licensed under Minnesota Statutes, sections 148.171 to 148.285, and meets one of the following criteria:

(a) is certified as a clinical nurse specialist;

(b) for children, is certified as a nurse practitioner in child or adolescent or family psychiatric and mental health nursing by a national nurse certification organization; or

(c) for adults, is certified as a nurse practitioner in adult or family psychiatric and mental health nursing by a national nurse certification organization.

B. A mental health practitioner for a child client must have training working with children. A mental health practitioner for an adult client must have training working with adults. A mental health practitioner must be qualified in at least one of the following ways:

(1) holds a bachelor's degree in one of the behavioral sciences or related fields from an accredited college or university; and

(a) has at least 2,000 hours of supervised experience in the delivery of mental health services to clients with mental illness; or

(b) is fluent in the non-English language of the cultural group to which at least 50 percent of the practitioner's clients belong, completes 40 hours of training in the delivery of services to clients with mental illness, and receives clinical supervision from a mental health professional at least once a week until the requirements of 2,000 hours of supervised experience are met;

(2) has at least 6,000 hours of supervised experience in the delivery of mental health services to clients with mental illness. Hours worked as a mental health behavioral aide I or II under Minnesota Statutes, section 256B.0943, subdivision 7, may be included in the 6,000 hours of experience for child clients;

(3) is a graduate student in one of the mental health professional disciplines defined in item A and is formally assigned by an accredited college or university to an agency or facility for clinical training;

(4) holds a master's or other graduate degree in one of the mental health professional disciplines defined in item A from an accredited college or university; or

(5) is an individual who meets the standards in Minnesota Statutes, section 256B.02, subdivision 7, paragraphs (b) and (c), who is serving a federally recognized Indian tribe.

C. Medical assistance covers diagnostic assessment, explanation of findings, and psychotherapy performed by a mental health practitioner working as a clinical trainee when:

(1) the mental health practitioner is:

(a) complying with requirements for licensure or board certification as a mental health professional, as defined in item A, including supervised practice in the delivery of mental health services for the treatment of mental illness; or

(b) a student in a bona fide field placement or internship under a program leading to completion of the requirements for licensure as a mental health professional defined in item A; and

(2) the mental health practitioner's clinical supervision experience is helping the practitioner gain knowledge and skills necessary to practice effectively and independently. This may include supervision of:

- (a) direct practice;
- (b) treatment team collaboration;
- (c) continued professional learning; and
- (d) job management.

D. A clinical supervisor must:

(1) be a mental health professional licensed as specified in item A;

(2) hold a license without restrictions that has been in good standing for at least one year while having performed at least 1,000 hours of clinical practice;

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(3) be approved, certified, or in some other manner recognized as a qualified clinical supervisor by the person's professional licensing board, when this is a board requirement;

(4) be competent as demonstrated by experience and graduate-level training in the area of practice and the activities being supervised;

(5) not be the supervisee's blood or legal relative or cohabitant, or someone who has acted as the supervisee's therapist within the past two years;

(6) have experience and skills that are informed by advanced training, years of experience, and mastery of a range of competencies that demonstrate the following:

(a) capacity to provide services that incorporate best practice;

(b) ability to recognize and evaluate competencies in supervisees;

(c) ability to review assessments and treatment plans for accuracy and appropriateness;

(d) ability to give clear direction to mental health staff related to alternative strategies when a client is struggling with moving towards recovery; and

(e) ability to coach, teach, and practice skills with supervisees;

(7) accept full professional liability for a supervisee's direction of a client's mental health services;

(8) instruct a supervisee in the supervisee's work, and oversee the quality and outcome of the supervisee's work with clients;

(9) review, approve, and sign the diagnostic assessment, individual treatment plans, and treatment plan reviews of clients treated by a supervisee;

(10) review and approve the progress notes of clients treated by the supervisee according to the supervisee's supervision plan;

(11) apply evidence-based practices and research-informed models to treat clients;

(12) be employed by or under contract with the same agency as the supervisee;

(13) develop a clinical supervision plan for each supervisee;

(14) ensure that each supervisee receives the guidance and support needed to provide treatment services in areas where the supervisee practices;

(15) establish an evaluation process that identifies the performance and competence of each supervisee; and

(16) document clinical supervision of each supervisee and securely maintain the documentation record.

Subp. 6. Release of information. Providers who receive a request for client information and providers who request client information must:

A. comply with data practices and medical records standards in Minnesota Statutes, chapter 13, and Code of Federal Regulations, title 45, part 164; and

B. subject to the limitations in item A, promptly provide client information, including a written diagnostic assessment, to other providers who are treating the client to ensure that the client will get services without undue delay.

Subp. 7. Individual treatment plan. Except as provided in subpart 2, item A, subitem (1), a medical assistance payment is available only for services provided in accordance with the client's written individual treatment plan (ITP). The client must be involved in the development, review, and revision of the client's ITP. For all mental health services, except

as provided in subpart 2, item A, subitem (1), and medication management, the ITP and subsequent revisions of the ITP must be signed by the client before treatment begins. The mental health professional or practitioner shall request the client, or other person authorized by statute to consent to mental health services for the client, to sign the client's ITP or revision of the ITP. In the case of a child, the child's parent, primary caregiver, or other person authorized by statute to consent to mental health services for the child shall be asked to sign the child's ITP and revisions of the ITP. If the client or authorized person refuses to sign the plan or a revision of the plan, the mental health professional or mental health practitioner shall note on the plan the refusal to sign the plan and the reason or reasons for the refusal. A client's individual treatment plan must be:

- A. based on the client's current diagnostic assessment;
- B. developed by identifying the client's service needs and considering relevant cultural influences to identify planned interventions that contain specific treatment goals and measurable objectives for the client; and
- C. reviewed at least once every 90 days, and revised as necessary. Revisions to the initial individual treatment plan do not require a new diagnostic assessment unless the client's mental health status has changed markedly as provided in subpart 2.

Subp. 8. Documentation. To obtain medical assistance payment for an outpatient mental health service, a mental health professional or a mental health practitioner must promptly document:

- A. in the client's mental health record:
 - (1) each occurrence of service to the client including the date, type of service, start and stop time, scope of the mental health service, name and title of the person who gave the service, and date of documentation; and
 - (2) all diagnostic assessments and other assessments, psychological test results, treatment plans, and treatment plan reviews;
- B. the provider's contact with persons interested in the client such as representatives of the courts, corrections systems, or schools, or the client's other mental health providers, case manager, family, primary caregiver, legal representative, including the name and date of the contact or, if applicable, the reason the client's family, primary caregiver, or legal representative was not contacted; and
- C. dates that treatment begins and ends and reason for the discontinuation of the mental health service.

Subp. 9. Service coordination. The provider must coordinate client services as authorized by the client as follows:

- A. When a recipient receives mental health services from more than one mental health provider, each provider must coordinate mental health services they provide to the client with other mental health service providers to ensure services are provided in the most efficient manner to achieve maximum benefit for the client.
- B. The mental health provider must coordinate mental health care with the client's physical health provider.

Subp. 10. Telemedicine services. Mental health services in part 9505.0372 covered as direct face-to-face services may be provided via two-way interactive video if it is medically appropriate to the client's condition and needs. The interactive video equipment and connection must comply with Medicare standards that are in effect at the time of service. The commissioner may specify parameters within which mental health services can be provided via telemedicine.

9505.0372 COVERED SERVICES.

Subpart 1. Diagnostic assessment. Medical assistance covers four types of diagnostic assessments when they are provided in accordance with the requirements in this subpart.

A. To be eligible for medical assistance payment, a diagnostic assessment must:

(1) identify a mental health diagnosis and recommended mental health services, which are the factual basis to develop the recipient's mental health services and treatment plan; or

(2) include a finding that the client does not meet the criteria for a mental health disorder.

B. A standard diagnostic assessment must include a face-to-face interview with the client and contain a written evaluation of a client by a mental health professional or practitioner working under clinical supervision as a clinical trainee according to part 9505.0371, subpart 5, item C. The standard diagnostic assessment must be done within the cultural context of the client and must include relevant information about:

(1) the client's current life situation, including the client's:

(a) age;

(b) current living situation, including household membership and housing status;

(c) basic needs status including economic status;

(d) education level and employment status;

(e) significant personal relationships, including the client's evaluation of relationship quality;

(f) strengths and resources, including the extent and quality of social networks;

(g) belief systems;

(h) contextual nonpersonal factors contributing to the client's presenting concerns;

(i) general physical health and relationship to client's culture; and

(j) current medications;

(2) the reason for the assessment, including the client's:

(a) perceptions of the client's condition;

(b) description of symptoms, including reason for referral;

(c) history of mental health treatment, including review of the client's records;

(d) important developmental incidents;

(e) maltreatment, trauma, or abuse issues;

(f) history of alcohol and drug usage and treatment;

(g) health history and family health history, including physical, chemical, and mental health history; and

(h) cultural influences and their impact on the client;

(3) the client's mental status examination;

(4) the assessment of client's needs based on the client's baseline measurements, symptoms, behavior, skills, abilities, resources, vulnerabilities, and safety needs;

(5) the screenings used to determine the client's substance use, abuse, or dependency and other standardized screening instruments determined by the commissioner;

(6) assessment methods and use of standardized assessment tools by the provider as determined and periodically updated by the commissioner;

(7) the client's clinical summary, recommendations, and prioritization of needed mental health, ancillary or other services, client and family participation in assessment and service preferences, and referrals to services required by statute or rule; and

(8) the client data that is adequate to support the findings on all axes of the current edition of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association; and any differential diagnosis.

C. An extended diagnostic assessment must include a face-to-face interview with the client and contain a written evaluation of a client by a mental health professional or practitioner working under clinical supervision as a clinical trainee according to part 9505.0371, subpart 5, item C. The face-to-face interview is conducted over three or more assessment appointments because the client's complex needs necessitate significant additional assessment time. Complex needs are those caused by acuity of psychotic disorder; cognitive or neurocognitive impairment; need to consider past diagnoses and determine their current applicability; co-occurring substance abuse use disorder; or disruptive or changing environments, communication barriers, or cultural considerations as documented in the assessment. For child clients, the appointments may be conducted outside the diagnostician's office for face-to-face consultation and information gathering with family members, doctors, caregivers, teachers, and other providers, with or without the child present, and may involve directly observing the child in various settings that the child frequents such as home, school, or care settings. To complete the diagnostic assessment with adult clients, the appointments may be conducted outside of the diagnostician's office for face-to-face assessment with the adult client. The appointment may involve directly observing the adult client in various settings that the adult frequents, such as home, school, job, service settings, or community settings. The appointments may include face-to-face meetings with the adult client and the client's family members, doctors, caregivers, teachers, social support network members, recovery support resource representatives, and other providers for consultation and information gathering for the diagnostic assessment. The components of an extended diagnostic assessment include the following relevant information:

(1) for children under age 5:

(a) utilization of the DC:0-3R diagnostic system for young children;

(b) an early childhood mental status exam that assesses the client's developmental, social, and emotional functioning and style both within the family and with the examiner and includes:

i. physical appearance including dysmorphic features;

ii. reaction to new setting and people and adaptation during evaluation;

iii. self-regulation, including sensory regulation, unusual behaviors, activity level, attention span, and frustration tolerance;

iv. physical aspects, including motor function, muscle tone, coordination, tics, abnormal movements, and seizure activity;

v. vocalization and speech production, including expressive and receptive language;

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- vi. thought, including fears, nightmares, dissociative states, and hallucinations;
 - vii. affect and mood, including modes of expression, range, responsiveness, duration, and intensity;
 - viii. play, including structure, content, symbolic functioning, and modulation of aggression;
 - ix. cognitive functioning; and
 - x. relatedness to parents, other caregivers, and examiner; and
- (c) other assessment tools as determined and periodically revised by the commissioner;
- (2) for children ages 5 to 18, completion of other assessment standards for children as determined and periodically revised by the commissioner; and
- (3) for adults, completion of other assessment standards for adults as determined and periodically revised by the commissioner.

D. A brief diagnostic assessment must include a face-to-face interview with the client and a written evaluation of the client by a mental health professional or practitioner working under clinical supervision as a clinical trainee according to part 9505.0371, subpart 5, item C. The professional or practitioner must gather initial background information using the components of a standard diagnostic assessment in item B, subitems (1), (2), unit (b), (3), and (5), and draw a provisional clinical hypothesis. The clinical hypothesis may be used to address the client's immediate needs or presenting problem. Treatment sessions conducted under authorization of a brief assessment may be used to gather additional information necessary to complete a standard diagnostic assessment or an extended diagnostic assessment.

E. Adult diagnostic assessment update includes a face-to-face interview with the client, and contains a written evaluation of the client by a mental health professional or practitioner working under clinical supervision as a clinical trainee according to part 9505.0371, subpart 5, item C, who reviews a standard or extended diagnostic assessment. The adult diagnostic assessment update must update the most recent assessment document in writing in the following areas:

- (1) review of the client's life situation, including an interview with the client about the client's current life situation, and a written update of those parts where significant new or changed information exists, and documentation where there has not been significant change;
- (2) review of the client's presenting problems, including an interview with the client about current presenting problems and a written update of those parts where there is significant new or changed information, and note parts where there has not been significant change;
- (3) screenings for substance use, abuse, or dependency and other screenings as determined by the commissioner;
- (4) the client's mental health status examination;
- (5) assessment of client's needs based on the client's baseline measurements, symptoms, behavior, skills, abilities, resources, vulnerabilities, and safety needs;
- (6) the client's clinical summary, recommendations, and prioritization of needed mental health, ancillary, or other services, client and family participation in assessment and service preferences, and referrals to services required by statute or rule; and
- (7) the client's diagnosis on all axes of the current edition of the Diagnostic and Statistical Manual and any differential diagnosis.

Subp. 2. Neuropsychological assessment. A neuropsychological assessment must include a face-to-face interview with the client, the interpretation of the test results, and preparation and completion of a report. A client is eligible for a neuropsychological assessment if at least one of the following criteria is met:

A. There is a known or strongly suspected brain disorder based on medical history or neurological evaluation such as a history of significant head trauma, brain tumor, stroke, seizure disorder, multiple sclerosis, neurodegenerative disorders, significant exposure to neurotoxins, central nervous system infections, metabolic or toxic encephalopathy, fetal alcohol syndrome, or congenital malformations of the brain; or

B. In the absence of a medically verified brain disorder based on medical history or neurological evaluation, there are cognitive or behavioral symptoms that suggest that the client has an organic condition that cannot be readily attributed to functional psychopathology, or suspected neuropsychological impairment in addition to functional psychopathology. Examples include:

- (1) poor memory or impaired problem solving;
- (2) change in mental status evidenced by lethargy, confusion, or disorientation;
- (3) deterioration in level of functioning;
- (4) marked behavioral or personality change;
- (5) in children or adolescents, significant delays in academic skill acquisition or poor attention relative to peers;
- (6) in children or adolescents, significant plateau in expected development of cognitive, social, emotional, or physical function, relative to peers; and
- (7) in children or adolescents, significant inability to develop expected knowledge, skills, or abilities as required to adapt to new or changing cognitive, social, emotional, or physical demands.

C. If neither criterion in item A nor B is fulfilled, neuropsychological evaluation is not indicated.

D. The neuropsychological assessment must be conducted by a neuropsychologist with competence in the area of neuropsychological assessment as stated to the Minnesota Board of Psychology who:

- (1) was awarded a diploma by the American Board of Clinical Neuropsychology, the American Board of Professional Neuropsychology, or the American Board of Pediatric Neuropsychology;
- (2) earned a doctoral degree in psychology from an accredited university training program:
 - (a) completed an internship, or its equivalent, in a clinically relevant area of professional psychology;
 - (b) completed the equivalent of two full-time years of experience and specialized training, at least one which is at the postdoctoral level, in the study and practices of clinical neuropsychology and related neurosciences supervised by a clinical neuropsychologist; and
 - (c) holds a current license to practice psychology independently in accordance with Minnesota Statutes, sections 148.88 to 148.98;
- (3) is licensed or credentialed by another state's board of psychology examiners in the specialty of neuropsychology using requirements equivalent to requirements specified by one of the boards named in subitem (1); or

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(4) was approved by the commissioner as an eligible provider of neuropsychological assessment prior to December 31, 2010.

Subp. 3. Neuropsychological testing.

A. Medical assistance covers neuropsychological testing when the client has either:

(1) a significant mental status change that is not a result of a metabolic disorder that has failed to respond to treatment;

(2) in children or adolescents, a significant plateau in expected development of cognitive, social, emotional, or physical function, relative to peers;

(3) in children or adolescents, significant inability to develop expected knowledge, skills, or abilities, as required to adapt to new or changing cognitive, social, physical, or emotional demands; or

(4) a significant behavioral change, memory loss, or suspected neuropsychological impairment in addition to functional psychopathology, or other organic brain injury or one of the following:

(a) traumatic brain injury;

(b) stroke;

(c) brain tumor;

(d) substance abuse or dependence;

(e) cerebral anoxic or hypoxic episode;

(f) central nervous system infection or other infectious disease;

(g) neoplasms or vascular injury of the central nervous system;

(h) neurodegenerative disorders;

(i) demyelinating disease;

(j) extrapyramidal disease;

(k) exposure to systemic or intrathecal agents or cranial radiation known to be associated with cerebral dysfunction;

(l) systemic medical conditions known to be associated with cerebral dysfunction, including renal disease, hepatic encephalopathy, cardiac anomaly, sickle cell disease, and related hematologic anomalies, and autoimmune disorders such as lupus, erythematosus, or celiac disease;

(m) congenital genetic or metabolic disorders known to be associated with cerebral dysfunction, such as phenylketonuria, craniofacial syndromes, or congenital hydrocephalus;

(n) severe or prolonged nutrition or malabsorption syndromes; or

(o) a condition presenting in a manner making it difficult for a clinician to distinguish between:

i. the neurocognitive effects of a neurogenic syndrome such as dementia or encephalopathy; and

ii. a major depressive disorder when adequate treatment for major depressive disorder has not resulted in improvement in neurocognitive function, or another disorder such as autism, selective mutism, anxiety disorder, or reactive attachment disorder.

B. Neuropsychological testing must be administered or clinically supervised by a neuropsychologist qualified as defined in subpart 2, item D.

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C. Neuropsychological testing is not covered when performed:

- (1) primarily for educational purposes;
- (2) primarily for vocational counseling or training;
- (3) for personnel or employment testing;
- (4) as a routine battery of psychological tests given at inpatient admission or continued stay; or
- (5) for legal or forensic purposes.

Subp. 4. Psychological testing. Psychological testing must meet the following requirements:

A. The psychological testing must:

- (1) be administered or clinically supervised by a licensed psychologist with competence in the area of psychological testing as stated to the Minnesota Board of Psychology; and
- (2) be validated in a face-to-face interview between the client and a licensed psychologist or a mental health practitioner working as a clinical psychology trainee as required by part 9505.0371, subpart 5, item C, under the clinical supervision of a licensed psychologist according to part 9505.0371, subpart 5, item A, subitem (2).

B. The administration, scoring, and interpretation of the psychological tests must be done under the clinical supervision of a licensed psychologist when performed by a technician, psychometrist, or psychological assistant or as part of a computer-assisted psychological testing program.

C. The report resulting from the psychological testing must be:

- (1) signed by the psychologist conducting the face-to-face interview;
- (2) placed in the client's record; and
- (3) released to each person authorized by the client.

Subp. 5. Explanations of findings. To be eligible for medical assistance payment, the mental health professional providing the explanation of findings must obtain the authorization of the client or the client's representative to release the information as required in part 9505.0371, subpart 6. Explanation of findings is provided to the client, client's family, and caregivers, or to other providers to help them understand the results of the testing or diagnostic assessment, better understand the client's illness, and provide professional insight needed to carry out a plan of treatment. An explanation of findings is not paid separately when the results of psychological testing or a diagnostic assessment are explained to the client or the client's representative as part of the psychological testing or a diagnostic assessment.

Subp. 6. Psychotherapy. Medical assistance covers psychotherapy as conducted by a mental health professional or a mental health practitioner as defined in part 9505.0371, subpart 5, item C, as provided in this subpart.

A. Individual psychotherapy is psychotherapy designed for one client.

B. Family psychotherapy is designed for the client and one or more family members or the client's primary caregiver whose participation is necessary to accomplish the client's treatment goals. Family members or primary caregivers participating in a therapy session do not need to be eligible for medical assistance. For purposes of this subpart, the phrase "whose participation is necessary to accomplish the client's treatment goals" does not include shift or facility staff members at the client's residence. Medical assistance payment for family psychotherapy is limited to face-to-face sessions at which the client is present throughout the family psychotherapy session unless the mental health professional believes

the client's absence from the family psychotherapy session is necessary to carry out the client's individual treatment plan. If the client is excluded, the mental health professional must document the reason for and the length of time of the exclusion. The mental health professional must also document the reason or reasons why a member of the client's family is excluded.

C. Group psychotherapy is appropriate for individuals who because of the nature of their emotional, behavioral, or social dysfunctions can derive mutual benefit from treatment in a group setting. For a group of three to eight persons, one mental health professional or practitioner is required to conduct the group. For a group of nine to 12 persons, a team of at least two mental health professionals or two mental health practitioners or one mental health professional and one mental health practitioner is required to co-conduct the group. Medical assistance payment is limited to a group of no more than 12 persons.

D. A multiple-family group psychotherapy session is eligible for medical assistance payment if the psychotherapy session is designed for at least two but not more than five families. Multiple-family group psychotherapy is clearly directed toward meeting the identified treatment needs of each client as indicated in client's treatment plan. If the client is excluded, the mental health professional or practitioner must document the reason for and the length of the time of the exclusion. The mental health professional or practitioner must document the reasons why a member of the client's family is excluded.

Subp. 7. Medication management. The determination or evaluation of the effectiveness of a client's prescribed drug must be carried out by a physician or by an advanced practice registered nurse, as defined in Minnesota Statutes, sections 148.171 to 148.285, who is qualified in psychiatric nursing.

Subp. 8. Adult day treatment. Adult day treatment payment limitations include the following conditions.

A. Adult day treatment must consist of at least one hour of group psychotherapy, and must include group time focused on rehabilitative interventions, or other therapeutic services that are provided by a multidisciplinary staff. Adult day treatment is an intensive psychotherapeutic treatment. The services must stabilize the client's mental health status, and develop and improve the client's independent living and socialization skills. The goal of adult day treatment is to reduce or relieve the effects of mental illness so that an individual is able to benefit from a lower level of care and to enable the client to live and function more independently in the community. Day treatment services are not a part of inpatient or residential treatment services.

B. To be eligible for medical assistance payment, a day treatment program must:

- (1) be reviewed by and approved by the commissioner;
- (2) be provided to a group of clients by a multidisciplinary staff under the clinical supervision of a mental health professional;
- (3) be available to the client at least two days a week for at least three consecutive hours per day. The day treatment may be longer than three hours per day, but medical assistance must not reimburse a provider for more than 15 hours per week;

(4) include group psychotherapy done by a mental health professional, or mental health practitioner qualified according to part 9505.0371, subpart 5, item C, and rehabilitative interventions done by a mental health professional or mental health practitioner daily;

(5) be included in the client's individual treatment plan as necessary and appropriate. The individual treatment plan must include attainable, measurable goals as they relate to services and must be completed before the first day treatment session. The vendor must review the recipient's progress and update the treatment plan at least every 30 days until the client is discharged and include an available discharge plan for the client in the treatment plan; and

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(6) document the interventions provided and the client's response daily.

C. To be eligible for adult day treatment, a recipient must:

(1) be 18 years of age or older;

(2) not be residing in a nursing facility, hospital, institute of mental disease, or regional treatment center, unless the recipient has an active discharge plan that indicates a move to an independent living arrangement within 180 days;

(3) have a diagnosis of mental illness as determined by a diagnostic assessment;

(4) have the capacity to engage in the rehabilitative nature, the structured setting, and the therapeutic parts of psychotherapy and skills activities of a day treatment program and demonstrate measurable improvements in the recipient's functioning related to the recipient's mental illness that would result from participating in the day treatment program;

(5) have at least three areas of functional impairment as determined by a functional assessment with the domains prescribed by Minnesota Statutes, section 245.462, subdivision 11a;

(6) have a level of care determination that supports the need for the level of intensity and duration of a day treatment program; and

(7) be determined to need day treatment by a mental health professional who must deem the day treatment services medically necessary.

D. The following services are not covered by medical assistance if they are provided by a day treatment program:

(1) a service that is primarily recreation-oriented or that is provided in a setting that is not medically supervised. This includes: sports activities, exercise groups, craft hours, leisure time, social hours, meal or snack time, trips to community activities, and tours;

(2) a social or educational service that does not have or cannot reasonably be expected to have a therapeutic outcome related to the client's mental illness;

(3) consultation with other providers or service agency staff about the care or progress of a client;

(4) prevention or education programs provided to the community;

(5) day treatment for recipients with primary diagnoses of alcohol or other drug abuse;

(6) day treatment provided in the client's home;

(7) psychotherapy for more than two hours daily; and

(8) participation in meal preparation and eating that is not part of a clinical treatment plan to address the client's eating disorder.

Subp. 9. Partial hospitalization. Partial hospitalization is a covered service when it is an appropriate alternative to inpatient hospitalization for a client who is experiencing an acute episode of mental illness that meets the criteria for an inpatient hospital admission as specified in part 9505.0520, subpart 1, and who has the family and community resources necessary and appropriate to support the client's residence in the community. Partial hospitalization consists of multiple intensive short-term therapeutic services provided by a multidisciplinary staff to treat the client's mental illness.

Subp. 10. Dialectical behavior therapy (DBT). Dialectical behavior therapy (DBT) treatment services must meet the following criteria:

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A. DBT must be provided according to this subpart and Minnesota Statutes, section 256B.0625, subdivision 51.

B. DBT is an outpatient service that is determined to be medically necessary by either: (1) a mental health professional qualified according to part 9505.0371, subpart 5, or (2) a mental health practitioner working as a clinical trainee according to part 9505.0371, subpart 5, item C, who is under the clinical supervision of a mental health professional according to part 9505.0371, subpart 5, item D, with specialized skill in dialectical behavior therapy. The treatment recommendation must be based upon a comprehensive evaluation that includes a diagnostic assessment and functional assessment of the client, and review of the client's prior treatment history. Treatment services must be provided pursuant to the client's individual treatment plan and provided to a client who satisfies the criteria in item C.

C. To be eligible for DBT, a client must:

- (1) be 18 years of age or older;
- (2) have mental health needs that cannot be met with other available community-based services or that must be provided concurrently with other community-based services;
- (3) meet one of the following criteria:
 - (a) have a diagnosis of borderline personality disorder; or
 - (b) have multiple mental health diagnoses and exhibit behaviors characterized by impulsivity, intentional self-harm behavior, and be at significant risk of death, morbidity, disability, or severe dysfunction across multiple life areas;
- (4) understand and be cognitively capable of participating in DBT as an intensive therapy program and be able and willing to follow program policies and rules assuring safety of self and others; and
- (5) be at significant risk of one or more of the following if DBT is not provided:
 - (a) mental health crisis;
 - (b) requiring a more restrictive setting such as hospitalization;
 - (c) decompensation; or
 - (d) engaging in intentional self-harm behavior.

D. The treatment components of DBT are individual therapy and group skills as follows:

- (1) Individual DBT combines individualized rehabilitative and psychotherapeutic interventions to treat suicidal and other dysfunctional behaviors and reinforce the use of adaptive skillful behaviors. The therapist must:
 - (a) identify, prioritize, and sequence behavioral targets;
 - (b) treat behavioral targets;
 - (c) generalize DBT skills to the client's natural environment through telephone coaching outside of the treatment session;
 - (d) measure the client's progress toward DBT targets;
 - (e) help the client manage crisis and life-threatening behaviors; and
 - (f) help the client learn and apply effective behaviors when working with other treatment providers.

(2) Individual DBT therapy is provided by a mental health professional or a mental health practitioner working as a clinical trainee, according to part 9505.0371, subpart 5, item C, under the supervision of a licensed mental health professional according to part 9505.0371, subpart 5, item D.

(3) Group DBT skills training combines individualized psychotherapeutic and psychiatric rehabilitative interventions conducted in a group format to reduce the client's suicidal and other dysfunctional coping behaviors and restore function by teaching the client adaptive skills in the following areas:

- (a) mindfulness;
- (b) interpersonal effectiveness;
- (c) emotional regulation; and
- (d) distress tolerance.

(4) Group DBT skills training is provided by two mental health professionals, or by a mental health professional cofacilitating with a mental health practitioner.

(5) The need for individual DBT skills training must be determined by a mental health professional or a mental health practitioner working as a clinical trainee, according to part 9505.0371, subpart 5, item C, under the supervision of a licensed mental health professional according to part 9505.0371, subpart 5, item D.

E. A program must be certified by the commissioner as a DBT provider. To qualify for certification, a provider must:

- (1) hold current accreditation as a DBT program from a nationally recognized certification body approved by the commissioner or submit to the commissioner's inspection and provide evidence that the DBT program's policies, procedures, and practices will continuously meet the requirements of this subpart;
- (2) be enrolled as a MHCP provider;
- (3) collect and report client outcomes as specified by the commissioner; and
- (4) have a manual that outlines the DBT program's policies, procedures, and practices which meet the requirements of this subpart.

F. The DBT treatment team must consist of persons who are trained in DBT treatment. The DBT treatment team may include persons from more than one agency. Professional and clinical affiliations with the DBT team must be delineated:

- (1) A DBT team leader must:
 - (a) be a mental health professional employed by, affiliated with, or contracted by a DBT program certified by the commissioner;
 - (b) have appropriate competencies and working knowledge of the DBT principles and practices; and
 - (c) have knowledge of and ability to apply the principles and DBT practices that are consistent with evidence-based practices.
- (2) DBT team members who provide individual DBT or group skills training must:
 - (a) be a mental health professional or be a mental health practitioner, who is employed by, affiliated with, or contracted with a DBT program certified by the commissioner;
 - (b) have or obtain appropriate competencies and working knowledge of DBT principles and practices within the first six months of becoming a part of the DBT program;

- (c) have or obtain knowledge of and ability to apply the principles and practices of DBT consistently with evidence-based practices within the first six months of working at the DBT program;
- (d) participate in DBT consultation team meetings; and
- (e) require mental health practitioners to have ongoing clinical supervision by a mental health professional who has appropriate competencies and working knowledge of DBT principles and practices.

Subp. 11. Noncovered services. The mental health services in items A to J are not eligible for medical assistance payment under this part:

- A. a mental health service that is not medically necessary;
- B. a neuropsychological assessment carried out by a person other than a neuropsychologist who is qualified according to part 9505.0372, subpart 2, item D;
- C. a service ordered by a court that is solely for legal purposes and not related to the recipient's diagnosis or treatment for mental illness;
- D. services dealing with external, social, or environmental factors that do not directly address the recipient's physical or mental health;
- E. a service that is only for a vocational purpose or an educational purpose that is not mental health related;
- F. staff training that is not related to a client's individual treatment plan or plan of care;
- G. child and adult protection services;
- H. fund-raising activities;
- I. community planning; and
- J. client transportation.

9520.0010 STATUTORY AUTHORITY AND PURPOSE.

Parts 9520.0010 to 9520.0230 provide methods and procedures relating to the establishment and operation of area-wide, comprehensive, community-based mental health, developmental disability, and chemical dependency programs under state grant-in-aid as provided under Minnesota Statutes, sections 245.61 to 245.69. Minnesota Statutes, sections 245.61 to 245.69 are entitled The Community Mental Health Services Act. For purposes of these parts, "community mental health services" includes services to persons who have mental or emotional disorders or other psychiatric disabilities, developmental disabilities, and chemical dependency, including drug abuse and alcoholism.

9520.0020 BOARD DUTIES.

The community mental health board has the responsibility for ensuring the planning, development, implementation, coordination, and evaluation of the community comprehensive mental health program for the mentally ill/behaviorally disabled, developmentally disabled, and chemically dependent populations in the geographic area it serves. It also has the responsibility for ensuring delivery of services designated by statute.

9520.0030 DEFINITIONS.

Parts 9520.0040 and 9520.0050 also set forth definitions of community mental health centers and community mental health clinics.

9520.0040 COMMUNITY MENTAL HEALTH CENTER.

A community mental health center means an agency which includes all of the following:

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A. Established under the provision of Minnesota Statutes, sections 245.61 to 245.69.

B. Provides as a minimum the following services for individuals with mental or emotional disorders, developmental disabilities, alcoholism, drug abuse, and other psychiatric conditions. The extent of each service to be provided by the center shall be indicated in the program plan, which is to reflect the problems, needs, and resources of the community served:

(1) collaborative and cooperative services with public health and other groups for programs of prevention of mental illness, developmental disability, alcoholism, drug abuse, and other psychiatric disorders;

(2) informational and educational services to schools, courts, health and welfare agencies, both public and private;

(3) informational and educational services to the general public, lay, and professional groups;

(4) consultative services to schools, courts, and health and welfare agencies, both public and private;

(5) outpatient diagnostic and treatment services; and

(6) rehabilitative services, particularly for those who have received prior treatment in an inpatient facility.

C. Provides or contracts for detoxification, evaluation, and referral for chemical dependency services (Minnesota Statutes, section 254A.08).

D. Provides specific coordination for mentally ill/behaviorally disabled, developmental disability, and chemical dependency programs. (Minnesota Statutes, sections 254A.07 and 245.61).

E. Has a competent multidisciplinary mental health/developmental disability/chemical dependency professional team whose members meet the professional standards in their respective fields.

F. The professional mental health team is qualified by specific mental health training and experience and shall include as a minimum the services of each of the following:

(1) a licensed physician, who has completed an approved residency program in psychiatry; and

(2) a doctoral clinical, counseling, or health care psychologist, who is licensed under Minnesota Statutes, sections 148.88 to 148.98; and one or both of the following:

(3) a clinical social worker with a master's degree in social work from an accredited college or university; and/or

(4) a clinical psychiatric nurse with a master's degree from an accredited college or university and is registered under Minnesota Statutes, section 148.171. The master's degree shall be in psychiatric nursing or a related psychiatric nursing program such as public health nursing with mental health major, maternal and child health with mental health major, etc.

G. The multidisciplinary staff shall be sufficient in number to implement and operate the described program of the center. In addition to the above, this team should include other professionals, paraprofessionals, and disciplines, particularly in the preventive and rehabilitative components of the program, subject to review and approval of job descriptions and qualifications by the commissioner. If any of the minimum required professional staff are not immediately available, the commissioner may approve and make grants for the operation of the center, provided that the board and director can show evidence acceptable to the commissioner that they are making sincere, reasonable, and ongoing efforts

to acquire such staff and show evidence of how the specialized functions of the required professionals are being met. The services being rendered by employed personnel shall be consistent with their professional discipline.

9520.0050 COMMUNITY MENTAL HEALTH CLINIC.

Subpart 1. Definitions. A community mental health clinic is an agency which devotes, as its major service, at least two-thirds of its resources for outpatient mental health diagnosis, treatment, and consultation by a multidisciplinary professional mental health team. The multidisciplinary professional mental health team is qualified by special mental health training and experience and shall include as a minimum the services of each of the following:

- A. a licensed physician, who has completed an approved residency program in psychiatry; and
- B. a doctoral clinical, or counseling or health care psychologist who is licensed under Minnesota Statutes, sections 148.88 to 148.98; and one or both of the following:
- C. a clinical social worker with a master's degree in social work from an accredited college or university; and/or
- D. a clinical psychiatric nurse with a master's degree from an accredited college or university and is registered under Minnesota Statutes, section 148.171. The master's degree shall be in psychiatric nursing or a related psychiatric nursing program such as public health with a mental health major, maternal and child health with a mental health major.

Subp. 2. Other members of multidisciplinary team. The multidisciplinary team shall be sufficient in number to implement and operate the described program of the clinic. In addition to the above, this team should include other professionals, paraprofessionals and disciplines, particularly in the preventive and rehabilitative components of the program, subject to review and approval of job descriptions and qualifications by the commissioner.

Subp. 3. Efforts to acquire staff. If any of the minimum required professional staff are not immediately available, the commissioner may approve and make grants for the operation of the clinic, provided that the board and director can show evidence acceptable to the commissioner that they are making sincere, reasonable, and ongoing efforts to acquire such staff and evidence of how the specialized functions of the required professional positions are being met. The services being rendered by employed personnel shall be consistent with their professional discipline.

9520.0060 ANNUAL PLAN AND BUDGET.

On or before the date designated by the commissioner, each year the chair of the community mental health board or director of the community mental health program, provided for in Minnesota Statutes, section 245.62, shall submit an annual plan identifying program priorities in accordance with state grant-in-aid guidelines, and a budget on prescribed report forms for the next state fiscal year, together with the recommendations of the community mental health board, to the commissioner of human services for approval as provided under Minnesota Statutes, section 245.63.

9520.0070 FISCAL AFFILIATES.

Other providers of community mental health services may affiliate with the community mental health center and may be approved and eligible for state grant-in-aid funds. The state funding for other community mental health services shall be contingent upon appropriate inclusion in the center's community mental health plan for the continuum of community mental health services and conformity with the state's appropriate disability plan for mental health, developmental disability, or chemical dependency. Fiscal affiliates (funded contracting agencies) providing specialized services under contract must meet all rules and standards that apply to the services they are providing.

9520.0080 OTHER REQUIRED REPORTS.

The program director of the community mental health program shall provide the commissioner of human services with such reports of program activities as the commissioner may require.

9520.0090 FUNDING.

All state community mental health funding shall go directly to the community mental health board or to a human service board established pursuant to Laws of Minnesota 1975, chapter 402, which itself provides or contracts with another agency to provide the community mental health program. Such programs must meet the standards and rules for community mental health programs as enunciated in parts 9520.0010 to 9520.0230 in accordance with Laws of Minnesota 1975, chapter 402.

9520.0100 OPERATION OF OTHER PROGRAMS.

When the governing authority of the community mental health program operates other programs, services, or activities, only the community mental health center program shall be subject to these parts.

9520.0110 APPLICATIONS AND AGREEMENTS BY LOCAL COUNTIES.

New applications for state assistance or applications for renewal of support must be accompanied by an agreement executed by designated signatories on behalf of the participating counties that specifies the involved counties, the amount and source of local funds in each case, and the period of support. The local funds to be used to match state grant-in-aid must be assured in writing on Department of Human Services forms by the local funding authority(ies).

9520.0120 USE OF MATCHING FUNDS.

Funds utilized by the director as authorized by the community mental health board to match a state grant-in-aid must be available to that director for expenditures for the same general purpose as the state grant-in-aid funds.

9520.0130 QUARTERLY REPORTS.

The director of the community mental health program shall, within 20 days after the end of the quarter, submit quarterly prescribed reports to the commissioner of human services (controller's office), containing all receipts, expenditures, and cash balance, subject to an annual audit by the commissioner or his/her designee.

9520.0140 PAYMENTS.

Payments on approved grants will be made subsequent to the department's receipt of the program's quarterly reporting forms, unless the commissioner of human services has determined that funds allocated to a program are not needed for that program. Payments shall be in an amount of at least equal to the quarterly allocation minus any unexpended balance from the previous quarter providing this payment does not exceed the program grant award. In the event the program does not report within the prescribed time, the department will withhold the process of the program's payment until the next quarterly cycle.

9520.0150 FEES.

No fees shall be charged until the director with approval of the community mental health board has established fee schedules for the services rendered and they have been submitted to the commissioner of human services at least two months prior to the effective date thereof and have been approved by him/her. All fees shall conform to the approved schedules, which are accessible to the public.

9520.0160 SUPPLEMENTAL AWARDS.

The commissioner of human services may make supplemental awards to the community mental health boards.

9520.0170 WITHDRAWAL OF FUNDS.

The commissioner of human services may withdraw funds from any program that is not administered in accordance with its approved plan and budget. Written notice of such intended action will be provided to the director and community mental health board. Opportunity for hearing before the commissioner or his/her designee shall be provided.

9520.0180 BUDGET TRANSFERS.

Community mental health boards may make budget transfers within specified limits during any fiscal year without prior approval of the department. The specified limit which can be transferred in any fiscal year between program activity budgets shall be up to ten percent or up to \$5,000 whichever is less. Transfers within an activity can be made into or out of line items with a specified limit of up to ten percent or up to \$5,000 whichever is less. No line item can be increased or decreased by more than \$5,000 or ten percent in a fiscal year without prior approval of the commissioner. Transfers above the specified limits can be made with prior approval from the commissioner. All transfers within and into program budget activities and/or line items must have prior approval by the community mental health board and this approval must be reflected in the minutes of its meeting, it must be reported to the commissioner with the reasons therefor, including a statement of how the transfer will affect program objectives.

9520.0190 BUDGET ADJUSTMENTS.

Budget adjustments made necessary by funding limitations shall be made by the commissioner and provided in writing to the director and board of the community mental health center.

9520.0200 CENTER DIRECTOR.

Every community mental health board receiving state funds for a community mental health program shall have a center director, who is the full-time qualified professional staff member who serves as the executive officer. To be considered qualified, the individual must have professional training to at least the level of graduate degree in his/her clinical and/or administrative discipline, which is relevant to MH-DD-CD and a minimum of two years experience in community mental health programs. The center director is responsible for the planning/design, development, coordination, and evaluation of a comprehensive, area-wide program and for the overall administration of services operated by the board.

The center director shall be appointed by the community mental health board and shall be approved by the commissioner of human services.

9520.0210 DEADLINE FOR APPROVAL OR DENIAL OF REQUEST FOR APPROVAL STATUS.

The commissioner shall approve or deny, in whole or in part, an application for state financial assistance within 90 days of receipt of the grant-in-aid application or by the beginning of the state fiscal year, whichever is the later.

9520.0230 ADVISORY COMMITTEE.

Subpart 1. **Purpose.** To assist the community mental health board in meeting its responsibilities as described in Minnesota Statutes, section 245.68 and to provide opportunity for broad community representation necessary for effective comprehensive mental health, developmental disability, and chemical dependency program planning, each community

mental health board shall appoint a separate advisory committee in at least the three disability areas of mental health, developmental disability, and chemical dependency.

Subp. 2. Membership. The advisory committees shall consist of residents of the geographic area served who are interested and knowledgeable in the area governed by such committee.

Subp. 3. Nominations for membership. Nominations for appointments as members of the advisory committees are to be made to the community mental health board from agencies, organizations, groups, and individuals within the area served by the community mental health center. Appointments to the advisory committees are made by the community mental health board.

Subp. 4. Board member on committee. One community mental health board member shall serve on each advisory committee.

Subp. 5. Nonprovider members. Each advisory committee shall have at least one-half of its membership composed of individuals who are not providers of services to the three disability groups.

Subp. 6. Representative membership. Membership of each advisory committee shall generally reflect the population distribution of the service delivery area of the community mental health center.

Subp. 7. Chairperson appointed. The community mental health board shall appoint a chairperson for each advisory committee. The chairperson shall not be a community mental health board member nor a staff member. The power to appoint the chairperson may be delegated by the community mental health board to the individual advisory committee.

Subp. 8. Committee responsibility to board. Each advisory committee shall be directly responsible to the community mental health board. Direct communication shall be effected and maintained through contact between the chairperson of the particular advisory committee, or his/her designee, and the chairperson of the community mental health board, or his/her designee.

Subp. 9. Staff. Staff shall be assigned by the director to serve the staffing needs of each advisory committee.

Subp. 10. Study groups and task forces. Each advisory committee may appoint study groups and task forces upon consultation with the community mental health board. It is strongly recommended that specific attention be given to the aging and children and youth populations.

Subp. 11. Quarterly meetings required. Each advisory committee shall meet at least quarterly.

Subp. 12. Annual report required. Each advisory committee must make a formal written and oral report on its work to the community mental health board at least annually.

Subp. 13. Minutes. Each advisory committee shall submit copies of minutes of their meetings to the community mental health board and to the Department of Human Services (respective disability group program divisions).

Subp. 14. Duties of advisory committee. The advisory committees shall be charged by the community mental health board with assisting in the identification of the community's needs for mentally ill/behaviorally disabled, developmental disability, and chemical dependency programs. The advisory committee also assists the community mental health board in determining priorities for the community programs. Based on the priorities, each advisory committee shall recommend to the community mental health board ways in which the limited available community resources (work force, facilities, and finances) can be put to maximum and optimal use.

Subp. 15. Recommendations. The advisory committee recommendations made to the community mental health board shall be included as a separate section in the grant-in-aid request submitted to the Department of Human Services by the community mental health board.

Subp. 16. Assessment of programs. The advisory committees shall assist the community mental health board in assessing the programs carried on by the community mental health board, and make recommendations regarding the reordering of priorities and modifying of programs where necessary.

9549.0057 DETERMINATION OF INTERIM AND SETTLE UP OPERATING COST PAYMENT RATES.

Subpart 1. Conditions. To receive an interim payment rate, a nursing facility must comply with the requirements and is subject to the conditions in part 9549.0060, subpart 14, items A to C. The commissioner shall determine interim and settle up operating cost payment rates for a newly constructed nursing facility, or one with an increase in licensed capacity of 50 percent or more according to subparts 2 and 3.

Subp. 2. Interim operating cost payment rate. For the rate year or portion of an interim period beginning on or after July 1, 1986, the interim total operating cost payment rate must be determined according to parts 9549.0050 to 9549.0059 (Temporary) in effect on March 1, 1987. For the rate year or portion of an interim period beginning on or after July 1, 1987, the interim total operating cost payment rate must be determined according to parts 9549.0051 to 9549.0059, except that:

A. The nursing facility must project its anticipated resident days for each resident class. The anticipated resident days for each resident class must be multiplied by the weight for that resident class as listed in part 9549.0058 to determine the anticipated standardized resident days for the reporting period.

B. The commissioner shall use anticipated standardized resident days in determining the allowable historical case mix operating cost standardized per diem.

C. The commissioner shall use the anticipated resident days in determining both the allowable historical other care related operating cost per diem and the allowable historical other operating cost per diem.

D. The annual adjustment factors determined in part 9549.0055, subpart 1, must not be applied to the nursing facility's allowable historical per diems as provided in part 9549.0056, subparts 2 and 4.

E. The limits established in part 9549.0055, subpart 2, items C and E, as indexed in part 9549.0055, subpart 3 and in effect at the beginning of the interim period, must be increased by ten percent.

F. The efficiency incentive in part 9549.0056, subpart 4, item A or B, must not apply.

G. The phase in provisions in part 9549.0056, subpart 7, must not apply.

Subp. 3. Settle up operating cost payment rate. The settle up total operating cost payment rate must be determined according to items A to C.

A. The settle up operating cost payment rate for interim periods before July 1, 1987, is subject to the rule parts that were in effect during the interim period.

B. To determine the settle up operating cost payment rate for interim periods or the portion of an interim period occurring after July 1, 1987, subitems (1) to (7) must be applied.

(1) The standardized resident days as determined in part 9549.0054, subpart 2, must be used for the interim period.

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(2) The commissioner shall use the standardized resident days in subitem (1) in determining the allowable historical case mix operating cost standardized per diem.

(3) The commissioner shall use the actual resident days in determining both the allowable historical other care related operating cost per diem and the allowable historical other operating cost per diem.

(4) The annual adjustment factors determined in part 9549.0055, subpart 1, must not be applied to the nursing facility's allowable historical per diems as provided in part 9549.0056, subparts 2 and 4.

(5) The limits established in part 9549.0055, subpart 2, item E, must be the limits for the settle up reporting periods occurring after July 1, 1987. If the interim period includes more than one July 1 date, the commissioner shall use the limit established in part 9549.0055, subpart 2, items C and E, as indexed in part 9549.0055, subpart 3, increased by ten percent for the second July 1 date.

(6) The efficiency incentive in part 9549.0056, subpart 4, item A or B, must not apply.

(7) The phase in provisions in part 9549.0056, subpart 7 must not apply.

C. For the nine month period following the settle up reporting period, the total operating cost payment rate must be determined according to item B except that the efficiency incentive as computed in part 9549.0056, subpart 4, item A or B, applies.

D. The total operating cost payment rate for the rate year beginning July 1 following the nine month period in item C must be determined under parts 9549.0050 to 9549.0059.

E. A newly constructed nursing facility or one with an increase in licensed capacity of 50 percent or more must continue to receive the interim total operating cost payment rate until the settle up total operating cost payment rate is determined under this subpart.

9549.0060 DETERMINATION OF THE PROPERTY-RELATED PAYMENT RATE.

Subp. 4. Determination of allowable appraised value. A nursing facility's appraised value must be limited by items A to C.

A. For rate years beginning after June 30, 1985, the replacement cost new per bed limit for licensed beds in single bedrooms and multiple bedrooms is determined according to subitems (1) to (4):

(1) Effective January 1, 1984, the replacement cost new per bed limit for licensed beds in single bedrooms is \$41,251 and for licensed beds in multiple bedrooms is \$27,500. On January 1, 1985, the commissioner shall adjust the replacement cost new per bed limit by the percentage change in the composite cost of construction index published by the Bureau of Economic Analysis of the United States Department of Commerce in the Survey of Current Business Statistics for the two previous Octobers. The index is incorporated by reference and is available at the James J. Hill Reference Library, Saint Paul, Minnesota.

(2) The average historical cost per bed for depreciable equipment is computed by adding the historical cost of depreciable equipment for each nursing facility as determined in subpart 10, item A, and dividing the sum by the total number of licensed beds in those nursing facilities. The amount is then subtracted from the replacement cost new per bed limits determined in subitem (1).

(3) The differences computed in subitem (2) are the replacement cost new per bed limits for licensed beds in single bedrooms and multiple bedrooms effective for the rate year beginning on July 1, 1985.

(4) On January 1, 1986, and each succeeding January 1, the commissioner shall adjust the limit in subitem (3) by the percentage change in the composite cost of

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construction index published by the Bureau of Economic Analysis of the United States Department of Commerce in the Survey of Current Business Statistics for the two previous Octobers.

B. Each nursing facility's maximum allowable replacement cost new is determined annually according to subitems (1) to (3):

(1) The multiple bedroom replacement cost new per bed limit in item A must be multiplied by the number of licensed beds in multiple bedrooms.

(2) The single bedroom replacement cost new per bed limit in item A must be multiplied by the number of licensed beds in single bedrooms except as provided in subpart 11, item C, subitem (2).

(3) The nursing facility's maximum allowable replacement cost new is the sum of subitems (1) and (2).

C. The nursing facility's replacement cost new determined in subparts 1 to 3 must be reduced by the replacement cost new of portions of the nursing facility used for functions whose costs are disallowed under parts 9549.0010 to 9549.0080.

D. The adjusted replacement cost new is the lesser of item B or C.

E. The adjusted depreciation is determined by subtracting from the depreciation in subparts 1 to 3 the amount of depreciation, if any, related to the portion of the nursing facility's replacement cost new disallowed in item C or D.

F. The nursing facility's allowable appraised value is determined by subtracting the amount determined in item E from the amount in item D. If no adjustment to the replacement cost new is required in items C and D, then the nursing facility's allowable appraised value is the appraised value determined in subparts 1 to 3.

Subp. 5. Allowable debt. For purposes of determining the property-related payment rate, the commissioner shall allow or disallow debt according to items A to D.

A. Debt shall be limited as follows:

(1) Debt incurred for the purchase of land directly used for resident care and the purchase or construction of nursing facility buildings, attached fixtures, or land improvements or the capitalized replacement or capitalized repair of existing buildings, attached fixtures, or land improvements shall be allowed. Debt incurred for any other purpose shall not be allowed.

(2) Working capital debt shall not be allowed.

(3) An increase in the amount of a debt as a result of refinancing of capital assets which occurs after May 22, 1983, shall not be allowed except to the extent that the increase in debt is the result of refinancing costs such as points, loan origination fees, or title searches.

(4) An increase in the amount of total outstanding debt incurred after May 22, 1983, as a result of a change in ownership or reorganization of provider entities, shall not be allowed and the previous owner's allowable debt as of May 22, 1983, shall be allowed under item B.

(5) Any portion of the total allowable debt exceeding the appraised value as determined in subpart 4 shall not be allowed.

(6) Any portion of a debt of which the proceeds exceed the historical cost of the capital asset acquired shall not be allowed.

B. The nursing facility shall apportion debts incurred before October 1, 1984, among land and buildings, attached fixtures, land improvements, depreciable equipment and working capital by direct identification. If direct identification of any part of the debt is not possible, that portion of the debt which cannot be directly identified shall be

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apportioned to each component, except working capital debt, based on the ratio of the historical cost of the component to the total historical cost of all components. The portion of debt assigned to land and buildings, attached fixtures, and land improvements is allowable debt.

A hospital attached nursing facility that has debts that are not directly identifiable to the hospital or the nursing facility shall allocate the portion of allowable debt computed according to subpart 5, and allowable interest expense computed according to subpart 7 assigned to land and buildings, attached fixtures, and land improvements using the Medicare stepdown method described in subpart 1.

C. For debts incurred after September 30, 1984, the nursing facility shall directly identify the proceeds of the debt associated with specific land and buildings, attached fixtures, and land improvements, and keep records that separate such debt proceeds from all other debt. Only the debt identified with specific land and buildings, attached fixtures, and land improvement shall be allowed.

D. For reporting years ending on or after September 30, 1984, the total amount of allowable debt shall be the sum of all allowable debts at the beginning of the reporting year plus all allowable debts at the end of the reporting year divided by two. Nursing facilities which have a debt with a zero balance at the beginning or end of the reporting year must use a monthly average for the reporting year.

E. Debt incurred as a result of loans between related organizations must not be allowed.

Subp. 6. Limitations on interest rates. The commissioner shall limit interest rates according to items A to C.

A. Except as provided in item B, the effective interest rate of each allowable debt, including points, financing charges, and amortization bond premiums or discounts, entered into after September 30, 1984, is limited to the lesser of:

- (1) the effective interest rate on the debt; or
- (2) 16 percent.

B. Variable or adjustable rates for allowable debt are allowed subject to item A. For each allowable debt with a variable or adjustable rate, the effective interest rate must be computed by dividing the interest expense for the reporting year by the average allowable debt computed under subpart 5, item D.

C. For rate years beginning on July 1, 1985, and July 1, 1986, the effective interest rate for debts incurred before October 1, 1984, is allowed if the interest rate is not in excess of what the borrower would have had to pay in an arms length transaction in the market in which the debt was incurred. For rate years beginning after June 30, 1987, the effective interest rate for debts incurred before October 1, 1984, is allowed subject to item A.

Subp. 7. Allowable interest expense. The commissioner shall allow or disallow interest expense including points, finance charges, and amortization bond premiums or discounts under items A to G.

A. Interest expense is allowed only on the debt which is allowed under subpart 5 and within the interest rate limits in subpart 6.

B. A nonprofit nursing facility shall use its restricted funds to purchase or replace capital assets to the extent of the cost of those capital assets before it borrows funds for the purchase or replacement of those capital assets. For purposes of this item and part 9549.0035, subpart 2, a restricted fund is a fund for which use is restricted to the purchase or replacement of capital assets by the donor or by the nonprofit nursing facility's board.

C. Construction period interest expense must be capitalized as a part of the cost of the building. The period of construction extends to the earlier of either the first day a

resident is admitted to the nursing facility, or the date the nursing facility is certified to receive medical assistance recipients.

D. Interest expense for allowable debts entered into after May 22, 1983, is allowed for the portion of the debt which together with all outstanding allowable debt does not exceed 100 percent of the most recent allowable appraised value as determined in subparts 1 to 4.

E. Increases in interest expense after May 22, 1983, which are the result of changes in ownership or reorganization of provider entities, are not allowable.

F. Except as provided in item G, increases in total interest expense which are the result of refinancing of debt after May 22, 1983, are not allowed. The total interest expense must be computed as the sum of the annual interest expense over the remaining term of the debt refinanced.

G. Increases in total interest expense which result from refinancing a balloon payment on allowable debt after May 22, 1983, shall be allowed according to subitems (1) to (3).

(1) The interest rate on the refinanced debt shall be limited under subpart 6, item A.

(2) The refinanced debt shall not exceed the balloon payment.

(3) The term of the refinanced debt must not exceed the term of the original debt computed as though the balloon payment did not exist.

Subp. 10. **Equipment allowance.** For rate years beginning after June 30, 1985, the equipment allowance must be computed according to items A to E.

A. The historical cost of depreciable equipment for nursing facilities which do not have costs for operating leases for depreciable equipment in excess of \$10,000 during the reporting year ending September 30, 1984, is determined under subitem (1) or (2).

(1) The total historical cost of depreciable equipment reported on the nursing facility's audited financial statement for the reporting year ending September 30, 1984, must be multiplied by 70 percent. The product is the historical cost of depreciable equipment.

(2) The nursing facility may submit an analysis which classifies the historical cost of each item of depreciable equipment reported on September 30, 1984. The analysis must include an itemized description of each piece of depreciable equipment and its historical cost. The sum of the historical cost of each piece of equipment is the total historical cost of depreciable equipment for that nursing facility.

For purposes of this item, a hospital attached nursing facility shall use the allocation method in subpart 1 to stepdown the historical cost of depreciable equipment.

B. The historical cost per bed of depreciable equipment for each nursing facility must be computed by dividing the total historical cost of depreciable equipment determined in item A by the nursing facility's total number of licensed beds on September 30, 1984.

C. All nursing facilities must be grouped in one of the following:

(1) nursing facilities with total licensed beds of less than 61 beds;

(2) nursing facilities with total licensed beds of more than 60 beds and less than 101 beds; or

(3) nursing facilities with more than 100 total licensed beds.

D. Within each group determined in item C, the historical cost per bed for each nursing facility determined in item B must be ranked and the median historical cost per bed established.

E. The median historical cost per bed for each group in item C as determined in item D must be increased by ten percent. For rate years beginning after June 30, 1986, this

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amount shall be adjusted annually by the percentage change indicated by the urban consumer price index for Minneapolis-Saint Paul, as published by the Bureau of Labor Statistics, new series index (1967=100) for the two previous Decembers. This index is incorporated by reference and available at the James J. Hill Reference Library, Saint Paul, Minnesota.

F. The equipment allowance for each group in item C shall be the amount computed in item E multiplied by 15 percent and divided by 350.

Subp. 11. **Capacity days.** The number of capacity days is determined under items A to C.

A. The number of capacity days is determined by multiplying the number of licensed beds in the nursing facility by the number of days in the nursing facility's reporting period.

B. Except as in item C, nursing facilities shall increase the number of capacity days by multiplying the number of licensed single bedrooms by 0.5 and by the number of days in the nursing facility's reporting period.

C. The commissioner shall waive the requirements of item B if a nursing facility agrees in writing to subitems (1) to (3).

(1) The nursing facility shall agree not to request a private room payment in part 9549.0070, subpart 3 for any of its medical assistance residents in licensed single bedrooms.

(2) The nursing facility shall agree not to use the single bedroom replacement cost new limit for any of its licensed single bedrooms in the computation of the allowable appraised value in subpart 4.

(3) The nursing facility shall agree not to charge any private paying resident in a single bedroom a payment rate that exceeds the amount calculated under units (a) to (c).

(a) The nursing facility's average total payment rate shall be determined by multiplying the total payment rate for each case mix resident class by the number of resident days for that class in the nursing facility's reporting year and dividing the sum of the resident class amounts by the total number of resident days in the nursing facility's reporting year.

(b) The nursing facility's maximum single bedroom adjustment must be determined by multiplying its average total payment rate calculated under unit (a) by ten percent.

(c) The nursing facility's single bedroom adjustment which must not exceed the amount computed in unit (b) must be added to each total payment rate established in Minnesota Statutes, sections 256B.431, 256B.434, and 256B.441, to determine the nursing facility's single bedroom payment rates.

Subp. 14. **Determination of interim and settle-up payment rates.** The commissioner shall determine interim and settle-up payment rates according to items A to J.

A. A newly constructed nursing facility, or one with a capacity increase of 50 percent or more, may submit a written application to the commissioner to receive an interim payment rate. The nursing facility shall submit cost reports and other supporting information as required in parts 9549.0010 to 9549.0080 for the reporting year in which the nursing facility plans to begin operation at least 60 days before the first day a resident is admitted to the newly constructed nursing facility bed. The nursing facility shall state the reasons for noncompliance with parts 9549.0010 to 9549.0080. The effective date of the interim payment rate is the earlier of either the first day a resident is admitted to the newly constructed nursing facility or the date the nursing facility bed is certified for medical assistance. The interim payment rate for a newly constructed nursing facility, or a nursing facility with a capacity increase of 50 percent or more, is determined under items B to D.

B. The interim payment rate must not be in effect more than 17 months. When the interim payment rate begins between May 1 and September 30, the nursing facility shall file settle-up cost reports for the period from the beginning of the interim payment rate through September 30 of the following year. When the interim payment rate begins between October 1 and April 30, the nursing facility shall file settle-up cost reports for the period from the beginning of the interim payment rate to the first September 30 following the beginning of the interim payment rate.

C. The interim payment rate for a nursing facility which commenced construction prior to July 1, 1985, is determined by 12 MCAR S 2.05014 [Temporary] except that capital assets must be classified under parts 9549.0010 to 9549.0080.

D. The interim property-related payment rate for a nursing facility which commences construction after June 30, 1985, is determined as follows:

(1) At least 60 days before the first day a resident is admitted to the newly constructed nursing facility bed and upon receipt of written application from the nursing facility, the commissioner shall establish the nursing facility's appraised value according to subparts 1 and 4.

(2) The nursing facility shall project the allowable debt and the allowable interest expense according to subparts 5 and 7.

(3) The interim building capital allowance must be determined under subpart 8 or 9.

(4) The equipment allowance during the interim period must be the equipment allowance computed in accordance with subpart 10 which is in effect on the effective date of the interim property-related payment rate.

(5) The interim property-related payment rate must be the sum of subitems (3) and (4).

(6) Anticipated resident days may be used instead of 96 percent capacity days.

E. The settle-up property-related payment rate and the property-related payment rate for the nine months following the settle up for a nursing facility which commenced construction before July 1, 1985, is determined under 12 MCAR S 2.05014 [Temporary]. The property-related payment rate for the rate year beginning July 1 following the nine month period is determined under part 9549.0060.

F. The settle-up property-related payment rate for a nursing facility which commenced construction after June 30, 1985, shall be established as follows:

(1) The appraised value determined in item D, subitem (1), must be updated in accordance with subpart 2, item B prorated for each rate year, or portion of a rate year, included in the interim payment rate period.

(2) The nursing facility's allowable debt, allowable interest rate, and allowable interest expense for the interim rate period shall be computed in accordance with subparts 5, 6, and 7.

(3) The settle-up building capital allowance shall be determined in accordance with subpart 8 or 9.

(4) The equipment allowance shall be updated in accordance with subpart 10 prorated for each rate year, or portion of a rate year, included in the interim payment rate period.

(5) The settle-up property-related payment rate must be the sum of subitems (3) and (4).

(6) Resident days may be used instead of 96 percent capacity days.

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G. The property-related payment rate for the nine months following the settle up for a nursing facility which commenced construction after June 30, 1985, shall be established in accordance with item F except that 96 percent capacity days must be used.

H. The property-related payment rate for the rate year beginning July 1 following the nine month period in item G must be determined under this part.

I. A newly constructed nursing facility or one with a capacity increase of 50 percent or more must continue to receive the interim property-related payment rate until the settle-up property-related payment rate is determined under this subpart.

J. The interim real estate taxes and special assessments payment rate shall be established using the projected real estate taxes and special assessments cost divided by anticipated resident days. The settle-up real estate taxes and special assessments payment rate shall be established using the real estate taxes and special assessments divided by resident days. The real estate and special assessments payment rate for the nine months following the settle up shall be equal to the settle-up real estate taxes and special assessments payment rate.