

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	1532a	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, consumer

1.7 protections, administrator qualifications, dementia care services, assisted living

1.8 facility resident rights, and medical cannabis; establishing OneCare Buy-In;

1.9 establishing assisted living licensure; requiring reports; making technical changes;

1.10 establishing controlled substance registration requirement and registration fee;

1.11 establishing councils; establishing OneCare Buy-In reserve account; modifying

1.12 penalties; providing for rulemaking; modifying and making fees; making forecast

1.13 adjustments; appropriating money; amending Minnesota Statutes 2018, sections

1.14 13.69, subdivision 1; 15C.02; 16A.724, subdivision 2; 62A.152, subdivision 3;

1.15 62A.3094, subdivision 1; 62J.497, subdivision 1; 119B.011, subdivisions 19, 20,

1.16 by adding a subdivision; 119B.02, subdivision 7; 119B.025, subdivision 1; 119B.03,

1.17 subdivision 9; 119B.09, subdivisions 1, 7; 119B.095, subdivision 2, by adding a

1.18 subdivision; 119B.125, subdivision 6; 119B.13, subdivisions 1, 6, 7; 119B.16,

1.19 subdivisions 1, 1a, 1b, by adding subdivisions; 144.051, subdivisions 4, 5, 6;

1.20 144.057, subdivision 1; 144.0724, subdivisions 4, 5, 8; 144.122; 144.3831,

1.21 subdivision 1; 144A.04, subdivision 5; 144A.071, subdivisions 1a, 2, 3, 4a, 4c,

1.22 5a; 144A.073, subdivision 3c; 144A.20, subdivision 1; 144A.24; 144A.26; 144A.44,

1.23 subdivision 1; 144A.45, subdivision 1; 144A.471, subdivisions 7, 9; 144A.472,

1.24 subdivision 7; 144A.474, subdivisions 9, 11; 144A.475, subdivisions 3b, 5;

1.25 144A.476, subdivision 1; 144A.4791, subdivision 10; 144A.4799; 147D.27, by

1.26 adding a subdivision; 147E.40, subdivision 1; 147F.17, subdivision 1; 148.59;

1.27 148.6445, subdivisions 1, 2, 2a, 3, 4, 5, 6, 10; 148.7815, subdivision 1; 148B.5301,

1.28 subdivision 2; 148E.0555, subdivision 6; 148E.120, subdivision 2; 148E.180;

1.29 148F.11, subdivision 1; 150A.06, by adding subdivisions; 150A.091, by adding

1.30 subdivisions; 151.01, by adding subdivisions; 151.065, subdivisions 1, 2, 3, 6, by

1.31 adding a subdivision; 151.252, subdivision 1; 151.47, by adding a subdivision;

1.32 152.01, by adding a subdivision; 152.10; 152.11, subdivisions 1, 1a, 2, 2a, 2b, 2c;

1.33 152.12, subdivisions 1, 2, 3, 4; 152.125, subdivisions 2, 3, 4; 152.22, subdivision

1.34 13; 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, by adding a subdivision;

2.1 245.467, subdivisions 2, 3; 245.469, subdivisions 1, 2; 245.470, subdivision 1;
 2.2 245.4712, subdivision 2; 245.472, subdivision 2; 245.4863; 245.4871, subdivisions
 2.3 9a, 10, 11a, 17, 21, 26, 27, 29, 32, 34; 245.4876, subdivisions 2, 3; 245.4879,
 2.4 subdivisions 1, 2; 245.488, subdivision 1; 245.4889, subdivision 1; 245.696, by
 2.5 adding a subdivision; 245.735, subdivision 3; 245A.02, subdivisions 5a, 18;
 2.6 245A.04, by adding a subdivision; 245A.10, subdivision 4; 245A.14, subdivisions
 2.7 4, 8, by adding subdivisions; 245A.151; 245A.16, subdivision 1; 245A.18,
 2.8 subdivision 2; 245A.40; 245A.41; 245A.50; 245A.51, subdivision 3, by adding
 2.9 subdivisions; 245A.66, subdivisions 2, 3; 245C.02, subdivision 6a, by adding
 2.10 subdivisions; 245C.03, subdivision 1, by adding a subdivision; 245C.05,
 2.11 subdivisions 5, 5a; 245C.08, subdivisions 1, 3; 245C.10, by adding a subdivision;
 2.12 245C.13, subdivision 2, by adding a subdivision; 245C.24, by adding a subdivision;
 2.13 245C.30, subdivisions 1, 2, 3; 245D.03, subdivision 1; 245D.071, subdivision 1;
 2.14 245D.081, subdivision 3; 245E.06, subdivision 3; 245F.05, subdivision 2; 245H.01,
 2.15 by adding subdivisions; 245H.03, by adding a subdivision; 245H.07; 245H.10,
 2.16 subdivision 1; 245H.11; 245H.12; 245H.13, subdivision 5, by adding subdivisions;
 2.17 245H.14, subdivisions 1, 3, 4, 5, 6; 245H.15, subdivision 1; 246B.10; 252.275,
 2.18 subdivision 3; 252.41, subdivisions 3, 4, 5, 6, 7, 9; 252.42; 252.43; 252.44; 252.45;
 2.19 254A.03, subdivision 3; 254B.02, subdivision 1; 254B.03, subdivisions 2, 4;
 2.20 254B.04, subdivision 1; 254B.05, subdivisions 1a, 5; 254B.06, subdivisions 1, 2;
 2.21 256.01, subdivision 14b; 256.478; 256.9365; 256.962, subdivision 5; 256.969,
 2.22 subdivisions 2b, 3a, 9, 17, 19; 256B.04, subdivisions 21, 22; 256B.055, subdivision
 2.23 2; 256B.056, subdivision 3; 256B.0615, subdivision 1; 256B.0616, subdivisions
 2.24 1, 3; 256B.0622, subdivisions 1, 2, 3a, 4, 5a, 7, 7a, 7b, 7d; 256B.0623, subdivisions
 2.25 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 12; 256B.0624, subdivisions 2, 4, 5, 6, 7, 8, 9, 11;
 2.26 256B.0625, subdivisions 3b, 5, 5l, 13, 13e, 13f, 17, 19c, 23, 24, 30, 42, 45a, 48,
 2.27 49, 56a, 57, 61, 62, 65, by adding subdivisions; 256B.064, subdivision 1a;
 2.28 256B.0644; 256B.0659, subdivision 21; 256B.0757, subdivision 2; 256B.0915,
 2.29 subdivisions 3a, 3b; 256B.092, subdivision 13; 256B.0941, subdivision 1;
 2.30 256B.0943, subdivisions 1, 2, 3, 4, 5, 6, 7, 8, 9, 11; 256B.0944, subdivisions 1, 3,
 2.31 4, 5, 6, 7, 8, 9; 256B.0946, subdivisions 1, 1a, 2, 3, 4, 6; 256B.0947, subdivisions
 2.32 1, 2, 3, 3a, 5, 6, 7a; 256B.0949, subdivisions 2, 4, 5a, by adding a subdivision;
 2.33 256B.49, subdivision 24; 256B.4914, subdivisions 2, 3, 4, 5, 6, 7, 8, 9, 10, 10a,
 2.34 14, 15, by adding a subdivision; 256B.69, subdivision 6d; 256B.76, subdivisions
 2.35 2, 4; 256B.766; 256B.767; 256B.85, subdivision 3; 256I.03, subdivision 15;
 2.36 256I.04, subdivisions 1, 2a, 2f; 256I.06, subdivision 8; 256L.03, by adding a
 2.37 subdivision; 256L.07, subdivision 2, by adding a subdivision; 256L.11, subdivisions
 2.38 2, 7; 256R.02, subdivisions 8, 19; 256R.16, subdivision 1; 256R.21, by adding a
 2.39 subdivision; 256R.23, subdivision 5; 256R.24, subdivision 3; 256R.25; 256R.26;
 2.40 256R.44; 256R.47; 256R.50, subdivision 6; 260C.007, subdivision 18, by adding
 2.41 a subdivision; 260C.178, subdivision 1; 260C.201, subdivisions 1, 2, 6; 260C.212,
 2.42 subdivision 2; 260C.452, subdivision 4; 260C.503, subdivision 1; 295.582,
 2.43 subdivision 1; 325F.72; 518A.32, subdivision 3; 626.5572, subdivisions 6, 21;
 2.44 Laws 2003, First Special Session chapter 14, article 13C, section 2, subdivision
 2.45 6, as amended; Laws 2017, First Special Session chapter 6, article 3, section 49;
 2.46 article 8, sections 71; 72; article 18, section 2, subdivisions 1, 3, 5, 15; proposing
 2.47 coding for new law in Minnesota Statutes, chapters 119B; 144; 144A; 145; 148;
 2.48 151; 245; 245A; 245D; 256; 256B; 256L; 256M; 256R; 260C; proposing coding
 2.49 for new law as Minnesota Statutes, chapters 144I; 245I; 256T; repealing Minnesota
 2.50 Statutes 2018, sections 119B.16, subdivision 2; 144A.071, subdivision 4d;
 2.51 144A.441; 144A.442; 144A.472, subdivision 4; 144D.01; 144D.015; 144D.02;
 2.52 144D.025; 144D.03; 144D.04; 144D.045; 144D.05; 144D.06; 144D.065; 144D.066;
 2.53 144D.07; 144D.08; 144D.09; 144D.10; 144D.11; 144G.01; 144G.02; 144G.03;
 2.54 144G.04; 144G.05; 144G.06; 214.17; 214.18; 214.19; 214.20; 214.21; 214.22;
 2.55 214.23; 214.24; 245.462, subdivision 4a; 245E.06, subdivisions 2, 4, 5; 245H.10,
 2.56 subdivision 2; 246.18, subdivisions 8, 9; 252.41, subdivision 8; 252.431; 252.451;
 2.57 254B.03, subdivision 4a; 256B.0615, subdivisions 2, 4, 5; 256B.0616, subdivisions
 2.58 2, 4, 5; 256B.0624, subdivision 10; 256B.0625, subdivision 63; 256B.0659,

3.1 subdivision 22; 256B.0705; 256B.0943, subdivision 10; 256B.0944, subdivision
 3.2 10; 256B.0946, subdivision 5; 256B.0947, subdivision 9; 256B.431, subdivisions
 3.3 3a, 3f, 3g, 3i, 13, 15, 17, 17a, 17c, 17d, 17e, 18, 21, 22, 30, 45; 256B.434,
 3.4 subdivisions 4, 4f, 4i, 4j; 256L.11, subdivisions 2a, 6a; 256R.36; 256R.40; 256R.41;
 3.5 Laws 2010, First Special Session chapter 1, article 25, section 3, subdivision 10;
 3.6 Minnesota Rules, parts 2960.3030, subpart 3; 3400.0185, subpart 5; 6400.6970;
 3.7 7200.6100; 7200.6105; 9502.0425, subparts 4, 16, 17; 9503.0155, subpart 8;
 3.8 9505.0370; 9505.0371; 9505.0372; 9520.0010; 9520.0020; 9520.0030; 9520.0040;
 3.9 9520.0050; 9520.0060; 9520.0070; 9520.0080; 9520.0090; 9520.0100; 9520.0110;
 3.10 9520.0120; 9520.0130; 9520.0140; 9520.0150; 9520.0160; 9520.0170; 9520.0180;
 3.11 9520.0190; 9520.0200; 9520.0210; 9520.0230; 9549.0057; 9549.0060, subparts
 3.12 4, 5, 6, 7, 10, 11, 14.

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

3.14 **ARTICLE 1**

3.15 **CHILDREN AND FAMILIES SERVICES**

3.16 Section 1. Minnesota Statutes 2018, section 119B.011, is amended by adding a subdivision
 3.17 to read:

3.18 Subd. 13b. **Homeless.** "Homeless" means a self-declared housing status as defined in
 3.19 the McKinney-Vento Homeless Assistance Act and United States Code, title 42, section
 3.20 11302, paragraph (a).

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

3.22 Sec. 2. Minnesota Statutes 2018, section 119B.011, subdivision 19, is amended to read:

3.23 Subd. 19. **Provider.** "Provider" means:

3.24 (1) an individual or child care center or facility, ~~either licensed or unlicensed, providing~~
 3.25 ~~legal child care services as defined~~ licensed to provide child care under section 245A.03
 3.26 chapter 245A when operating within the terms of the license; or

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

3.28 (3) an individual or child care center or facility ~~holding~~ that: (i) holds a valid child care
 3.29 license issued by another state or a tribe and providing; (ii) provides child care services in
 3.30 the licensing state or in the area under the licensing tribe's jurisdiction; and (iii) is in
 3.31 compliance with federal health and safety requirements as certified by the licensing state
 3.32 or tribe, or as determined by receipt of child care development block grant funds in the
 3.33 licensing state; or

3.34 (4) a legal nonlicensed child care provider as defined under section 119B.011, subdivision
 3.35 16, providing legal child care services. A ~~legally unlicensed family~~ legal nonlicensed child
 3.36 care provider must be at least 18 years of age, and not a member of the MFIP assistance

4.1 unit or a member of the family receiving child care assistance to be authorized under this
 4.2 chapter.

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

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

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

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

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

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

4.17 Subd. 7. **Child care market rate survey.** ~~Biennially,~~ The commissioner shall conduct
 4.18 the next survey of prices charged by child care providers in Minnesota in state fiscal year
 4.19 2021 and every three years thereafter to determine the 75th percentile for like-care
 4.20 arrangements in county price clusters.

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

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

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

4.26 (1) identity of adults;

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

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

4.30 (4) age;

- 5.1 (5) immigration status, if related to eligibility;
- 5.2 (6) Social Security number, if given;
- 5.3 (7) counted income;
- 5.4 (8) spousal support and child support payments made to persons outside the household;
- 5.5 (9) residence; and
- 5.6 (10) inconsistent information, if related to eligibility.

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

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

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

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

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

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

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

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

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

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

5.29 Subd. 9. **Portability pool.** (a) The commissioner shall establish a pool of up to five
5.30 percent of the annual appropriation for the basic sliding fee program to provide continuous

6.1 child care assistance for eligible families who move between Minnesota counties. At the
 6.2 end of each allocation period, any unspent funds in the portability pool must be used for
 6.3 assistance under the basic sliding fee program. If expenditures from the portability pool
 6.4 exceed the amount of money available, the reallocation pool must be reduced to cover these
 6.5 shortages.

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

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

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

6.13 (c) The receiving county must:

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

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

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

6.21 **EFFECTIVE DATE.** This section is effective December 2, 2019.

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

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

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

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

7.1 (b) Child care services must be made available as in-kind services.

7.2 (c) All applicants for child care assistance and families currently receiving child care
7.3 assistance must be assisted and required to cooperate in establishment of paternity and
7.4 enforcement of child support obligations for all children in the family at application and
7.5 redetermination as a condition of program eligibility. For purposes of this section, a family
7.6 is considered to meet the requirement for cooperation when the family complies with the
7.7 requirements of section 256.741.

7.8 (d) All applicants for child care assistance and families currently receiving child care
7.9 assistance must pay the co-payment fee under section 119B.12, subdivision 2, as a condition
7.10 of eligibility. The co-payment fee may include additional recoupment fees due to a child
7.11 care assistance program overpayment.

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

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

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

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

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

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

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

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

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

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

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

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

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

8.17 (1) the child's school schedule;

8.18 (2) the custody schedule; or

8.19 (3) the provider's availability.

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

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

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

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

8.29 Subd. 3. **Assistance for persons who are homeless.** An applicant who is homeless and
8.30 eligible for child care assistance is exempt from the activity participation requirements under

9.1 this chapter for three months. The applicant under this subdivision is eligible for 60 hours
 9.2 of child care assistance per service period for three months from the date the county receives
 9.3 the application. Additional hours may be authorized as needed based on the applicant's
 9.4 participation in employment, education, or MFIP or DWP employment plan. To continue
 9.5 receiving child care assistance after the initial three months, the applicant must verify that
 9.6 the applicant meets eligibility and activity requirements for child care assistance under this
 9.7 chapter.

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

9.9 Sec. 11. Minnesota Statutes 2018, section 119B.125, subdivision 6, is amended to read:

9.10 Subd. 6. **Record-keeping requirement.** (a) As a condition of payment, all providers
 9.11 receiving child care assistance payments must:

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

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

9.18 ~~The~~ (b) As a condition of payment, attendance records must be completed daily and
 9.19 include the date, the first and last name of each child in attendance, and the times when
 9.20 each child is dropped off and picked up. To the extent possible, the times that the child was
 9.21 dropped off to and picked up from the child care provider must be entered by the person
 9.22 dropping off or picking up the child. The daily attendance records must be retained at the
 9.23 site where services are delivered for six years after the date of service.

9.24 (c) A county or the commissioner may deny or revoke a provider's authorization as a
 9.25 child care provider to any applicant, rescind authorization of any provider, to receive child
 9.26 care assistance payments under section 119B.13, subdivision 6, paragraph (d), pursue a
 9.27 fraud disqualification under section 256.98, take an action against the provider under chapter
 9.28 245E, or establish an attendance record overpayment claim in the system under paragraph
 9.29 (d) against a current or former provider, when the county or the commissioner knows or
 9.30 has reason to believe that the provider has not complied with the record-keeping requirement
 9.31 in this subdivision. A provider's failure to produce attendance records as requested on more
 9.32 than one occasion constitutes grounds for disqualification as a provider.

10.1 (d) To calculate an attendance record overpayment under this subdivision, the
 10.2 commissioner or county agency shall subtract the maximum daily rate from the total amount
 10.3 paid to a provider for each day that a child's attendance record is missing, unavailable,
 10.4 incomplete, illegible, inaccurate, or otherwise inadequate.

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

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

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

10.9 Subdivision 1. **Subsidy restrictions.** (a) Beginning ~~February 3, 2014,~~ September 20,
 10.10 2019, the maximum rate paid for child care assistance in any county or county price cluster
 10.11 under the child care fund shall be the greater of the 25th percentile of the ~~2014~~ 2018 child
 10.12 care provider rate survey under section 119B.02, subdivision 7, or the maximum rate effective
 10.13 ~~November 28, 2014~~ February 3, 2014. For a child care provider located within the boundaries
 10.14 of a city located in two or more of the counties of Benton, Sherburne, and Stearns, the
 10.15 maximum rate paid for child care assistance shall be equal to the maximum rate paid in the
 10.16 county with the highest maximum reimbursement rates or the provider's charge, whichever
 10.17 is less. The commissioner may: (1) assign a county with no reported provider prices to a
 10.18 similar price cluster; and (2) consider county level access when determining final price
 10.19 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 2018 child care provider rate survey under section
11.14 119B.02, subdivision 7, or the registration fee in effect February 3, 2014. Maximum
11.15 registration fees must be set for licensed family child care and for child care centers. For a
11.16 child care provider located within the boundaries of a city located in two or more of the
11.17 counties of Benton, Sherburne, and Stearns, the maximum registration fee paid for child
11.18 care assistance shall be equal to the maximum registration fee paid in the county with the
11.19 highest maximum registration fee or the provider's charge, whichever is less.

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

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

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

11.28 (b) If a provider has received an authorization of care and been issued a billing form for
11.29 an eligible family, the bill must be submitted within 60 days of the last date of service on
11.30 the bill. A bill submitted more than 60 days after the last date of service must be paid if the
11.31 county determines that the provider has shown good cause why the bill was not submitted
11.32 within 60 days. Good cause must be defined in the county's child care fund plan under
11.33 section 119B.08, subdivision 3, and the definition of good cause must include county error.

12.1 Any bill submitted more than a year after the last date of service on the bill must not be
12.2 paid.

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

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

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

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

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

12.18 (4) the provider is operating after:

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

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

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

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

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

12.26 (7) the provider fails to report decreases in a child's attendance, as required under section
12.27 119B.125, subdivision 9.

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

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

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

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

13.7 Subd. 7. **Absent days.** (a) Licensed child care providers and license-exempt centers
 13.8 must not be reimbursed for more than 25 full-day absent days per child, excluding holidays,
 13.9 in a ~~fiscal~~ calendar year, or for more than ten consecutive full-day absent days. "Absent
 13.10 day" means any day that the child is authorized and scheduled to be in care with a licensed
 13.11 provider or license exempt center, and the child is absent from the care for the entire day.

13.12 Legal nonlicensed family child care providers must not be reimbursed for absent days. If a
 13.13 child attends for part of the time authorized to be in care in a day, but is absent for part of
 13.14 the time authorized to be in care in that same day, the absent time must be reimbursed but
 13.15 the time must not count toward the absent days limit. Child care providers must only be
 13.16 reimbursed for absent days if the provider has a written policy for child absences and charges
 13.17 all other families in care for similar absences.

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

13.28 (c) Notwithstanding paragraph (a), children in families may exceed the absent days limit
 13.29 if at least one parent: (1) is under the age of 21; (2) does not have a high school diploma or
 13.30 commissioner of education-selected high school equivalency certification; and (3) is a
 13.31 student in a school district or another similar program that provides or arranges for child
 13.32 care, parenting support, social services, career and employment supports, and academic
 13.33 support to achieve high school graduation, upon request of the program and approval of the

14.1 county. If a child attends part of an authorized day, payment to the provider must be for the
 14.2 full amount of care authorized for that day.

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

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

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

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

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

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

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

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

14.26 Subdivision 1. **Fair hearing allowed for applicants and recipients.** (a) An applicant
 14.27 or recipient adversely affected by an action of a county agency ~~action~~ or the commissioner,
 14.28 for an action taken directly against the applicant or recipient, may request and receive a fair
 14.29 hearing in accordance with this subdivision and section 256.045. An applicant or recipient
 14.30 does not have a right to a fair hearing if a county agency or the commissioner takes action
 14.31 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 (c), 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 (c), 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 of decertification. (a) The certification holder may request
24.17 reconsideration of the decertification by notifying the commissioner by certified mail or
24.18 personal service. The request must be made in writing. If sent by certified mail, the request
24.19 must be postmarked and sent to the commissioner within ten calendar days after the
24.20 certification holder received the order. If a request is made by personal service, it must be
24.21 received by the commissioner within ten calendar days after the certification holder received
24.22 the order. With the request for reconsideration, the certification holder may submit a written
24.23 argument or evidence in support of the request for reconsideration.

24.24 (b) The commissioner's disposition of a request for reconsideration is final and not
24.25 subject to appeal under chapter 14.

24.26 Subd. 3. Decertification due to revocation of child care assistance. If the commissioner
24.27 decertifies a center that had payments revoked pursuant to chapter 119B, and if the center
24.28 appeals the revocation of the center's authorization to receive child care assistance payments,
24.29 the final decertification determination is stayed until the appeal of the center's authorization
24.30 under chapter 119B is resolved. If the center also requests reconsideration of the
24.31 decertification, the center must do so according to subdivision 2, paragraph (a). The final
24.32 decision on reconsideration is stayed until the appeal of the center's authorization under
24.33 chapter 119B is resolved.

25.1 **EFFECTIVE DATE.** Subdivisions 1 and 2 are effective September 30, 2019.

25.2 Subdivision 3 is effective February 26, 2021.

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

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

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

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

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

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

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

25.32 (4)(i) have capacity to respond to reports of abuse and neglect under section 626.556;
 25.33 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 colocation 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 colocation 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 colocation 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-deny 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) The Child Welfare Training Academy must serve the primary training audiences of
47.22 (1) county and tribal child welfare workers, (2) county and tribal child welfare supervisors,
47.23 and (3) staff at private agencies providing out-of-home placement services for children
47.24 involved in Minnesota's county and tribal child welfare system.

47.25 Subd. 3. **Partnerships.** The commissioner of human services shall enter into a partnership
47.26 with the University of Minnesota to collaborate in the administration of workforce training.

47.27 Subd. 4. **Rulemaking.** The commissioner of human services may adopt rules as necessary
47.28 to establish the Child Welfare Training Academy.

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

47.30 (a) The commissioner of human services shall conduct a child welfare caseload study
47.31 to collect data on (1) the number of child welfare workers in Minnesota, and (2) the amount

48.1 of time that child welfare workers spend on different components of child welfare work.

48.2 The study must be completed by October 1, 2020.

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

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

48.9 Sec. 46. **REPEALER.**

48.10 (a) Minnesota Statutes 2018, sections 119B.16, subdivision 2; and 245E.06, subdivisions
 48.11 2, 4, and 5, and Minnesota Rules, part 3400.0185, subpart 5, are repealed effective February
 48.12 26, 2021.

48.13 (b) Minnesota Rules, part 2960.3030, subpart 3, is repealed.

48.14 **ARTICLE 2**

48.15 **OPERATIONS**

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

48.17 **15C.02 LIABILITY FOR CERTAIN ACTS.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

50.13 (c) When a single school-age child uses the restroom within the licensed space,
50.14 supervision occurs when a program staff person has knowledge of the child's activity and
50.15 location and checks on the child at least every five minutes. When a school-age child uses
50.16 the restroom outside the licensed space, including but not limited to field trips, supervision
50.17 occurs when staff accompany children to the restroom.

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

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

50.23 Sec. 3. Minnesota Statutes 2018, section 245A.10, subdivision 4, is amended to read:

50.24 Subd. 4. **License or certification fee for certain programs.** (a) Child care centers shall
50.25 pay an annual nonrefundable license fee based on the following schedule:

50.26		Child Care Center
50.27	Licensed Capacity	License Fee
50.28	1 to 24 persons	\$200
50.29	25 to 49 persons	\$300
50.30	50 to 74 persons	\$400
50.31	75 to 99 persons	\$500
50.32	100 to 124 persons	\$600
50.33	125 to 149 persons	\$700

51.1	150 to 174 persons	\$800
51.2	175 to 199 persons	\$900
51.3	200 to 224 persons	\$1,000
51.4	225 or more persons	\$1,100

51.5 (b)(1) A program licensed to provide one or more of the home and community-based
 51.6 services and supports identified under chapter 245D to persons with disabilities or age 65
 51.7 and older, shall pay an annual nonrefundable license fee based on revenues derived from
 51.8 the provision of services that would require licensure under chapter 245D during the calendar
 51.9 year immediately preceding the year in which the license fee is paid, according to the
 51.10 following schedule:

51.11	License Holder Annual Revenue	License Fee
51.12	less than or equal to \$10,000	\$200 <u>\$240</u>
51.13	greater than \$10,000 but less than or	
51.14	equal to \$25,000	\$300 <u>\$360</u>
51.15	greater than \$25,000 but less than or	
51.16	equal to \$50,000	\$400 <u>\$480</u>
51.17	greater than \$50,000 but less than or	
51.18	equal to \$100,000	\$500 <u>\$600</u>
51.19	greater than \$100,000 but less than or	
51.20	equal to \$150,000	\$600 <u>\$720</u>
51.21	greater than \$150,000 but less than or	
51.22	equal to \$200,000	\$800 <u>\$960</u>
51.23	greater than \$200,000 but less than or	
51.24	equal to \$250,000	\$1,000 <u>\$1,200</u>
51.25	greater than \$250,000 but less than or	
51.26	equal to \$300,000	\$1,200 <u>\$1,440</u>
51.27	greater than \$300,000 but less than or	
51.28	equal to \$350,000	\$1,400 <u>\$1,680</u>
51.29	greater than \$350,000 but less than or	
51.30	equal to \$400,000	\$1,600 <u>\$1,920</u>
51.31	greater than \$400,000 but less than or	
51.32	equal to \$450,000	\$1,800 <u>\$2,160</u>
51.33	greater than \$450,000 but less than or	
51.34	equal to \$500,000	\$2,000 <u>\$2,400</u>
51.35	greater than \$500,000 but less than or	
51.36	equal to \$600,000	\$2,250 <u>\$2,700</u>
51.37	greater than \$600,000 but less than or	
51.38	equal to \$700,000	\$2,500 <u>\$3,000</u>
51.39	greater than \$700,000 but less than or	
51.40	equal to \$800,000	\$2,750 <u>\$3,300</u>
51.41	greater than \$800,000 but less than or	
51.42	equal to \$900,000	\$3,000 <u>\$3,600</u>

52.1	greater than \$900,000 but less than or	
52.2	equal to \$1,000,000	\$3,250 <u>\$3,900</u>
52.3	greater than \$1,000,000 but less than or	
52.4	equal to \$1,250,000	\$3,500 <u>\$4,200</u>
52.5	greater than \$1,250,000 but less than or	
52.6	equal to \$1,500,000	\$3,750 <u>\$4,500</u>
52.7	greater than \$1,500,000 but less than or	
52.8	equal to \$1,750,000	\$4,000 <u>\$4,800</u>
52.9	greater than \$1,750,000 but less than or	
52.10	equal to \$2,000,000	\$4,250 <u>\$5,100</u>
52.11	greater than \$2,000,000 but less than or	
52.12	equal to \$2,500,000	\$4,500 <u>\$5,400</u>
52.13	greater than \$2,500,000 but less than or	
52.14	equal to \$3,000,000	\$4,750 <u>\$5,700</u>
52.15	greater than \$3,000,000 but less than or	
52.16	equal to \$3,500,000	\$5,000 <u>\$6,000</u>
52.17	greater than \$3,500,000 but less than or	
52.18	equal to \$4,000,000	\$5,500 <u>\$6,600</u>
52.19	greater than \$4,000,000 but less than or	
52.20	equal to \$4,500,000	\$6,000 <u>\$7,200</u>
52.21	greater than \$4,500,000 but less than or	
52.22	equal to \$5,000,000	\$6,500 <u>\$7,800</u>
52.23	greater than \$5,000,000 but less than or	
52.24	equal to \$7,500,000	\$7,000 <u>\$9,000</u>
52.25	greater than \$7,500,000 but less than or	
52.26	equal to \$10,000,000	\$8,500 <u>\$13,500</u>
52.27	greater than \$10,000,000 but less than or	
52.28	equal to \$12,500,000	\$10,000 <u>\$18,000</u>
52.29	greater than \$12,500,000 but less than or	
52.30	equal to \$15,000,000	\$14,000 <u>\$22,500</u>
52.31	<u>greater than \$15,000,000 but less than or</u>	
52.32	<u>equal to \$17,500,000</u>	\$18,000 <u>\$27,000</u>
52.33	<u>greater than \$17,500,000 but less than or</u>	
52.34	<u>equal to \$20,000,000</u>	<u>\$31,500</u>
52.35	<u>greater than \$20,000,000 but less than or</u>	
52.36	<u>equal to \$25,000,000</u>	<u>\$36,000</u>
52.37	<u>greater than \$25,000,000 but less than or</u>	
52.38	<u>equal to \$30,000,000</u>	<u>\$45,000</u>
52.39	<u>greater than \$30,000,000 but less than or</u>	
52.40	<u>equal to \$35,000,000</u>	<u>\$54,000</u>
52.41	<u>greater than \$35,000,000 but less than or</u>	
52.42	<u>equal to \$40,000,000</u>	<u>\$63,000</u>
52.43	<u>greater than \$40,000,000</u>	<u>\$72,000</u>

53.1 (2) If requested, the license holder shall provide the commissioner information to verify
 53.2 the license holder's annual revenues or other information as needed, including copies of
 53.3 documents submitted to the Department of Revenue.

53.4 (3) At each annual renewal, a license holder may elect to pay the highest renewal fee,
 53.5 and not provide annual revenue information to the commissioner.

53.6 (4) A license holder that knowingly provides the commissioner incorrect revenue amounts
 53.7 for the purpose of paying a lower license fee shall be subject to a civil penalty in the amount
 53.8 of double the fee the provider should have paid.

53.9 ~~(5) Notwithstanding clause (1), a license holder providing services under one or more~~
 53.10 ~~licenses under chapter 245B that are in effect on May 15, 2013, shall pay an annual license~~
 53.11 ~~fee for calendar years 2014, 2015, and 2016, equal to the total license fees paid by the license~~
 53.12 ~~holder for all licenses held under chapter 245B for calendar year 2013. For calendar year~~
 53.13 ~~2017 and thereafter, the license holder shall pay an annual license fee according to clause~~
 53.14 ~~(1).~~

53.15 (c) A chemical dependency treatment program licensed under chapter 245G, to provide
 53.16 chemical dependency treatment shall pay an annual nonrefundable license fee based on the
 53.17 following schedule:

53.18	Licensed Capacity	License Fee
53.19	1 to 24 persons	\$600
53.20	25 to 49 persons	\$800
53.21	50 to 74 persons	\$1,000
53.22	75 to 99 persons	\$1,200
53.23	100 or more persons	\$1,400

53.24 (d) A chemical dependency program licensed under Minnesota Rules, parts 9530.6510
 53.25 to 9530.6590, to provide detoxification services shall pay an annual nonrefundable license
 53.26 fee based on the following schedule:

53.27	Licensed Capacity	License Fee
53.28	1 to 24 persons	\$760
53.29	25 to 49 persons	\$960
53.30	50 or more persons	\$1,160

53.31 (e) Except for child foster care, a residential facility licensed under Minnesota Rules,
 53.32 chapter 2960, to serve children shall pay an annual nonrefundable license fee based on the
 53.33 following schedule:

	Licensed Capacity	License Fee
54.1		
54.2	1 to 24 persons	\$1,000
54.3	25 to 49 persons	\$1,100
54.4	50 to 74 persons	\$1,200
54.5	75 to 99 persons	\$1,300
54.6	100 or more persons	\$1,400

54.7 (f) A residential facility licensed under Minnesota Rules, parts 9520.0500 to 9520.0670,
 54.8 to serve persons with mental illness shall pay an annual nonrefundable license fee based on
 54.9 the following schedule:

	Licensed Capacity	License Fee
54.10		
54.11	1 to 24 persons	\$2,525
54.12	25 or more persons	\$2,725

54.13 (g) A residential facility licensed under Minnesota Rules, parts 9570.2000 to 9570.3400,
 54.14 to serve persons with physical disabilities shall pay an annual nonrefundable license fee
 54.15 based on the following schedule:

	Licensed Capacity	License Fee
54.16		
54.17	1 to 24 persons	\$450
54.18	25 to 49 persons	\$650
54.19	50 to 74 persons	\$850
54.20	75 to 99 persons	\$1,050
54.21	100 or more persons	\$1,250

54.22 (h) A program licensed to provide independent living assistance for youth under section
 54.23 245A.22 shall pay an annual nonrefundable license fee of \$1,500.

54.24 (i) A private agency licensed to provide foster care and adoption services under Minnesota
 54.25 Rules, parts 9545.0755 to 9545.0845, shall pay an annual nonrefundable license fee of \$875.

54.26 (j) A program licensed as an adult day care center licensed under Minnesota Rules, parts
 54.27 9555.9600 to 9555.9730, shall pay an annual nonrefundable license fee based on the
 54.28 following schedule:

	Licensed Capacity	License Fee
54.29		
54.30	1 to 24 persons	\$500
54.31	25 to 49 persons	\$700
54.32	50 to 74 persons	\$900
54.33	75 to 99 persons	\$1,100
54.34	100 or more persons	\$1,300

55.1 (k) A program licensed to provide treatment services to persons with sexual psychopathic
55.2 personalities or sexually dangerous persons under Minnesota Rules, parts 9515.3000 to
55.3 9515.3110, shall pay an annual nonrefundable license fee of \$20,000.

55.4 (l) A mental health center or mental health clinic requesting certification for purposes
55.5 of insurance and subscriber contract reimbursement under Minnesota Rules, parts 9520.0750
55.6 to 9520.0870, shall pay a certification fee of \$1,550 per year. If the mental health center or
55.7 mental health clinic provides services at a primary location with satellite facilities, the
55.8 satellite facilities shall be certified with the primary location without an additional charge.

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

55.10 Subd. 4. **Special family day care homes.** Nonresidential child care programs serving
55.11 14 or fewer children that are conducted at a location other than the license holder's own
55.12 residence shall be licensed under this section and the rules governing family day care or
55.13 group family day care if:

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

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

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

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

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

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

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

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

56.3 (4) the facility has square footage required per child under Minnesota Rules, part
56.4 9502.0425;

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

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

56.7 (i) if the program serves more than five children older than 2-1/2 years of age, but no
56.8 more than five children 2-1/2 years of age or less, the applicable fire code is educational
56.9 occupancy, as provided in Group E Occupancy under the Minnesota State Fire Code ~~2003~~
56.10 2015, Section 202; or

56.11 (ii) if the program serves more than five children 2-1/2 years of age or less, the applicable
56.12 fire code is Group I-4 Occupancies, as provided in the Minnesota State Fire Code ~~2003~~
56.13 2015, Section 202, unless the rooms in which the children are cared for are located on a
56.14 level of exit discharge and each of these child care rooms has an exit door directly to the
56.15 exterior, then the applicable fire code is Group E occupancies, as provided in the Minnesota
56.16 State Fire Code 2015, Section 202; and

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

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

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

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

56.23 (i) if the program serves more than five children older than 2-1/2 years of age, but no
56.24 more than five children 2-1/2 years of age or less, the applicable fire code is educational
56.25 occupancy, as provided in Group E Occupancy under the Minnesota State Fire Code ~~2003~~
56.26 2015, Section 202; or

56.27 (ii) if the program serves more than five children 2-1/2 years of age or less, the applicable
56.28 fire code is Group I-4 Occupancies, as provided under the Minnesota State Fire Code ~~2003~~
56.29 2015, Section 202;

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

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

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

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

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

57.14 Sec. 5. Minnesota Statutes 2018, section 245A.14, subdivision 8, is amended to read:

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

57.18 (1) a teacher is in the facility;

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

57.22 ~~(3)~~ (2) the individual is at least 20 years old; and

57.23 ~~(4)~~ (3) the individual has at least 4,160 hours of child care experience as a staff member
 57.24 in a licensed child care center or as the license holder of a family day care home, 120 days
 57.25 of which must be in the employment of the current company.

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

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

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

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

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

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

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

58.11 Sec. 7. Minnesota Statutes 2018, section 245A.14, is amended by adding a subdivision to
58.12 read:

58.13 Subd. 17. **Reusable water bottles or cups.** Notwithstanding any law to the contrary, a
58.14 licensed child care center may provide drinking water to a child in a reusable water bottle
58.15 or reusable cup if the center develops and ensures implementation of a written policy that
58.16 at a minimum includes the following procedures:

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

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

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

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

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

58.26 Sec. 8. Minnesota Statutes 2018, section 245A.151, is amended to read:

58.27 **245A.151 FIRE MARSHAL INSPECTION.**

58.28 When licensure under this chapter or certification under chapter 245H requires an
58.29 inspection by a fire marshal to determine compliance with the State Fire Code under section
58.30 299F.011, a local fire code inspector approved by the state fire marshal may conduct the

59.1 inspection. If a community does not have a local fire code inspector or if the local fire code
59.2 inspector does not perform the inspection, the state fire marshal must conduct the inspection.
59.3 A local fire code inspector or the state fire marshal may recover the cost of these inspections
59.4 through a fee of no more than \$50 per inspection charged to the applicant or license holder
59.5 or license-exempt child care center certification holder. The fees collected by the state fire
59.6 marshal under this section are appropriated to the commissioner of public safety for the
59.7 purpose of conducting the inspections.

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

59.9 Sec. 9. Minnesota Statutes 2018, section 245A.16, subdivision 1, is amended to read:

59.10 Subdivision 1. **Delegation of authority to agencies.** (a) County agencies and private
59.11 agencies that have been designated or licensed by the commissioner to perform licensing
59.12 functions and activities under section 245A.04 and background studies for family child care
59.13 under chapter 245C; to recommend denial of applicants under section 245A.05; to issue
59.14 correction orders, to issue variances, and recommend a conditional license under section
59.15 245A.06; or to recommend suspending or revoking a license or issuing a fine under section
59.16 245A.07, shall comply with rules and directives of the commissioner governing those
59.17 functions and with this section. The following variances are excluded from the delegation
59.18 of variance authority and may be issued only by the commissioner:

59.19 (1) dual licensure of family child care and child foster care, dual licensure of child and
59.20 adult foster care, and adult foster care and family child care;

59.21 (2) adult foster care maximum capacity;

59.22 (3) adult foster care minimum age requirement;

59.23 (4) child foster care maximum age requirement;

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

59.30 (6) the required presence of a caregiver in the adult foster care residence during normal
59.31 sleeping hours; ~~and~~

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

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

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

60.9 (b) Before the implementation of NETStudy 2.0, county agencies must report information
60.10 about disqualification reconsiderations under sections 245C.25 and 245C.27, subdivision
60.11 2, paragraphs (a) and (b), and variances granted under paragraph (a), clause (5), to the
60.12 commissioner at least monthly in a format prescribed by the commissioner.

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

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

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

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

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

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

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

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

60.26 (g) Licensing authority specific to section 245D.06, subdivisions 5, 6, 7, and 8, or
60.27 successor provisions; and section 245D.061 or successor provisions, for family child foster
60.28 care programs providing out-of-home respite, as identified in section 245D.03, subdivision
60.29 1, paragraph (b), clause (1), is excluded from the delegation of authority to county and
60.30 private agencies.

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

61.1 (1) the results of each licensing review completed, including the date of the review, and
 61.2 any licensing correction order issued; ~~and~~

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

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

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

61.8 Sec. 10. Minnesota Statutes 2018, section 245A.18, subdivision 2, is amended to read:

61.9 Subd. 2. **Child passenger restraint systems; training requirement.** (a) Programs
 61.10 licensed by the Department of Human Services under Minnesota Rules, chapter 2960, that
 61.11 serve a child or children under nine years of age must document training that fulfills the
 61.12 requirements in this subdivision.

61.13 (b) Before a license holder, staff person, or caregiver transports a child or children under
 61.14 age nine in a motor vehicle, the person transporting the child must satisfactorily complete
 61.15 training on the proper use and installation of child restraint systems in motor vehicles.
 61.16 Training completed under this section may be used to meet initial or ongoing training under
 61.17 Minnesota Rules, part 2960.3070, subparts 1 and 2.

61.18 ~~For all providers licensed prior to July 1, 2006, the training required in this subdivision~~
 61.19 ~~must be obtained by December 31, 2007.~~

61.20 (c) Training required under this section must be at least one hour in length, completed
 61.21 at orientation or initial training, and repeated at least once every five years. At a minimum,
 61.22 the training must address the proper use of child restraint systems based on the child's size,
 61.23 weight, and age, and the proper installation of a car seat or booster seat in the motor vehicle
 61.24 used by the license holder to transport the child or children.

61.25 (d) Training under paragraph (c) must be provided by individuals who are certified and
 61.26 approved by the Department of Public Safety, Office of Traffic Safety. License holders may
 61.27 obtain a list of certified and approved trainers through the Department of Public Safety
 61.28 website or by contacting the agency.

61.29 ~~(e) Child care providers that only transport school age children as defined in section~~
 61.30 ~~245A.02, subdivision 16, in school buses as defined in section 169.011, subdivision 71,~~
 61.31 ~~paragraphs (e) to (f), are exempt from this subdivision.~~

62.1 Sec. 11. Minnesota Statutes 2018, section 245A.40, is amended to read:

62.2 **245A.40 CHILD CARE CENTER TRAINING REQUIREMENTS.**

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

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

62.13 (2) specific job responsibilities;

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

62.15 (4) the reporting responsibilities in section 626.556, and Minnesota Rules, part
 62.16 9503.0130~~;~~₂;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

63.23 Subd. 2. **Child development and learning training.** (a) ~~For purposes of child care~~
 63.24 ~~centers,~~ The director and all staff hired after July 1, 2006, persons, substitutes, and
 63.25 unsupervised volunteers shall complete and document at least two hours of child development
 63.26 and learning training within the first 90 days of employment. The director and staff persons,
 63.27 not including substitutes, must complete at least two hours of training on child development
 63.28 and learning. The training for substitutes and unsupervised volunteers is not required to be
 63.29 of a minimum length. For purposes of this subdivision, "child development and learning
 63.30 training" means any training in Knowledge and Competency Area I: Child Development
 63.31 and Learning, which is training in understanding how children develop physically,
 63.32 cognitively, emotionally, and socially and learn as part of the children's family, culture, and

64.1 community. ~~Training completed under this subdivision may be used to meet the in-service~~
 64.2 ~~training requirements under subdivision 7.~~

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

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

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

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

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

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

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

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

64.20 Subd. 3. **First aid.** ~~(a) All teachers and assistant teachers in a child care center governed~~
 64.21 ~~by Minnesota Rules, parts 9503.0005 to 9503.0170, and at least one staff person during~~
 64.22 ~~field trips and when transporting children in care, must satisfactorily complete pediatric~~
 64.23 ~~first aid training within 90 days of the start of work, unless the training has been completed~~
 64.24 ~~within the previous two years. Unless training has been completed within the previous two~~
 64.25 ~~years, the director, staff persons, substitutes, and unsupervised volunteers must satisfactorily~~
 64.26 ~~complete pediatric first aid training prior to having unsupervised direct contact with a child,~~
 64.27 ~~but not to exceed the first 90 days of employment.~~

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

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

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

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

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

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

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

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

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

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

65.30 (c) The Pediatric CPR training must:

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

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

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

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

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

66.8 **Subd. 5. Sudden unexpected infant death and abusive head trauma training.** (a)
 66.9 Before caring for infants, the director, staff persons, substitutes, and unsupervised volunteers
 66.10 must receive training on the standards under section 245A.1435 and on reducing the risk
 66.11 of sudden unexpected infant death during orientation and each calendar year thereafter.

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

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

66.19 **Subd. 5a. Abusive head trauma training.** ~~(a) License holders must document that~~
 66.20 ~~before staff persons and volunteers care for infants, they are instructed on the standards in~~
 66.21 ~~section 245A.1435 and receive training on reducing the risk of sudden unexpected infant~~
 66.22 ~~death. In addition, license holders must document that before staff persons care for infants~~
 66.23 ~~or children under school age, they receive training on the risk of abusive head trauma from~~
 66.24 ~~shaking infants and young children. The training in this subdivision may be provided as~~
 66.25 ~~orientation training under subdivision 1 and in-service training under subdivision 7.~~ (a)
 66.26 Before caring for children under school age, the director, staff persons, substitutes, and
 66.27 unsupervised volunteers must receive training on the risk of abusive head trauma during
 66.28 orientation and each calendar year thereafter.

66.29 ~~(b) Sudden unexpected infant death reduction training required under this subdivision~~
 66.30 ~~must be at least one-half hour in length and must be completed at least once every year. At~~
 66.31 ~~a minimum, the training must address the risk factors related to sudden unexpected infant~~
 66.32 ~~death, means of reducing the risk of sudden unexpected infant death in child care, and license~~

67.1 ~~holder communication with parents regarding reducing the risk of sudden unexpected infant~~
67.2 ~~death.~~

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

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

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

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

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

67.22 ~~(2)~~ (b) Training required under this subdivision must be ~~at least one hour in length,~~
67.23 ~~completed at orientation,~~ and repeated at least once every five years. At a minimum, the
67.24 training must address the proper use of child restraint systems based on the child's size,
67.25 weight, and age, and the proper installation of a car seat or booster seat in the motor vehicle
67.26 used by the license holder to transport the child or children.

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

67.31 ~~(4)~~ (d) Child care providers that only transport school-age children as defined in section
67.32 245A.02, subdivision 16, in child care buses as defined in section 169.448, subdivision 1,
67.33 paragraph (e), are exempt from this subdivision.

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

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

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

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

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

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

68.20 (2) the reporting responsibilities under section 626.556 and Minnesota Rules, part
 68.21 9503.0130;

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

68.25 (4) at least one-half hour of training on the risk of abusive head trauma from shaking
 68.26 infants and young children as required under subdivision 5a, if applicable.

68.27 (e) Each year, or when a change is made, whichever is more frequent, in-service training
 68.28 must be provided on: (1) the center's risk reduction plan under section 245A.66, subdivision
 68.29 2; and (2) a child's individual child care program plan as required under Minnesota Rules,
 68.30 part 9503.0065, subpart 3.

68.31 (f) At least once every two calendar years, the in-service training must include:

68.32 (1) child development and learning training under subdivision 2;

- 69.1 (2) pediatric first aid that meets the requirements of subdivision 3;
- 69.2 (3) pediatric cardiopulmonary resuscitation training that meets the requirements of
- 69.3 subdivision 4;
- 69.4 (4) cultural dynamics training to increase awareness of cultural differences; and
- 69.5 (5) disabilities training to increase awareness of differing abilities of children.
- 69.6 (g) At least once every five years, in-service training must include child passenger
- 69.7 restraint training that meets the requirements of subdivision 6, if applicable.
- 69.8 (h) The remaining hours of the in-service training requirement must be met by completing
- 69.9 training in the following content areas of the Minnesota Knowledge and Competency
- 69.10 Framework:
- 69.11 (1) Content area I: child development and learning;
- 69.12 (2) Content area II: developmentally appropriate learning experiences;
- 69.13 (3) Content area III: relationships with families;
- 69.14 (4) Content area IV: assessment, evaluation, and individualization;
- 69.15 (5) Content area V: historical and contemporary development of early childhood
- 69.16 education;
- 69.17 (6) Content area VI: professionalism; and
- 69.18 (7) Content area VII: health, safety, and nutrition; and
- 69.19 (8) Content area VIII: application through clinical experiences.
- 69.20 ~~(b)~~ (i) For purposes of this subdivision, the following terms have the meanings given
- 69.21 them.
- 69.22 (1) "Child development and learning training" ~~has the meaning given it in subdivision~~
- 69.23 ~~2, paragraph (a).~~ means training in understanding how children develop physically,
- 69.24 cognitively, emotionally, and socially and learn as part of the children's family, culture, and
- 69.25 community.
- 69.26 (2) "Developmentally appropriate learning experiences" means creating positive learning
- 69.27 experiences, promoting cognitive development, promoting social and emotional development,
- 69.28 promoting physical development, and promoting creative development.
- 69.29 (3) "Relationships with families" means training on building a positive, respectful
- 69.30 relationship with the child's family.

70.1 (4) "Assessment, evaluation, and individualization" means training in observing,
 70.2 recording, and assessing development; assessing and using information to plan; and assessing
 70.3 and using information to enhance and maintain program quality.

70.4 (5) "Historical and contemporary development of early childhood education" means
 70.5 training in past and current practices in early childhood education and how current events
 70.6 and issues affect children, families, and programs.

70.7 (6) "Professionalism" means training in knowledge, skills, and abilities that promote
 70.8 ongoing professional development.

70.9 (7) "Health, safety, and nutrition" means training in establishing health practices, ensuring
 70.10 safety, and providing healthy nutrition.

70.11 (8) "Application through clinical experiences" means clinical experiences in which a
 70.12 person applies effective teaching practices using a range of educational programming models.

70.13 ~~(e) The director and all program staff persons must annually complete a number of hours~~
 70.14 ~~of in-service training equal to at least two percent of the hours for which the director or~~
 70.15 ~~program staff person is annually paid, unless one of the following is applicable.~~

70.16 ~~(1) A teacher at a child care center must complete one percent of working hours of~~
 70.17 ~~in-service training annually if the teacher:~~

70.18 ~~(i) possesses a baccalaureate or master's degree in early childhood education or school-age~~
 70.19 ~~care;~~

70.20 ~~(ii) is licensed in Minnesota as a prekindergarten teacher, an early childhood educator,~~
 70.21 ~~a kindergarten to sixth grade teacher with a prekindergarten specialty, an early childhood~~
 70.22 ~~special education teacher, or an elementary teacher with a kindergarten endorsement; or~~

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

70.24 ~~(2) A teacher or assistant teacher at a child care center must complete one and one-half~~
 70.25 ~~percent of working hours of in-service training annually if the individual is:~~

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

70.27 ~~(ii) possesses a Montessori certificate, a technical college certificate in early childhood~~
 70.28 ~~development, or a child development associate certificate; or~~

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

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

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

71.6 ~~(f) (j) The license holder must ensure that, when a staff person completes in-service~~
 71.7 ~~training, the training is documented in the staff person's personnel record. The documentation~~
 71.8 ~~must include the date training was completed, the goal of the training and topics covered,~~
 71.9 ~~trainer's name and organizational affiliation, trainer's signed statement that training was~~
 71.10 ~~successfully completed, documentation, as required in subdivision 10, includes the number~~
 71.11 ~~of total training hours required to be completed, name of the training, the Minnesota~~
 71.12 ~~Knowledge and Competency Framework content area, number of hours completed, and the~~
 71.13 ~~director's approval of the training.~~

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

71.17 ~~Subd. 8. **Cultural dynamics and disabilities training for child care providers.** (a)~~
 71.18 ~~The training required of licensed child care center staff must include training in the cultural~~
 71.19 ~~dynamics of early childhood development and child care. The cultural dynamics and~~
 71.20 ~~disabilities training and skills development of child care providers must be designed to~~
 71.21 ~~achieve outcomes for providers of child care that include, but are not limited to:~~

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

71.24 ~~(2) understanding the importance of awareness of cultural differences and similarities~~
 71.25 ~~in working with children and their families;~~

71.26 ~~(3) understanding and support of the needs of families and children with differences in~~
 71.27 ~~ability;~~

71.28 ~~(4) developing skills to help children develop unbiased attitudes about cultural differences~~
 71.29 ~~and differences in ability;~~

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

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

72.1 ~~(b) Curriculum for cultural dynamics and disability training shall be approved by the~~
72.2 ~~commissioner.~~

72.3 ~~(c) The commissioner shall amend current rules relating to the training of the licensed~~
72.4 ~~child care center staff to require cultural dynamics training. Timelines established in the~~
72.5 ~~rule amendments for complying with the cultural dynamics training requirements must be~~
72.6 ~~based on the commissioner's determination that curriculum materials and trainers are available~~
72.7 ~~statewide.~~

72.8 ~~(d) For programs caring for children with special needs, the license holder shall ensure~~
72.9 ~~that any additional staff training required by the child's individual child care program plan~~
72.10 ~~required under Minnesota Rules, part 9503.0065, subpart 3, is provided.~~

72.11 ~~Subd. 9. **Ongoing health and safety training.** A staff person's orientation training on~~
72.12 ~~maintaining health and safety and handling emergencies and accidents, as required in~~
72.13 ~~subdivision 1, must be repeated at least once each calendar year by each staff person. The~~
72.14 ~~completion of the annual training must be documented in the staff person's personnel record.~~

72.15 ~~Subd. 10. **Documentation.** All training must be documented and maintained on site in~~
72.16 ~~each personnel record. In addition to any requirements for each training provided in this~~
72.17 ~~section, documentation for each staff person must include the staff person's first date of~~
72.18 ~~direct contact and first date of unsupervised contact with a child in care.~~

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

72.20 Sec. 12. Minnesota Statutes 2018, section 245A.41, is amended to read:

72.21 **245A.41 CHILD CARE CENTER HEALTH AND SAFETY REQUIREMENTS.**

72.22 Subdivision 1. **Allergy prevention and response.** (a) Before admitting a child for care,
72.23 the license holder must obtain documentation of any known allergy from the child's parent
72.24 or legal guardian or the child's source of medical care. If a child has a known allergy, the
72.25 license holder must maintain current information about the allergy in the child's record and
72.26 develop an individual child care program plan as specified in Minnesota Rules, part
72.27 9503.0065, subpart 3. The individual child care program plan must include but not be limited
72.28 to a description of the allergy, specific triggers, avoidance techniques, symptoms of an
72.29 allergic reaction, and procedures for responding to an allergic reaction, including medication,
72.30 dosages, and a doctor's contact information.

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

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

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

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

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

73.15 (1) surfaces that come in contact with potentially infectious bodily fluids, including
 73.16 blood and vomit, must be cleaned and disinfected according to Minnesota Rules, part
 73.17 9503.0005, subpart 11;

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

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

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

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

73.26 Subd. 3. **Emergency preparedness.** (a) ~~No later than September 30, 2017,~~ A licensed
 73.27 child care center must have a written emergency plan for emergencies that require evacuation,
 73.28 sheltering, or other protection of a child, such as fire, natural disaster, intruder, or other
 73.29 threatening situation that may pose a health or safety hazard to a child. The plan must be
 73.30 written on a form developed by the commissioner and must include:

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

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

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

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

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

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

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

74.9 (8) accommodations for infants and toddlers.

74.10 ~~(b) The license holder must train staff persons on the emergency plan at orientation,~~
74.11 ~~when changes are made to the plan, and at least once each calendar year. Training must be~~
74.12 ~~documented in each staff person's personnel file.~~

74.13 ~~(e)~~ (b) The license holder must conduct drills according to the requirements in Minnesota
74.14 Rules, part 9503.0110, subpart 3. The date and time of the drills must be documented.

74.15 ~~(d)~~ (c) The license holder must review and update the emergency plan ~~annually~~ at least
74.16 once each calendar year. Staff must be informed of any changes made to the emergency
74.17 plan. Documentation of the annual yearly emergency plan review and staff notification of
74.18 changes shall be maintained in the program's administrative records.

74.19 ~~(e)~~ (d) The license holder must include the emergency plan in the program's policies
74.20 and procedures as specified under section 245A.04, subdivision 14. ~~The license holder must~~
74.21 ~~provide a physical or electronic copy of the emergency plan to the child's parent or legal~~
74.22 ~~guardian upon enrollment.~~

74.23 ~~(f)~~ (e) The relocation site and evacuation route must be posted in a visible place as part
74.24 of the written procedures for emergencies and accidents in Minnesota Rules, part 9503.0140,
74.25 subpart 21.

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

74.28 Subd. 5. Telephone requirement in licensed child care centers. (a) A working telephone
74.29 which is capable of making outgoing calls and receiving incoming calls must be located
74.30 within the licensed child care center at all times. Staff must have access to a working
74.31 telephone while providing care and supervision to children in care, even if the care occurs

75.1 outside of the child care facility. A license holder may use a cellular telephone to meet the
75.2 requirements of this subdivision.

75.3 (b) If a cellular telephone is used to satisfy the requirements of this subdivision, the
75.4 cellular telephone must be accessible to staff, be stored in a centrally located area when not
75.5 in use, and be sufficiently charged for use at all times.

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

75.7 Sec. 13. Minnesota Statutes 2018, section 245A.50, is amended to read:

75.8 **245A.50 FAMILY CHILD CARE TRAINING REQUIREMENTS.**

75.9 Subdivision 1. **Initial training.** (a) License holders, caregivers, ~~and substitutes,~~ and
75.10 helpers must comply with the training requirements in this section.

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

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

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

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

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

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

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

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

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

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

75.29 (c) Before caring for a child, each substitute must complete:

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

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

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

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

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

76.8 (d) Each helper must complete:

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

76.12 (2) within 90 days of the start of employment, the one-hour Child Development for
 76.13 Helpers course developed by the commissioner; and

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

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

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

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

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

76.22 ~~(e)~~ (f) Training requirements established under this section that must be completed prior
 76.23 to initial licensure must be satisfied only by a newly licensed child care provider or by a
 76.24 child care provider who has not held an active child care license in Minnesota in the previous
 76.25 12 months. A child care provider who relocates within the state or who voluntarily cancels
 76.26 a license or allows the license to lapse for a period of less than 12 months and who seeks
 76.27 reinstatement of the lapsed or canceled license within 12 months of the lapse or cancellation
 76.28 must satisfy the annual, ongoing training requirements, and is not required to satisfy the
 76.29 training requirements that must be completed prior to initial licensure.

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

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

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

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

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

77.11 **Subd. 2. Child development and learning and behavior guidance training.** (a) ~~For~~
 77.12 ~~purposes of family and group family child care, The license holder and each adult caregiver~~
 77.13 ~~who provides care in the licensed setting for more than 30 days in any 12-month period~~
 77.14 ~~shall complete and document at least four hours of child growth and learning and behavior~~
 77.15 ~~guidance training prior to initial licensure, and before caring for children. For purposes of~~
 77.16 ~~this subdivision, "child development and learning training" means training in understanding~~
 77.17 ~~how children develop physically, cognitively, emotionally, and socially and learn as part~~
 77.18 ~~of the children's family, culture, and community. "Behavior guidance training" means~~
 77.19 ~~training in the understanding of the functions of child behavior and strategies for managing~~
 77.20 ~~challenging situations. At least two hours of child development and learning or behavior~~
 77.21 ~~guidance training must be repeated annually. Training curriculum shall be developed or~~
 77.22 ~~approved by the commissioner of human services.~~

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

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

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

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

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

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

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

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

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

78.21 Subd. 4. **Cardiopulmonary resuscitation.** (a) ~~When children are present in a family~~
 78.22 ~~child care home governed by Minnesota Rules, parts 9502.0315 to 9502.0445, at least one~~
 78.23 ~~caregiver must be present in the home who has been trained in cardiopulmonary resuscitation~~
 78.24 ~~(CPR), including CPR techniques for infants and children, and in the treatment of obstructed~~
 78.25 ~~airways. The CPR training must have been provided by an individual approved to provide~~
 78.26 ~~CPR instruction, must be repeated at least once every two years, and must be documented~~
 78.27 ~~in the caregiver's records. The family child care license holder must complete pediatric~~
 78.28 ~~cardiopulmonary resuscitation (CPR) training prior to licensure. Caregivers and substitutes~~
 78.29 ~~must complete pediatric CPR training prior to caring for children. Training that has been~~
 78.30 ~~completed in the previous two years fulfills this requirement.~~

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

79.1 ~~(c) Persons providing CPR training must use CPR training that has been developed. The~~
 79.2 Pediatric CPR training must:

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

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

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

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

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

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

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

79.20 (b) The license holder must complete training on reducing the risk of abusive head
 79.21 trauma, prior to caring for infants and children under school age. In addition, license holders
 79.22 must ~~document~~ ensure that before ~~staff persons~~, caregivers, substitutes, and helpers assist
 79.23 in the care of infants and children under school age, they receive training on reducing the
 79.24 risk of abusive head trauma ~~from shaking infants and young children.~~ ~~The training in this~~
 79.25 ~~subdivision may be provided as initial training under subdivision 1 or ongoing annual~~
 79.26 ~~training under subdivision 7.~~

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

79.32 ~~(e)~~ (d) Abusive head trauma training required under this subdivision must, at a minimum,
 79.33 address the risk factors related to shaking infants and young children, means of reducing

80.1 the risk of abusive head trauma in child care, and license holder communication with parents
80.2 regarding reducing the risk of abusive head trauma.

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

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

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

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

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

80.28 (a) (1) Before A license holder, staff person, caregiver, or helper caregiver, or substitute
80.29 transports may transport a child or children under age nine eight in a motor vehicle, the
80.30 person Before placing the child or children in a passenger restraint, the person must
80.31 satisfactorily complete training on the proper use and installation of child restraint systems
80.32 in motor vehicles. Training completed under this subdivision may be used to meet initial
80.33 training under subdivision 1 or ongoing training under subdivision 7.

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

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

81.6 ~~(3)~~ (4) Training under this subdivision must be provided by individuals who are certified
 81.7 and approved by the Department of Public Safety, Office of Traffic Safety. License holders
 81.8 may obtain a list of certified and approved trainers through the Department of Public Safety
 81.9 website or by contacting the agency.

81.10 ~~(e)~~ (b) Child care providers that only transport school-age children as defined in section
 81.11 245A.02, subdivision 19, paragraph (f), in child care buses as defined in section 169.448,
 81.12 subdivision 1, paragraph (e), are exempt from this subdivision.

81.13 Subd. 7. **Ongoing training requirements for family and group family child care**
 81.14 **license holders and caregivers.** ~~For purposes of family and group family child care, (a)~~
 81.15 The license holder and each ~~primary~~ caregiver must complete 16 hours of ongoing training
 81.16 each year. ~~For purposes of this subdivision, a primary caregiver is an adult caregiver who~~
 81.17 ~~provides services in the licensed setting for more than 30 days in any 12-month period.~~
 81.18 ~~Repeat of topical training requirements in subdivisions 2 to 8 shall count toward the annual~~
 81.19 ~~16-hour training requirement.~~

81.20 (b) The license holder and caregiver must annually complete ongoing training as follows:

81.21 (1) as required by subdivision 2, a two-hour course in: child development that may be
 81.22 fulfilled by any course in Knowledge and Competency Area I: Child Development and
 81.23 Learning; or behavior guidance that may be fulfilled by any course in Knowledge and
 81.24 Competency Area II-C: Promoting Social and Emotional Development;

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

81.28 (3) if applicable, ongoing training in reducing the risk of sudden unexpected infant death
 81.29 and abusive head trauma, as required under subdivision 5.

81.30 (c) At least once every two years, the license holder and caregiver must complete ongoing
 81.31 training as follows:

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

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

82.2 (3) a two-hour course on accommodating children with disabilities or on cultural
 82.3 dynamics that may be fulfilled by completing any course in Knowledge and Competency
 82.4 Area III: Relationships with Families.

82.5 (d) At least once every five years, the license holder and caregiver must complete ongoing
 82.6 training as follows:

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

82.8 (2) if applicable, ongoing training in child passenger restraint, as required under
 82.9 subdivision 6.

82.10 (e) Additional ongoing training subjects to meet the annual 16-hour training requirement
 82.11 must be selected from the following areas training in the following content areas of the
 82.12 Minnesota Knowledge and Competency Framework:

82.13 (1) Content area I: child development and learning, including training under subdivision
 82.14 2, paragraph (a) in understanding how children develop physically, cognitively, emotionally,
 82.15 and socially; and learn as part of the children's family, culture, and community;

82.16 (2) Content area II: developmentally appropriate learning experiences, including training
 82.17 in creating positive learning experiences, promoting cognitive development, promoting
 82.18 social and emotional development, promoting physical development, promoting creative
 82.19 development; and behavior guidance;

82.20 (3) Content area III: relationships with families, including training in building a positive,
 82.21 respectful relationship with the child's family;

82.22 (4) Content area IV: assessment, evaluation, and individualization, including training
 82.23 in observing, recording, and assessing development; assessing and using information to
 82.24 plan; and assessing and using information to enhance and maintain program quality;

82.25 (5) Content area V: historical and contemporary development of early childhood
 82.26 education, including training in past and current practices in early childhood education and
 82.27 how current events and issues affect children, families, and programs;

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

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

83.1 Subd. 8. ~~Other required training requirements~~ Ongoing training requirements for
 83.2 substitutes and helpers. ~~(a) The training required of family and group family child care~~
 83.3 ~~providers and staff must include training in the cultural dynamics of early childhood~~
 83.4 ~~development and child care. The cultural dynamics and disabilities training and skills~~
 83.5 ~~development of child care providers must be designed to achieve outcomes for providers~~
 83.6 ~~of child care that include, but are not limited to:~~

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

83.9 ~~(2) understanding the importance of awareness of cultural differences and similarities~~
 83.10 ~~in working with children and their families;~~

83.11 ~~(3) understanding and support of the needs of families and children with differences in~~
 83.12 ~~ability;~~

83.13 ~~(4) developing skills to help children develop unbiased attitudes about cultural differences~~
 83.14 ~~and differences in ability;~~

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

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

83.17 ~~The commissioner shall approve the curriculum for cultural dynamics and disability~~
 83.18 ~~training.~~

83.19 ~~(b) The provider must meet the training requirement in section 245A.14, subdivision~~
 83.20 ~~11, paragraph (a), clause (4), to be eligible to allow a child cared for at the family child care~~
 83.21 ~~or group family child care home to use the swimming pool located at the home.~~

83.22 (a) Each substitute must complete ongoing training on the following schedule:

83.23 (1) annually, if applicable, training in reducing the risk of sudden unexpected infant
 83.24 death and abusive head trauma as required under subdivision 5;

83.25 (2) at least once every two years: (i) training in pediatric first aid as required under
 83.26 subdivision 3; (ii) training in pediatric CPR as required under subdivision 4; and (iii) the
 83.27 four-hour Basics of Licensed Family Child Care for Substitutes course; and

83.28 (3) at least once every five years, if applicable, training in child passenger restraints, as
 83.29 required under subdivision 6.

83.30 (b) Each helper must complete training on the following schedule:

84.1 (1) annually, if applicable, training in reducing the risk of sudden unexpected infant
 84.2 death and abusive head trauma as required under subdivision 5; and

84.3 (2) at least once every two years: (i) the one-hour course Basics of Child Development
 84.4 for Helpers; or (ii) any course in Knowledge and Competency Area I: Child Development
 84.5 and Learning.

84.6 ~~Subd. 9. **Supervising for safety; training requirement.** (a) Before initial licensure and~~
 84.7 ~~before caring for a child, all family child care license holders and each adult caregiver who~~
 84.8 ~~provides care in the licensed family child care home for more than 30 days in any 12-month~~
 84.9 ~~period shall complete and document the completion of the six-hour Supervising for Safety~~
 84.10 ~~for Family Child Care course developed by the commissioner.~~

84.11 ~~(b) The family child care license holder and each adult caregiver who provides care in~~
 84.12 ~~the licensed family child care home for more than 30 days in any 12-month period shall~~
 84.13 ~~complete and document:~~

84.14 ~~(1) the annual completion of a two-hour active supervision course developed by the~~
 84.15 ~~commissioner; and~~

84.16 ~~(2) the completion at least once every five years of the two-hour courses Health and~~
 84.17 ~~Safety I and Health and Safety II. A license holder's or adult caregiver's completion of either~~
 84.18 ~~training in a given year meets the annual active supervision training requirement in clause~~
 84.19 ~~(1).~~

84.20 **Subd. 10. Approved training.** County licensing staff must accept training approved by
 84.21 ~~the Minnesota Center for Professional Development~~ Achieve - the MN Center for
 84.22 Professional Development, including:

84.23 (1) face-to-face or classroom training;

84.24 (2) online training; and

84.25 (3) relationship-based professional development, such as mentoring, coaching, and
 84.26 consulting.

84.27 **Subd. 11. Provider training.** New and increased training requirements under this section
 84.28 must not be imposed on providers until the commissioner establishes statewide accessibility
 84.29 to the required provider training.

84.30 **Subd. 12. Documentation.** The license holder must document the date of a completed
 84.31 training required by this section for the license holder, each caregiver, substitute, and helper.

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

85.1 Sec. 14. Minnesota Statutes 2018, section 245A.51, subdivision 3, is amended to read:

85.2 Subd. 3. **Emergency preparedness plan.** ~~(a) No later than September 30, 2017, A~~
 85.3 licensed family child care provider must have a written emergency preparedness plan for
 85.4 emergencies that require evacuation, sheltering, or other protection of children, such as fire,
 85.5 natural disaster, intruder, or other threatening situation that may pose a health or safety
 85.6 hazard to children. The plan must be written on a form developed by the commissioner and
 85.7 updated at least annually. The plan must include:

- 85.8 (1) procedures for an evacuation, relocation, shelter-in-place, or lockdown;
- 85.9 (2) a designated relocation site and evacuation route;
- 85.10 (3) procedures for notifying a child's parent or legal guardian of the evacuation,
 85.11 shelter-in-place, or lockdown, including procedures for reunification with families;
- 85.12 (4) accommodations for a child with a disability or a chronic medical condition;
- 85.13 (5) procedures for storing a child's medically necessary medicine that facilitate easy
 85.14 removal during an evacuation or relocation;
- 85.15 (6) procedures for continuing operations in the period during and after a crisis; ~~and~~
- 85.16 (7) procedures for communicating with local emergency management officials, law
 85.17 enforcement officials, or other appropriate state or local authorities; and
- 85.18 (8) accommodations for infants and toddlers.

85.19 (b) The license holder must train caregivers before the caregiver provides care and at
 85.20 least annually on the emergency preparedness plan and document completion of this training.

85.21 (c) The license holder must conduct drills according to the requirements in Minnesota
 85.22 Rules, part 9502.0435, subpart 8. The date and time of the drills must be documented.

85.23 ~~(d) The license holder must have the emergency preparedness plan available for review~~
 85.24 ~~and posted in a prominent location. The license holder must provide a physical or electronic~~
 85.25 ~~copy of the plan to the child's parent or legal guardian upon enrollment.~~

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

85.27 Sec. 15. Minnesota Statutes 2018, section 245A.51, is amended by adding a subdivision
 85.28 to read:

85.29 Subd. 4. **Transporting children.** A license holder must ensure compliance with all seat
 85.30 belt and child passenger restraint system requirements under section 169.685.

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

86.2 Sec. 16. Minnesota Statutes 2018, section 245A.51, is amended by adding a subdivision
86.3 to read:

86.4 Subd. 5. **Telephone requirement.** Notwithstanding Minnesota Rules, part 9502.0435,
86.5 subpart 8, item B, a license holder is not required to post a list of emergency numbers. A
86.6 license holder may use a cellular telephone to meet the requirements of Minnesota Rules,
86.7 part 9502.0435, subpart 8, if the cellular telephone is sufficiently charged for use at all times.

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

86.9 Sec. 17. **[245A.52] FAMILY CHILD CARE PHYSICAL SPACE REQUIREMENTS.**

86.10 Subdivision 1. **Means of escape.** (a) (1) At least one emergency escape route separate
86.11 from the main exit from the space must be available in each room used for sleeping by
86.12 anyone receiving licensed care, and (2) a basement used for child care. One means of escape
86.13 must be a stairway or door leading to the floor of exit discharge. The other must be a door
86.14 or window leading directly outside. A window used as an emergency escape route must be
86.15 openable without special knowledge.

86.16 (b) In homes with construction that began before May 2, 2016, the interior of the window
86.17 leading directly outside must have a net clear opening area of not less than 4.5 square feet
86.18 or 648 square inches and have minimum clear opening dimensions of 20 inches wide and
86.19 20 inches high. The opening must be no higher than 48 inches from the floor. The height
86.20 to the window may be measured from a platform if a platform is located below the window.

86.21 (c) In homes with construction that began on or after May 2, 2016, the interior of the
86.22 window leading directly outside must have minimum clear opening dimensions of 20 inches
86.23 wide and 24 inches high. The net clear opening dimensions shall be the result of normal
86.24 operation of the opening. The opening must be no higher than 44 inches from the floor.

86.25 (d) Additional requirements are dependent on the distance of the openings from the
86.26 ground outside the window: (1) windows or other openings with a sill height not more than
86.27 44 inches above or below the finished ground level adjacent to the opening (grade-floor
86.28 emergency escape and rescue openings) must have a minimum opening of five square feet;
86.29 and (2) non-grade floor emergency escape and rescue openings must have a minimum
86.30 opening of 5.7 square feet.

86.31 Subd. 2. **Door to attached garage.** Notwithstanding Minnesota Rules, part 9502.0425,
86.32 subpart 5, day care residences with an attached garage are not required to have a self-closing

87.1 door to the residence. The door to the residence may be a steel insulated door if the door is
87.2 at least 1-3/8 inches thick.

87.3 Subd. 3. **Heating and venting systems.** Notwithstanding Minnesota Rules, part
87.4 9502.0425, subpart 7, items that can be ignited and support combustion, including but not
87.5 limited to plastic, fabric, and wood products must not be located within 18 inches of a gas
87.6 or fuel-oil heater or furnace. If a license holder produces manufacturer instructions listing
87.7 a smaller distance, then the manufacturer instructions control the distance combustible items
87.8 must be from gas, fuel-oil, or solid-fuel burning heaters or furnaces.

87.9 Subd. 4. **Fire extinguisher.** A portable, operational, multipurpose, dry chemical fire
87.10 extinguisher with a minimum 2 A 10 BC rating must be located in or near the kitchen and
87.11 cooking areas of the residence at all times. The fire extinguisher must be serviced annually
87.12 by a qualified inspector. All caregivers must know how to properly use the fire extinguisher.

87.13 Subd. 5. **Carbon monoxide and smoke alarms.** (a) All homes must have an approved
87.14 and operational carbon monoxide alarm installed within ten feet of each room used for
87.15 sleeping children in care.

87.16 (b) Smoke alarms that have been listed by the Underwriter Laboratory must be properly
87.17 installed and maintained on all levels including basements, but not including crawl spaces
87.18 and uninhabitable attics, and in hallways outside rooms used for sleeping children in care.

87.19 (c) In homes with construction that began on or after May 2, 2016, smoke alarms must
87.20 be installed and maintained in each room used for sleeping children in care.

87.21 Subd. 6. **Updates.** After readoption of the Minnesota State Fire Code, the fire marshal
87.22 must notify the commissioner of any changes that conflict with this section and Minnesota
87.23 Rules, chapter 9502. The state fire marshal must identify necessary statutory changes to
87.24 align statutes with the revised code. The commissioner must recommend updates to sections
87.25 of chapter 245A that are derived from the Minnesota State Fire Code in the legislative
87.26 session following readoption of the code.

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

87.28 Sec. 18. **[245A.53] USE OF SUBSTITUTES AND REPLACEMENTS.**

87.29 Subdivision 1. **Total hours allowed.** Notwithstanding Minnesota Rules, part 9502.0365,
87.30 subpart 5, the use of a substitute caregiver must be limited to a cumulative total of not more
87.31 than 300 hours in a calendar year. The provider shall document the dates, number of hours,
87.32 and name of the substitute who provided care.

88.1 Subd. 2. Replacement in an emergency. In an emergency, a licensed family child care
88.2 provider may use an adult who has not complied with the training requirements of this
88.3 chapter or the background study requirements of chapter 245C to supervise children. For
88.4 the purposes of this section, an emergency is a situation in which:

88.5 (1) the family child care provider has begun operating for the day and for reasons beyond
88.6 the provider's control, including a serious illness or injury, accident, or situation requiring
88.7 the provider's immediate attention, the provider needs, or feels the need, to leave the licensed
88.8 space and close the child care program for the day; and

88.9 (2) parents or guardians are contacted to pick up their children as soon as practicable.

88.10 Subd. 3. Conditions of use of a replacement in an emergency. (a) If a replacement
88.11 is used in an emergency pursuant to subdivision 2, the licensed family child care provider
88.12 shall make reasonable efforts to minimize the time the replacement has unsupervised contact
88.13 with the children in care, and the amount of time shall not exceed 24 hours per emergency
88.14 incident.

88.15 (b) The licensed family child care provider shall not knowingly use an individual as a
88.16 replacement who has been convicted of a crime that would, if a background study was
88.17 conducted, cause the individual to be disqualified from providing care to children.

88.18 (c) To the extent practicable, the licensed family child care provider must first attempt
88.19 to arrange for care by a substitute.

88.20 (d) To the extent practicable before the licensed family child care provider leaves the
88.21 children in the care of a replacement or, if not done before, within seven calendar days after
88.22 the date when the family child care provider left the children in the care of a replacement,
88.23 the provider shall obtain a signed, written statement from the replacement that, to the best
88.24 of the replacement's knowledge, the replacement:

88.25 (1) has not been convicted of a crime that would, if a background study were conducted,
88.26 cause the replacement to be disqualified from providing care to children;

88.27 (2) has not been disqualified from providing care to children by a background study;
88.28 and

88.29 (3) is not being investigated for maltreatment or other child or adult protection matters
88.30 by any state or local government agency.

88.31 (e) The replacement's signed, written statement shall be submitted to the family child
88.32 care provider's county licenser within seven calendar days after the occurrence. The county

89.1 agency must submit the statement to the commissioner within three business days after the
89.2 county agency receives the statement.

89.3 Subd. 4. **No requirement to name a substitute for emergencies.** Notwithstanding
89.4 Minnesota Rules, part 9502.0405, a licensed family child care provider is not required to
89.5 provide the names of individuals who may be used as substitutes or replacements in
89.6 emergencies.

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

89.8 Sec. 19. Minnesota Statutes 2018, section 245A.66, subdivision 2, is amended to read:

89.9 Subd. 2. **Child care centers; risk reduction plan.** (a) Child care centers licensed under
89.10 this chapter and Minnesota Rules, chapter 9503, must develop a risk reduction plan that
89.11 identifies the general risks to children served by the child care center. The license holder
89.12 must establish procedures to minimize identified risks, train staff on the procedures, and
89.13 annually review the procedures.

89.14 (b) The risk reduction plan must include an assessment of risk to children the center
89.15 serves or intends to serve and identify specific risks based on the outcome of the assessment.
89.16 The assessment of risk must be based on the following:

89.17 (1) an assessment of the risks presented by the physical plant where the licensed services
89.18 are provided, including an evaluation of the following factors: the condition and design of
89.19 the facility and its outdoor space, bathrooms, storage areas, and accessibility of medications
89.20 and cleaning products that are harmful to children when children are not supervised and the
89.21 existence of areas that are difficult to supervise; and

89.22 (2) an assessment of the risks presented by the environment for each facility and for
89.23 each site, including an evaluation of the following factors: the type of grounds and terrain
89.24 surrounding the building and the proximity to hazards, busy roads, and publicly accessed
89.25 businesses.

89.26 (c) The risk reduction plan must include a statement of measures that will be taken to
89.27 minimize the risk of harm presented to children for each risk identified in the assessment
89.28 required under paragraph (b) related to the physical plant and environment. At a minimum,
89.29 the stated measures must include the development and implementation of specific policies
89.30 and procedures or reference to existing policies and procedures that minimize the risks
89.31 identified.

89.32 (d) In addition to any program-specific risks identified in paragraph (b), the plan must
89.33 include development and implementation of specific policies and procedures or refer to

90.1 existing policies and procedures that minimize the risk of harm or injury to children,
90.2 including:

90.3 (1) closing children's fingers in doors, including cabinet doors;

90.4 (2) leaving children in the community without supervision;

90.5 (3) children leaving the facility without supervision;

90.6 (4) caregiver dislocation of children's elbows;

90.7 (5) burns from hot food or beverages, whether served to children or being consumed by
90.8 caregivers, and the devices used to warm food and beverages;

90.9 (6) injuries from equipment, such as scissors and glue guns;

90.10 (7) sunburn;

90.11 (8) feeding children foods to which they are allergic;

90.12 (9) children falling from changing tables; and

90.13 (10) children accessing dangerous items or chemicals or coming into contact with residue
90.14 from harmful cleaning products.

90.15 (e) The plan shall prohibit the accessibility of hazardous items to children.

90.16 (f) The plan must include specific policies and procedures to ensure adequate supervision
90.17 of children at all times as defined under section 245A.02, subdivision 18, with particular
90.18 emphasis on:

90.19 (1) times when children are transitioned from one area within the facility to another;

90.20 (2) nap-time supervision, including infant crib rooms as specified under section 245A.02,
90.21 subdivision 18, which requires that when an infant is placed in a crib to sleep, supervision
90.22 occurs when a staff person is within sight or hearing of the infant. When supervision of a
90.23 crib room is provided by sight or hearing, the center must have a plan to address the other
90.24 supervision components;

90.25 (3) child drop-off and pick-up times;

90.26 (4) supervision during outdoor play and on community activities, including but not
90.27 limited to field trips and neighborhood walks; ~~and~~

90.28 (5) supervision of children in hallways; and

90.29 (6) supervision of school-age children when using the restroom and visiting the child's
90.30 personal storage space.

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

91.2 Sec. 20. Minnesota Statutes 2018, section 245A.66, subdivision 3, is amended to read:

91.3 Subd. 3. ~~Orientation to~~ **Yearly review of risk reduction plan and annual review of**
 91.4 **plan.** (a) The license holder shall ensure that all mandated reporters, as defined in section
 91.5 ~~626.556, subdivision 3, who are under the control of the license holder, receive an orientation~~
 91.6 ~~to the risk reduction plan prior to first providing unsupervised direct contact services, as~~
 91.7 ~~defined in section 245C.02, subdivision 11, to children, not to exceed 14 days from the first~~
 91.8 ~~supervised direct contact, and annually thereafter. The license holder must document the~~
 91.9 ~~orientation to the risk reduction plan in the mandated reporter's personnel records.~~

91.10 (b) The license holder must review the risk reduction plan ~~annually~~ each calendar year
 91.11 and document the ~~annual~~ review. When conducting the review, the license holder must
 91.12 consider incidents that have occurred in the center since the last review, including:

91.13 (1) the assessment factors in the plan;

91.14 (2) the internal reviews conducted under this section, if any;

91.15 (3) substantiated maltreatment findings, if any; and

91.16 (4) incidents that caused injury or harm to a child, if any, that occurred since the last
 91.17 review.

91.18 Following any change to the risk reduction plan, the license holder must inform ~~mandated~~
 91.19 ~~reporters~~ staff persons, under the control of the license holder, of the changes in the risk
 91.20 reduction plan, and document that the ~~mandated reporters~~ staff were informed of the changes.

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

91.22 Sec. 21. Minnesota Statutes 2018, section 245C.02, is amended by adding a subdivision
 91.23 to read:

91.24 Subd. 5a. **License-exempt child care center certification holder.** "License-exempt
 91.25 child care center certification holder" has the meaning given for "certification holder" in
 91.26 section 245H.01, subdivision 4.

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

91.28 Sec. 22. Minnesota Statutes 2018, section 245C.02, subdivision 6a, is amended to read:

91.29 Subd. 6a. **Child care background study subject.** (a) "Child care background study
 91.30 subject" means an individual who is affiliated with a licensed child care center, certified

92.1 license exempt child care center, licensed family child care program, or legal nonlicensed
 92.2 child care provider authorized under chapter 119B, and who is:

92.3 (1) ~~who is~~ employed by a child care provider for compensation;

92.4 (2) ~~whose activities involve~~ assisting in the supervision care of a child for a child care
 92.5 provider; ~~or~~

92.6 (3) ~~who is required to have a background study under section 245C.03, subdivision 1.~~

92.7 (3) a person applying for licensure, certification, or enrollment;

92.8 (4) a controlling individual as defined in section 245A.02, subdivision 5a;

92.9 (5) an individual 13 years of age or older who lives in the household where the licensed
 92.10 program will be provided and who is not receiving licensed services from the program;

92.11 (6) an individual ten to 12 years of age who lives in the household where the licensed
 92.12 services will be provided when the commissioner has reasonable cause as defined in section
 92.13 245C.02, subdivision 15;

92.14 (7) an individual who, without providing direct contact services at a licensed program,
 92.15 certified program, or program authorized under chapter 119B, may have unsupervised access
 92.16 to a child receiving services from a program when the commissioner has reasonable cause
 92.17 as defined in section 245C.02, subdivision 15; or

92.18 (8) a volunteer, contractor, prospective employee, or other individual who has
 92.19 unsupervised physical access to a child served by a program and who is not under direct,
 92.20 continuous supervision by an individual listed in clause (1) or (5), regardless of whether
 92.21 the individual provides program services.

92.22 (b) Notwithstanding paragraph (a), an individual who is providing services that are not
 92.23 part of the child care program is not required to have a background study if:

92.24 (1) the child receiving services is signed out of the child care program for the duration
 92.25 that the services are provided;

92.26 (2) the licensed child care center, certified license exempt child care center, licensed
 92.27 family child care program, or legal nonlicensed child care provider authorized under chapter
 92.28 119B has obtained advanced written permission from the parent authorizing the child to
 92.29 receive the services, which is maintained in the child's record;

92.30 (3) the licensed child care center, certified license exempt child care center, licensed
 92.31 family child care program, or legal nonlicensed child care provider authorized under chapter

93.1 119B maintains documentation on-site that identifies the individual service provider and
 93.2 the services being provided; and

93.3 (4) the licensed child care center, certified license exempt child care center, licensed
 93.4 family child care program, or legal nonlicensed child care provider authorized under chapter
 93.5 119B ensures that the service provider does not have unsupervised access to a child not
 93.6 receiving the provider's services.

93.7 Sec. 23. Minnesota Statutes 2018, section 245C.03, subdivision 1, is amended to read:

93.8 Subdivision 1. **Licensed programs.** (a) The commissioner shall conduct a background
 93.9 study on:

93.10 (1) the person or persons applying for a license;

93.11 (2) an individual age 13 and over living in the household where the licensed program
 93.12 will be provided who is not receiving licensed services from the program;

93.13 (3) current or prospective employees or contractors of the applicant who will have direct
 93.14 contact with persons served by the facility, agency, or program;

93.15 (4) volunteers or student volunteers who will have direct contact with persons served
 93.16 by the program to provide program services if the contact is not under the continuous, direct
 93.17 supervision by an individual listed in clause (1) or (3);

93.18 (5) an individual age ten to 12 living in the household where the licensed services will
 93.19 be provided when the commissioner has reasonable cause as defined in section 245C.02,
 93.20 subdivision 15;

93.21 (6) an individual who, without providing direct contact services at a licensed program,
 93.22 may have unsupervised access to children or vulnerable adults receiving services from a
 93.23 program, when the commissioner has reasonable cause as defined in section 245C.02,
 93.24 subdivision 15;

93.25 (7) all controlling individuals as defined in section 245A.02, subdivision 5a; and

93.26 (8) notwithstanding the other requirements in this subdivision, child care background
 93.27 study subjects as defined in section 245C.02, subdivision 6a.

93.28 ~~(b) Paragraph (a), clauses (2), (5), and (6), apply to legal nonlicensed child care and~~
 93.29 ~~certified license-exempt child care programs.~~

93.30 ~~(e)~~ (b) For child foster care when the license holder resides in the home where foster
 93.31 care services are provided, a short-term substitute caregiver providing direct contact services

94.1 for a child for less than 72 hours of continuous care is not required to receive a background
94.2 study under this chapter.

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

94.4 Subd. 5a. **Background study requirements for minors.** (a) A background study
94.5 completed under this chapter on a subject who is required to be studied under section
94.6 245C.03, subdivision 1, and is 17 years of age or younger shall be completed by the
94.7 commissioner for:

94.8 (1) a legal nonlicensed child care provider authorized under chapter 119B;

94.9 (2) a licensed family child care program; or

94.10 (3) a licensed foster care home.

94.11 (b) The subject shall submit to the commissioner only the information under subdivision
94.12 1, paragraph (a).

94.13 (c) A subject who is 17 years of age or younger is required to submit fingerprints and a
94.14 photograph, and the commissioner shall conduct a national criminal history record check,
94.15 if:

94.16 (1) the commissioner has reasonable cause to require a national criminal history record
94.17 check defined in section 245C.02, subdivision 15a; or

94.18 (2) under paragraph (a), clauses (1) and (2), the subject is employed by the provider or
94.19 supervises children served by the program.

94.20 (d) A subject who is 17 years of age or younger is required to submit
94.21 non-fingerprint-based data according to section 245C.08, subdivision 1, paragraph (a),
94.22 clause (6), item (iii), and the commissioner shall conduct the check if:

94.23 (1) the commissioner has reasonable cause to require a national criminal history record
94.24 check defined in section 245C.02, subdivision 15a; or

94.25 (2) the subject is employed by the provider or supervises children served by the program
94.26 under paragraph (a), clauses (1) and (2).

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

94.28 Subdivision 1. **Background studies conducted by Department of Human Services.** (a)
94.29 For a background study conducted by the Department of Human Services, the commissioner
94.30 shall review:

95.1 (1) information related to names of substantiated perpetrators of maltreatment of
95.2 vulnerable adults that has been received by the commissioner as required under section
95.3 626.557, subdivision 9c, paragraph (j);

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

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

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

95.12 (5) except as provided in clause (6), information received as a result of submission of
95.13 fingerprints for a national criminal history record check, as defined in section 245C.02,
95.14 subdivision 13c, when the commissioner has reasonable cause for a national criminal history
95.15 record check as defined under section 245C.02, subdivision 15a, or as required under section
95.16 144.057, subdivision 1, clause (2);

95.17 (6) for a background study related to a child foster care application for licensure, a
95.18 transfer of permanent legal and physical custody of a child under sections 260C.503 to
95.19 260C.515, or adoptions, and for a background study required for family child care, certified
95.20 license-exempt child care, child care centers, and legal nonlicensed child care authorized
95.21 under chapter 119B, the commissioner shall also review:

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

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

95.27 (iii) when the background study subject is 18 years of age or older or a minor under
95.28 section 245C.05, subdivision 5a, paragraph (d), for licensed family child care, certified
95.29 license-exempt child care, licensed child care centers, and legal nonlicensed child care
95.30 authorized under chapter 119B, information obtained using non-fingerprint-based data
95.31 including information from the criminal and sex offender registries for any state in which
95.32 the background study subject resided for the past five years and information from the national
95.33 crime information database and the national sex offender registry; and

96.1 (7) for a background study required for family child care, certified license-exempt child
96.2 care centers, licensed child care centers, and legal nonlicensed child care authorized under
96.3 chapter 119B, the background study shall also include, to the extent practicable, a name
96.4 and date-of-birth search of the National Sex Offender Public website.

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

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

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

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

96.21 Sec. 26. Minnesota Statutes 2018, section 245C.08, subdivision 3, is amended to read:

96.22 Subd. 3. **Arrest and investigative information.** (a) For any background study completed
96.23 under this section, if the commissioner has reasonable cause to believe the information is
96.24 pertinent to the disqualification of an individual, the commissioner also may review arrest
96.25 and investigative information from:

96.26 (1) the Bureau of Criminal Apprehension;

96.27 (2) the ~~commissioner~~ commissioners of health and human services;

96.28 (3) a county attorney;

96.29 (4) a county sheriff;

96.30 (5) a county agency;

96.31 (6) a local chief of police;

97.1 (7) other states;

97.2 (8) the courts;

97.3 (9) the Federal Bureau of Investigation;

97.4 (10) the National Criminal Records Repository; and

97.5 (11) criminal records from other states.

97.6 (b) Except when specifically required by law, the commissioner is not required to conduct
 97.7 more than one review of a subject's records from the Federal Bureau of Investigation if a
 97.8 review of the subject's criminal history with the Federal Bureau of Investigation has already
 97.9 been completed by the commissioner and there has been no break in the subject's affiliation
 97.10 with the ~~license holder~~ entity that initiated the background study.

97.11 (c) If the commissioner conducts a national criminal history record check when required
 97.12 by law and uses the information from the national criminal history record check to make a
 97.13 disqualification determination, the data obtained is private data and cannot be shared with
 97.14 county agencies, private agencies, or prospective employers of the background study subject.

97.15 (d) If the commissioner conducts a national criminal history record check when required
 97.16 by law and uses the information from the national criminal history record check to make a
 97.17 disqualification determination, the license holder or entity that submitted the study is not
 97.18 required to obtain a copy of the background study subject's disqualification letter under
 97.19 section 245C.17, subdivision 3.

97.20 **EFFECTIVE DATE.** This section is effective for background studies requested on or
 97.21 after October 1, 2019.

97.22 Sec. 27. Minnesota Statutes 2018, section 245C.13, subdivision 2, is amended to read:

97.23 Subd. 2. **Direct contact pending completion of background study.** The subject of a
 97.24 background study may not perform any activity requiring a background study under
 97.25 paragraph (b) until the commissioner has issued one of the notices under paragraph (a).

97.26 (a) Notices from the commissioner required prior to activity under paragraph (b) include:

97.27 (1) a notice of the study results under section 245C.17 stating that:

97.28 (i) the individual is not disqualified; or

97.29 (ii) more time is needed to complete the study but the individual is not required to be
 97.30 removed from direct contact or access to people receiving services prior to completion of
 97.31 the study as provided under section 245C.17, subdivision 1, paragraph (b) or (c). The notice

98.1 that more time is needed to complete the study must also indicate whether the individual is
 98.2 required to be under continuous direct supervision prior to completion of the background
 98.3 study;

98.4 (2) a notice that a disqualification has been set aside under section 245C.23; or

98.5 (3) a notice that a variance has been granted related to the individual under section
 98.6 245C.30.

98.7 (b) For a background study affiliated with a licensed child care center or certified license
 98.8 exempt child care center, the notice sent under paragraph (a), clause (1), item (ii), must
 98.9 require the individual to be under continuous direct supervision prior to completion of the
 98.10 background study except as permitted in subdivision 3.

98.11 (c) Activities prohibited prior to receipt of notice under paragraph (a) include:

98.12 (1) being issued a license;

98.13 (2) living in the household where the licensed program will be provided;

98.14 (3) providing direct contact services to persons served by a program unless the subject
 98.15 is under continuous direct supervision; ~~or~~

98.16 (4) having access to persons receiving services if the background study was completed
 98.17 under section 144.057, subdivision 1, or 245C.03, subdivision 1, paragraph (a), clause (2),
 98.18 (5), or (6), unless the subject is under continuous direct supervision; or

98.19 (5) for licensed child care center and certified license exempt child care centers, providing
 98.20 direct contact services to persons served by the program.

98.21 Sec. 28. Minnesota Statutes 2018, section 245C.13, is amended by adding a subdivision
 98.22 to read:

98.23 Subd. 3. **Other state information.** If the commissioner has not received criminal, sex
 98.24 offender, or maltreatment information from another state that is required to be reviewed
 98.25 under this chapter within ten days of requesting the information, and the lack of the
 98.26 information is the only reason that a notice is issued under subdivision 2, paragraph (a),
 98.27 clause (1), item (ii), the commissioner may issue a notice under subdivision 2, paragraph
 98.28 (a), clause (1), item (i). The commissioner may take action on information received from
 98.29 other states after issuing a notice under subdivision 2, paragraph (a), clause (1), item (ii).

99.1 Sec. 29. Minnesota Statutes 2018, section 245C.30, subdivision 1, is amended to read:

99.2 Subdivision 1. **License holder and license-exempt child care center certification**
99.3 **holder variance.** (a) Except for any disqualification under section 245C.15, subdivision 1,
99.4 when the commissioner has not set aside a background study subject's disqualification, and
99.5 there are conditions under which the disqualified individual may provide direct contact
99.6 services or have access to people receiving services that minimize the risk of harm to people
99.7 receiving services, the commissioner may grant a time-limited variance to a license holder
99.8 or license-exempt child care center certification holder.

99.9 (b) The variance shall state the reason for the disqualification, the services that may be
99.10 provided by the disqualified individual, and the conditions with which the license holder,
99.11 license-exempt child care center certification holder, or applicant must comply for the
99.12 variance to remain in effect.

99.13 (c) Except for programs licensed to provide family child care, foster care for children
99.14 in the provider's own home, or foster care or day care services for adults in the provider's
99.15 own home, the variance must be requested by the license holder or license-exempt child
99.16 care center certification holder.

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

99.18 Sec. 30. Minnesota Statutes 2018, section 245C.30, subdivision 2, is amended to read:

99.19 Subd. 2. **Disclosure of reason for disqualification.** (a) The commissioner may not grant
99.20 a variance for a disqualified individual unless the applicant, license-exempt child care center
99.21 certification holder, or license holder requests the variance and the disqualified individual
99.22 provides written consent for the commissioner to disclose to the applicant, license-exempt
99.23 child care center certification holder, or license holder the reason for the disqualification.

99.24 (b) This subdivision does not apply to programs licensed to provide family child care
99.25 for children, foster care for children in the provider's own home, or foster care or day care
99.26 services for adults in the provider's own home. When the commissioner grants a variance
99.27 for a disqualified individual in connection with a license to provide the services specified
99.28 in this paragraph, the disqualified individual's consent is not required to disclose the reason
99.29 for the disqualification to the license holder in the variance issued under subdivision 1,
99.30 provided that the commissioner may not disclose the reason for the disqualification if the
99.31 disqualification is based on a felony-level conviction for a drug-related offense within the
99.32 past five years.

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

100.1 Sec. 31. Minnesota Statutes 2018, section 245C.30, subdivision 3, is amended to read:

100.2 Subd. 3. **Consequences for failing to comply with conditions of variance.** When a
100.3 license holder or license-exempt child care center certification holder permits a disqualified
100.4 individual to provide any services for which the subject is disqualified without complying
100.5 with the conditions of the variance, the commissioner may terminate the variance effective
100.6 immediately and subject the license holder to a licensing action under sections 245A.06
100.7 and 245A.07 or a license-exempt child care center certification holder to an action under
100.8 sections 245H.06 and 245H.07.

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

100.10 Sec. 32. Minnesota Statutes 2018, section 245H.01, is amended by adding a subdivision
100.11 to read:

100.12 Subd. 7. **Substitute.** "Substitute" means an adult who is temporarily filling a position
100.13 as a staff person for less than 240 hours total in a calendar year due to the absence of a
100.14 regularly employed staff person who provides direct contact services to a child.

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

100.16 Sec. 33. Minnesota Statutes 2018, section 245H.01, is amended by adding a subdivision
100.17 to read:

100.18 Subd. 8. **Staff person.** "Staff person" means an employee of a certified center who
100.19 provides direct contact services to children.

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

100.21 Sec. 34. Minnesota Statutes 2018, section 245H.01, is amended by adding a subdivision
100.22 to read:

100.23 Subd. 9. **Unsupervised volunteer.** "Unsupervised volunteer" means an individual who:
100.24 (1) assists in the care of a child in care; (2) is not under the continuous direct supervision
100.25 of a staff person; and (3) is not employed by the certified center.

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

100.27 Sec. 35. Minnesota Statutes 2018, section 245H.03, is amended by adding a subdivision
100.28 to read:

100.29 Subd. 4. **Reconsideration of certification denial.** (a) The applicant may request
100.30 reconsideration of the denial by notifying the commissioner by certified mail or personal

101.1 service. The request must be made in writing. If sent by certified mail, the request must be
 101.2 postmarked and sent to the commissioner within ten calendar days after the applicant received
 101.3 the order. If a request is made by personal service, it must be received by the commissioner
 101.4 within ten calendar days after the applicant received the order. The applicant may submit
 101.5 with the request for reconsideration a written argument or evidence in support of the request
 101.6 for reconsideration.

101.7 (b) The commissioner's disposition of a request for reconsideration is final and not
 101.8 subject to appeal under chapter 14.

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

101.10 Sec. 36. Minnesota Statutes 2018, section 245H.07, is amended to read:

101.11 **245H.07 DECERTIFICATION.**

101.12 Subdivision 1. **Generally.** (a) The commissioner may decertify a center if a certification
 101.13 holder:

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

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

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

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

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

101.25 Subd. 2. **Reconsideration of decertification.** (a) The certification holder may request
 101.26 reconsideration of the decertification by notifying the commissioner by certified mail or
 101.27 personal service. The request must be made in writing. If sent by certified mail, the request
 101.28 must be postmarked and sent to the commissioner within ten calendar days after the
 101.29 certification holder received the order. If a request is made by personal service, it must be
 101.30 received by the commissioner within ten calendar days after the certification holder received
 101.31 the order. With the request for reconsideration, the certification holder may submit a written
 101.32 argument or evidence in support of the request for reconsideration.

102.1 (b) The commissioner's disposition of a request for reconsideration is final and not
 102.2 subject to appeal under chapter 14.

102.3 Subd. 3. **Decertification due to maltreatment.** If the commissioner decertifies a center
 102.4 pursuant to subdivision 1, paragraph (a), clause (1), based on a determination that the center
 102.5 was responsible for maltreatment, and if the center requests reconsideration of the
 102.6 decertification according to subdivision 2, paragraph (a), and appeals the maltreatment
 102.7 determination under section 626.556, subdivision 10i, the final decertification determination
 102.8 is stayed until the commissioner issues a final decision regarding the maltreatment appeal.

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

102.10 Sec. 37. Minnesota Statutes 2018, section 245H.10, subdivision 1, is amended to read:

102.11 Subdivision 1. ~~Documentation~~ **Individuals to be studied.** (a) The applicant or
 102.12 certification holder must submit ~~and maintain documentation of~~ a completed background
 102.13 study for: each child care background study subject as defined in section 245C.02, subdivision
 102.14 6a.

102.15 ~~(1) each person applying for the certification;~~

102.16 ~~(2) each person identified as a center operator or program operator as defined in section~~
 102.17 ~~245H.01, subdivision 3;~~

102.18 ~~(3) each current or prospective staff person or contractor of the certified center who will~~
 102.19 ~~have direct contact with a child served by the center;~~

102.20 ~~(4) each volunteer who has direct contact with a child served by the center if the contact~~
 102.21 ~~is not under the continuous, direct supervision by an individual listed in clause (1), (2), or~~
 102.22 ~~(3); and~~

102.23 ~~(5) each managerial staff person of the certification holder with oversight and supervision~~
 102.24 ~~of the certified center.~~

102.25 (b) To be accepted for certification, a background study on every individual in paragraph
 102.26 ~~(a), clause (1),~~ applying for certification must be completed under chapter 245C and result
 102.27 in a not disqualified determination under section 245C.14 or a disqualification that was set
 102.28 aside under section 245C.22.

103.1 Sec. 38. Minnesota Statutes 2018, section 245H.11, is amended to read:

103.2 **245H.11 REPORTING.**

103.3 (a) The certification holder must comply and must have written policies for staff to
103.4 comply with the reporting requirements for abuse and neglect specified in section 626.556.

103.5 A person mandated to report physical or sexual child abuse or neglect occurring within a
103.6 certified center shall report the information to the commissioner.

103.7 (b) The certification holder must inform the commissioner within 24 hours of:

103.8 (1) the death of a child in the program; and

103.9 (2) any injury to a child in the program that required treatment by a physician.

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

103.11 Sec. 39. Minnesota Statutes 2018, section 245H.12, is amended to read:

103.12 **245H.12 FEES.**

103.13 ~~The commissioner shall consult with stakeholders to develop an administrative fee to~~
103.14 ~~implement this chapter. By February 15, 2019, the commissioner shall provide~~
103.15 ~~recommendations on the amount of an administrative fee to the legislative committees with~~
103.16 ~~jurisdiction over health and human services policy and finance. A certified center must pay~~
103.17 an initial application fee of \$200. For calendar year 2020 and thereafter, a certified center
103.18 shall pay an annual nonrefundable certification fee of \$100.

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

103.20 Sec. 40. Minnesota Statutes 2018, section 245H.13, subdivision 5, is amended to read:

103.21 Subd. 5. **Building and physical premises; free of hazards.** ~~(a) The certified center~~
103.22 ~~must document compliance with the State Fire Code by providing~~ To be accepted for
103.23 certification, the applicant must demonstrate compliance with the State Fire Code, section
103.24 299F.011, by either:

103.25 (1) providing documentation of a fire marshal inspection completed within the previous
103.26 three years by a state fire marshal or a local fire code inspector trained by the state fire
103.27 marshal; or

103.28 (2) complying with the fire marshal inspection requirements according to section
103.29 245A.151.

104.1 (b) The certified center must designate a primary indoor and outdoor space used for
104.2 child care on a facility site floor plan.

104.3 (c) The certified center must ensure the areas used by a child are clean and in good repair,
104.4 with structurally sound and functional furniture and equipment that is appropriate to the
104.5 age and size of a child who uses the area.

104.6 (d) The certified center must ensure hazardous items including but not limited to sharp
104.7 objects, medicines, cleaning supplies, poisonous plants, and chemicals are out of reach of
104.8 a child.

104.9 (e) The certified center must safely handle and dispose of bodily fluids and other
104.10 potentially infectious fluids by using gloves, disinfecting surfaces that come in contact with
104.11 potentially infectious bodily fluids, and disposing of bodily fluid in a securely sealed plastic
104.12 bag.

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

104.14 Sec. 41. Minnesota Statutes 2018, section 245H.13, is amended by adding a subdivision
104.15 to read:

104.16 **Subd. 7. Risk reduction plan.** (a) The certified center must develop a risk reduction
104.17 plan that identifies risks to children served by the child care center. The assessment of risk
104.18 must include risks presented by (1) the physical plant where the certified services are
104.19 provided, including electrical hazards; and (2) the environment, including the proximity to
104.20 busy roads and bodies of water.

104.21 (b) The certification holder must establish policies and procedures to minimize identified
104.22 risks. After any change to the risk reduction plan, the certification holder must inform staff
104.23 of the change in the risk reduction plan and document that staff were informed of the change.

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

104.25 Sec. 42. Minnesota Statutes 2018, section 245H.13, is amended by adding a subdivision
104.26 to read:

104.27 **Subd. 8. Required policies.** A certified center must have written policies for health and
104.28 safety items in subdivisions 1 to 6.

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

105.1 Sec. 43. Minnesota Statutes 2018, section 245H.13, is amended by adding a subdivision
105.2 to read:

105.3 Subd. 9. **Behavior guidance.** The certified center must ensure that staff and volunteers
105.4 use positive behavior guidance and do not subject children to:

105.5 (1) corporal punishment, including but not limited to rough handling, shoving, hair
105.6 pulling, ear pulling, shaking, slapping, kicking, biting, pinching, hitting, and spanking;

105.7 (2) humiliation;

105.8 (3) abusive language;

105.9 (4) the use of mechanical restraints, including tying;

105.10 (5) the use of physical restraints other than to physically hold a child when containment
105.11 is necessary to protect a child or others from harm; or

105.12 (6) the withholding or forcing of food and other basic needs.

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

105.14 Sec. 44. Minnesota Statutes 2018, section 245H.13, is amended by adding a subdivision
105.15 to read:

105.16 Subd. 10. **Supervision.** Staff must supervise each child at all times. Staff are responsible
105.17 for the ongoing activity of each child, appropriate visual or auditory awareness, physical
105.18 proximity, and knowledge of activity requirements and each child's needs. Staff must
105.19 intervene when necessary to ensure a child's safety. In determining the appropriate level of
105.20 supervision of a child, staff must consider: (1) the age of a child; (2) individual differences
105.21 and abilities; (3) indoor and outdoor layout of the child care program; and (4) environmental
105.22 circumstances, hazards, and risks.

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

105.24 Sec. 45. Minnesota Statutes 2018, section 245H.14, subdivision 1, is amended to read:

105.25 ~~Subdivision 1. **First aid and cardiopulmonary resuscitation.** At least one designated~~
105.26 ~~staff person who completed pediatric first aid training and pediatric cardiopulmonary~~
105.27 ~~resuscitation (CPR) training must be present at all times at the program, during field trips,~~
105.28 ~~and when transporting a child. The designated staff person must repeat pediatric first aid~~
105.29 ~~training and pediatric CPR training at least once every two years.~~

106.1 (a) Before having unsupervised direct contact with a child, but within the first 90 days
 106.2 of employment for the director and all staff persons, and within 90 days after the first date
 106.3 of direct contact with a child for substitutes and unsupervised volunteers, each person must
 106.4 successfully complete pediatric first aid and pediatric cardiopulmonary resuscitation (CPR)
 106.5 training, unless the training has been completed within the previous two calendar years.
 106.6 Staff must complete the pediatric first aid and pediatric CPR training at least every other
 106.7 calendar year and the center must document the training in the staff person's personnel
 106.8 record.

106.9 (b) Training completed under this subdivision may be used to meet the in-service training
 106.10 requirements under subdivision 6.

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

106.12 Sec. 46. Minnesota Statutes 2018, section 245H.14, subdivision 3, is amended to read:

106.13 Subd. 3. **Abusive head trauma.** A certified center that cares for a child ~~through four~~
 106.14 ~~years of age~~ under school age must ensure that the director and all staff persons and
 106.15 ~~volunteers, including substitutes and unsupervised volunteers,~~ receive training on abusive
 106.16 head trauma ~~from shaking infants and young children~~ before assisting in the care of a child
 106.17 ~~through four years of age~~ under school age.

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

106.19 Sec. 47. Minnesota Statutes 2018, section 245H.14, subdivision 4, is amended to read:

106.20 Subd. 4. **Child development.** The certified center must ensure ~~each staff person completes~~
 106.21 ~~at least two hours of~~ that the director and all staff persons complete child development and
 106.22 learning training within ~~14~~ 90 days of employment and ~~annually~~ every second calendar year
 106.23 thereafter. Substitutes and unsupervised volunteers must complete child development and
 106.24 learning training within 90 days after the first date of direct contact with a child and every
 106.25 second calendar year thereafter. The director and staff persons not including substitutes
 106.26 must complete at least two hours of training on child development. The training for substitutes
 106.27 and unsupervised volunteers is not required to be of a minimum length. For purposes of
 106.28 this subdivision, "child development and learning training" means how a child develops
 106.29 physically, cognitively, emotionally, and socially and learns as part of the child's family,
 106.30 culture, and community.

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

107.1 Sec. 48. Minnesota Statutes 2018, section 245H.14, subdivision 5, is amended to read:

107.2 Subd. 5. **Orientation.** The certified center must ensure ~~each staff person is~~ the director
107.3 and all staff persons, substitutes, and unsupervised volunteers are trained at orientation on
107.4 health and safety requirements in sections 245H.11, 245H.13, 245H.14, and 245H.15. The
107.5 certified center must provide ~~staff with an~~ orientation within 14 days of employment after
107.6 the first date of direct contact with a child. Before the completion of orientation, ~~a staff~~
107.7 ~~person~~ these individuals must be supervised while providing direct care to a child.

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

107.9 Sec. 49. Minnesota Statutes 2018, section 245H.14, subdivision 6, is amended to read:

107.10 Subd. 6. **In service.** (a) The certified center must ensure ~~each~~ that the director and all
107.11 staff person is persons, including substitutes and unsupervised volunteers, are trained at
107.12 least ~~annually~~ once each calendar year on health and safety requirements in sections 245H.11,
107.13 245H.13, 245H.14, and 245H.15.

107.14 (b) The director and each staff person, not including substitutes, must ~~annually~~ complete
107.15 at least six hours of training each calendar year. Training required under paragraph (a) may
107.16 be used toward the hourly training requirements of this subdivision.

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

107.18 Sec. 50. Minnesota Statutes 2018, section 245H.15, subdivision 1, is amended to read:

107.19 Subdivision 1. **Written emergency plan.** (a) A certified center must have a written
107.20 emergency plan for emergencies that require evacuation, sheltering, or other protection of
107.21 children, such as fire, natural disaster, intruder, or other threatening situation that may pose
107.22 a health or safety hazard to children. The plan must be written on a form developed by the
107.23 commissioner and reviewed and updated at least once each calendar year. The annual review
107.24 of the emergency plan must be documented.

107.25 (b) The plan must include:

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

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

107.28 (3) procedures for notifying a child's parent or legal guardian of the relocation and
107.29 reunification with families;

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

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

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

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

108.6 (8) accommodations for infants and toddlers.

108.7 ~~(e) The certification holder must have an emergency plan available for review upon~~
108.8 ~~request by the child's parent or legal guardian.~~

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

108.10 Sec. 51. **REPEALER.**

108.11 (a) Minnesota Rules, parts 9502.0425, subparts 4, 16, and 17; and 9503.0155, subpart
108.12 8, are repealed.

108.13 (b) Minnesota Statutes 2018, section 245H.10, subdivision 2, is repealed.

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

108.15

ARTICLE 3

108.16

DIRECT CARE AND TREATMENT

108.17 Section 1. Minnesota Statutes 2018, section 246B.10, is amended to read:

108.18 **246B.10 LIABILITY OF COUNTY; REIMBURSEMENT.**

108.19 (a) The civilly committed sex offender's county shall pay to the state a portion of the
108.20 cost of care provided in the Minnesota sex offender program to a civilly committed sex
108.21 offender who has legally settled in that county.

108.22 (b) A county's payment must be made from the county's own sources of revenue and
108.23 payments must:

108.24 (1) equal ten percent of the cost of care, as determined by the commissioner, for each
108.25 day or portion of a day that the civilly committed sex offender spends at the facility for
108.26 individuals admitted to the Minnesota sex offender program before August 1, 2011; or

108.27 (2) equal 25 percent of the cost of care, as determined by the commissioner, for each
108.28 day or portion of a day; that the civilly committed sex offender:

109.1 (i) spends at the facility; for individuals admitted to the Minnesota sex offender program
 109.2 on or after August 1, 2011; or

109.3 (ii) receives services within a program operated by the Minnesota sex offender program
 109.4 while on provisional discharge.

109.5 (c) The county is responsible for paying the state the remaining amount if payments
 109.6 received by the state under this chapter exceed:

109.7 (1) 90 percent of the cost of care for individuals admitted to the Minnesota sex offender
 109.8 program before August 1, 2011; or

109.9 (2) 75 percent of the cost of care; ~~the county is responsible for paying the state the~~
 109.10 ~~remaining amount~~ for individuals:

109.11 (i) admitted to the Minnesota sex offender program on or after August 1, 2011; or

109.12 (ii) receiving services within a program operated by the Minnesota sex offender program
 109.13 while on provisional discharge.

109.14 (d) The county is not entitled to reimbursement from the civilly committed sex offender,
 109.15 the civilly committed sex offender's estate, or from the civilly committed sex offender's
 109.16 relatives, except as provided in section 246B.07.

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

109.18 **Sec. 2. REPEALER.**

109.19 (a) Minnesota Statutes 2018, section 246.18, subdivisions 8 and 9, are repealed.

109.20 (b) Laws 2010, First Special Session chapter 1, article 25, section 3, subdivision 10, is
 109.21 repealed.

109.22

ARTICLE 4

109.23

CONTINUING CARE FOR OLDER ADULTS

109.24 Section 1. Minnesota Statutes 2018, section 144.0724, subdivision 4, is amended to read:

109.25 Subd. 4. **Resident assessment schedule.** (a) A facility must conduct and electronically
 109.26 submit to the commissioner of health MDS assessments that conform with the assessment
 109.27 schedule defined by Code of Federal Regulations, title 42, section 483.20, and published
 109.28 by the United States Department of Health and Human Services, Centers for Medicare and
 109.29 Medicaid Services, in the Long Term Care Assessment Instrument User's Manual, version
 109.30 3.0, and subsequent updates when issued by the Centers for Medicare and Medicaid Services.

110.1 The commissioner of health may substitute successor manuals or question and answer
110.2 documents published by the United States Department of Health and Human Services,
110.3 Centers for Medicare and Medicaid Services, to replace or supplement the current version
110.4 of the manual or document.

110.5 (b) The assessments used to determine a case mix classification for reimbursement
110.6 include the following:

110.7 (1) a new admission assessment;

110.8 (2) an annual assessment which must have an assessment reference date (ARD) within
110.9 92 days of the previous assessment and the previous comprehensive assessment;

110.10 (3) a significant change in status assessment must be completed within 14 days of the
110.11 identification of a significant change, whether improvement or decline, and regardless of
110.12 the amount of time since the last significant change in status assessment; Effective for
110.13 rehabilitation therapy completed on or after January 1, 2020, a facility must complete a
110.14 significant change in status assessment if for any reason all speech, occupational, and
110.15 physical therapies have ended. The ARD of the significant change in status assessment must
110.16 be the eighth day after all speech, occupational, and physical therapies have ended. The last
110.17 day on which rehabilitation therapy was furnished is considered day zero when determining
110.18 the ARD for the significant change in status assessment;

110.19 (4) all quarterly assessments must have an assessment reference date (ARD) within 92
110.20 days of the ARD of the previous assessment;

110.21 (5) any significant correction to a prior comprehensive assessment, if the assessment
110.22 being corrected is the current one being used for RUG classification; ~~and~~

110.23 (6) any significant correction to a prior quarterly assessment, if the assessment being
110.24 corrected is the current one being used for RUG classification; and

110.25 (7) modifications to the most recent assessment in clauses (1) to (6).

110.26 (c) In addition to the assessments listed in paragraph (b), the assessments used to
110.27 determine nursing facility level of care include the following:

110.28 (1) preadmission screening completed under section 256.975, subdivisions 7a to 7c, by
110.29 the Senior LinkAge Line or other organization under contract with the Minnesota Board on
110.30 Aging; and

110.31 (2) a nursing facility level of care determination as provided for under section 256B.0911,
110.32 subdivision 4e, as part of a face-to-face long-term care consultation assessment completed

111.1 under section 256B.0911, by a county, tribe, or managed care organization under contract
111.2 with the Department of Human Services.

111.3 Sec. 2. Minnesota Statutes 2018, section 144.0724, subdivision 5, is amended to read:

111.4 Subd. 5. **Short stays.** (a) A facility must submit to the commissioner of health an
111.5 admission assessment for all residents who stay in the facility 14 days or less.

111.6 (b) Notwithstanding the admission assessment requirements of paragraph (a), a facility
111.7 may elect to accept a short stay rate with a case mix index of 1.0 for all facility residents
111.8 who stay 14 days or less in lieu of submitting an admission assessment. Facilities shall make
111.9 this election annually.

111.10 (c) Nursing facilities must elect one of the options described in paragraphs (a) and (b)
111.11 by reporting to the commissioner of health, as prescribed by the commissioner. The election
111.12 is effective on July 1 each year.

111.13 (d) An admission assessment is not required regardless of the facility's election status
111.14 when a resident is admitted to and discharged from the facility on the same day.

111.15 **EFFECTIVE DATE.** This section is effective for admissions on or after July 1, 2019.

111.16 Sec. 3. Minnesota Statutes 2018, section 144.0724, subdivision 8, is amended to read:

111.17 Subd. 8. **Request for reconsideration of resident classifications.** (a) The resident, or
111.18 resident's representative, or the nursing facility or boarding care home may request that the
111.19 commissioner of health reconsider the assigned reimbursement classification including any
111.20 items changed during the audit process. The request for reconsideration must be submitted
111.21 in writing to the commissioner within 30 days of the day the resident or the resident's
111.22 representative receives the resident classification notice. The request for reconsideration
111.23 must include the name of the resident, the name and address of the facility in which the
111.24 resident resides, the reasons for the reconsideration, and documentation supporting the
111.25 request. The documentation accompanying the reconsideration request is limited to ~~a copy~~
111.26 ~~of the MDS that determined the classification and other~~ documents that would support or
111.27 change the MDS findings.

111.28 (b) Upon request, the nursing facility must give the resident or the resident's representative
111.29 a copy of the assessment form and the other documentation that was given to the
111.30 commissioner of health to support the assessment findings. The nursing facility shall also
111.31 provide access to and a copy of other information from the resident's record that has been
111.32 requested by or on behalf of the resident to support a resident's reconsideration request. A

112.1 copy of any requested material must be provided within three working days of receipt of a
112.2 written request for the information. Notwithstanding any law to the contrary, the facility
112.3 may not charge a fee for providing copies of the requested documentation. If a facility fails
112.4 to provide the material within this time, it is subject to the issuance of a correction order
112.5 and penalty assessment under sections 144.653 and 144A.10. Notwithstanding those sections,
112.6 any correction order issued under this subdivision must require that the nursing facility
112.7 immediately comply with the request for information and that as of the date of the issuance
112.8 of the correction order, the facility shall forfeit to the state a \$100 fine for the first day of
112.9 noncompliance, and an increase in the \$100 fine by \$50 increments for each day the
112.10 noncompliance continues.

112.11 (c) In addition to the information required under paragraphs (a) and (b), a reconsideration
112.12 request from a nursing facility must contain the following information: (i) the date the
112.13 reimbursement classification notices were received by the facility; (ii) the date the
112.14 classification notices were distributed to the resident or the resident's representative; and
112.15 (iii) a copy of a notice sent to the resident or to the resident's representative. This notice
112.16 must inform the resident or the resident's representative that a reconsideration of the resident's
112.17 classification is being requested, the reason for the request, that the resident's rate will change
112.18 if the request is approved by the commissioner, the extent of the change, that copies of the
112.19 facility's request and supporting documentation are available for review, and that the resident
112.20 also has the right to request a reconsideration. If the facility fails to provide the required
112.21 information listed in item (iii) with the reconsideration request, the commissioner may
112.22 request that the facility provide the information within 14 calendar days. The reconsideration
112.23 request must be denied if the information is then not provided, and the facility may not
112.24 make further reconsideration requests on that specific reimbursement classification.

112.25 (d) Reconsideration by the commissioner must be made by individuals not involved in
112.26 reviewing the assessment, audit, or reconsideration that established the disputed classification.
112.27 The reconsideration must be based upon the assessment that determined the classification
112.28 and upon the information provided to the commissioner under paragraphs (a) and (b). If
112.29 necessary for evaluating the reconsideration request, the commissioner may conduct on-site
112.30 reviews. Within 15 working days of receiving the request for reconsideration, the
112.31 commissioner shall affirm or modify the original resident classification. The original
112.32 classification must be modified if the commissioner determines that the assessment resulting
112.33 in the classification did not accurately reflect characteristics of the resident at the time of
112.34 the assessment. The resident and the nursing facility or boarding care home shall be notified
112.35 within five working days after the decision is made. A decision by the commissioner under

113.1 this subdivision is the final administrative decision of the agency for the party requesting
113.2 reconsideration.

113.3 (e) The resident classification established by the commissioner shall be the classification
113.4 that applies to the resident while the request for reconsideration is pending. If a request for
113.5 reconsideration applies to an assessment used to determine nursing facility level of care
113.6 under subdivision 4, paragraph (c), the resident shall continue to be eligible for nursing
113.7 facility level of care while the request for reconsideration is pending.

113.8 (f) The commissioner may request additional documentation regarding a reconsideration
113.9 necessary to make an accurate reconsideration determination.

113.10 Sec. 4. Minnesota Statutes 2018, section 144A.071, subdivision 1a, is amended to read:

113.11 Subd. 1a. **Definitions.** For purposes of sections 144A.071 to 144A.073, the following
113.12 terms have the meanings given them:

113.13 (a) "Attached fixtures" has the meaning given in Minnesota Rules, part 9549.0020,
113.14 subpart 6.

113.15 (b) ~~"Buildings"~~ "Building" has the meaning given in ~~Minnesota Rules, part 9549.0020,~~
113.16 ~~subpart 7~~ section 256R.261, subdivision 4.

113.17 (c) "Capital assets" has the meaning given in section ~~256B.421, subdivision 16~~ 256R.02,
113.18 subdivision 8.

113.19 (d) "Commenced construction" means that all of the following conditions were met: the
113.20 final working drawings and specifications were approved by the commissioner of health;
113.21 the construction contracts were let; a timely construction schedule was developed, stipulating
113.22 dates for beginning, achieving various stages, and completing construction; and all zoning
113.23 and building permits were applied for.

113.24 (e) "Completion date" means the date on which clearance for the construction project
113.25 is issued, or if a clearance for the construction project is not required, the date on which the
113.26 construction project assets are available for facility use.

113.27 (f) "Construction" means any erection, building, alteration, reconstruction, modernization,
113.28 or improvement necessary to comply with the nursing home licensure rules.

113.29 (g) "Construction project" means:

113.30 (1) a capital asset addition to, or replacement of a nursing home or certified boarding
113.31 care home that results in new space or the remodeling of or renovations to existing facility
113.32 space; and

114.1 (2) the remodeling or renovation of existing facility space the use of which is modified
 114.2 as a result of the project described in clause (1). This existing space and the project described
 114.3 in clause (1) must be used for the functions as designated on the construction plans on
 114.4 completion of the project described in clause (1) for a period of not less than 24 months.

114.5 (h) "~~Depreciation guidelines~~" ~~means the most recent publication of "The Estimated~~
 114.6 ~~Useful Lives of Depreciable Hospital Assets," issued by the American Hospital Association,~~
 114.7 ~~840 North Lake Shore Drive, Chicago, Illinois, 60611~~ has the meaning given in section
 114.8 256R.261, subdivision 9.

114.9 (i) "New licensed" or "new certified beds" means:

114.10 (1) newly constructed beds in a facility or the construction of a new facility that would
 114.11 increase the total number of licensed nursing home beds or certified boarding care or nursing
 114.12 home beds in the state; or

114.13 (2) newly licensed nursing home beds or newly certified boarding care or nursing home
 114.14 beds that result from remodeling of the facility that involves relocation of beds but does not
 114.15 result in an increase in the total number of beds, except when the project involves the upgrade
 114.16 of boarding care beds to nursing home beds, as defined in section 144A.073, subdivision
 114.17 1. "Remodeling" includes any of the type of conversion, renovation, replacement, or
 114.18 upgrading projects as defined in section 144A.073, subdivision 1.

114.19 ~~(j) "Project construction costs" means the cost of the following items that have a~~
 114.20 ~~completion date within 12 months before or after the completion date of the project described~~
 114.21 ~~in item (g), clause (1):~~

114.22 ~~(1) facility capital asset additions;~~

114.23 ~~(2) replacements;~~

114.24 ~~(3) renovations;~~

114.25 ~~(4) remodeling projects;~~

114.26 ~~(5) construction site preparation costs;~~

114.27 ~~(6) related soft costs; and~~

114.28 ~~(7) the cost of new technology implemented as part of the construction project and~~
 114.29 ~~depreciable equipment directly identified to the project, if the construction costs for clauses~~
 114.30 ~~(1) to (6) exceed the threshold for additions and replacements stated in section 256B.431,~~
 114.31 ~~subdivision 16. Technology and depreciable equipment shall be included in the project~~
 114.32 ~~construction costs unless a written election is made by the facility, to not include it in the~~

115.1 ~~facility's appraised value for purposes of Minnesota Rules, part 9549.0020, subpart 5. Debt~~
 115.2 ~~incurred for purchase of technology and depreciable equipment shall be included as allowable~~
 115.3 ~~debt for purposes of Minnesota Rules, part 9549.0060, subpart 5, items A and C, unless the~~
 115.4 ~~written election is to not include it. Any new technology and depreciable equipment included~~
 115.5 ~~in the project construction costs that the facility elects not to include in its appraised value~~
 115.6 ~~and allowable debt shall be treated as provided in section 256B.431, subdivision 17,~~
 115.7 ~~paragraph (b). Written election under this paragraph must be included in the facility's request~~
 115.8 ~~for the rate change related to the project, and this election may not be changed.~~

115.9 ~~(k) "Technology" means information systems or devices that make documentation,~~
 115.10 ~~charting, and staff time more efficient or encourage and allow for care through alternative~~
 115.11 ~~settings including, but not limited to, touch screens, monitors, hand-helds, swipe cards,~~
 115.12 ~~motion detectors, pagers, telemedicine, medication dispensers, and equipment to monitor~~
 115.13 ~~vital signs and self-injections, and to observe skin and other conditions.~~

115.14 **EFFECTIVE DATE.** This section is effective January 1, 2020.

115.15 Sec. 5. Minnesota Statutes 2018, section 144A.071, subdivision 2, is amended to read:

115.16 Subd. 2. **Moratorium.** The commissioner of health, in coordination with the
 115.17 commissioner of human services, shall deny each request for new licensed or certified
 115.18 nursing home or certified boarding care beds except as provided in subdivision 3 or 4a, or
 115.19 section 144A.073. "Certified bed" means a nursing home bed or a boarding care bed certified
 115.20 by the commissioner of health for the purposes of the medical assistance program, under
 115.21 United States Code, title 42, sections 1396 et seq. Certified beds in facilities which do not
 115.22 allow medical assistance intake shall be deemed to be decertified for purposes of this section
 115.23 only.

115.24 The commissioner of human services, in coordination with the commissioner of health,
 115.25 shall deny any request to issue a license under section 252.28 and chapter 245A to a nursing
 115.26 home or boarding care home, if that license would result in an increase in the medical
 115.27 assistance reimbursement amount.

115.28 In addition, the commissioner of health must not approve any construction project whose
 115.29 cost exceeds ~~\$1,000,000~~ \$1,500,000, unless:

115.30 (a) any construction costs exceeding ~~\$1,000,000~~ \$1,500,000 are not added to the facility's
 115.31 appraised value and are not included in the facility's payment rate for reimbursement under
 115.32 the medical assistance program; or

115.33 (b) the project:

116.1 (1) has been approved through the process described in section 144A.073;

116.2 (2) meets an exception in subdivision 3 or 4a;

116.3 (3) is necessary to correct violations of state or federal law issued by the commissioner
116.4 of health;

116.5 (4) is necessary to repair or replace a portion of the facility that was damaged by fire,
116.6 lightning, ground shifts, or other such hazards, including environmental hazards, provided
116.7 that the provisions of subdivision 4a, clause (a), are met;

116.8 (5) as of May 1, 1992, the facility has submitted to the commissioner of health written
116.9 documentation evidencing that the facility meets the "commenced construction" definition
116.10 as specified in subdivision 1a, paragraph (d), or that substantial steps have been taken prior
116.11 to April 1, 1992, relating to the construction project. "Substantial steps" require that the
116.12 facility has made arrangements with outside parties relating to the construction project and
116.13 include the hiring of an architect or construction firm, submission of preliminary plans to
116.14 the Department of Health or documentation from a financial institution that financing
116.15 arrangements for the construction project have been made; or

116.16 (6) is being proposed by a licensed nursing facility that is not certified to participate in
116.17 the medical assistance program and will not result in new licensed or certified beds.

116.18 Prior to the final plan approval of any construction project, the ~~commissioner~~
116.19 commissioners of health and human services shall be provided with an itemized cost estimate
116.20 for the project construction costs. If a construction project is anticipated to be completed in
116.21 phases, the total estimated cost of all phases of the project shall be submitted to the
116.22 ~~commissioner~~ commissioners and shall be considered as one construction project. Once the
116.23 construction project is completed and prior to the final clearance by the ~~commissioner~~
116.24 commissioners, the total project construction costs for the construction project shall be
116.25 submitted to the ~~commissioner~~ commissioners. If the final project construction cost exceeds
116.26 the dollar threshold in this subdivision, the commissioner of human services shall not
116.27 recognize any of the project construction costs or the related financing costs in excess of
116.28 this threshold in establishing the facility's property-related payment rate.

116.29 The dollar thresholds for construction projects are as follows: for construction projects
116.30 other than those authorized in clauses (1) to (6), the dollar threshold is \$1,000,000. For
116.31 projects authorized after July 1, 1993, under clause (1), the dollar threshold is the cost
116.32 estimate submitted with a proposal for an exception under section 144A.073, plus inflation
116.33 as calculated according to section 256B.431, subdivision 3f, paragraph (a). For projects
116.34 authorized under clauses (2) to (4), the dollar threshold is the itemized estimate project

117.1 construction costs submitted to the commissioner of health at the time of final plan approval,
117.2 plus inflation as calculated according to section 256B.431, subdivision 3f, paragraph (a).

117.3 The commissioner of health shall adopt rules to implement this section or to amend the
117.4 emergency rules for granting exceptions to the moratorium on nursing homes under section
117.5 144A.073.

117.6 Sec. 6. Minnesota Statutes 2018, section 144A.071, subdivision 3, is amended to read:

117.7 Subd. 3. **Exceptions authorizing increase in beds; hardship areas.** (a) The
117.8 commissioner of health, in coordination with the commissioner of human services, may
117.9 approve the addition of new licensed and Medicare and Medicaid certified nursing home
117.10 beds, using the criteria and process set forth in this subdivision.

117.11 (b) The commissioner, in cooperation with the commissioner of human services, shall
117.12 consider the following criteria when determining that an area of the state is a hardship area
117.13 with regard to access to nursing facility services:

117.14 (1) a low number of beds per thousand in a specified area using as a standard the beds
117.15 per thousand people age 65 and older, in five year age groups, using data from the most
117.16 recent census and population projections, weighted by each group's most recent nursing
117.17 home utilization, of the county at the 20th percentile, as determined by the commissioner
117.18 of human services;

117.19 (2) a high level of out-migration for nursing facility services associated with a described
117.20 area from the county or counties of residence to other Minnesota counties, as determined
117.21 by the commissioner of human services, using as a standard an amount greater than the
117.22 out-migration of the county ranked at the 50th percentile;

117.23 (3) an adequate level of availability of noninstitutional long-term care services measured
117.24 as public spending for home and community-based long-term care services per individual
117.25 age 65 and older, in five year age groups, using data from the most recent census and
117.26 population projections, weighted by each group's most recent nursing home utilization, as
117.27 determined by the commissioner of human services using as a standard an amount greater
117.28 than the 50th percentile of counties;

117.29 (4) there must be a declaration of hardship resulting from insufficient access to nursing
117.30 home beds by local county agencies and area agencies on aging; and

117.31 (5) other factors that may demonstrate the need to add new nursing facility beds.

118.1 (c) On August 15 of odd-numbered years, the commissioner, in cooperation with the
118.2 commissioner of human services, may publish in the State Register a request for information
118.3 in which interested parties, using the data provided under section 144A.351, along with any
118.4 other relevant data, demonstrate that a specified area is a hardship area with regard to access
118.5 to nursing facility services. For a response to be considered, the commissioner must receive
118.6 it by November 15. The commissioner shall make responses to the request for information
118.7 available to the public and shall allow 30 days for comment. The commissioner shall review
118.8 responses and comments and determine if any areas of the state are to be declared hardship
118.9 areas.

118.10 (d) For each designated hardship area determined in paragraph (c), the commissioner
118.11 shall publish a request for proposals in accordance with section 144A.073 and Minnesota
118.12 Rules, parts 4655.1070 to 4655.1098. The request for proposals must be published in the
118.13 State Register by March 15 following receipt of responses to the request for information.
118.14 The request for proposals must specify the number of new beds which may be added in the
118.15 designated hardship area, which must not exceed the number which, if added to the existing
118.16 number of beds in the area, including beds in layaway status, would have prevented it from
118.17 being determined to be a hardship area under paragraph (b), clause (1). Beginning July 1,
118.18 2011, the number of new beds approved must not exceed 200 beds statewide per biennium.
118.19 After June 30, 2019, the number of new beds that may be approved in a biennium must not
118.20 exceed 300 statewide. For a proposal to be considered, the commissioner must receive it
118.21 within six months of the publication of the request for proposals. The commissioner shall
118.22 review responses to the request for proposals and shall approve or disapprove each proposal
118.23 by the following July 15, in accordance with section 144A.073 and Minnesota Rules, parts
118.24 4655.1070 to 4655.1098. The commissioner shall base approvals or disapprovals on a
118.25 comparison and ranking of proposals using only the criteria in subdivision 4a. Approval of
118.26 a proposal expires after 18 months unless the facility has added the new beds using existing
118.27 space, subject to approval by the commissioner, or has commenced construction as defined
118.28 in subdivision 1a, paragraph (d). If, after the approved beds have been added, fewer than
118.29 50 percent of the beds in a facility are newly licensed, the operating payment rates previously
118.30 in effect shall remain. If, after the approved beds have been added, 50 percent or more of
118.31 the beds in a facility are newly licensed, operating and external fixed payment rates shall
118.32 be determined according to ~~Minnesota Rules, part 9549.0057, using the limits under sections~~
118.33 ~~256R.23, subdivision 5, and 256R.24, subdivision 3. External fixed costs payment rates~~
118.34 ~~must be determined according to section 256R.25~~ section 256R.21, subdivision 5. Property
118.35 payment rates for facilities with beds added under this subdivision must be determined in

119.1 ~~the same manner as rate determinations resulting from projects approved and completed~~
 119.2 ~~under section 144A.073~~ under section 256R.26.

119.3 (e) The commissioner may:

119.4 (1) certify or license new beds in a new facility that is to be operated by the commissioner
 119.5 of veterans affairs or when the costs of constructing and operating the new beds are to be
 119.6 reimbursed by the commissioner of veterans affairs or the United States Veterans
 119.7 Administration; and

119.8 (2) license or certify beds in a facility that has been involuntarily delicensed or decertified
 119.9 for participation in the medical assistance program, provided that an application for
 119.10 relicensure or recertification is submitted to the commissioner by an organization that is
 119.11 not a related organization as defined in section 256R.02, subdivision 43, to the prior licensee
 119.12 within 120 days after delicensure or decertification.

119.13 **EFFECTIVE DATE.** This section is effective January 1, 2020.

119.14 Sec. 7. Minnesota Statutes 2018, section 144A.071, subdivision 4a, is amended to read:

119.15 Subd. 4a. **Exceptions for replacement beds.** It is in the best interest of the state to
 119.16 ensure that nursing homes and boarding care homes continue to meet the physical plant
 119.17 licensing and certification requirements by permitting certain construction projects. Facilities
 119.18 should be maintained in condition to satisfy the physical and emotional needs of residents
 119.19 while allowing the state to maintain control over nursing home expenditure growth.

119.20 The commissioner of health in coordination with the commissioner of human services,
 119.21 may approve the renovation, replacement, upgrading, or relocation of a nursing home or
 119.22 boarding care home, under the following conditions:

119.23 (a) to license or certify beds in a new facility constructed to replace a facility or to make
 119.24 repairs in an existing facility that was destroyed or damaged after June 30, 1987, by fire,
 119.25 lightning, or other hazard provided:

119.26 (i) destruction was not caused by the intentional act of or at the direction of a controlling
 119.27 person of the facility;

119.28 (ii) at the time the facility was destroyed or damaged the controlling persons of the
 119.29 facility maintained insurance coverage for the type of hazard that occurred in an amount
 119.30 that a reasonable person would conclude was adequate;

119.31 (iii) the net proceeds from an insurance settlement for the damages caused by the hazard
 119.32 are applied to the cost of the new facility or repairs;

120.1 (iv) the number of licensed and certified beds in the new facility does not exceed the
120.2 number of licensed and certified beds in the destroyed facility; and

120.3 (v) the commissioner determines that the replacement beds are needed to prevent an
120.4 inadequate supply of beds.

120.5 Project construction costs incurred for repairs authorized under this clause shall not be
120.6 considered in the dollar threshold amount defined in subdivision 2;

120.7 (b) to license or certify beds that are moved from one location to another within a nursing
120.8 home facility, provided the total costs of remodeling performed in conjunction with the
120.9 relocation of beds does not exceed \$1,000,000;

120.10 (c) to license or certify beds in a project recommended for approval under section
120.11 144A.073;

120.12 (d) to license or certify beds that are moved from an existing state nursing home to a
120.13 different state facility, provided there is no net increase in the number of state nursing home
120.14 beds;

120.15 (e) to certify and license as nursing home beds boarding care beds in a certified boarding
120.16 care facility if the beds meet the standards for nursing home licensure, or in a facility that
120.17 was granted an exception to the moratorium under section 144A.073, and if the cost of any
120.18 remodeling of the facility does not exceed \$1,000,000. If boarding care beds are licensed
120.19 as nursing home beds, the number of boarding care beds in the facility must not increase
120.20 beyond the number remaining at the time of the upgrade in licensure. The provisions
120.21 contained in section 144A.073 regarding the upgrading of the facilities do not apply to
120.22 facilities that satisfy these requirements;

120.23 (f) to license and certify up to 40 beds transferred from an existing facility owned and
120.24 operated by the Amherst H. Wilder Foundation in the city of St. Paul to a new unit at the
120.25 same location as the existing facility that will serve persons with Alzheimer's disease and
120.26 other related disorders. The transfer of beds may occur gradually or in stages, provided the
120.27 total number of beds transferred does not exceed 40. At the time of licensure and certification
120.28 of a bed or beds in the new unit, the commissioner of health shall delicense and decertify
120.29 the same number of beds in the existing facility. As a condition of receiving a license or
120.30 certification under this clause, the facility must make a written commitment to the
120.31 commissioner of human services that it will not seek to receive an increase in its
120.32 property-related payment rate as a result of the transfers allowed under this paragraph;

121.1 (g) to license and certify nursing home beds to replace currently licensed and certified
121.2 boarding care beds which may be located either in a remodeled or renovated boarding care
121.3 or nursing home facility or in a remodeled, renovated, newly constructed, or replacement
121.4 nursing home facility within the identifiable complex of health care facilities in which the
121.5 currently licensed boarding care beds are presently located, provided that the number of
121.6 boarding care beds in the facility or complex are decreased by the number to be licensed as
121.7 nursing home beds and further provided that, if the total costs of new construction,
121.8 replacement, remodeling, or renovation exceed ten percent of the appraised value of the
121.9 facility or \$200,000, whichever is less, the facility makes a written commitment to the
121.10 commissioner of human services that it will not seek to receive an increase in its
121.11 property-related payment rate by reason of the new construction, replacement, remodeling,
121.12 or renovation. The provisions contained in section 144A.073 regarding the upgrading of
121.13 facilities do not apply to facilities that satisfy these requirements;

121.14 (h) to license as a nursing home and certify as a nursing facility a facility that is licensed
121.15 as a boarding care facility but not certified under the medical assistance program, but only
121.16 if the commissioner of human services certifies to the commissioner of health that licensing
121.17 the facility as a nursing home and certifying the facility as a nursing facility will result in
121.18 a net annual savings to the state general fund of \$200,000 or more;

121.19 (i) to certify, after September 30, 1992, and prior to July 1, 1993, existing nursing home
121.20 beds in a facility that was licensed and in operation prior to January 1, 1992;

121.21 (j) to license and certify new nursing home beds to replace beds in a facility acquired
121.22 by the Minneapolis Community Development Agency as part of redevelopment activities
121.23 in a city of the first class, provided the new facility is located within three miles of the site
121.24 of the old facility. Operating and property costs for the new facility must be determined and
121.25 allowed under section 256B.431 or 256B.434 or chapter 256R;

121.26 (k) to license and certify up to 20 new nursing home beds in a community-operated
121.27 hospital and attached convalescent and nursing care facility with 40 beds on April 21, 1991,
121.28 that suspended operation of the hospital in April 1986. The commissioner of human services
121.29 shall provide the facility with the same per diem property-related payment rate for each
121.30 additional licensed and certified bed as it will receive for its existing 40 beds;

121.31 (l) to license or certify beds in renovation, replacement, or upgrading projects as defined
121.32 in section 144A.073, subdivision 1, so long as the cumulative total costs of the facility's
121.33 remodeling projects do not exceed \$1,000,000;

122.1 (m) to license and certify beds that are moved from one location to another for the
122.2 purposes of converting up to five four-bed wards to single or double occupancy rooms in
122.3 a nursing home that, as of January 1, 1993, was county-owned and had a licensed capacity
122.4 of 115 beds;

122.5 (n) to allow a facility that on April 16, 1993, was a 106-bed licensed and certified nursing
122.6 facility located in Minneapolis to layaway all of its licensed and certified nursing home
122.7 beds. These beds may be relicensed and recertified in a newly constructed teaching nursing
122.8 home facility affiliated with a teaching hospital upon approval by the legislature. The
122.9 proposal must be developed in consultation with the interagency committee on long-term
122.10 care planning. The beds on layaway status shall have the same status as voluntarily delicensed
122.11 and decertified beds, except that beds on layaway status remain subject to the surcharge in
122.12 section 256.9657. This layaway provision expires July 1, 1998;

122.13 (o) to allow a project which will be completed in conjunction with an approved
122.14 moratorium exception project for a nursing home in southern Cass County and which is
122.15 directly related to that portion of the facility that must be repaired, renovated, or replaced,
122.16 to correct an emergency plumbing problem for which a state correction order has been
122.17 issued and which must be corrected by August 31, 1993;

122.18 (p) to allow a facility that on April 16, 1993, was a 368-bed licensed and certified nursing
122.19 facility located in Minneapolis to layaway, upon 30 days prior written notice to the
122.20 commissioner, up to 30 of the facility's licensed and certified beds by converting three-bed
122.21 wards to single or double occupancy. Beds on layaway status shall have the same status as
122.22 voluntarily delicensed and decertified beds except that beds on layaway status remain subject
122.23 to the surcharge in section 256.9657, remain subject to the license application and renewal
122.24 fees under section 144A.07 and shall be subject to a \$100 per bed reactivation fee. In
122.25 addition, at any time within three years of the effective date of the layaway, the beds on
122.26 layaway status may be:

122.27 (1) relicensed and recertified upon relocation and reactivation of some or all of the beds
122.28 to an existing licensed and certified facility or facilities located in Pine River, Brainerd, or
122.29 International Falls; provided that the total project construction costs related to the relocation
122.30 of beds from layaway status for any facility receiving relocated beds may not exceed the
122.31 dollar threshold provided in subdivision 2 unless the construction project has been approved
122.32 through the moratorium exception process under section 144A.073;

123.1 (2) relicensed and recertified, upon reactivation of some or all of the beds within the
123.2 facility which placed the beds in layaway status, if the commissioner has determined a need
123.3 for the reactivation of the beds on layaway status.

123.4 The property-related payment rate of a facility placing beds on layaway status must be
123.5 adjusted by the incremental change in its rental per diem after recalculating the rental per
123.6 diem as provided in section 256B.431, subdivision 3a, paragraph (c). The property-related
123.7 payment rate for a facility relicensing and recertifying beds from layaway status must be
123.8 adjusted by the incremental change in its rental per diem after recalculating its rental per
123.9 diem using the number of beds after the relicensing to establish the facility's capacity day
123.10 divisor, which shall be effective the first day of the month following the month in which
123.11 the relicensing and recertification became effective. Any beds remaining on layaway status
123.12 more than three years after the date the layaway status became effective must be removed
123.13 from layaway status and immediately delicensed and decertified;

123.14 (q) to license and certify beds in a renovation and remodeling project to convert 12
123.15 four-bed wards into 24 two-bed rooms, expand space, and add improvements in a nursing
123.16 home that, as of January 1, 1994, met the following conditions: the nursing home was located
123.17 in Ramsey County; had a licensed capacity of 154 beds; and had been ranked among the
123.18 top 15 applicants by the 1993 moratorium exceptions advisory review panel. The total
123.19 project construction cost estimate for this project must not exceed the cost estimate submitted
123.20 in connection with the 1993 moratorium exception process;

123.21 (r) to license and certify up to 117 beds that are relocated from a licensed and certified
123.22 138-bed nursing facility located in St. Paul to a hospital with 130 licensed hospital beds
123.23 located in South St. Paul, provided that the nursing facility and hospital are owned by the
123.24 same or a related organization and that prior to the date the relocation is completed the
123.25 hospital ceases operation of its inpatient hospital services at that hospital. After relocation,
123.26 the nursing facility's status shall be the same as it was prior to relocation. The nursing
123.27 facility's property-related payment rate resulting from the project authorized in this paragraph
123.28 shall become effective no earlier than April 1, 1996. For purposes of calculating the
123.29 incremental change in the facility's rental per diem resulting from this project, the allowable
123.30 appraised value of the nursing facility portion of the existing health care facility physical
123.31 plant prior to the renovation and relocation may not exceed \$2,490,000;

123.32 (s) to license and certify two beds in a facility to replace beds that were voluntarily
123.33 delicensed and decertified on June 28, 1991;

124.1 (t) to allow 16 licensed and certified beds located on July 1, 1994, in a 142-bed nursing
124.2 home and 21-bed boarding care home facility in Minneapolis, notwithstanding the licensure
124.3 and certification after July 1, 1995, of the Minneapolis facility as a 147-bed nursing home
124.4 facility after completion of a construction project approved in 1993 under section 144A.073,
124.5 to be laid away upon 30 days' prior written notice to the commissioner. Beds on layaway
124.6 status shall have the same status as voluntarily delicensed or decertified beds except that
124.7 they shall remain subject to the surcharge in section 256.9657. The 16 beds on layaway
124.8 status may be relicensed as nursing home beds and recertified at any time within five years
124.9 of the effective date of the layaway upon relocation of some or all of the beds to a licensed
124.10 and certified facility located in Watertown, provided that the total project construction costs
124.11 related to the relocation of beds from layaway status for the Watertown facility may not
124.12 exceed the dollar threshold provided in subdivision 2 unless the construction project has
124.13 been approved through the moratorium exception process under section 144A.073.

124.14 The property-related payment rate of the facility placing beds on layaway status must
124.15 be adjusted by the incremental change in its rental per diem after recalculating the rental
124.16 per diem as provided in section 256B.431, subdivision 3a, paragraph (c). The property-related
124.17 payment rate for the facility relicensing and recertifying beds from layaway status must be
124.18 adjusted by the incremental change in its rental per diem after recalculating its rental per
124.19 diem using the number of beds after the relicensing to establish the facility's capacity day
124.20 divisor, which shall be effective the first day of the month following the month in which
124.21 the relicensing and recertification became effective. Any beds remaining on layaway status
124.22 more than five years after the date the layaway status became effective must be removed
124.23 from layaway status and immediately delicensed and decertified;

124.24 (u) to license and certify beds that are moved within an existing area of a facility or to
124.25 a newly constructed addition which is built for the purpose of eliminating three- and four-bed
124.26 rooms and adding space for dining, lounge areas, bathing rooms, and ancillary service areas
124.27 in a nursing home that, as of January 1, 1995, was located in Fridley and had a licensed
124.28 capacity of 129 beds;

124.29 (v) to relocate 36 beds in Crow Wing County and four beds from Hennepin County to
124.30 a 160-bed facility in Crow Wing County, provided all the affected beds are under common
124.31 ownership;

124.32 (w) to license and certify a total replacement project of up to 49 beds located in Norman
124.33 County that are relocated from a nursing home destroyed by flood and whose residents were
124.34 relocated to other nursing homes. The operating cost payment rates for the new nursing
124.35 facility shall be determined based on the interim and settle-up payment provisions of

125.1 ~~Minnesota Rules, part 9549.0057, section 256R.27~~ and the reimbursement provisions of
125.2 chapter 256R. Property-related reimbursement rates shall be determined under section
125.3 256R.26, taking into account any federal or state flood-related loans or grants provided to
125.4 the facility;

125.5 (x) to license and certify to the licensee of a nursing home in Polk County that was
125.6 destroyed by flood in 1997 replacement projects with a total of up to 129 beds, with at least
125.7 25 beds to be located in Polk County and up to 104 beds distributed among up to three other
125.8 counties. These beds may only be distributed to counties with fewer than the median number
125.9 of age intensity adjusted beds per thousand, as most recently published by the commissioner
125.10 of human services. If the licensee chooses to distribute beds outside of Polk County under
125.11 this paragraph, prior to distributing the beds, the commissioner of health must approve the
125.12 location in which the licensee plans to distribute the beds. The commissioner of health shall
125.13 consult with the commissioner of human services prior to approving the location of the
125.14 proposed beds. The licensee may combine these beds with beds relocated from other nursing
125.15 facilities as provided in section 144A.073, subdivision 3c. The operating payment rates for
125.16 the new nursing facilities shall be determined based on the interim and settle-up payment
125.17 provisions of Minnesota Rules, parts 9549.0010 to 9549.0080. Property-related
125.18 reimbursement rates shall be determined under section 256R.26. If the replacement beds
125.19 permitted under this paragraph are combined with beds from other nursing facilities, the
125.20 rates shall be calculated as the weighted average of rates determined as provided in this
125.21 paragraph and section 256R.50;

125.22 (y) to license and certify beds in a renovation and remodeling project to convert 13
125.23 three-bed wards into 13 two-bed rooms and 13 single-bed rooms, expand space, and add
125.24 improvements in a nursing home that, as of January 1, 1994, met the following conditions:
125.25 the nursing home was located in Ramsey County, was not owned by a hospital corporation,
125.26 had a licensed capacity of 64 beds, and had been ranked among the top 15 applicants by
125.27 the 1993 moratorium exceptions advisory review panel. The total project construction cost
125.28 estimate for this project must not exceed the cost estimate submitted in connection with the
125.29 1993 moratorium exception process;

125.30 (z) to license and certify up to 150 nursing home beds to replace an existing 285 bed
125.31 nursing facility located in St. Paul. The replacement project shall include both the renovation
125.32 of existing buildings and the construction of new facilities at the existing site. The reduction
125.33 in the licensed capacity of the existing facility shall occur during the construction project
125.34 as beds are taken out of service due to the construction process. Prior to the start of the
125.35 construction process, the facility shall provide written information to the commissioner of

126.1 health describing the process for bed reduction, plans for the relocation of residents, and
126.2 the estimated construction schedule. The relocation of residents shall be in accordance with
126.3 the provisions of law and rule;

126.4 (aa) to allow the commissioner of human services to license an additional 36 beds to
126.5 provide residential services for the physically disabled under Minnesota Rules, parts
126.6 9570.2000 to 9570.3400, in a 198-bed nursing home located in Red Wing, provided that
126.7 the total number of licensed and certified beds at the facility does not increase;

126.8 (bb) to license and certify a new facility in St. Louis County with 44 beds constructed
126.9 to replace an existing facility in St. Louis County with 31 beds, which has resident rooms
126.10 on two separate floors and an antiquated elevator that creates safety concerns for residents
126.11 and prevents nonambulatory residents from residing on the second floor. The project shall
126.12 include the elimination of three- and four-bed rooms;

126.13 (cc) to license and certify four beds in a 16-bed certified boarding care home in
126.14 Minneapolis to replace beds that were voluntarily delicensed and decertified on or before
126.15 March 31, 1992. The licensure and certification is conditional upon the facility periodically
126.16 assessing and adjusting its resident mix and other factors which may contribute to a potential
126.17 institution for mental disease declaration. The commissioner of human services shall retain
126.18 the authority to audit the facility at any time and shall require the facility to comply with
126.19 any requirements necessary to prevent an institution for mental disease declaration, including
126.20 delicensure and decertification of beds, if necessary;

126.21 (dd) to license and certify 72 beds in an existing facility in Mille Lacs County with 80
126.22 beds as part of a renovation project. The renovation must include construction of an addition
126.23 to accommodate ten residents with beginning and midstage dementia in a self-contained
126.24 living unit; creation of three resident households where dining, activities, and support spaces
126.25 are located near resident living quarters; designation of four beds for rehabilitation in a
126.26 self-contained area; designation of 30 private rooms; and other improvements;

126.27 (ee) to license and certify beds in a facility that has undergone replacement or remodeling
126.28 as part of a planned closure under section 256R.40;

126.29 (ff) to license and certify a total replacement project of up to 124 beds located in Wilkin
126.30 County that are in need of relocation from a nursing home significantly damaged by flood.
126.31 The operating cost payment rates for the new nursing facility shall be determined based on
126.32 the interim and settle-up payment provisions of ~~Minnesota Rules, part 9549.0057, section~~
126.33 256R.27 and the reimbursement provisions of chapter 256R. Property-related reimbursement

127.1 rates shall be determined under section 256R.26, taking into account any federal or state
127.2 flood-related loans or grants provided to the facility;

127.3 (gg) to allow the commissioner of human services to license an additional nine beds to
127.4 provide residential services for the physically disabled under Minnesota Rules, parts
127.5 9570.2000 to 9570.3400, in a 240-bed nursing home located in Duluth, provided that the
127.6 total number of licensed and certified beds at the facility does not increase;

127.7 (hh) to license and certify up to 120 new nursing facility beds to replace beds in a facility
127.8 in Anoka County, which was licensed for 98 beds as of July 1, 2000, provided the new
127.9 facility is located within four miles of the existing facility and is in Anoka County. Operating
127.10 and property rates shall be determined and allowed under chapter 256R and Minnesota
127.11 Rules, parts 9549.0010 to 9549.0080; or

127.12 (ii) to transfer up to 98 beds of a 129-licensed bed facility located in Anoka County that,
127.13 as of March 25, 2001, is in the active process of closing, to a 122-licensed bed nonprofit
127.14 nursing facility located in the city of Columbia Heights or its affiliate. The transfer is effective
127.15 when the receiving facility notifies the commissioner in writing of the number of beds
127.16 accepted. The commissioner shall place all transferred beds on layaway status held in the
127.17 name of the receiving facility. The layaway adjustment provisions of section 256B.431,
127.18 subdivision 30, do not apply to this layaway. The receiving facility may only remove the
127.19 beds from layaway for recertification and relicensure at the receiving facility's current site,
127.20 or at a newly constructed facility located in Anoka County. The receiving facility must
127.21 receive statutory authorization before removing these beds from layaway status, or may
127.22 remove these beds from layaway status if removal from layaway status is part of a
127.23 moratorium exception project approved by the commissioner under section 144A.073.

127.24 Sec. 8. Minnesota Statutes 2018, section 144A.071, subdivision 4c, is amended to read:

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

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

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

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

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

128.18 (4) to license and certify up to 80 beds transferred from an existing state-owned nursing
128.19 facility in Cass County to a new facility located on the grounds of the Ah-Gwah-Ching
128.20 campus. The operating cost payment rates for the new facility shall be determined based
128.21 on the interim and settle-up payment provisions of ~~Minnesota Rules, part 9549.0057, section~~
128.22 256R.27 and the reimbursement provisions of chapter 256R. The property payment rate for
128.23 the first three years of operation shall be \$35 per day. For subsequent years, the property
128.24 payment rate of \$35 per day shall be adjusted for inflation as provided in section 256B.434,
128.25 subdivision 4, paragraph (c), as long as the facility has a contract under section 256B.434;

128.26 (5) to initiate a pilot program to license and certify up to 80 beds transferred from an
128.27 existing county-owned nursing facility in Steele County relocated to the site of a new acute
128.28 care facility as part of the county's Communities for a Lifetime comprehensive plan to create
128.29 innovative responses to the aging of its population. Upon relocation to the new site, the
128.30 nursing facility shall delicense 28 beds. The payment rate for external fixed costs for the
128.31 new facility shall be increased by an amount as calculated according to items (i) to (v):

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

129.1 (ii) compute the annual savings to the medical assistance program from the delicensure
129.2 of 28 beds by multiplying the anticipated decrease in medical assistance residents, determined
129.3 in item (i), by the existing facility's weighted average payment rate multiplied by 365;

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

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

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

129.12 (6) to consolidate and relocate nursing facility beds to a new site in Goodhue County
129.13 and to integrate these services with other community-based programs and services under a
129.14 communities for a lifetime pilot program and comprehensive plan to create innovative
129.15 responses to the aging of its population. Two nursing facilities, one for 84 beds and one for
129.16 65 beds, in the city of Red Wing licensed on July 1, 2015, shall be consolidated into a newly
129.17 renovated 64-bed nursing facility resulting in the delicensure of 85 beds. Notwithstanding
129.18 the carryforward of the approval authority in section 144A.073, subdivision 11, the funding
129.19 approved in April 2009 by the commissioner of health for a project in Goodhue County
129.20 shall not carry forward. The closure of the 85 beds shall not be eligible for a planned closure
129.21 rate adjustment under section 256R.40. The construction project permitted in this clause
129.22 shall not be eligible for a threshold project rate adjustment under section 256B.434,
129.23 subdivision 4f. The payment rate for external fixed costs for the new facility shall be
129.24 increased by an amount as calculated according to items (i) to (vi):

129.25 (i) compute the estimated decrease in medical assistance residents served by both nursing
129.26 facilities by multiplying the difference between the occupied beds of the two nursing facilities
129.27 for the reporting year ending September 30, 2009, and the projected occupancy of the facility
129.28 at 95 percent occupancy by the historical percentage of medical assistance resident days;

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

129.33 (iii) compute the anticipated annual costs for community-based services by multiplying
129.34 the anticipated decrease in medical assistance residents served by the facilities, determined

130.1 in item (i), by the average monthly elderly waiver service costs for individuals in Goodhue
 130.2 County multiplied by 12;

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

130.4 (v) multiply the amount in item (iv) by 57.2 percent; and

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

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

130.11 Sec. 9. Minnesota Statutes 2018, section 144A.071, subdivision 5a, is amended to read:

130.12 Subd. 5a. **Cost estimate of a moratorium exception project.** (a) For the purposes of
 130.13 this section and section 144A.073, the cost estimate of a moratorium exception project shall
 130.14 include the effects of the proposed project on the costs of the state subsidy for
 130.15 community-based services, nursing services, and housing in institutional and noninstitutional
 130.16 settings. The commissioner of health, in cooperation with the commissioner of human
 130.17 services, shall define the method for estimating these costs in the permanent rule
 130.18 implementing section 144A.073. The commissioner of human services shall prepare an
 130.19 estimate of the property-related payment rate to be established upon completion of the
 130.20 project and total state annual long-term costs of each moratorium exception proposal. The
 130.21 property-related payment rate estimate shall be made using the actual cost of the project
 130.22 but the final property rate must be based on the appraisal and subject to the limitations in
 130.23 section 256R.26, subdivision 6.

130.24 ~~(b) The interest rate to be used for estimating the cost of each moratorium exception~~
 130.25 ~~project proposal shall be the lesser of either the prime rate plus two percentage points, or~~
 130.26 ~~the posted yield for standard conventional fixed rate mortgages of the Federal Home Loan~~
 130.27 ~~Mortgage Corporation plus two percentage points as published in the Wall Street Journal~~
 130.28 ~~and in effect 56 days prior to the application deadline. If the applicant's proposal uses this~~
 130.29 ~~interest rate, the commissioner of human services, in determining the facility's actual~~
 130.30 ~~property-related payment rate to be established upon completion of the project must use the~~
 130.31 ~~actual interest rate obtained by the facility for the project's permanent financing up to the~~
 130.32 ~~maximum permitted under Minnesota Rules, part 9549.0060, subpart 6.~~

131.1 ~~The applicant may choose an alternate interest rate for estimating the project's cost. If~~
 131.2 ~~the applicant makes this election, the commissioner of human services, in determining the~~
 131.3 ~~facility's actual property-related payment rate to be established upon completion of the~~
 131.4 ~~project, must use the lesser of the actual interest rate obtained for the project's permanent~~
 131.5 ~~financing or the interest rate which was used to estimate the proposal's project cost. For~~
 131.6 ~~succeeding rate years, the applicant is at risk for financing costs in excess of the interest~~
 131.7 ~~rate selected.~~

131.8 **EFFECTIVE DATE.** This section is effective January 1, 2020.

131.9 Sec. 10. Minnesota Statutes 2018, section 144A.073, subdivision 3c, is amended to read:

131.10 Subd. 3c. **Cost neutral Relocation projects.** ~~(a)~~ Notwithstanding subdivision 3, the
 131.11 commissioner may at any time accept proposals, or amendments to proposals previously
 131.12 approved under this section, for relocations ~~that are cost neutral with respect to state costs~~
 131.13 ~~as defined in section 144A.071, subdivision 5a.~~ The commissioner, in consultation with the
 131.14 commissioner of human services, shall evaluate proposals according to subdivision 4a,
 131.15 clauses (1), (4), (5), (6), and (8), and other criteria established in rule or law. ~~The~~
 131.16 ~~commissioner of human services shall determine the allowable payment rates of the facility~~
 131.17 ~~receiving the beds in accordance with section 256R.50.~~ The commissioner shall approve or
 131.18 disapprove a project within 90 days.

131.19 ~~(b) For the purposes of paragraph (a), cost neutrality shall be measured over the first~~
 131.20 ~~three 12-month periods of operation after completion of the project.~~

131.21 **EFFECTIVE DATE.** This section is effective January 1, 2020.

131.22 Sec. 11. Minnesota Statutes 2018, section 256R.02, subdivision 8, is amended to read:

131.23 Subd. 8. **Capital assets.** "Capital assets" means a nursing facility's buildings, ~~attached~~
 131.24 ~~fixtures~~ fixed equipment, land improvements, leasehold improvements, and all additions to
 131.25 or replacements of those assets used directly for resident care.

131.26 Sec. 12. Minnesota Statutes 2018, section 256R.02, subdivision 19, is amended to read:

131.27 Subd. 19. **External fixed costs.** "External fixed costs" means costs related to the nursing
 131.28 home surcharge under section 256.9657, subdivision 1; licensure fees under section 144.122;
 131.29 family advisory council fee under section 144A.33; scholarships under section 256R.37;
 131.30 ~~planned closure rate adjustments under section 256R.40; consolidation rate adjustments~~
 131.31 ~~under section 144A.071, subdivisions 4c, paragraph (a), clauses (5) and (6), and 4d;~~
 131.32 ~~single-bed room incentives under section 256R.41;~~ property taxes, special assessments, and

132.1 payments in lieu of taxes; employer health insurance costs; quality improvement incentive
132.2 payment rate adjustments under section 256R.39; performance-based incentive payments
132.3 under section 256R.38; special dietary needs under section 256R.51; rate adjustments for
132.4 compensation-related costs for minimum wage changes under section 256R.49 provided
132.5 on or after January 1, 2018; and Public Employees Retirement Association employer costs.

132.6 **EFFECTIVE DATE.** This section is effective January 1, 2020.

132.7 Sec. 13. Minnesota Statutes 2018, section 256R.16, subdivision 1, is amended to read:

132.8 Subdivision 1. **Calculation of a quality score.** (a) The commissioner shall determine
132.9 a quality score for each nursing facility using quality measures established in section
132.10 256B.439, according to methods determined by the commissioner in consultation with
132.11 stakeholders and experts, and using the most recently available data as provided in the
132.12 Minnesota Nursing Home Report Card. These methods shall be exempt from the rulemaking
132.13 requirements under chapter 14.

132.14 (b) For each quality measure, a score shall be determined with the number of points
132.15 assigned as determined by the commissioner using the methodology established according
132.16 to this subdivision. The determination of the quality measures to be used and the methods
132.17 of calculating scores may be revised annually by the commissioner.

132.18 (c) The quality score shall include up to 50 points related to the Minnesota quality
132.19 indicators score derived from the minimum data set, up to 40 points related to the resident
132.20 quality of life score derived from the consumer survey conducted under section 256B.439,
132.21 subdivision 3, and up to ten points related to the state inspection results score.

132.22 (d) The commissioner, in cooperation with the commissioner of health, may adjust the
132.23 formula in paragraph (c), or the methodology for computing the total quality score, ~~effective~~
132.24 ~~July 1 of any year,~~ with five months advance public notice. In changing the formula, the
132.25 commissioner shall consider quality measure priorities registered by report card users, advice
132.26 of stakeholders, and available research.

132.27 Sec. 14. Minnesota Statutes 2018, section 256R.21, is amended by adding a subdivision
132.28 to read:

132.29 **Subd. 5. Total payment rate for new facilities.** For a new nursing facility created under
132.30 section 144A.073, subdivision 3c, the total payment rate must be determined according to
132.31 this section, except:

133.1 (1) the direct care payment rate used in subdivision 2, clause (1), must be determined
 133.2 according to section 256R.27;

133.3 (2) the other care-related payment rate used in subdivision 2, clause (2), must be
 133.4 determined according to section 256R.27;

133.5 (3) the external fixed costs payment rate used in subdivision 4, clause (2), must be
 133.6 determined according to section 256R.27; and

133.7 (4) the property payment rate used in subdivision 4, clause (3), must be determined
 133.8 according to section 256R.26.

133.9 **EFFECTIVE DATE.** This section is effective January 1, 2020.

133.10 Sec. 15. Minnesota Statutes 2018, section 256R.23, subdivision 5, is amended to read:

133.11 Subd. 5. **Determination of total care-related payment rate limits.** The commissioner
 133.12 must determine each facility's total care-related payment rate limit by:

133.13 (1) multiplying the facility's quality score, as determined under section 256R.16,
 133.14 subdivision 1, paragraph (d), by ~~0.5625~~ 2.0;

133.15 (2) ~~adding 89.375 to~~ subtracting 40.0 from the amount determined in clause (1), and
 133.16 dividing the total by 100; ~~and~~

133.17 (3) multiplying the amount determined in clause (2) by the median total care-related
 133.18 cost per day; and

133.19 (4) multiplying the amount determined in clause (3) by the most-recent available
 133.20 Core-Based Statistical Area wage indices established by the Centers for Medicare and
 133.21 Medicaid Services for the Skilled Nursing Facility Prospective Payment System.

133.22 **EFFECTIVE DATE.** This section is effective January 1, 2020.

133.23 Sec. 16. Minnesota Statutes 2018, section 256R.24, subdivision 3, is amended to read:

133.24 Subd. 3. **Determination of the other operating payment rate.** A facility's other
 133.25 operating payment rate equals the lesser of (1) 105 percent of the median other operating
 133.26 cost per day as determined by subdivisions 1 and 2, or (2) the prior year operating payment
 133.27 rate adjusted by a forecasting market basket and forecasting index. The adjustment factor
 133.28 shall come from the Information Handling Services Healthcare Cost Review, the Skilled
 133.29 Nursing Facility Total Market Basket Index, and the four-quarter moving average percentage
 133.30 change line or a comparable index if this index ceases to be published. The commissioner
 133.31 shall use the fourth quarter index of the upcoming calendar year from the forecast published

134.1 for the third quarter of the calendar year immediately prior to the rate year for which the
 134.2 rate is being determined.

134.3 Sec. 17. Minnesota Statutes 2018, section 256R.25, is amended to read:

134.4 **256R.25 EXTERNAL FIXED COSTS PAYMENT RATE.**

134.5 (a) The payment rate for external fixed costs is the sum of the amounts in paragraphs
 134.6 (b) to ~~(n)~~ (k).

134.7 (b) For a facility licensed as a nursing home, the portion related to the provider surcharge
 134.8 under section 256.9657 is equal to \$8.86 per resident day. For a facility licensed as both a
 134.9 nursing home and a boarding care home, the portion related to the provider surcharge under
 134.10 section 256.9657 is equal to \$8.86 per resident day multiplied by the result of its number
 134.11 of nursing home beds divided by its total number of licensed beds.

134.12 (c) The portion related to the licensure fee under section 144.122, paragraph (d), is the
 134.13 amount of the fee divided by the sum of the facility's resident days.

134.14 (d) The portion related to development and education of resident and family advisory
 134.15 councils under section 144A.33 is \$5 per resident day divided by 365.

134.16 (e) The portion related to scholarships is determined under section 256R.37.

134.17 ~~(f) The portion related to planned closure rate adjustments is as determined under section~~
 134.18 ~~256R.40, subdivision 5, and Minnesota Statutes 2010, section 256B.436.~~

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

134.21 ~~(h) The portion related to single-bed room incentives is as determined under section~~
 134.22 ~~256R.41.~~

134.23 ~~(i)~~ (f) The portions related to real estate taxes, special assessments, and payments made
 134.24 in lieu of real estate taxes directly identified or allocated to the nursing facility are the ~~actual~~
 134.25 allowable amounts divided by the sum of the facility's resident days. Allowable costs under
 134.26 this paragraph for payments made by a nonprofit nursing facility that are in lieu of real
 134.27 estate taxes shall not exceed the amount which the nursing facility would have paid to a
 134.28 city or township and county for fire, police, sanitation services, and road maintenance costs
 134.29 had real estate taxes been levied on that property for those purposes.

134.30 ~~(j)~~ (g) The portion related to employer health insurance costs is the allowable costs
 134.31 divided by the sum of the facility's resident days.

135.1 ~~(k)~~ (h) The portion related to the Public Employees Retirement Association is ~~actual~~
 135.2 allowable costs divided by the sum of the facility's resident days.

135.3 ~~(h)~~ (i) The portion related to quality improvement incentive payment rate adjustments
 135.4 is the amount determined under section 256R.39.

135.5 ~~(m)~~ (j) The portion related to performance-based incentive payments is the amount
 135.6 determined under section 256R.38.

135.7 ~~(n)~~ (k) The portion related to special dietary needs is the amount determined under
 135.8 section 256R.51.

135.9 **EFFECTIVE DATE.** This section is effective January 1, 2020.

135.10 Sec. 18. Minnesota Statutes 2018, section 256R.26, is amended to read:

135.11 **256R.26 PROPERTY PAYMENT RATE.**

135.12 Subdivision 1. **Generally.** The property payment rate for a nursing facility is the property
 135.13 rate established for the facility under sections 256B.431 and 256B.434. (a) For rate years
 135.14 beginning on or after January 1, 2020, the commissioner shall reimburse nursing facilities
 135.15 participating in the medical assistance program for the rental use of real estate and depreciable
 135.16 assets according to this section and sections 256R.261 to 256R.27. The property payment
 135.17 rate made under this methodology is the only payment for costs related to capital assets,
 135.18 including depreciation, interest and lease expenses for all depreciable assets, also including
 135.19 movable equipment, land improvements, and land.

135.20 (b) The commercial valuation system selected by the commissioner must be utilized in
 135.21 all appraisals. The appraisal is not intended to exactly reflect market value, and no
 135.22 adjustments or substitutions are permitted for any alternative analysis of properties than the
 135.23 selected commercial valuation system.

135.24 (c) Based on the valuation of a building and fixed equipment, the property appraisal
 135.25 firm selected by the commissioner must produce a report detailing both the depreciated
 135.26 replacement cost (DRC) and undepreciated replacement cost (URC) of the nursing facility.
 135.27 The valuation excludes movable equipment, land, or land improvements. The valuation
 135.28 must be adjusted for any shared area included in the DRC and URC not used for nursing
 135.29 facility purposes. Physical plant for central office operations is not included in the appraisal.

135.30 (d) The appraisal initially may include the full value of all shared areas. The DRC, URC,
 135.31 and square footage are established by an appraisal and must be adjusted to reflect only the
 135.32 nursing facility usage of shared areas in the final nursing facility values. The adjustment

136.1 must be based on a Medicare-approved allocation basis for the type of service provided by
136.2 each area. Shared areas outside the appraised space must be added to the DRC, URC, and
136.3 related square footage using the average of each value from the space in the appraisal.

136.4 Subd. 2. **Appraised value.** For rate years beginning on or after January 1, 2020, the
136.5 DRC and URC are based on the appraisals of a building and attached fixtures as determined
136.6 by the contracted property appraisal firm using a commercial valuation system selected by
136.7 the commissioner.

136.8 Subd. 3. **Initial rate year.** The property payment rate calculated under section 256R.265
136.9 for the initial rate year effective January 1, 2020, must be a per diem amount based on the
136.10 DRC and URC of a nursing facility's building and attached fixtures, as estimated by a
136.11 commercial property appraisal firm in 2016. The initial values for both the DRC and URC,
136.12 adjusted for nonnursing facility space, must be increased by six percent.

136.13 Subd. 4. **Subsequent rate years.** (a) Beginning in calendar year 2020, the commissioner
136.14 shall contract with a property appraisal firm to appraise the building and attached fixtures
136.15 for nursing facilities using the commercial valuation system. Approximately one-third of
136.16 the nursing facilities must be appraised each year.

136.17 (b) If a nursing facility wishes to appeal findings of fact in the appraisal report, the
136.18 nursing facility must request a revision within 20 calendar days after receipt of the appraisal
136.19 report.

136.20 (c) The property payment rate for rate year beginning January 1, 2021, for the one-third
136.21 of nursing facilities that are newly appraised in 2020 must be based upon new DRCs and
136.22 URCs for buildings and attached fixtures as determined by the contracted property appraisal
136.23 firm.

136.24 (d) The property payment rate for rate years beginning January 1, 2021, and January 1,
136.25 2022, for the remainder of the nursing facilities that were not previously appraised, must
136.26 use the net DRC and URC used in the January 1, 2020, property payment rates adjusted for
136.27 inflation before any formula limitations are applied. The index for the inflation adjustment
136.28 must be based on the change in the United States All-Items Consumer Price Index (CPI-U)
136.29 forecasted by the Reports and Forecasts Division of the Department of Human Services in
136.30 the third quarter of the calendar year preceding the rate year. The inflation adjustment must
136.31 be based on the 12-month period from the midpoint of the previous rate year to the midpoint
136.32 of the rate year for which the rate is being determined. Nursing facilities under this paragraph
136.33 must have the property payment rates beginning January 1, 2022, and January 1, 2023,

137.1 based on new replacement costs and depreciated values as determined in appraisals based
137.2 on the three-year cycle.

137.3 (e) For the nursing facility's new physical appraisal after the nursing facility's 2016
137.4 appraisal, the most recent DRC and URC must be updated through the commercial valuation
137.5 system. These valuations are updates only and not subject to revisions of any of the original
137.6 valuations or appeal by the nursing facility.

137.7 Subd. 5. **Special reappraisals.** (a) A nursing facility that completes an addition to or
137.8 replacement of a building or attached fixtures as approved in section 144A.073 after January
137.9 1, 2020, may request a property rate adjustment effective the first of January, April, July,
137.10 or October after project completion. The nursing facility must submit all cost data related
137.11 to the project to the commissioner within 90 days of project completion. The commissioner
137.12 must add the nursing facility to the next group of scheduled appraisals. The nursing facility's
137.13 updated appraisal must be used to calculate a revised property rate effective the first of
137.14 January, April, July, or October after project completion. If an updated appraisal cannot be
137.15 scheduled within 90 days of the effective date of the revised property, the commissioner
137.16 must establish an interim valuation which must be adjusted retroactively when the updated
137.17 appraisal is available. For a nursing facility with projects approved under section 144A.073
137.18 prior to January 1, 2020, moratorium project construction adjustments must be calculated
137.19 under Minnesota Statutes 2018, section 256B.434, subdivision 4f, and the adjustment added
137.20 to the nursing facility's hold harmless rate effective the first of January, April, July, or
137.21 October after project completion. This adjustment is in addition to the updated appraisal
137.22 described in this paragraph.

137.23 (b) A nursing facility that completes a threshold construction project after January 1,
137.24 2020, may submit a project rate adjustment request to the commissioner if the building
137.25 improvement or addition costs exceed \$300,000 and the threshold construction project is
137.26 not reflected in an appraisal used for rate setting. The cost must be incurred by the nursing
137.27 facility, or if the nursing facility is leased and the cost is incurred by the lease holder, the
137.28 provider's lease has been increased for the project. Threshold project costs exceeding a total
137.29 of \$1,500,000 within a three-year period, or a prorated amount if the appraisals are less than
137.30 three years apart, must not be recognized. The property payment rate must be updated to
137.31 reflect the new DRC and URC values effective the first of January or July after project
137.32 completion. In subsequent property payment rate calculations, an addition to the DRC and
137.33 URC must be eliminated once a full appraisal is complete for the nursing facility after project
137.34 completion. At the option of the commissioner the appraisal schedule may be adjusted for

138.1 nursing facilities completing threshold projects. Threshold project costs are not considered
138.2 if the costs were incurred prior to the date of the last appraisal.

138.3 (c) Effective January 1, 2020, a nursing facility new to the medical assistance program
138.4 must have the building and fixed equipment appraised by the property appraisal firm upon
138.5 completion of construction of the nursing facility, or, if not newly constructed, upon entering
138.6 the medical assistance program. If an appraisal cannot be scheduled within 90 days of the
138.7 certification date, the commissioner must establish an interim valuation to be adjusted
138.8 retroactively when the appraisal is available.

138.9 Subd. 6. **Limitation on appraisal valuations.** Effective for appraisals conducted on or
138.10 after January 1, 2020, the increase in the URC is limited to \$500,000 per year since the last
138.11 completed appraisal plus any completed project costs approved under section 144A.073.
138.12 Any limitation to the URC must be applied in the same proportion to the DRC.

138.13 Subd. 7. **Total hold harmless rate.** (a) Total hold harmless rate includes closure
138.14 adjustments under Minnesota Statutes 2018, section 256R.40, subdivision 5; consolidation
138.15 adjustments under section 144A.071, subdivisions 4c, paragraph (a), clauses (5) and (6),
138.16 and 4d; equity incentives under sections 256B.431, subdivision 16, and Minnesota Statutes
138.17 2018, 256B.434, subdivision 4f; single-bed incentives under Minnesota Statutes 2018,
138.18 section 256R.41; project construction costs under Minnesota Statutes 2018, section 144A.071,
138.19 subdivision 1a, paragraph (j); and all components of the property payment rate under section
138.20 256R.26 in effect on December 31, 2019.

138.21 (b) For moratorium projects as defined under sections 144A.071 and 144A.073 that are
138.22 eligible for rate adjustments approved prior to January 1, 2020, but not reflected in the rate
138.23 on December 31, 2019, the moratorium rate adjustments determined under Minnesota
138.24 Statutes 2018, sections 256B.431, subdivisions 3f, 17, 17a, 17c, 17d, 17e, 21, 30, and 45,
138.25 and 256B.434, subdivisions 4f and 4j, must be added to the total hold harmless rate in effect
138.26 on the first of January, April, July, or October after project completion.

138.27 (c) Effective January 1, 2020, rate adjustments under Minnesota Statutes 2018, section
138.28 256R.25, paragraphs (f) to (h) from previous rate years shall be included in the total hold
138.29 harmless rate.

138.30 Subd. 8. **Phase out of hold harmless rate.** (a) For a nursing facility that has a higher
138.31 total hold harmless rate than the rate calculated in section 256R.265, the nursing facility
138.32 must receive 100 percent of the total hold harmless rate for the rate year beginning January
138.33 1, 2020.

139.1 (b) For rate years beginning January 1, 2021, to January 1, 2024, the property payment
139.2 rate is a blending of the total hold harmless rate and the property rate determined in section
139.3 256R.265, plus any adjustments issued for construction projects between appraisals, if a
139.4 higher rate results. If not, the property payment rate is determined according to section
139.5 256R.265.

139.6 (c) For the rate year beginning January 1, 2021, for eligible nursing facilities, the property
139.7 payment rate is 80 percent of the total hold harmless rate and 20 percent of the property
139.8 payment rate calculated in section 256R.265.

139.9 (d) For the rate year beginning January 1, 2022, for eligible nursing facilities, the property
139.10 payment rate is 60 percent of the total hold harmless rate and 40 percent of the property
139.11 payment rate calculated in section 256R.265.

139.12 (e) For the rate year beginning January 1, 2023, for eligible nursing facilities, the property
139.13 payment rate is 40 percent of the total hold harmless rate and 60 percent of the property
139.14 payment rate calculated in section 256R.265.

139.15 (f) For the rate year beginning January 1, 2024, for eligible nursing facilities, the property
139.16 payment rate is 20 percent of the total hold harmless rate and 80 percent of the property
139.17 payment rate calculated in section 256R.265.

139.18 (g) For rate years beginning January 1, 2025, and thereafter, the property payment rate
139.19 is as calculated under section 256R.265.

139.20 **Sec. 19. [256R.261] NURSING FACILITY PROPERTY RATE DEFINITIONS.**

139.21 Subdivision 1. **Definitions.** For purposes of sections 256R.26 to 256R.27, the following
139.22 terms have the meanings given them.

139.23 Subd. 2. **Addition.** "Addition" means an extension, enlargement, or expansion of the
139.24 nursing facility for the purpose of increasing the number of licensed beds or improving
139.25 resident care.

139.26 Subd. 3. **Appraisal.** "Appraisal" means an evaluation of the nursing facility's physical
139.27 real estate conducted by a property appraisal firm selected by the commissioner to establish
139.28 the valuation of a building and fixed equipment.

139.29 Subd. 4. **Building.** "Building" means the physical plant and fixed equipment used directly
139.30 for resident care and licensed under chapter 144A or sections 144.50 to 144.56. Building
139.31 excludes buildings or portions of buildings used by central, affiliated, or corporate offices.

140.1 Subd. 5. **Commercial valuation system.** "Commercial valuation system" means a
140.2 commercially available building valuation system selected by the commissioner that may
140.3 include the Marshall and Swift Valuation System.

140.4 Subd. 6. **Depreciable movable equipment.** "Depreciable movable equipment" means
140.5 the standard movable care equipment and support service equipment generally used in
140.6 nursing facilities. Depreciable movable equipment includes equipment specified in the major
140.7 movable equipment table of the depreciation guidelines. The general characteristics of this
140.8 equipment are: (1) a relatively fixed location in the building; (2) capable of being moved
140.9 as distinguished from building equipment; (3) a unit cost sufficient to justify ledger control;
140.10 and (4) sufficient size and identity to make control feasible by means of identification tags.

140.11 Subd. 7. **Depreciated replacement cost or DRC.** "Depreciated replacement cost" or
140.12 "DRC" means the depreciated replacement cost determined by an appraisal using the
140.13 commercial valuation system. DRC excludes costs related to parking structures.

140.14 Subd. 8. **Depreciation expense.** "Depreciation expense" means the portion of a capital
140.15 asset deemed to be consumed or expired over the life of the asset.

140.16 Subd. 9. **Depreciation guidelines.** "Depreciation guidelines" means the most recent
140.17 publication of "Estimated Useful Lives of Depreciable Hospital Assets" issued by the
140.18 American Hospital Association.

140.19 Subd. 10. **Equipment allowance.** "Equipment allowance" means the component of the
140.20 property-related payment rate which is a payment for the use of depreciable movable
140.21 equipment.

140.22 Subd. 11. **Fair rental value system.** "Fair rental value system" means a system that
140.23 establishes a price for the use of a space based on an appraised value of the property. The
140.24 price is established without consideration of the actual accounting cost to construct or
140.25 remodel the property. The price is the nursing facility value, subject to limits, multiplied
140.26 by an established rental rate.

140.27 Subd. 12. **Fixed equipment.** "Fixed equipment" means equipment affixed to the building
140.28 and not subject to transfer, including but not limited to wiring, electrical fixtures, plumbing,
140.29 elevators, and heating and air conditioning systems.

140.30 Subd. 13. **Land improvement.** "Land improvement" means improvement to the land
140.31 surrounding the nursing facility directly used for nursing facility operations as specified in
140.32 the land improvements table of the depreciation guidelines. Land improvement includes

141.1 construction of auxiliary buildings including sheds, garages, storage buildings, and parking
141.2 structures.

141.3 Subd. 14. **Rental rate.** "Rental rate" means the percentage applied to the allowable value
141.4 of the building and attached fixtures per year in the property payment calculation as
141.5 determined by the commissioner.

141.6 Subd. 15. **Shared area.** "Shared area" means square footage that a nursing facility shares
141.7 with a non-nursing facility operation to provide a support service.

141.8 Subd. 16. **Threshold project.** "Threshold project" means additions to a building or fixed
141.9 equipment that exceed the costs specified in section 256R.26, subdivision 5, paragraph (b).
141.10 Threshold projects exclude land, land improvements, and movable equipment purchases.

141.11 Subd. 17. **Undepreciated replacement cost or URC.** "Undepreciated replacement cost"
141.12 or "URC" means the undepreciated replacement cost determined by the appraisal for building
141.13 and attached fixtures using a commercial valuation system. URC excludes costs related to
141.14 parking structures.

141.15 Subd. 18. **Undepreciated replacement cost (URC) per bed limit.** "Undepreciated
141.16 replacement cost (URC) per bed limit" means the maximum allowed URC per nursing
141.17 facility bed as established by the commissioner based on values across the industry and
141.18 compared to an industry standard for reasonableness.

141.19 Sec. 20. **[256R.265] PROPERTY RATE CALCULATION UNDER FAIR RENTAL**
141.20 **VALUE SYSTEM.**

141.21 Subdivision 1. **Square feet per bed limit.** The square feet per bed limit is calculated as
141.22 follows:

141.23 (1) the URC of the nursing facility from the appraisal is divided by the allowable nursing
141.24 facility square feet;

141.25 (2) the allowable total square feet is calculated by dividing the actual square feet from
141.26 the appraisal, after adjustment for non-nursing facility area, by the number of licensed beds
141.27 three months prior to the beginning of the rate year limited to the following maximum. The
141.28 allowable square feet maximum is 800 square feet per bed plus 25 percent of the square
141.29 feet over 800 up to 1,200 square feet per bed. Square feet over 1,200 square feet per bed is
141.30 not recognized; and

142.1 (3) the allowable total square feet in clause (2) is multiplied by the amount in clause (1)
142.2 and by the number of licensed beds three months prior to the beginning of the rate year to
142.3 determine the square feet per bed limit.

142.4 Subd. 2. **Total URC limit.** The total URC limit is calculated as follows:

142.5 (1) the allowable square feet per bed limit as determined in subdivision 1 is divided by
142.6 the number of licensed beds three months prior to the beginning of the rate year to determine
142.7 allowable URC per bed limit for each nursing facility, adjusted for square feet limitation;

142.8 (2) the allowable URC per bed limit, adjusted for square feet limitation, for all nursing
142.9 facilities is placed in an array annually to determine the value at the 75th percentile. This
142.10 is the limit for URC per bed limit for non-single beds;

142.11 (3) the value determined in clause (2) is multiplied by 115 percent to determine the limit
142.12 for URC per bed limit for single beds;

142.13 (4) the number of non-single-licensed beds three months prior to the beginning of the
142.14 rate year is multiplied by the amount in clause (2);

142.15 (5) the number of single-licensed beds three months prior to the beginning of the rate
142.16 year is multiplied by the amount in clause (3); and

142.17 (6) the amounts in clauses (4) and (5) are summed to determine the total URC limit;

142.18 Subd. 3. **Calculation of total property rate.** The total property rate is calculated as
142.19 follows:

142.20 (1) the lower of the allowable URC based on square feet per bed limit as determined
142.21 under subdivision 1 or the total URC limit in subdivision 2 is the final allowed URC;

142.22 (2) the final allowed URC determined in clause (1) is divided by the URC from the
142.23 appraisal to determine the allowed percentage. The allowed percentage is multiplied by the
142.24 depreciated replacement value from the appraisal, adjusted for non-nursing facility area, to
142.25 determine the final allowed depreciated replacement value;

142.26 (3) the number of licensed beds three months prior to the beginning of the rate year is
142.27 multiplied by \$5,305 to determine reimbursement for land and land improvements. There
142.28 is no separate addition to the property rate for parking structures;

142.29 (4) the values in clauses (2) and (3) are summed and then multiplied by the rental rate
142.30 of 5.5 percent to determine allowable property reimbursement;

142.31 (5) the allowable property reimbursement determined in clause (4) is divided by 90
142.32 percent of capacity days to determine the building property rate. Capacity days are determined

143.1 by multiplying the number of licensed beds three months prior to the beginning of the report
143.2 year by 365;

143.3 (6) for the rate year beginning January 1, 2020, the equipment allowance is \$2.77 per
143.4 resident day. For the rate year beginning January 1, 2021, the equipment allowance must
143.5 be adjusted annually for inflation. The index for the inflation adjustment must be based on
143.6 the change in the United States All Items Consumer Price Index (CPI-U) forecasted by the
143.7 Reports and Forecasts Division of the Department of Human Services in the third quarter
143.8 of the calendar year preceding the rate year. The inflation adjustment must be based on the
143.9 12-month period from the midpoint of the previous rate year to the midpoint of the rate year
143.10 for which the rate is being determined; and

143.11 (7) the sum of the building property rate and the equipment allowance is the total property
143.12 rate.

143.13 **Sec. 21. [256R.27] INTERIM AND SETTLE UP TOTAL OPERATING AND**
143.14 **EXTERNAL FIXED COST PAYMENT RATES.**

143.15 Subdivision 1. **Generally.** (a) A newly constructed nursing facility, or a nursing facility
143.16 with a capacity increase of 50 percent or more, must receive an interim total operating rate
143.17 payment and settle up total operating cost payment according to this section.

143.18 (b) The nursing facility shall submit a written application to the commissioner to receive
143.19 an interim total operating payment rate. In its application, the nursing facility shall state
143.20 any reasons for noncompliance with this chapter.

143.21 (c) The effective date of the interim total operating payment rate is the earlier of either
143.22 the first day a resident is admitted to the newly constructed nursing facility or the date the
143.23 nursing facility bed is certified for the medical assistance program. The interim total operating
143.24 payment rate must not be in effect more than 17 months.

143.25 (d) The nursing facility must continue to receive the interim total operating payment
143.26 rate until the settle up total operating cost payment is determined under subdivision 3.

143.27 (e) The settle up total operating cost payment rate is effective retroactively to the
143.28 beginning of the interim cost report period, and is effective until the end of the interim rate
143.29 period.

143.30 (f) For the 15-month period following the settle up reporting period, the total operating
143.31 rate payment and external fixed cost payment rate must be determined according to
143.32 subdivision 3, paragraph (b).

144.1 (g) The total operating rate payment and external fixed cost payment rate for the rate
144.2 year beginning January 1 following the 15-month period in paragraph (f) must be determined
144.3 under this chapter.

144.4 (h) The commissioner shall determine interim total operating cost payment rates and
144.5 settle up total operating cost payment rates for a newly constructed nursing facility, or a
144.6 nursing facility with an increase in licensed capacity of 50 percent or more, according to
144.7 subdivisions 2 and 3.

144.8 **Subd. 2. Determination of interim operating and external fixed cost payment rate.** (a)
144.9 The nursing facility shall submit an interim cost report in a format similar to the Minnesota
144.10 Statistical and Cost Report and other supporting information as required by this chapter for
144.11 the reporting year in which the nursing facility plans to begin operation at least 60 days
144.12 before the first day a resident is admitted to the newly constructed nursing facility bed. The
144.13 interim cost report must include the nursing facility's anticipated interim costs and anticipated
144.14 interim resident days for each resident class in the interim cost report. The anticipated interim
144.15 resident days for each resident class is multiplied by the weight for that resident class to
144.16 determine the anticipated interim standardized days as defined in section 256R.02,
144.17 subdivision 50, and resident days as defined in section 256R.02, subdivision 45, for the
144.18 reporting period.

144.19 (b) The interim total operating cost payment rate is determined according to this section,
144.20 except that:

144.21 (1) the anticipated interim costs and anticipated interim resident days reported on the
144.22 interim cost report and the anticipated interim standardized days as defined by section
144.23 256R.02, subdivision 50, must be used for the interim;

144.24 (2) the commissioner shall use anticipated interim costs and anticipated interim
144.25 standardized days in determining the allowable historical direct care cost per standardized
144.26 day as determined under section 256R.23, subdivision 2;

144.27 (3) the commissioner shall use anticipated interim costs and anticipated interim resident
144.28 days in determining the allowable historical other care-related cost per resident day as
144.29 determined under section 256R.23, subdivision 3;

144.30 (4) the commissioner shall use anticipated interim costs and anticipated interim resident
144.31 days to determine the allowable historical external fixed cost per day under section 256R.25,
144.32 paragraphs (b) to (k);

145.1 (5) the total care-related payment rate limits established in section 256R.23, subdivision
145.2 5, and in effect at the beginning of the interim period, must be increased by ten percent; and

145.3 (6) the other operating payment rate as determined under section 256R.24 in effect for
145.4 the rate year must be used for the other operating cost per day.

145.5 **Subd. 3. Determination of settle up operating and external fixed cost payment**
145.6 **rate.** (a) When the interim payment rate begins between May 1 and September 30, the
145.7 nursing facility shall file settle up cost reports for the period from the beginning of the
145.8 interim payment rate through September 30 of the following year.

145.9 (b) When the interim payment rate begins between October 1 and April 30, the nursing
145.10 facility shall file settle up cost reports for the period from the beginning of the interim
145.11 payment rate to the first September 30 following the beginning of the interim payment rate.

145.12 (c) The settle up total operating cost payment rate is determined according to this section,
145.13 except that:

145.14 (1) the allowable costs and resident days reported on the settle up cost report and the
145.15 standardized days as defined by section 256R.02, subdivision 50, must be used for the
145.16 interim and settle-up period;

145.17 (2) the commissioner shall use the allowable costs and standardized days in clause (1)
145.18 to determine the allowable historical direct care cost per standardized day as determined
145.19 under section 256R.23, subdivision 2;

145.20 (3) the commissioner shall use the allowable costs and the allowable resident days to
145.21 determine both the allowable historical other care-related cost per resident day as determined
145.22 under section 256R.23, subdivision 3;

145.23 (4) the commissioner shall use the allowable costs and the allowable resident days to
145.24 determine the allowable historical external fixed cost per day under section 256R.25,
145.25 paragraphs (b) to (k);

145.26 (5) the total care-related payment limits established in section 256R.23, subdivision 5,
145.27 are the limits for the settle up reporting periods. If the interim period includes more than
145.28 one July 1 date, the commissioner shall use the total care-related payment limit established
145.29 in section 256R.23, subdivision 5, increased by ten percent for the second July 1 date; and

145.30 (6) the other operating payment rate as determined under section 256R.24 in effect for
145.31 the rate year must be used for the other operating cost per day.

146.1 Sec. 22. Minnesota Statutes 2018, section 256R.44, is amended to read:

146.2 **256R.44 RATE ADJUSTMENT FOR PRIVATE ROOMS FOR MEDICAL**
146.3 **NECESSITY.**

146.4 The amount paid for a private room is ~~41.5~~ 110 percent of the established total payment
146.5 rate for a resident if the resident is a medical assistance recipient and the private room is
146.6 considered a medical necessity for the resident or others who are affected by the resident's
146.7 condition, ~~except as provided in Minnesota Rules, part 9549.0060, subpart 11, item C.~~
146.8 Conditions requiring a private room must be determined by the resident's attending physician
146.9 and submitted to the commissioner for approval or denial by the commissioner on the basis
146.10 of medical necessity.

146.11 **EFFECTIVE DATE.** This section is effective January 1, 2020.

146.12 Sec. 23. Minnesota Statutes 2018, section 256R.47, is amended to read:

146.13 **256R.47 RATE ADJUSTMENT FOR CRITICAL ACCESS NURSING**
146.14 **FACILITIES.**

146.15 (a) The commissioner, in consultation with the commissioner of health, may designate
146.16 certain nursing facilities as critical access nursing facilities. The designation shall be granted
146.17 on a competitive basis, within the limits of funds appropriated for this purpose.

146.18 (b) The commissioner shall request proposals from nursing facilities every two years.
146.19 Proposals must be submitted in the form and according to the timelines established by the
146.20 commissioner. In selecting applicants to designate, the commissioner, in consultation with
146.21 the commissioner of health, and with input from stakeholders, shall develop criteria designed
146.22 to preserve access to nursing facility services in isolated areas, rebalance long-term care,
146.23 and improve quality. To the extent practicable, the commissioner shall ensure an even
146.24 distribution of designations across the state.

146.25 (c) The commissioner shall allow the benefits in clauses (1) to (5) for nursing facilities
146.26 designated as critical access nursing facilities:

146.27 (1) partial rebasing, with the commissioner allowing a designated facility operating
146.28 payment rates being the sum of up to 60 percent of the operating payment rate determined
146.29 in accordance with section 256R.21, subdivision 3, and at least 40 percent, with the sum of
146.30 the two portions being equal to 100 percent, of the operating payment rate that would have
146.31 been allowed had the facility not been designated. The commissioner may adjust these
146.32 percentages by up to 20 percent and may approve a request for less than the amount allowed;

147.1 (2) enhanced payments for leave days. Notwithstanding section 256R.43, upon
147.2 designation as a critical access nursing facility, the commissioner shall limit payment for
147.3 leave days to 60 percent of that nursing facility's total payment rate for the involved resident,
147.4 and shall allow this payment only when the occupancy of the nursing facility, inclusive of
147.5 bed hold days, is equal to or greater than 90 percent;

147.6 (3) two designated critical access nursing facilities, with up to 100 beds in active service,
147.7 may jointly apply to the commissioner of health for a waiver of Minnesota Rules, part
147.8 4658.0500, subpart 2, in order to jointly employ a director of nursing. The commissioner
147.9 of health shall consider each waiver request independently based on the criteria under
147.10 Minnesota Rules, part 4658.0040;

147.11 (4) the minimum threshold under section 256B.431, subdivision 15, paragraph (e), shall
147.12 be 40 percent of the amount that would otherwise apply; and

147.13 (5) the quality-based rate limits under section 256R.23, subdivisions 5 to 7, apply to
147.14 designated critical access nursing facilities.

147.15 (d) Designation of a critical access nursing facility is for a period of two years, after
147.16 which the benefits allowed under paragraph (c) shall be removed. Designated facilities may
147.17 apply for continued designation.

147.18 (e) This section is suspended and no state or federal funding shall be appropriated or
147.19 allocated for the purposes of this section from January 1, 2016, to ~~December 31, 2019,~~
147.20 through December 31, 2023.

147.21 Sec. 24. Minnesota Statutes 2018, section 256R.50, subdivision 6, is amended to read:

147.22 Subd. 6. **Determination of rate adjustment.** (a) If the amount determined in subdivision
147.23 5 is less than or equal to the amount determined in subdivision 4, the commissioner shall
147.24 allow a total payment rate equal to the amount used in subdivision 5, clause (3).

147.25 (b) If the amount determined in subdivision 5 is greater than the amount determined in
147.26 subdivision 4, the commissioner shall allow a rate with a case mix index of 1.0 that when
147.27 used in subdivision 5, clause (3), results in the amount determined in subdivision 5 being
147.28 equal to the amount determined in subdivision 4.

147.29 (c) If the commissioner relies upon provider estimates in subdivision 5, clause (1) or
147.30 (2), then annually, for three years after the rates determined in this section take effect, the
147.31 commissioner shall determine the accuracy of the alternative factors of medical assistance
147.32 case load and the facility average case mix index used in this section and shall reduce the
147.33 total payment rate if the factors used result in medical assistance costs exceeding the amount

148.1 in subdivision 4. If the actual medical assistance costs exceed the estimates by more than
 148.2 five percent, the commissioner shall also recover the difference between the estimated costs
 148.3 in subdivision 5 and the actual costs according to section 256B.0641. The commissioner
 148.4 may require submission of data from the receiving facility needed to implement this
 148.5 paragraph.

148.6 (d) When beds approved for relocation are put into active service at the destination
 148.7 facility, rates determined in this section must be adjusted by any adjustment amounts that
 148.8 were implemented after the date of the letter of approval.

148.9 (e) Rate adjustments determined under this subdivision expire after three full rate years
 148.10 following the effective date of the rate adjustment. This subdivision expires when the final
 148.11 rate adjustment determined under this subdivision expires.

148.12 Sec. 25. **DIRECTION TO COMMISSIONER; MORATORIUM EXCEPTION**
 148.13 **FUNDING.**

148.14 In fiscal year 2019, the commissioner of health may approve moratorium exception
 148.15 projects under Minnesota Statutes, section 144A.073, for which the full annualized state
 148.16 share of medical assistance costs does not exceed \$1,500,000 plus any carryover of previous
 148.17 appropriations for this purpose.

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

148.19 Sec. 26. **REPEALER.**

148.20 (a) Minnesota Statutes 2018, sections 144A.071, subdivision 4d; 256R.40; and 256R.41,
 148.21 are repealed effective July 1, 2019.

148.22 (b) Minnesota Statutes 2018, sections 256B.431, subdivisions 3a, 3f, 3g, 3i, 13, 15, 17,
 148.23 17a, 17c, 17d, 17e, 18, 21, 22, 30, and 45; 256B.434, subdivisions 4, 4f, 4i, and 4j; and
 148.24 256R.36, and Minnesota Rules, parts 9549.0057; and 9549.0060, subparts 4, 5, 6, 7, 10, 11,
 148.25 and 14, are repealed effective January 1, 2020.

148.26 ARTICLE 5

148.27 DISABILITY SERVICES

148.28 Section 1. Minnesota Statutes 2018, section 237.50, subdivision 4a, is amended to read:

148.29 Subd. 4a. **Deaf.** "Deaf" means a hearing loss of such severity that the ~~individual~~ person
 148.30 must depend primarily upon visual communication such as writing, lip reading, sign language,
 148.31 and gestures.

149.1 **EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented
149.2 by October 1, 2019.

149.3 Sec. 2. Minnesota Statutes 2018, section 237.50, is amended by adding a subdivision to
149.4 read:

149.5 Subd. 4c. **Discounted telecommunications or Internet services.** "Discounted
149.6 telecommunications or Internet services" means private, nonprofit, and public programs
149.7 intended to subsidize or reduce the monthly costs of telecommunications or Internet services
149.8 for a person who meets a program's eligibility requirements.

149.9 **EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented
149.10 by October 1, 2019.

149.11 Sec. 3. Minnesota Statutes 2018, section 237.50, subdivision 6a, is amended to read:

149.12 Subd. 6a. **Hard-of-hearing.** "Hard-of-hearing" means a hearing loss resulting in a
149.13 functional limitation, but not to the extent that the ~~individual~~ person must depend primarily
149.14 upon visual communication in all interactions.

149.15 **EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented
149.16 by October 1, 2019.

149.17 Sec. 4. Minnesota Statutes 2018, section 237.50, is amended by adding a subdivision to
149.18 read:

149.19 Subd. 6b. **Interconnectivity product.** "Interconnectivity product" means a device,
149.20 accessory, or application for which the primary function is use with a telecommunications
149.21 device. Interconnectivity product may include a cell phone amplifier, hearing aid streamer,
149.22 Bluetooth-enabled device that connects to a wireless telecommunications device, advanced
149.23 communications application for a smartphone, or other applicable technology.

149.24 **EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented
149.25 by October 1, 2019.

149.26 Sec. 5. Minnesota Statutes 2018, section 237.50, subdivision 10a, is amended to read:

149.27 Subd. 10a. **Telecommunications device.** "Telecommunications device" means a device
149.28 that (1) allows a person with a communication disability to have access to
149.29 telecommunications services as defined in subdivision 13, and (2) is specifically selected
149.30 by the Department of Human Services for its capacity to allow persons with communication

150.1 disabilities to use telecommunications services in a manner that is functionally equivalent
150.2 to the ability of ~~an individual~~ a person who does not have a communication disability. A
150.3 telecommunications device may include a ring signaler, an amplified telephone, a hands-free
150.4 telephone, a text telephone, a captioned telephone, a wireless device, a device that produces
150.5 Braille output for use with a telephone, and any other device the Department of Human
150.6 Services deems appropriate.

150.7 **EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented
150.8 by October 1, 2019.

150.9 Sec. 6. Minnesota Statutes 2018, section 237.50, subdivision 11, is amended to read:

150.10 Subd. 11. **Telecommunications Relay Services.** "Telecommunications Relay Services"
150.11 or "TRS" means the telecommunications transmission services required under Federal
150.12 Communications Commission regulations at Code of Federal Regulations, title 47, sections
150.13 64.604 to 64.606. TRS allows ~~an individual~~ a person who has a communication disability
150.14 to use telecommunications services in a manner that is functionally equivalent to the ability
150.15 of ~~an individual~~ a person who does not have a communication disability.

150.16 **EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented
150.17 by October 1, 2019.

150.18 Sec. 7. Minnesota Statutes 2018, section 237.51, subdivision 1, is amended to read:

150.19 Subdivision 1. **Creation.** (a) The commissioner of commerce shall:

150.20 (1) administer through interagency agreement with the commissioner of human services
150.21 a program to distribute telecommunications devices and interconnectivity products to eligible
150.22 persons who have communication disabilities; and

150.23 (2) contract with one or more qualified vendors that serve persons who have
150.24 communication disabilities to provide telecommunications relay services.

150.25 (b) For purposes of sections 237.51 to 237.56, the Department of Commerce and any
150.26 organization with which it contracts pursuant to this section or section 237.54, subdivision
150.27 2, are not telephone companies or telecommunications carriers as defined in section 237.01.

150.28 **EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented
150.29 by October 1, 2019.

151.1 Sec. 8. Minnesota Statutes 2018, section 237.51, subdivision 5a, is amended to read:

151.2 Subd. 5a. **Commissioner of human services duties.** (a) In addition to any duties specified
151.3 elsewhere in sections 237.51 to 237.56, the commissioner of human services shall:

151.4 (1) define economic hardship, special needs, and household criteria so as to determine
151.5 the priority of eligible applicants for initial distribution of devices and products and to
151.6 determine circumstances necessitating provision of more than one telecommunications
151.7 device per household;

151.8 (2) establish a method to verify eligibility requirements;

151.9 (3) establish specifications for telecommunications devices and interconnectivity products
151.10 to be provided under section 237.53, subdivision 3;

151.11 (4) inform the public and specifically persons who have communication disabilities of
151.12 the program; ~~and~~

151.13 (5) provide devices and products based on the assessed need of eligible applicants; and

151.14 (6) assist a person with completing an application for discounted telecommunications
151.15 or Internet services.

151.16 (b) The commissioner may establish an advisory board to advise the department in
151.17 carrying out the duties specified in this section and to advise the commissioner of commerce
151.18 in carrying out duties under section 237.54. If so established, the advisory board must
151.19 include, at a minimum, the following persons:

151.20 (1) at least one member who is deaf;

151.21 (2) at least one member who has a speech disability;

151.22 (3) at least one member who has a physical disability that makes it difficult or impossible
151.23 for the person to access telecommunications services; and

151.24 (4) at least one member who is hard-of-hearing.

151.25 (c) The membership terms, compensation, and removal of members and the filling of
151.26 membership vacancies are governed by section 15.059. Advisory board meetings shall be
151.27 held at the discretion of the commissioner.

151.28 **EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented
151.29 by October 1, 2019.

152.1 Sec. 9. Minnesota Statutes 2018, section 237.52, subdivision 5, is amended to read:

152.2 Subd. 5. **Expenditures.** (a) Money in the fund may only be used for:

152.3 (1) expenses of the Department of Commerce, including personnel cost, public relations,
152.4 advisory board members' expenses, preparation of reports, and other reasonable expenses
152.5 not to exceed ten percent of total program expenditures;

152.6 (2) reimbursing the commissioner of human services for purchases made or services
152.7 provided pursuant to section 237.53; and

152.8 (3) contracting for the provision of TRS required by section 237.54.

152.9 (b) All costs directly associated with the establishment of the program, the purchase and
152.10 distribution of telecommunications devices, and interconnectivity products, and the provision
152.11 of TRS are either reimbursable or directly payable from the fund after authorization by the
152.12 commissioner of commerce. The commissioner of commerce shall contract with one or
152.13 more TRS providers to indemnify the telecommunications service providers for any fines
152.14 imposed by the Federal Communications Commission related to the failure of the relay
152.15 service to comply with federal service standards. Notwithstanding section 16A.41, the
152.16 commissioner may advance money to the TRS providers if the providers establish to the
152.17 commissioner's satisfaction that the advance payment is necessary for the provision of the
152.18 service. The advance payment may be used only for working capital reserve for the operation
152.19 of the service. The advance payment must be offset or repaid by the end of the contract
152.20 fiscal year together with interest accrued from the date of payment.

152.21 **EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented
152.22 by October 1, 2019.

152.23 Sec. 10. Minnesota Statutes 2018, section 237.53, is amended to read:

152.24 **237.53 TELECOMMUNICATIONS ~~DEVICE~~ DEVICES AND**
152.25 **INTERCONNECTIVITY PRODUCTS.**

152.26 Subdivision 1. **Application.** A person applying for a telecommunications device or
152.27 interconnectivity product under this section must apply to the program administrator on a
152.28 form prescribed by the Department of Human Services.

152.29 Subd. 2. **Eligibility.** To be eligible to obtain a telecommunications device or
152.30 interconnectivity product under this section, a person must:

152.31 (1) be able to benefit from and use the equipment for its intended purpose;

152.32 (2) have a communication disability;

153.1 (3) be a resident of the state;

153.2 (4) be a resident in a household that has a median income at or below the applicable
153.3 median household income in the state, except a person who is deafblind applying for a
153.4 Braille device may reside in a household that has a median income no more than 150 percent
153.5 of the applicable median household income in the state; and

153.6 (5) be a resident in a household that has telecommunications service or that has made
153.7 application for service and has been assigned a telephone number; or a resident in a residential
153.8 care facility, such as a nursing home or group home where telecommunications service is
153.9 not included as part of overall service provision.

153.10 Subd. 2a. **Assessment of needs.** After a person is determined to be eligible for the
153.11 program, the commissioner of human services shall assess the person's telecommunications
153.12 needs to determine: (1) the type of telecommunications device that provides the person with
153.13 functionally equivalent access to telecommunications services; and (2) appropriate
153.14 interconnectivity products for the person.

153.15 Subd. 3. **Distribution.** The commissioner of human services shall (1) purchase ~~and~~
153.16 ~~distribute~~ a sufficient number of telecommunications devices and interconnectivity products
153.17 so that each eligible household receives appropriate devices and products as determined
153.18 under section 237.51, subdivision 5a. ~~The commissioner of human services shall, and (2)~~
153.19 ~~distribute the devices~~ and products to eligible households free of charge.

153.20 Subd. 4. **Training; information; maintenance.** The commissioner of human services
153.21 shall maintain the telecommunications devices and interconnectivity products until the
153.22 warranty period expires, and provide training, without charge, to first-time users of the
153.23 ~~devices- and products.~~ The commissioner shall provide information about assistive
153.24 communications devices and products that may benefit a program participant and about
153.25 where a person may obtain or purchase assistive communications devices and products.
153.26 Assistive communications devices and products include a pocket talker for a person who
153.27 is hard-of-hearing, a communication board for a person with a speech disability, a one-to-one
153.28 video communication application for a person who is deaf, and other devices and products
153.29 designed to facilitate effective communication for a person with a communication disability.

153.30 Subd. 6. **Ownership.** Telecommunications devices and interconnectivity products
153.31 purchased pursuant to subdivision 3, clause (1), are the property of the state of Minnesota.
153.32 Policies and procedures for the return of distributed devices ~~from individuals who withdraw~~
153.33 ~~from the program or whose eligibility status changes~~ and products shall be determined by
153.34 the commissioner of human services.

154.1 Subd. 7. **Standards.** The telecommunications devices distributed under this section must
154.2 comply with the electronic industries alliance standards and be approved by the Federal
154.3 Communications Commission. The commissioner of human services must provide each
154.4 eligible person a choice of several models of devices, the retail value of which may not
154.5 exceed \$600 for a text telephone, and a retail value of \$7,000 for a Braille device, or an
154.6 amount authorized by the Department of Human Services for all other telecommunications
154.7 devices ~~and~~, auxiliary equipment, and interconnectivity products it deems cost-effective
154.8 and appropriate to distribute according to sections 237.51 to 237.56.

154.9 Subd. 9. **Discounted telecommunications or Internet services assistance.** The
154.10 commissioner of human services shall assist a person who is applying for telecommunication
154.11 devices and products in applying for discounted telecommunications or Internet services.

154.12 **EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented
154.13 by October 1, 2019.

154.14 Sec. 11. Minnesota Statutes 2018, section 245C.03, is amended by adding a subdivision
154.15 to read:

154.16 Subd. 13. **Early intensive developmental and behavioral intervention providers.** The
154.17 commissioner shall conduct background studies according to this chapter when initiated by
154.18 an early intensive developmental and behavioral intervention provider under section
154.19 256B.0949.

154.20 Sec. 12. Minnesota Statutes 2018, section 245C.10, is amended by adding a subdivision
154.21 to read:

154.22 Subd. 14. **Early intensive developmental and behavioral intervention providers.** The
154.23 commissioner shall recover the cost of background studies required under section 245C.03,
154.24 subdivision 13, for the purposes of early intensive developmental and behavioral intervention
154.25 under section 256B.0949, through a fee of no more than \$32 per study charged to the enrolled
154.26 agency. Fees collected under this subdivision are appropriated to the commissioner for the
154.27 purpose of conducting background studies.

154.28 Sec. 13. Minnesota Statutes 2018, section 245D.03, subdivision 1, is amended to read:

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

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

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

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

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

155.19 (4) 24-hour emergency assistance, personal emergency response as defined under the
155.20 community access for disability inclusion and developmental disability waiver plans;

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

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

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

155.27 (8) individualized home supports services as defined under the brain injury, community
155.28 alternative care, and community access for disability inclusion, and developmental disability
155.29 waiver plans.

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

155.33 (1) intervention services, including:

- 156.1 (i) behavioral support services as defined under the brain injury and community access
 156.2 for disability inclusion waiver plans;
- 156.3 (ii) in-home or out-of-home crisis respite services as defined under the developmental
 156.4 disability waiver plan; and
- 156.5 (iii) specialist services as defined under the current developmental disability waiver
 156.6 plan;
- 156.7 (2) in-home support services, including:
- 156.8 (i) in-home family support and supported living services as defined under the
 156.9 developmental disability waiver plan;
- 156.10 (ii) independent living services training as defined under the brain injury and community
 156.11 access for disability inclusion waiver plans;
- 156.12 (iii) semi-independent living services; ~~and~~
- 156.13 ~~(iv) individualized home supports services as defined under the brain injury, community~~
 156.14 ~~alternative care, and community access for disability inclusion waiver plans;~~
- 156.15 (iv) individualized home support with training services as defined under the brain injury,
 156.16 community alternative care, community access for disability inclusion, and developmental
 156.17 disability waiver plans; and
- 156.18 (v) individualized home support with family training services as defined under the brain
 156.19 injury, community alternative care, community access for disability inclusion, and
 156.20 developmental disability waiver plans;
- 156.21 (3) residential supports and services, including:
- 156.22 (i) supported living services as defined under the developmental disability waiver plan
 156.23 provided in a family or corporate child foster care residence, a family adult foster care
 156.24 residence, a community residential setting, or a supervised living facility;
- 156.25 (ii) foster care services as defined in the brain injury, community alternative care, and
 156.26 community access for disability inclusion waiver plans provided in a family or corporate
 156.27 child foster care residence, a family adult foster care residence, or a community residential
 156.28 setting; ~~and~~
- 156.29 (iii) community residential services as defined under the brain injury, community
 156.30 alternative care, community access for disability inclusion, and developmental disability
 156.31 waiver plans provided in a corporate child foster care residence, a community residential
 156.32 setting, or a supervised living facility;

157.1 (iv) family residential services as defined in the brain injury, community alternative
 157.2 care, community access for disability inclusion, and developmental disability waiver plans
 157.3 provided in a family child foster care residence or a family adult foster care residence; and

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

157.6 (4) day services, including:

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

157.8 (ii) day services under sections 252.41 to 252.46, and as defined under the brain injury,
 157.9 community alternative care, community access for disability inclusion, and developmental
 157.10 disability waiver plans;

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

157.13 ~~(iii)~~ (iv) prevocational services as defined under the brain injury and, community
 157.14 alternative care, community access for disability inclusion, and developmental disability
 157.15 waiver plans; and

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

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

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

157.25 (8) integrated community support as defined under the brain injury and community
 157.26 access for disability inclusion waiver plans beginning January 1, 2021, and community
 157.27 alternative care and developmental disability waiver plans beginning January 1, 2023.

157.28 **EFFECTIVE DATE.** This section is effective January 1, 2021, or upon federal approval,
 157.29 whichever is later. The commissioner of human services shall notify the revisor of statutes
 157.30 when federal approval is obtained.

158.1 Sec. 14. Minnesota Statutes 2018, section 245D.071, subdivision 1, is amended to read:

158.2 Subdivision 1. **Requirements for intensive support services.** Except for services
158.3 identified in section 245D.03, subdivision 1, paragraph (c), clauses (1) and (2), item (ii), a
158.4 license holder providing intensive support services identified in section 245D.03, subdivision
158.5 1, paragraph (c), must comply with the requirements in this section and section 245D.07,
158.6 subdivisions 1, 1a, and 3. Services identified in section 245D.03, subdivision 1, paragraph
158.7 (c), clauses (1) and (2), item (ii), must comply with the requirements in section 245D.07,
158.8 subdivision 2.

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

158.10 Sec. 15. **[245D.12] INTEGRATED COMMUNITY SUPPORTS; SETTING**
158.11 **CAPACITY REPORT.**

158.12 (a) The license holder providing integrated community support, as defined in section
158.13 245D.03, subdivision 1, paragraph (c), clause (8), must submit a setting capacity report to
158.14 the commissioner to ensure the identified location of service delivery meets the criteria of
158.15 the home and community-based service requirements as specified in section 256B.492.

158.16 (b) The license holder shall provide the setting capacity report on the forms and in the
158.17 manner prescribed by the commissioner. The report must include:

158.18 (1) the address of the multifamily housing building where the license holder delivers
158.19 integrated community supports and owns, leases, or has a direct or indirect financial
158.20 relationship with the property owner;

158.21 (2) the total number of living units in the multifamily housing building described in
158.22 clause (1) where integrated community supports are delivered;

158.23 (3) the total number of living units in the multifamily housing building described in
158.24 clause (1), including the living units identified in clause (2); and

158.25 (4) the percentage of living units that are controlled by the license holder in the
158.26 multifamily housing building by dividing clause (2) by clause (3).

158.27 (c) Only one license holder may deliver integrated community supports at the address
158.28 of the multifamily housing building.

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

159.1 Sec. 16. Minnesota Statutes 2018, section 252.275, subdivision 3, is amended to read:

159.2 Subd. 3. **Reimbursement.** Counties shall be reimbursed for all expenditures made
 159.3 pursuant to subdivision 1 at a rate of ~~70~~ 85 percent, up to the allocation determined pursuant
 159.4 to subdivisions 4 and 4b. However, the commissioner shall not reimburse costs of services
 159.5 for any person if the costs exceed the state share of the average medical assistance costs for
 159.6 services provided by intermediate care facilities for a person with a developmental disability
 159.7 for the same fiscal year, and shall not reimburse costs of a onetime living allowance for any
 159.8 person if the costs exceed \$1,500 in a state fiscal year. The commissioner may make
 159.9 payments to each county in quarterly installments. The commissioner may certify an advance
 159.10 of up to 25 percent of the allocation. Subsequent payments shall be made on a reimbursement
 159.11 basis for reported expenditures and may be adjusted for anticipated spending patterns.

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

159.13 Sec. 17. Minnesota Statutes 2018, section 252.41, subdivision 3, is amended to read:

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

159.17 (1) include supervision, training, assistance, support, center-based ~~center-based~~ facility-based
 159.18 work-related activities, or other community-integrated activities designed and implemented
 159.19 in accordance with the ~~individual service and individual habilitation plans~~ coordinated
 159.20 service and support plan and coordinated service and support plan addendum required under
 159.21 sections 245D.02, subdivision 4, paragraphs (a) and (b), and 256B.092, subdivision 1b, and
 159.22 Minnesota Rules, parts part 9525.0004, to 9525.0036 subpart 12, to help an adult reach and
 159.23 maintain the highest possible level of independence, productivity, and integration into the
 159.24 community; ~~and~~

159.25 (2) include day support services, prevocational services, day training and habilitation
 159.26 services, structured day services, and adult day services as defined in Minnesota's federally
 159.27 approved disability waiver plans; and

159.28 (3) are provided by a vendor licensed under sections 245A.01 to 245A.16 ~~and, 245D.27~~
 159.29 to 245D.31, 252.28, subdivision 2, and 252.41 to 252.46, and Minnesota Rules, parts
 159.30 9525.1200 to 9525.1330, to provide day ~~training and habilitation~~ services.

159.31 (b) Day ~~training and habilitation~~ services reimbursable under this section do not include
 159.32 special education and related services as defined in the Education of the Individuals with
 159.33 Disabilities Act, United States Code, title 20, chapter 33, section 1401, clauses (6) and (17),

160.1 or vocational services funded under section 110 of the Rehabilitation Act of 1973, United
160.2 States Code, title 29, section 720, as amended.

160.3 (c) Day ~~training and habilitation~~ services do not include employment exploration,
160.4 employment development, or employment support services as defined in the home and
160.5 community-based services waivers for people with disabilities authorized under sections
160.6 256B.092 and 256B.49.

160.7 **EFFECTIVE DATE.** This section is effective January 1, 2021, or upon federal approval,
160.8 whichever is later. The commissioner of human services shall notify the revisor of statutes
160.9 when federal approval is obtained.

160.10 Sec. 18. Minnesota Statutes 2018, section 252.41, subdivision 4, is amended to read:

160.11 Subd. 4. **Independence.** "Independence" means the extent to which persons with
160.12 ~~developmental~~ disabilities exert control and choice over their own lives.

160.13 **EFFECTIVE DATE.** This section is effective January 1, 2021.

160.14 Sec. 19. Minnesota Statutes 2018, section 252.41, subdivision 5, is amended to read:

160.15 Subd. 5. **Integration.** "Integration" means that persons with ~~developmental~~ disabilities:

160.16 (1) use the same community resources that are used by and available to individuals who
160.17 are not disabled;

160.18 (2) participate in the same community activities in which nondisabled individuals
160.19 participate; and

160.20 (3) regularly interact and have contact with nondisabled individuals.

160.21 **EFFECTIVE DATE.** This section is effective January 1, 2021.

160.22 Sec. 20. Minnesota Statutes 2018, section 252.41, subdivision 6, is amended to read:

160.23 Subd. 6. **Productivity.** "Productivity" means that persons with ~~developmental~~ disabilities:

160.24 (1) engage in income-producing work designed to improve their income level,
160.25 employment status, or job advancement; or

160.26 (2) engage in activities that contribute to a business, household, or community.

160.27 **EFFECTIVE DATE.** This section is effective January 1, 2021.

161.1 Sec. 21. Minnesota Statutes 2018, section 252.41, subdivision 7, is amended to read:

161.2 Subd. 7. **Regional center.** "Regional center" means any state-operated facility under
 161.3 the direct administrative authority of the commissioner that serves persons with
 161.4 ~~developmental~~ disabilities.

161.5 **EFFECTIVE DATE.** This section is effective January 1, 2021.

161.6 Sec. 22. Minnesota Statutes 2018, section 252.41, subdivision 9, is amended to read:

161.7 Subd. 9. **Vendor.** "Vendor" means a ~~nonprofit~~ legal entity that:

161.8 (1) is licensed under sections 245A.01 to 245A.16 ~~and~~, 245D.27 to 245D.31, 252.28,
 161.9 subdivision 2, and 252.41 to 252.46, and Minnesota Rules, parts 9525.1200 to 9525.1330,
 161.10 to provide day ~~training and habilitation~~ services to adults with ~~developmental~~ disabilities;
 161.11 and

161.12 (2) does not have a financial interest in the legal entity that provides residential services
 161.13 to the same person or persons to whom it provides day ~~training and habilitation~~ services.

161.14 This clause does not apply to regional treatment centers, state-operated, community-based
 161.15 programs operating according to section 252.50 until July 1, 2000, or vendors licensed prior
 161.16 to April 15, 1983.

161.17 **EFFECTIVE DATE.** This section is effective January 1, 2021.

161.18 Sec. 23. Minnesota Statutes 2018, section 252.42, is amended to read:

161.19 **252.42 SERVICE PRINCIPLES.**

161.20 The design and delivery of services eligible for reimbursement should reflect the
 161.21 following principles:

161.22 (1) services must suit a person's chronological age and be provided in the least restrictive
 161.23 environment possible, consistent with the needs identified in the person's ~~individual service~~
 161.24 ~~and individual habilitation plans under~~ coordinated service and support plan and coordinated
 161.25 service and support plan addendum required under sections 256B.092, subdivision 1b, and
 161.26 245D.02, subdivision 4, paragraphs (a) and (b), and Minnesota Rules, parts 9525.0004 to
 161.27 9525.0036, subpart 12;

161.28 (2) a person with a ~~developmental~~ disability whose individual ~~service and individual~~
 161.29 ~~habilitation plans~~ coordinated service and support plans and coordinated service and support
 161.30 plan addendums authorize employment or employment-related activities shall be given the

162.1 opportunity to participate in employment and employment-related activities in which
 162.2 nondisabled persons participate;

162.3 (3) a person with a ~~developmental~~ disability participating in work shall be paid wages
 162.4 commensurate with the rate for comparable work and productivity except as regional centers
 162.5 are governed by section 246.151;

162.6 (4) a person with a ~~developmental~~ disability shall receive services which include services
 162.7 offered in settings used by the general public and designed to increase the person's active
 162.8 participation in ordinary community activities;

162.9 (5) a person with a ~~developmental~~ disability shall participate in the patterns, conditions,
 162.10 and rhythms of everyday living and working that are consistent with the norms of the
 162.11 mainstream of society.

162.12 **EFFECTIVE DATE.** This section is effective January 1, 2021.

162.13 Sec. 24. Minnesota Statutes 2018, section 252.43, is amended to read:

162.14 **252.43 COMMISSIONER'S DUTIES.**

162.15 The commissioner shall supervise ~~county boards'~~ lead agencies' provision of day ~~training~~
 162.16 ~~and habilitation~~ services to adults with ~~developmental~~ disabilities. The commissioner shall:

162.17 (1) determine the need for day ~~training and habilitation~~ services under section ~~252.28~~
 162.18 256B.4914;

162.19 (2) establish payment rates as provided under section 256B.4914;

162.20 (3) add transportation costs to the day services payment rate;

162.21 (4) adopt rules for the administration and provision of day ~~training and habilitation~~
 162.22 services under sections ~~252.41 to 252.46~~ and sections 245A.01 to 245A.16 and, 252.28,
 162.23 subdivision 2, and 252.41 to 252.46, and Minnesota Rules, parts 9525.1200 to 9525.1330;

162.24 ~~(4)~~ (5) enter into interagency agreements necessary to ensure effective coordination and
 162.25 provision of day ~~training and habilitation~~ services;

162.26 ~~(5)~~ (6) monitor and evaluate the costs and effectiveness of day ~~training and habilitation~~
 162.27 services; and

162.28 ~~(6)~~ (7) provide information and technical help to ~~county boards'~~ lead agencies and vendors
 162.29 in their administration and provision of day ~~training and habilitation~~ services.

162.30 **EFFECTIVE DATE.** This section is effective January 1, 2021.

163.1 Sec. 25. Minnesota Statutes 2018, section 252.44, is amended to read:

163.2 **252.44 COUNTY LEAD AGENCY BOARD RESPONSIBILITIES.**

163.3 When the need for day ~~training and habilitation~~ services in a county or tribe has been
 163.4 determined under section 252.28, the board of commissioners for that ~~county~~ lead agency
 163.5 shall:

163.6 (1) authorize the delivery of services according to the ~~individual service and habilitation~~
 163.7 ~~plans~~ coordinated service and support plans and coordinated service and support plan
 163.8 addendums required as part of the ~~county's~~ lead agency's provision of case management
 163.9 services under sections 256B.0913, subdivision 8; 256B.0915, subdivision 6; 256B.092,
 163.10 subdivision 1b; and 256B.49, subdivision 15, and Minnesota Rules, parts 9525.0004 to
 163.11 9525.0036. ~~For calendar years for which section 252.46, subdivisions 2 to 10, apply, the~~
 163.12 ~~county board shall not authorize a change in service days from the number of days authorized~~
 163.13 ~~for the previous calendar year unless there is documentation for the change in the individual~~
 163.14 ~~service plan. An increase in service days must also be supported by documentation that the~~
 163.15 ~~goals and objectives assigned to the vendor cannot be met more economically and effectively~~
 163.16 ~~by other available community services and that without the additional days of service the~~
 163.17 ~~individual service plan could not be implemented in a manner consistent with the service~~
 163.18 ~~principles in section 252.42;~~

163.19 (2) ensure that transportation is provided or arranged by the vendor in the most efficient
 163.20 and reasonable way possible; and

163.21 (3) monitor and evaluate the cost and effectiveness of the services.

163.22 **EFFECTIVE DATE.** This section is effective January 1, 2021.

163.23 Sec. 26. Minnesota Statutes 2018, section 252.45, is amended to read:

163.24 **252.45 VENDOR'S DUTIES.**

163.25 A day service vendor enrolled with the commissioner is responsible for items under
 163.26 clauses (1), (2), and (3), and extends only to the provision of services that are reimbursable
 163.27 under state and federal law. A vendor providing day ~~training and habilitation~~ services shall:

163.28 (1) provide the amount and type of services authorized in the individual service plan
 163.29 under coordinated service and support plan and coordinated service and support plan
 163.30 addendum required under sections 245D.02, subdivision 4, paragraphs (a) and (b), and
 163.31 256B.092, subdivision 1b, and Minnesota Rules, parts part 9525.0004 to 9525.0036, subpart
 163.32 12;

164.1 (2) design the services to achieve the outcomes assigned to the vendor in the ~~individual~~
 164.2 ~~service plan~~ coordinated service and support plan and coordinated service and support plan
 164.3 addendum required under sections 245D.02, subdivision 4, paragraphs (a) and (b), and
 164.4 256B.092, subdivision 1b, and Minnesota Rules, part 9525.0004, subpart 12;

164.5 (3) provide or arrange for transportation of persons receiving services to and from service
 164.6 sites;

164.7 (4) enter into agreements with community-based intermediate care facilities for persons
 164.8 with developmental disabilities to ensure compliance with applicable federal regulations;
 164.9 and

164.10 (5) comply with state and federal law.

164.11 **EFFECTIVE DATE.** This section is effective January 1, 2021.

164.12 Sec. 27. Minnesota Statutes 2018, section 256.9365, is amended to read:

164.13 **256.9365 PURCHASE OF CONTINUATION HEALTH CARE COVERAGE FOR**
 164.14 **AIDS PATIENTS PEOPLE LIVING WITH HIV.**

164.15 Subdivision 1. **Program established.** The commissioner of human services shall establish
 164.16 a program to pay ~~private~~ the cost of health plan premiums and cost sharing for prescriptions,
 164.17 including co-payments, deductibles, and coinsurance for persons who have contracted human
 164.18 immunodeficiency virus (HIV) to enable them to continue coverage under or enroll in a
 164.19 group or individual health plan. If a person is determined to be eligible under subdivision
 164.20 2, the commissioner shall pay the ~~portion of the group plan premium for which the individual~~
 164.21 ~~is responsible, if the individual is responsible for at least 50 percent of the cost of the~~
 164.22 ~~premium, or pay the individual plan premium~~ health insurance premiums and prescription
 164.23 cost sharing, including co-payments and deductibles required under section 256B.0631.
 164.24 The commissioner shall not pay for that portion of a premium that is attributable to other
 164.25 family members or dependents or is paid by the individual's employer.

164.26 Subd. 2. **Eligibility requirements.** To be eligible for the program, an applicant must
 164.27 ~~satisfy the following requirements:~~ meet all eligibility requirements for and enroll in Part
 164.28 B of the Ryan White HIV/AIDS Treatment Extension Act of 2009, Public Law 111-87.

164.29 ~~(1) the applicant must provide a physician's, advanced practice registered nurse's, or~~
 164.30 ~~physician assistant's statement verifying that the applicant is infected with HIV and is, or~~
 164.31 ~~within three months is likely to become, too ill to work in the applicant's current employment~~
 164.32 ~~because of HIV-related disease;~~

165.1 ~~(2) the applicant's monthly gross family income must not exceed 300 percent of the~~
165.2 ~~federal poverty guidelines, after deducting medical expenses and insurance premiums;~~

165.3 ~~(3) the applicant must not own assets with a combined value of more than \$25,000; and~~

165.4 ~~(4) if applying for payment of group plan premiums, the applicant must be covered by~~
165.5 ~~an employer's or former employer's group insurance plan.~~

165.6 Subd. 3. **Cost-effective coverage.** Requirements for the payment of individual plan
165.7 premiums under subdivision 2, ~~clause (5)~~, must be designed to ensure that the state cost of
165.8 paying an individual plan premium does not exceed the estimated state cost that would
165.9 otherwise be incurred in the medical assistance program. The commissioner shall purchase
165.10 the most cost-effective coverage available for eligible individuals.

165.11 Sec. 28. Minnesota Statutes 2018, section 256B.0915, subdivision 3a, is amended to read:

165.12 Subd. 3a. **Elderly waiver cost limits.** (a) Effective on the first day of the state fiscal
165.13 year in which the resident assessment system as described in section 256R.17 for nursing
165.14 home rate determination is implemented and the first day of each subsequent state fiscal
165.15 year, the monthly limit for the cost of waived services to an individual elderly waiver
165.16 client shall be the monthly limit of the case mix resident class to which the waiver client
165.17 would be assigned under Minnesota Rules, parts 9549.0051 to 9549.0059, in effect on the
165.18 last day of the previous state fiscal year, adjusted by any legislatively adopted home and
165.19 community-based services percentage rate adjustment. If a legislatively authorized increase
165.20 is service-specific, the monthly cost limit shall be adjusted based on the overall average
165.21 increase to the elderly waiver program.

165.22 (b) The monthly limit for the cost of waived services under paragraph (a) to an
165.23 individual elderly waiver client assigned to a case mix classification A with:

165.24 (1) no dependencies in activities of daily living; or

165.25 (2) up to two dependencies in bathing, dressing, grooming, walking, and eating when
165.26 the dependency score in eating is three or greater as determined by an assessment performed
165.27 under section 256B.0911 shall be \$1,750 per month effective on July 1, 2011, for all new
165.28 participants enrolled in the program on or after July 1, 2011. This monthly limit shall be
165.29 applied to all other participants who meet this criteria at reassessment. This monthly limit
165.30 shall be increased annually as described in paragraphs (a) and (e).

165.31 (c) If extended medical supplies and equipment or environmental modifications are or
165.32 will be purchased for an elderly waiver client, the costs may be prorated for up to 12
165.33 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's

166.1 waived services exceeds the monthly limit established in paragraph (a), (b), (d), or (e),
166.2 the annual cost of all waived services shall be determined. In this event, the annual cost
166.3 of all waived services shall not exceed 12 times the monthly limit of waived services
166.4 as described in paragraph (a), (b), (d), or (e).

166.5 (d) Effective July 1, 2013, the monthly cost limit of waiver services, including any
166.6 necessary home care services described in section 256B.0651, subdivision 2, for individuals
166.7 who meet the criteria as ventilator-dependent given in section 256B.0651, subdivision 1,
166.8 paragraph (g), shall be the average of the monthly medical assistance amount established
166.9 for home care services as described in section 256B.0652, subdivision 7, and the annual
166.10 average contracted amount established by the commissioner for nursing facility services
166.11 for ventilator-dependent individuals. This monthly limit shall be increased annually as
166.12 described in paragraphs (a) and (e).

166.13 (e) Effective January 1, 2018, and each January 1 thereafter, the monthly cost limits for
166.14 elderly waiver services in effect on the previous December 31 shall be increased by the
166.15 difference between any legislatively adopted home and community-based provider rate
166.16 increases effective on January 1 or since the previous January 1 and the average statewide
166.17 percentage increase in nursing facility operating payment rates under chapter 256R, effective
166.18 the previous January 1. This paragraph shall only apply if the average statewide percentage
166.19 increase in nursing facility operating payment rates is greater than any legislatively adopted
166.20 home and community-based provider rate increases effective on January 1, or occurring
166.21 since the previous January 1.

166.22 (f) The commissioner shall approve an exception to the monthly case mix budget cap
166.23 in paragraph (a) to pay for an enhanced rate for personal care services as described in section
166.24 256B.0659. The exception shall not exceed 107.5 percent of the budget otherwise available
166.25 to the individual. The exception must be reapproved on an annual basis at the time of a
166.26 participant's annual reassessment.

166.27 **EFFECTIVE DATE.** This section is effective July 1, 2019, or upon federal approval,
166.28 whichever is later. The commissioner of human services shall notify the revisor of statutes
166.29 when federal approval is obtained.

166.30 Sec. 29. Minnesota Statutes 2018, section 256B.0949, is amended by adding a subdivision
166.31 to read:

166.32 Subd. 16a. **Background studies.** The requirements for background studies under this
166.33 section shall be met by an early intensive developmental and behavioral intervention services

167.1 agency through the commissioner's NETStudy system as provided under sections 245C.03,
167.2 subdivision 13, and 245C.10, subdivision 14.

167.3 Sec. 30. Minnesota Statutes 2018, section 256B.4914, subdivision 2, is amended to read:

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

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

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

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

167.12 (e) "Direct care staff" means employees providing direct services to an individual
167.13 receiving services under this section. Direct care staff excludes executive, managerial, or
167.14 administrative staff.

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

167.18 ~~(f)~~ (g) "Individual staffing" means the time spent as a one-to-one interaction specific to
167.19 an individual recipient by staff to provide direct support and assistance with activities of
167.20 daily living, instrumental activities of daily living, and training to participants, and is based
167.21 on the requirements in each individual's coordinated service and support plan under section
167.22 245D.02, subdivision 4b; any coordinated service and support plan addendum under section
167.23 245D.02, subdivision 4c; and an assessment tool. Provider observation of an individual's
167.24 needs must also be considered.

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

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

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

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

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

168.6 ~~(l)~~ (m) "Shared staffing" means time spent by employees, not defined under paragraph
168.7 (f), providing or available to provide more than one individual with direct support and
168.8 assistance with activities of daily living as defined under section 256B.0659, subdivision
168.9 1, paragraph (b); instrumental activities of daily living as defined under section 256B.0659,
168.10 subdivision 1, paragraph (i); ancillary activities needed to support individual services; and
168.11 training to participants, and is based on the requirements in each individual's coordinated
168.12 service and support plan under section 245D.02, subdivision 4b; any coordinated service
168.13 and support plan addendum under section 245D.02, subdivision 4c; an assessment tool; and
168.14 provider observation of an individual's service need. Total shared staffing hours are divided
168.15 proportionally by the number of individuals who receive the shared service provisions.

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

168.20 ~~(n)~~ (o) "Unit of service" means the following:

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

168.24 (2) for day services under subdivision 7:

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

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

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

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

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

169.3 (iii) for day support services, a unit of service is 15 minutes; and

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

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

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

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

169.11 (4) for unit-based services without programming under subdivision 9, a unit of service
 169.12 is 15 minutes.

169.13 Sec. 31. Minnesota Statutes 2018, section 256B.4914, subdivision 3, is amended to read:

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

169.18 (1) 24-hour customized living;

169.19 (2) adult day ~~care~~ services;

169.20 (3) adult day ~~care~~ services bath;

169.21 ~~(4) behavioral programming;~~

169.22 ~~(5)~~ (4) companion services;

169.23 (5) community residential services;

169.24 (6) customized living;

169.25 (7) day support services;

169.26 (8) day training and habilitation;

169.27 (9) employment exploration services;

169.28 (10) employment development services;

169.29 (11) employment support services;

- 170.1 (12) family residential services;
- 170.2 ~~(8)~~ (13) housing access coordination;
- 170.3 ~~(9)~~ (14) independent living skills;
- 170.4 (15) individualized home supports;
- 170.5 (16) individualized home supports with training;
- 170.6 (17) individualized home supports with family training;
- 170.7 ~~(10)~~ (18) in-home family support;
- 170.8 (19) integrated community supports;
- 170.9 ~~(11)~~ (20) night supervision;
- 170.10 ~~(12)~~ (21) personal support;
- 170.11 (22) positive support services;
- 170.12 ~~(13)~~ (23) prevocational services;
- 170.13 ~~(14) residential care services;~~
- 170.14 ~~(15)~~ (24) residential support services;
- 170.15 ~~(16)~~ (25) respite services;
- 170.16 ~~(17)~~ (26) structured day services;
- 170.17 ~~(18) supported employment services;~~
- 170.18 ~~(19)~~ (27) supported living services;
- 170.19 ~~(20)~~ (28) transportation services; and
- 170.20 ~~(21) individualized home supports;~~
- 170.21 ~~(22) independent living skills specialist services;~~
- 170.22 ~~(23) employment exploration services;~~
- 170.23 ~~(24) employment development services;~~
- 170.24 ~~(25) employment support services; and~~
- 170.25 ~~(26)~~ (29) other services as approved by the federal government in the state home and
- 170.26 community-based services plan.

170.27 **EFFECTIVE DATE.** This section is effective January 1, 2021, or upon federal approval,

170.28 whichever is later, except the amendment striking clause (18) related to supported

171.1 employment services is effective September 1, 2019. The commissioner of human services
 171.2 shall notify the revisor of statutes when federal approval is obtained.

171.3 Sec. 32. Minnesota Statutes 2018, section 256B.4914, subdivision 4, is amended to read:

171.4 Subd. 4. **Data collection for rate determination.** (a) Rates for applicable home and
 171.5 community-based waived services, including rate exceptions under subdivision 12, are
 171.6 set by the rates management system.

171.7 ~~(b) Data for services under section 256B.4913, subdivision 4a, shall be collected in a~~
 171.8 ~~manner prescribed by the commissioner.~~

171.9 ~~(e)~~ (b) Data and information in the rates management system may be used to calculate
 171.10 an individual's rate.

171.11 ~~(d)~~ (c) Service providers, with information from the community support plan and
 171.12 oversight by lead agencies, shall provide values and information needed to calculate an
 171.13 individual's rate into the rates management system. The determination of service levels must
 171.14 be part of a discussion with members of the support team as defined in section 245D.02,
 171.15 subdivision 34. This discussion must occur prior to the final establishment of each individual's
 171.16 rate. The values and information include:

171.17 (1) shared staffing hours;

171.18 (2) individual staffing hours;

171.19 (3) direct registered nurse hours;

171.20 (4) direct licensed practical nurse hours;

171.21 (5) staffing ratios;

171.22 (6) information to document variable levels of service qualification for variable levels
 171.23 of reimbursement in each framework;

171.24 (7) shared or individualized arrangements for unit-based services, including the staffing
 171.25 ratio;

171.26 (8) number of trips and miles for transportation services; and

171.27 (9) service hours provided through monitoring technology.

171.28 ~~(e)~~ (d) Updates to individual data must include:

171.29 (1) data for each individual that is updated annually when renewing service plans; and

172.1 (2) requests by individuals or lead agencies to update a rate whenever there is a change
172.2 in an individual's service needs, with accompanying documentation.

172.3 ~~(f)~~ (e) Lead agencies shall review and approve all services reflecting each individual's
172.4 needs, and the values to calculate the final payment rate for services with variables under
172.5 subdivisions 6, 7, 8, and 9 for each individual. Lead agencies must notify the individual and
172.6 the service provider of the final agreed-upon values and rate, and provide information that
172.7 is identical to what was entered into the rates management system. If a value used was
172.8 mistakenly or erroneously entered and used to calculate a rate, a provider may petition lead
172.9 agencies to correct it. Lead agencies must respond to these requests. When responding to
172.10 the request, the lead agency must consider:

172.11 (1) meeting the health and welfare needs of the individual or individuals receiving
172.12 services by service site, identified in their coordinated service and support plan under section
172.13 245D.02, subdivision 4b, and any addendum under section 245D.02, subdivision 4c;

172.14 (2) meeting the requirements for staffing under subdivision 2, paragraphs (f), (i), and
172.15 (m); and meeting or exceeding the licensing standards for staffing required under section
172.16 245D.09, subdivision 1; and

172.17 (3) meeting the staffing ratio requirements under subdivision 2, paragraph (n), and
172.18 meeting or exceeding the licensing standards for staffing required under section 245D.31.

172.19 Sec. 33. Minnesota Statutes 2018, section 256B.4914, subdivision 5, is amended to read:

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

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

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

172.32 (ii) 85 percent of the subtotal of 20 percent of the median wage for home health aide
172.33 (SOC code 31-1011); 20 percent of the median wage for personal and home health aide

173.1 (SOC code 39-9021); 20 percent of the median wage for nursing assistant (SOC code
 173.2 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053);
 173.3 and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

173.4 (2) for adult day services, 70 percent of the median wage for nursing assistant (SOC
 173.5 code 31-1014); and 30 percent of the median wage for personal care aide (SOC code
 173.6 39-9021);

173.7 (3) for day services, day support services, and prevocational services, 20 percent of the
 173.8 median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for
 173.9 psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social
 173.10 and human services aide (SOC code 21-1093);

173.11 ~~(3)~~ (4) for residential asleep-overnight staff, the wage is the minimum wage in Minnesota
 173.12 for large employers, except in a family foster care setting, the wage is 36 percent of the
 173.13 minimum wage in Minnesota for large employers;

173.14 ~~(4)~~ (5) for ~~behavior program~~ positive supports analyst staff, 100 percent of the median
 173.15 wage for mental health counselors (SOC code 21-1014);

173.16 ~~(5)~~ (6) for ~~behavior program~~ positive supports professional staff, 100 percent of the
 173.17 median wage for clinical counseling and school psychologist (SOC code 19-3031);

173.18 ~~(6)~~ (7) for ~~behavior program~~ positive supports specialist staff, 100 percent of the median
 173.19 wage for psychiatric technicians (SOC code 29-2053);

173.20 ~~(7)~~ (8) for supportive living services staff, 20 percent of the median wage for nursing
 173.21 assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician
 173.22 (SOC code 29-2053); and 60 percent of the median wage for social and human services
 173.23 aide (SOC code 21-1093);

173.24 ~~(8)~~ (9) for housing access coordination staff, 100 percent of the median wage for
 173.25 community and social services specialist (SOC code 21-1099);

173.26 ~~(9)~~ (10) for in-home family support and individualized home supports with family
 173.27 training staff, 20 percent of the median wage for nursing aide (SOC code 31-1012); 30
 173.28 percent of the median wage for community social service specialist (SOC code 21-1099);
 173.29 40 percent of the median wage for social and human services aide (SOC code 21-1093);
 173.30 and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

173.31 ~~(10)~~ (11) for individualized home supports with training services staff, 40 percent of the
 173.32 median wage for community social service specialist (SOC code 21-1099); 50 percent of

174.1 the median wage for social and human services aide (SOC code 21-1093); and ten percent
174.2 of the median wage for psychiatric technician (SOC code 29-2053);

174.3 ~~(11)~~ (12) for independent living skills staff, 40 percent of the median wage for community
174.4 social service specialist (SOC code 21-1099); 50 percent of the median wage for social and
174.5 human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric
174.6 technician (SOC code 29-2053);

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

174.9 ~~(13)~~ for supported employment staff, 20 percent of the median wage for nursing assistant
174.10 (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code
174.11 29-2053); and 60 percent of the median wage for social and human services aide (SOC code
174.12 21-1093);

174.13 ~~(14)~~ (13) for employment support services staff, 50 percent of the median wage for
174.14 rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for
174.15 community and social services specialist (SOC code 21-1099);

174.16 ~~(15)~~ (14) for employment exploration services staff, 50 percent of the median wage for
174.17 rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for
174.18 community and social services specialist (SOC code 21-1099);

174.19 ~~(16)~~ (15) for employment development services staff, 50 percent of the median wage
174.20 for education, guidance, school, and vocational counselors (SOC code 21-1012); and 50
174.21 percent of the median wage for community and social services specialist (SOC code
174.22 21-1099);

174.23 ~~(17)~~ (16) for adult companion staff, 50 percent of the median wage for personal and
174.24 home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant
174.25 (SOC code 31-1014);

174.26 (17) for individualized home supports staff, 50 percent of the median wage for personal
174.27 and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing
174.28 assistant (SOC code 31-1014);

174.29 (18) for night supervision staff, 20 percent of the median wage for home health aide
174.30 (SOC code 31-1011); 20 percent of the median wage for personal and home health aide
174.31 (SOC code 39-9021); 20 percent of the median wage for nursing assistant (SOC code
174.32 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053);
174.33 and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

175.1 (19) for respite staff, 50 percent of the median wage for personal and home care aide
175.2 (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code
175.3 31-1014);

175.4 (20) for personal support staff, 50 percent of the median wage for personal and home
175.5 care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant
175.6 (SOC code 31-1014);

175.7 (21) for supervisory staff, 100 percent of the median wage for community and social
175.8 services specialist (SOC code 21-1099), with the exception of the supervisor of ~~behavior~~
175.9 positive supports professional, ~~behavior~~ positive supports analyst, and ~~behavior~~ positive
175.10 supports specialists, which is 100 percent of the median wage for clinical counseling and
175.11 school psychologist (SOC code 19-3031);

175.12 (22) for registered nurse staff, 100 percent of the median wage for registered nurses
175.13 (SOC code 29-1141); and

175.14 (23) for licensed practical nurse staff, 100 percent of the median wage for licensed
175.15 practical nurses (SOC code 29-2061).

175.16 (b) The commissioner shall adjust the base wage index in paragraph (k) with a competitive
175.17 workforce factor of 4.7 percent to provide increased compensation to direct care staff. A
175.18 provider shall use the additional revenue from the competitive workforce factor to increase
175.19 wages for direct care staff or to improve benefits provided to direct care staff as defined in
175.20 subdivision 2, paragraph (e).

175.21 (c) Beginning February 1, 2021, and every two years thereafter, the commissioner shall
175.22 report to the chairs and ranking minority members of the legislative committees and divisions
175.23 with jurisdiction over health and human services policy and finance an analysis of the
175.24 competitive workforce factor. The report shall include recommendations to improve the
175.25 competitive workforce factor using (1) the most recently available wage data by SOC code
175.26 of the weighted average wage for direct-care staff for residential services and direct-care
175.27 staff for day services; (2) the most recently available wage data by SOC code of the weighted
175.28 average wage of comparable occupations; and (3) labor market data as required under
175.29 subdivision 10a, paragraph (g). The commissioner shall not recommend an increase or
175.30 decrease of the competitive workforce factor from the current value by more than two
175.31 percentage points. If, after a biennial analysis for the next report, the competitive workforce
175.32 factor is less than or equal to zero, the commissioner shall recommend a competitive
175.33 workforce factor of zero.

176.1 ~~(b)~~ (d) Component values for ~~residential~~ corporate foster care services, corporate
 176.2 supportive living services daily, community residential services, and integrated community
 176.3 support services are:

- 176.4 (1) supervisory span of control ratio: 11 percent;
- 176.5 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
- 176.6 (3) employee-related cost ratio: 23.6 percent;
- 176.7 (4) general administrative support ratio: 13.25 percent;
- 176.8 (5) program-related expense ratio: 1.3 percent; and
- 176.9 (6) absence and utilization factor ratio: 3.9 percent.

176.10 ~~(e)~~ (e) Component values for family foster care are:

- 176.11 (1) supervisory span of control ratio: 11 percent;
- 176.12 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
- 176.13 (3) employee-related cost ratio: 23.6 percent;
- 176.14 (4) general administrative support ratio: 3.3 percent;
- 176.15 (5) program-related expense ratio: 1.3 percent; and
- 176.16 (6) absence factor: 1.7 percent.

176.17 ~~(d)~~ (f) Component values for day training and habilitation, day support services, and
 176.18 prevocational services ~~for all services~~ are:

- 176.19 (1) supervisory span of control ratio: 11 percent;
- 176.20 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
- 176.21 (3) employee-related cost ratio: 23.6 percent;
- 176.22 (4) program plan support ratio: 5.6 percent;
- 176.23 (5) client programming and support ratio: ten percent;
- 176.24 (6) general administrative support ratio: 13.25 percent;
- 176.25 (7) program-related expense ratio: 1.8 percent; and
- 176.26 (8) absence and utilization factor ratio: ~~9.4~~ 4.5 percent.

176.27 (g) Component values for adult day services:

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

- 177.1 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
- 177.2 (3) employee-related cost ratio: 23.6 percent;
- 177.3 (4) program plan support ratio: 5.6 percent;
- 177.4 (5) client programming and support ratio: 7.4 percent;
- 177.5 (6) general administrative support ratio: 13.25 percent;
- 177.6 (7) program-related expense ratio: 1.8 percent; and
- 177.7 (8) absence and utilization factor ratio: 4.5 percent.
- 177.8 ~~(e)~~ (h) Component values for unit-based services with programming are:
- 177.9 (1) supervisory span of control ratio: 11 percent;
- 177.10 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
- 177.11 (3) employee-related cost ratio: 23.6 percent;
- 177.12 (4) program plan supports ratio: 15.5 percent;
- 177.13 (5) client programming and supports ratio: 4.7 percent;
- 177.14 (6) general administrative support ratio: 13.25 percent;
- 177.15 (7) program-related expense ratio: 6.1 percent; and
- 177.16 (8) absence and utilization factor ratio: 3.9 percent.
- 177.17 ~~(f)~~ (i) Component values for unit-based services without programming except respite
- 177.18 are:
- 177.19 (1) supervisory span of control ratio: 11 percent;
- 177.20 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
- 177.21 (3) employee-related cost ratio: 23.6 percent;
- 177.22 (4) program plan support ratio: 7.0 percent;
- 177.23 (5) client programming and support ratio: 2.3 percent;
- 177.24 (6) general administrative support ratio: 13.25 percent;
- 177.25 (7) program-related expense ratio: 2.9 percent; and
- 177.26 (8) absence and utilization factor ratio: 3.9 percent.
- 177.27 ~~(g)~~ (j) Component values for unit-based services without programming for respite are:

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

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

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

178.4 (4) general administrative support ratio: 13.25 percent;

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

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

178.7 ~~(h) On July 1, 2017, the commissioner shall update the base wage index in paragraph~~

178.8 ~~(a) based on the wage data by standard occupational code (SOC) from the Bureau of Labor~~

178.9 ~~Statistics available on December 31, 2016. The commissioner shall publish these updated~~

178.10 ~~values and load them into the rate management system. (k) On July 1, 2022, and every five~~

178.11 ~~two years thereafter, the commissioner shall update the base wage index in paragraph (a)~~

178.12 ~~based on the most recently available wage data by SOC from the Bureau of Labor Statistics~~

178.13 ~~available 18 months and one day prior. The commissioner shall publish these updated values~~

178.14 ~~and load them into the rate management system.~~

178.15 ~~(i) On July 1, 2017, the commissioner shall update the framework components in~~

178.16 ~~paragraph (d), clause (5); paragraph (e), clause (5); and paragraph (f), clause (5); subdivision~~

178.17 ~~6, clauses (8) and (9); and subdivision 7, clauses (10), (16), and (17), for changes in the~~

178.18 ~~Consumer Price Index. The commissioner will adjust these values higher or lower by the~~

178.19 ~~percentage change in the Consumer Price Index-All Items, United States city average~~

178.20 ~~(CPI-U) from January 1, 2014, to January 1, 2017. The commissioner shall publish these~~

178.21 ~~updated values and load them into the rate management system. (l) On July 1, 2022, and~~

178.22 ~~every five two years thereafter, the commissioner shall update the framework components~~

178.23 ~~in paragraph (d) (f), clause (5); paragraph (e) (h), clause (5); and paragraph (f) (i), clause~~

178.24 ~~(5); paragraph (g), clause (5); subdivision 6, paragraphs (b), clauses (8) and (9);, and (d),~~

178.25 ~~clause (9); and subdivision 7, clauses (10), (16), and (17), for changes in the Consumer~~

178.26 ~~Price Index. The commissioner shall adjust these values higher or lower by the percentage~~

178.27 ~~change in the CPI-U from the date of the previous update to the date of the data most recently~~

178.28 ~~available on December 31 two years prior to the scheduled update. The commissioner shall~~

178.29 ~~publish these updated values and load them into the rate management system.~~

178.30 (m) Upon the implementation of automatic inflation adjustments under paragraphs (k)

178.31 and (l), rate adjustments authorized under section 256B.439, subdivision 7; Laws 2013,

178.32 chapter 108, article 7, section 60; and Laws 2014, chapter 312, article 27, section 75, shall

178.33 be removed from service rates calculated under this section.

179.1 (n) Any rate adjustments applied to the service rates calculated under this section outside
179.2 of the cost components and rate methodology specified in this section shall be removed
179.3 from rate calculations upon implementation of automatic inflation adjustments under
179.4 paragraphs (k) and (l).

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

179.8 (p) In this subdivision, if the Bureau of Labor Statistics occupational codes used to
179.9 calculate the base wage index in paragraph (a) are revised, the commissioner shall use the
179.10 most recently available data prior to the scheduled update.

179.11 **EFFECTIVE DATE.** This section is effective January 1, 2021, or upon federal approval,
179.12 whichever is later, except the new paragraph (b) is effective January 1, 2020, or upon federal
179.13 approval, whichever is later; and the amendment striking paragraph (a), clause (13), related
179.14 to supported employment staff, is effective September 1, 2019. The commissioner of human
179.15 services shall notify the revisor of statutes when federal approval is obtained.

179.16 Sec. 34. Minnesota Statutes 2018, section 256B.4914, subdivision 6, is amended to read:

179.17 Subd. 6. **Payments for residential support services.** (a) For purposes of this subdivision,
179.18 residential support services include 24-hour customized living services, community residential
179.19 services, customized living services, family residential services, foster care services,
179.20 integrated community supports, and supportive living services daily.

179.21 (b) Payments for residential support services, as defined in sections 256B.092, subdivision
179.22 11, and 256B.49, subdivision 22, in which the person providing services does not live in
179.23 the setting where the service is provided, including community residential services, corporate
179.24 foster care services, and corporate supportive living services daily must be calculated as
179.25 follows:

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

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

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

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

180.4 (5) multiply the number of shared and individual direct staff hours provided on site or
180.5 through monitoring technology and nursing hours by the product of the supervision span
180.6 of control ratio in subdivision 5, paragraph (b), clause (1), and the appropriate supervision
180.7 wage in subdivision 5, paragraph (a), clause (21);

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

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

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

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

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

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

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

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

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

180.28 ~~(e)~~ (d) Payments for integrated community support services must be calculated as follows:

180.29 (1) the base shared staffing shall be eight hours divided by the number of people receiving
180.30 support in the integrated community support setting;

180.31 (2) the individual staffing hours shall be the average number of direct support hours
180.32 provided directly to the service recipient;

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

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

181.7 (5) multiply the number of shared and individual direct staff hours in clauses (1) and
181.8 (2) by the appropriate staff wages in subdivision 5, paragraph (a), or the customized
181.9 direct-care rate;

181.10 (6) multiply the number of shared and individual direct staff hours in clauses (1) and
181.11 (2) by the product of the supervision span of control ratio in subdivision 5, paragraph (b),
181.12 clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause
181.13 (21);

181.14 (7) combine the results of clauses (4) and (5) and multiply the result by one plus the
181.15 employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (b), clause
181.16 (2). This is defined as the direct staffing cost;

181.17 (8) for employee-related expenses, multiply the direct staffing cost by one plus the
181.18 employee-related cost ratio in subdivision 5, paragraph (b), clause (3); and

181.19 (9) for client programming and supports, the commissioner shall add \$2,260.21 divided
181.20 by 365.

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

181.22 (1) subtotal of paragraph (d), clauses (6) to (8);

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

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

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

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

182.1 recipient needs and adjusted by a factor to be determined by the commissioner to adjust for
 182.2 regional differences in the cost of providing services.

182.3 ~~(d) For individuals enrolled prior to January 1, 2014, the days of service authorized must~~
 182.4 ~~meet or exceed the days of service used to convert service agreements in effect on December~~
 182.5 ~~1, 2013, and must not result in a reduction in spending or service utilization due to conversion~~
 182.6 ~~during the implementation period under section 256B.4913, subdivision 4a. If during the~~
 182.7 ~~implementation period, an individual's historical rate, including adjustments required under~~
 182.8 ~~section 256B.4913, subdivision 4a, paragraph (c), is equal to or greater than the rate~~
 182.9 ~~determined in this subdivision, the number of days authorized for the individual is 365.~~

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

182.12 **EFFECTIVE DATE.** This section is effective January 1, 2021, or upon federal approval,
 182.13 whichever is later. The commissioner of human services shall notify the revisor of statutes
 182.14 when federal approval is obtained.

182.15 Sec. 35. Minnesota Statutes 2018, section 256B.4914, subdivision 7, is amended to read:

182.16 Subd. 7. **Payments for day programs.** Payments for services with day programs
 182.17 including adult day care services, day treatment and habilitation, day support services,
 182.18 prevocational services, and structured day services must be calculated as follows:

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

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

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

182.24 (2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics
 182.25 Minnesota-specific rates or rates derived by the commissioner as provided in subdivision
 182.26 5;

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

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

183.1 (5) multiply the number of day direct staff hours by the product of the supervision span
183.2 of control ratio in subdivision 5, paragraph (d), clause (1), and the appropriate supervision
183.3 wage in subdivision 5, paragraph (a), clause (21);

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

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

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

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

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

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

183.16 (12) this is the subtotal rate;

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

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

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

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

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

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

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

184.4 (iv) \$33.50 for a trip of 51 miles or more for a nonshared ride in a vehicle without a lift,
 184.5 \$16.50 for a shared ride in a vehicle without a lift, and \$20.75 for a shared ride in a vehicle
 184.6 with a lift;

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

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

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

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

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

184.17 **EFFECTIVE DATE.** This section is effective January 1, 2021, or upon federal approval,
 184.18 whichever is later. The commissioner of human services shall notify the revisor of statutes
 184.19 when federal approval is obtained.

184.20 Sec. 36. Minnesota Statutes 2018, section 256B.4914, subdivision 8, is amended to read:

184.21 Subd. 8. **Payments for unit-based services with programming.** Payments for unit-based
 184.22 services with programming, including ~~behavior programming~~ employment exploration
 184.23 services, employment development services, housing access coordination, individualized
 184.24 home supports with family training, individualized home supports with training, in-home
 184.25 family support, independent living skills training, independent living skills specialist services,
 184.26 individualized home supports, and hourly supported living services, ~~employment exploration~~
 184.27 ~~services, employment development services, supported employment, and employment~~
 184.28 ~~support services~~ provided to an individual outside of any day or residential service plan
 184.29 must be calculated as follows, unless the services are authorized separately under subdivision
 184.30 6 or 7:

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

185.1 (2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics
185.2 Minnesota-specific rates or rates derived by the commissioner as provided in subdivision
185.3 5;

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

185.7 (4) multiply the number of direct staff hours by the appropriate staff wage in subdivision
185.8 5, paragraph (a), or the customized direct-care rate;

185.9 (5) multiply the number of direct staff hours by the product of the supervision span of
185.10 control ratio in subdivision 5, paragraph (e), clause (1), and the appropriate supervision
185.11 wage in subdivision 5, paragraph (a), clause (21);

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

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

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

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

185.21 (10) this is the subtotal rate;

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

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

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

186.1 (13) for employment exploration services provided in a shared manner, divide the total
186.2 payment amount in clause (12) by the number of service recipients, not to exceed five. For
186.3 employment support services provided in a shared manner, divide the total payment amount
186.4 in clause (12) by the number of service recipients, not to exceed six. For independent living
186.5 skills training, individualized home supports with training, and individualized home supports
186.6 with family training provided in a shared manner, divide the total payment amount in clause
186.7 (12) by the number of service recipients, not to exceed two; and

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

186.10 **EFFECTIVE DATE.** This section is effective January 1, 2021, or upon federal approval,
186.11 whichever is later, except the amendments striking "supported employment," in paragraph
186.12 (a) and striking clause (13) related to supported employment are effective September 1,
186.13 2019. The commissioner of human services shall notify the revisor of statutes when federal
186.14 approval is obtained.

186.15 Sec. 37. Minnesota Statutes 2018, section 256B.4914, subdivision 9, is amended to read:

186.16 **Subd. 9. Payments for unit-based services without programming.** Payments for
186.17 unit-based services without programming, including individualized home supports, night
186.18 supervision, personal support, respite, and companion care provided to an individual outside
186.19 of any day or residential service plan must be calculated as follows unless the services are
186.20 authorized separately under subdivision 6 or 7:

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

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

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

186.28 (4) multiply the number of direct staff hours by the appropriate staff wage in subdivision
186.29 5 or the customized direct care rate;

186.30 (5) multiply the number of direct staff hours by the product of the supervision span of
186.31 control ratio in subdivision 5, paragraph (f), clause (1), and the appropriate supervision
186.32 wage in subdivision 5, paragraph (a), clause (21);

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

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

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

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

187.10 (10) this is the subtotal rate;

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

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

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

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

187.19 (15) for a recipient requiring deaf and hard-of-hearing customization under subdivision
187.20 12, add the customization rate provided in subdivision 12 to the result of clause (14). This
187.21 is defined as the customized direct care rate;

187.22 (16) multiply the number of direct staff hours by the appropriate staff wage in subdivision
187.23 5, paragraph (a);

187.24 (17) multiply the number of direct staff hours by the product of the supervisory span of
187.25 control ratio in subdivision 5, paragraph (g), clause (1), and the appropriate supervision
187.26 wage in subdivision 5, paragraph (a), clause (21);

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

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

188.1 (20) this is the subtotal rate;

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

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

188.6 (23) for individualized home supports provided in a shared manner, divide the total
188.7 payment amount in clause (12) by the number of service recipients, not to exceed two. For
188.8 respite care services provided in a shared manner, divide the total payment amount in clause
188.9 (22) by the number of service recipients, not to exceed three; and

188.10 (24) adjust the result of ~~clauses (12) and (22)~~ clause (23) by a factor to be determined
188.11 by the commissioner to adjust for regional differences in the cost of providing services.

188.12 **EFFECTIVE DATE.** This section is effective January 1, 2021, or upon federal approval,
188.13 whichever is later. The commissioner of human services shall notify the revisor of statutes
188.14 when federal approval is obtained.

188.15 Sec. 38. Minnesota Statutes 2018, section 256B.4914, subdivision 10, is amended to read:

188.16 Subd. 10. **Updating payment values and additional information.** (a) ~~From January~~
188.17 ~~1, 2014, through December 31, 2017,~~ The commissioner shall develop and implement
188.18 uniform procedures to refine terms and adjust values used to calculate payment rates in this
188.19 section.

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

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

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

188.27 (3) the distinct underlying costs for services provided by a license holder under sections
188.28 245D.05, 245D.06, 245D.07, 245D.071, 245D.081, and 245D.09, and for services provided
188.29 by a license holder certified under section 245D.33.

188.30 (c) ~~Beginning January 1, 2014, through December 31, 2018, using a statistically valid~~
188.31 ~~set of rates management system data, the commissioner, in consultation with stakeholders,~~
188.32 ~~shall analyze for each service the average difference in the rate on December 31, 2013, and~~

189.1 ~~the framework rate at the individual, provider, lead agency, and state levels. The~~
 189.2 ~~commissioner shall issue semiannual reports to the stakeholders on the difference in rates~~
 189.3 ~~by service and by county during the banding period under section 256B.4913, subdivision~~
 189.4 ~~4a. The commissioner shall issue the first report by October 1, 2014, and the final report~~
 189.5 ~~shall be issued by December 31, 2018.~~

189.6 ~~(d) No later than July 1, 2014,~~ (c) The commissioner, in consultation with stakeholders,
 189.7 shall ~~begin the review and evaluation of~~ evaluate the following values already in subdivisions
 189.8 6 to 9, or issues that impact all services, including, but not limited to:

189.9 (1) values for transportation rates;

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

189.11 (3) values for indirect services;

189.12 (4) values for nursing;

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

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

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

189.17 (8) direct care workforce labor market measures;

189.18 (9) any changes in state or federal law with a direct impact on the underlying cost of
 189.19 providing home and community-based services; ~~and~~

189.20 ~~(9)~~ (10) outcome measures, determined by the commissioner, for home and
 189.21 community-based services rates determined under this section; ~~and~~

189.22 (11) different competitive workforce factors by service, as determined under subdivision
 189.23 5, paragraph (k).

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

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

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

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

190.1 ~~(4)~~ January 15, ~~2020~~ 2021, with another full report, and a full report once every four
190.2 years thereafter.

190.3 ~~(f) The commissioner shall implement a regional adjustment factor to all rate calculations~~
190.4 ~~in subdivisions 6 to 9, effective no later than January 1, 2015.~~ (e) Beginning ~~July 1, 2017,~~
190.5 July 1, 2022, the commissioner shall renew analysis and implement changes to the regional
190.6 adjustment factors ~~when adjustments required under subdivision 5, paragraph (h), occur~~
190.7 once every six years. Prior to implementation, the commissioner shall consult with
190.8 stakeholders on the methodology to calculate the adjustment.

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

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

190.14 (2) service utilization;

190.15 (3) county and tribal allocation changes; and

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

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

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

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

190.28 ~~(j) Beginning July 1, 2017,~~ (h) The commissioner shall collect transportation and trip
190.29 information for all day services through the rates management system.

190.30 (i) The commissioner shall develop a new rate methodology for residential services in
190.31 which the service provider lives in the setting where the service is provided based on levels
190.32 of support needs. The commissioner shall submit recommendations to the legislative

191.1 committees with jurisdiction over human services of the new rate methodology to replace
 191.2 subdivision 6, paragraph (d), by January 1, 2020.

191.3 (j) The commissioner shall study value-based payment strategies for fee-for-service
 191.4 home and community-based services and submit a report to the legislative committees with
 191.5 jurisdiction over human services by October 1, 2020, with recommended strategies to
 191.6 improve the quality, efficiency, and effectiveness of services.

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

191.8 Sec. 39. Minnesota Statutes 2018, section 256B.4914, subdivision 10a, is amended to
 191.9 read:

191.10 Subd. 10a. **Reporting and analysis of cost data.** (a) The commissioner must ensure
 191.11 that wage values and component values in subdivisions 5 to 9 reflect the cost to provide the
 191.12 service. As determined by the commissioner, in consultation with stakeholders identified
 191.13 in section ~~256B.4913, subdivision 5~~ 256B.4914, subdivision 17, a provider enrolled to
 191.14 provide services with rates determined under this section must submit requested cost data
 191.15 to the commissioner to support research on the cost of providing services that have rates
 191.16 determined by the disability waiver rates system. Requested cost data may include, but is
 191.17 not limited to:

191.18 (1) worker wage costs;

191.19 (2) benefits paid;

191.20 (3) supervisor wage costs;

191.21 (4) executive wage costs;

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

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

191.24 (7) administrative costs paid;

191.25 (8) program costs paid;

191.26 (9) transportation costs paid;

191.27 (10) vacancy rates; and

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

192.1 (b) At least once in any five-year period, a provider must submit cost data for a fiscal
192.2 year that ended not more than 18 months prior to the submission date. The commissioner
192.3 shall provide each provider a 90-day notice prior to its submission due date. If a provider
192.4 fails to submit required reporting data, the commissioner shall provide notice to providers
192.5 that have not provided required data 30 days after the required submission date, and a second
192.6 notice for providers who have not provided required data 60 days after the required
192.7 submission date. The commissioner shall temporarily suspend payments to the provider if
192.8 cost data is not received 90 days after the required submission date. Withheld payments
192.9 shall be made once data is received by the commissioner.

192.10 (c) The commissioner shall conduct a random validation of data submitted under
192.11 paragraph (a) to ensure data accuracy. The commissioner shall analyze cost documentation
192.12 in paragraph (a) and provide recommendations for adjustments to cost components.

192.13 (d) The commissioner shall analyze cost documentation in paragraph (a) and, in
192.14 consultation with stakeholders identified in section ~~256B.4913~~, ~~subdivision 5~~ 256B.4914,
192.15 subdivision 17, may submit recommendations on component values and inflationary factor
192.16 adjustments to the chairs and ranking minority members of the legislative committees with
192.17 jurisdiction over human services every four years beginning January 1, ~~2020~~ 2021. The
192.18 commissioner shall make recommendations in conjunction with reports submitted to the
192.19 legislature according to subdivision 10, paragraph ~~(e)~~ (d). The commissioner shall release
192.20 cost data in an aggregate form, and cost data from individual providers shall not be released
192.21 except as provided for in current law.

192.22 (e) The commissioner, in consultation with stakeholders identified in section ~~256B.4913~~,
192.23 ~~subdivision 5~~ 256B.4914, subdivision 17, shall develop and implement a process for
192.24 providing training and technical assistance necessary to support provider submission of cost
192.25 documentation required under paragraph (a).

192.26 (f) By December 31, 2020, providers paid with rates calculated under subdivision 5,
192.27 paragraph (b), shall identify additional revenues from the competitive workforce factor and
192.28 prepare a written distribution plan for the revenues. A provider shall make the provider's
192.29 distribution plan available and accessible to all direct care staff for a minimum of one
192.30 calendar year. Upon request, a provider shall submit the written distribution plan to the
192.31 commissioner.

192.32 (g) Providers enrolled to provide services with rates determined under section 256B.4914,
192.33 subdivision 3, shall submit labor market data to the commissioner annually on or before
192.34 November 1, including but not limited to:

- 193.1 (1) number of direct care staff;
- 193.2 (2) wages of direct care staff;
- 193.3 (3) overtime wages of direct care staff;
- 193.4 (4) hours worked by direct care staff;
- 193.5 (5) overtime hours worked by direct care staff;
- 193.6 (6) benefits provided to direct care staff;
- 193.7 (7) direct care staff job vacancies; and
- 193.8 (8) direct care staff retention rates.
- 193.9 (h) The commissioner shall publish annual reports on provider and state-level labor
- 193.10 market data, including but not limited to the data obtained under paragraph (g).
- 193.11 (i) The commissioner shall temporarily suspend payments to the provider if data requested
- 193.12 under paragraph (g) is not received 90 days after the required submission date. Withheld
- 193.13 payments shall be made once data is received by the commissioner.
- 193.14 **EFFECTIVE DATE.** This section is effective the day following final enactment except
- 193.15 paragraph (g) is effective November 1, 2019, and paragraph (h) is effective February 1,
- 193.16 2020.
- 193.17 Sec. 40. Minnesota Statutes 2018, section 256B.4914, subdivision 14, is amended to read:
- 193.18 Subd. 14. **Exceptions.** (a) In a format prescribed by the commissioner, lead agencies
- 193.19 must identify individuals with exceptional needs that cannot be met under the disability
- 193.20 waiver rate system. The commissioner shall use that information to evaluate and, if necessary,
- 193.21 approve an alternative payment rate for those individuals. Whether granted, denied, or
- 193.22 modified, the commissioner shall respond to all exception requests in writing. The
- 193.23 commissioner shall include in the written response the basis for the action and provide
- 193.24 notification of the right to appeal under paragraph (h).
- 193.25 (b) Lead agencies must act on an exception request within 30 days and notify the initiator
- 193.26 of the request of their recommendation in writing. A lead agency shall submit all exception
- 193.27 requests along with its recommendation to the commissioner.
- 193.28 (c) An application for a rate exception may be submitted for the following criteria:
- 193.29 (1) an individual has service needs that cannot be met through additional units of service;

194.1 (2) an individual's rate determined under subdivisions 6, 7, 8, and 9 is so insufficient
194.2 that it has resulted in an individual receiving a notice of discharge from the individual's
194.3 provider; or

194.4 (3) an individual's service needs, including behavioral changes, require a level of service
194.5 which necessitates a change in provider or which requires the current provider to propose
194.6 service changes beyond those currently authorized.

194.7 (d) Exception requests must include the following information:

194.8 (1) the service needs required by each individual that are not accounted for in subdivisions
194.9 6, 7, 8, and 9;

194.10 (2) the service rate requested and the difference from the rate determined in subdivisions
194.11 6, 7, 8, and 9;

194.12 (3) a basis for the underlying costs used for the rate exception and any accompanying
194.13 documentation; and

194.14 (4) any contingencies for approval.

194.15 (e) Approved rate exceptions shall be managed within lead agency allocations under
194.16 sections 256B.092 and 256B.49.

194.17 (f) Individual disability waiver recipients, an interested party, or the license holder that
194.18 would receive the rate exception increase may request that a lead agency submit an exception
194.19 request. A lead agency that denies such a request shall notify the individual waiver recipient,
194.20 interested party, or license holder of its decision and the reasons for denying the request in
194.21 writing no later than 30 days after the request has been made and shall submit its denial to
194.22 the commissioner in accordance with paragraph (b). The reasons for the denial must be
194.23 based on the failure to meet the criteria in paragraph (c).

194.24 (g) The commissioner shall determine whether to approve or deny an exception request
194.25 no more than 30 days after receiving the request. If the commissioner denies the request,
194.26 the commissioner shall notify the lead agency and the individual disability waiver recipient,
194.27 the interested party, and the license holder in writing of the reasons for the denial.

194.28 (h) The individual disability waiver recipient may appeal any denial of an exception
194.29 request by either the lead agency or the commissioner, pursuant to sections 256.045 and
194.30 256.0451. When the denial of an exception request results in the proposed demission of a
194.31 waiver recipient from a residential or day habilitation program, the commissioner shall issue
194.32 a temporary stay of demission, when requested by the disability waiver recipient, consistent
194.33 with the provisions of section 256.045, subdivisions 4a and 6, paragraph (c). The temporary

195.1 stay shall remain in effect until the lead agency can provide an informed choice of
195.2 appropriate, alternative services to the disability waiver.

195.3 (i) Providers may petition lead agencies to update values that were entered incorrectly
195.4 or erroneously into the rate management system, based on past service level discussions
195.5 and determination in subdivision 4, without applying for a rate exception.

195.6 (j) The starting date for the rate exception will be the later of the date of the recipient's
195.7 change in support or the date of the request to the lead agency for an exception.

195.8 (k) The commissioner shall track all exception requests received and their dispositions.
195.9 The commissioner shall issue quarterly public exceptions statistical reports, including the
195.10 number of exception requests received and the numbers granted, denied, withdrawn, and
195.11 pending. The report shall include the average amount of time required to process exceptions.

195.12 (l) No later than January 15, 2016, the commissioner shall provide research findings on
195.13 the estimated fiscal impact, the primary cost drivers, and common population characteristics
195.14 of recipients with needs that cannot be met by the framework rates.

195.15 ~~(m) No later than July 1, 2016, the commissioner shall develop and implement, in~~
195.16 ~~consultation with stakeholders, a process to determine eligibility for rate exceptions for~~
195.17 ~~individuals with rates determined under the methodology in section 256B.4913, subdivision~~
195.18 ~~4a. Determination of eligibility for an exception will occur as annual service renewals are~~
195.19 ~~completed.~~

195.20 ~~(n)~~ (m) Approved rate exceptions will be implemented at such time that the individual's
195.21 rate is no longer banded and remain in effect in all cases until an individual's needs change
195.22 as defined in paragraph (c).

195.23 Sec. 41. Minnesota Statutes 2018, section 256B.4914, subdivision 15, is amended to read:

195.24 Subd. 15. **County or tribal allocations.** ~~(a) Upon implementation of the disability waiver~~
195.25 ~~rates management system on January 1, 2014,~~ The commissioner shall establish a method
195.26 of tracking and reporting the fiscal impact of the disability waiver rates management system
195.27 on individual lead agencies.

195.28 ~~(b) Beginning January 1, 2014,~~ The commissioner shall make annual adjustments to
195.29 lead agencies' home and community-based waived service budget allocations to adjust
195.30 for rate differences and the resulting impact on county allocations upon implementation of
195.31 the disability waiver rates system.

196.1 (c) Lead agencies exceeding their allocations shall be subject to the provisions under
196.2 sections 256B.0916, subdivision 11, and 256B.49, subdivision 26.

196.3 Sec. 42. Minnesota Statutes 2018, section 256B.4914, is amended by adding a subdivision
196.4 to read:

196.5 Subd. 17. Stakeholder consultation and county training. (a) The commissioner shall
196.6 continue consulting regularly with the existing stakeholder group established as part of the
196.7 rate-setting methodology process and others, to gather input, concerns, and data, to assist
196.8 in the implementation of the rate payment system, and to make pertinent information available
196.9 to the public through the department's website.

196.10 (b) The commissioner shall offer training at least annually for county personnel
196.11 responsible for administering the rate-setting framework in a manner consistent with this
196.12 section.

196.13 (c) The commissioner shall maintain an online instruction manual explaining the
196.14 rate-setting framework. The manual shall be consistent with this section and shall be
196.15 accessible to all stakeholders including recipients, representatives of recipients, county, or
196.16 tribal agencies, and license holders.

196.17 (d) The commissioner shall not defer to the county or tribal agency on matters of technical
196.18 application of the rate-setting framework and a county or tribal agency shall not set rates
196.19 in a manner that conflicts with this section.

196.20 Sec. 43. Minnesota Statutes 2018, section 256B.85, subdivision 3, is amended to read:

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

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

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

196.25 (3) is a waiver participant as defined under section 256B.0915, 256B.092, 256B.093, or
196.26 256B.49; or

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

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

197.1 (1) require assistance and be determined dependent in one activity of daily living or
 197.2 Level I behavior based on assessment under section 256B.0911; and

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

197.4 (c) A pregnant woman eligible for medical assistance under section 256B.055, subdivision
 197.5 6, is eligible for CFSS without federal financial participation if the woman: (1) is eligible
 197.6 for CFSS under paragraphs (a) and (b); and (2) does not meet institutional level of care, as
 197.7 determined under section 256B.0911.

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

197.9 Sec. 44. Laws 2017, First Special Session chapter 6, article 3, section 49, is amended to
 197.10 read:

197.11 Sec. 49. **ELECTRONIC SERVICE DELIVERY DOCUMENTATION SYSTEM**
 197.12 **VISIT VERIFICATION.**

197.13 Subdivision 1. **Documentation; establishment.** The commissioner of human services
 197.14 shall establish implementation requirements and standards for an electronic ~~service delivery~~
 197.15 ~~documentation system~~ visit verification to comply with the 21st Century Cures Act, Public
 197.16 Law 114-255. Within available appropriations, the commissioner shall take steps to comply
 197.17 with the electronic visit verification requirements in the 21st Century Cures Act, Public
 197.18 Law 114-255.

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

197.21 (b) "Electronic ~~service delivery documentation~~ visit verification" means the electronic
 197.22 documentation of the:

197.23 (1) type of service performed;

197.24 (2) individual receiving the service;

197.25 (3) date of the service;

197.26 (4) location of the service delivery;

197.27 (5) individual providing the service; and

197.28 (6) time the service begins and ends.

197.29 (c) "Electronic ~~service delivery documentation~~ visit verification system" means a system
 197.30 that provides electronic ~~service delivery documentation~~ verification of services that complies

198.1 with the 21st Century Cures Act, Public Law 114-255, and the requirements of subdivision
198.2 3.

198.3 (d) "Service" means one of the following:

198.4 (1) personal care assistance services as defined in Minnesota Statutes, section 256B.0625,
198.5 subdivision 19a, and provided according to Minnesota Statutes, section 256B.0659; ~~or~~

198.6 (2) community first services and supports under Minnesota Statutes, section 256B.85;

198.7 (3) home health services under Minnesota Statutes, section 256B.0625, subdivision 6a;

198.8 or

198.9 (4) other medical supplies and equipment or home and community-based services that
198.10 are required to be electronically verified by the 21st Century Cures Act, Public Law 114-255.

198.11 Subd. 3. **Requirements.** (a) In developing implementation requirements for ~~an electronic~~
198.12 ~~service delivery documentation system~~ visit verification, the commissioner shall ~~consider~~
198.13 ~~electronic visit verification systems and other electronic service delivery documentation~~
198.14 ~~methods. The commissioner shall convene stakeholders that will be impacted by an electronic~~
198.15 ~~service delivery system, including service providers and their representatives, service~~
198.16 ~~recipients and their representatives, and, as appropriate, those with expertise in the~~
198.17 ~~development and operation of an electronic service delivery documentation system, to ensure~~
198.18 that the requirements:

198.19 (1) are minimally administratively and financially burdensome to a provider;

198.20 (2) are minimally burdensome to the service recipient and the least disruptive to the
198.21 service recipient in receiving and maintaining allowed services;

198.22 (3) consider existing best practices and use of electronic ~~service delivery documentation~~
198.23 visit verification;

198.24 (4) are conducted according to all state and federal laws;

198.25 (5) are effective methods for preventing fraud when balanced against the requirements
198.26 of clauses (1) and (2); and

198.27 (6) are consistent with the Department of Human Services' policies related to covered
198.28 services, flexibility of service use, and quality assurance.

198.29 (b) The commissioner shall make training available to providers on the electronic ~~service~~
198.30 ~~delivery documentation~~ visit verification system requirements.

199.1 (c) The commissioner shall establish baseline measurements related to preventing fraud
 199.2 and establish measures to determine the effect of electronic service-delivery documentation
 199.3 visit verification requirements on program integrity.

199.4 (d) The commissioner shall make a state-selected electronic visit verification system
 199.5 available to providers of services.

199.6 Subd. 3a. **Provider requirements.** (a) A provider of services may select any electronic
 199.7 visit verification system that meets the requirements established by the commissioner.

199.8 (b) All electronic visit verification systems used by providers to comply with the
 199.9 requirements established by the commissioner must provide data to the commissioner in a
 199.10 format and at a frequency to be established by the commissioner.

199.11 (c) Providers must implement the electronic visit verification systems required under
 199.12 this section by a date established by the commissioner to be set after the state-selected
 199.13 electronic visit verification systems for personal care services and home health services are
 199.14 in production. For purposes of this paragraph, "personal care services" and "home health
 199.15 services" have the meanings given in United States Code, title 42, section 1396b(1)(5).

199.16 ~~Subd. 4. **Legislative report.** (a) The commissioner shall submit a report by January 15,~~
 199.17 ~~2018, to the chairs and ranking minority members of the legislative committees with~~
 199.18 ~~jurisdiction over human services with recommendations, based on the requirements of~~
 199.19 ~~subdivision 3, to establish electronic service-delivery documentation system requirements~~
 199.20 ~~and standards. The report shall identify:~~

199.21 ~~(1) the essential elements necessary to operationalize a base-level electronic service~~
 199.22 ~~delivery documentation system to be implemented by January 1, 2019; and~~

199.23 ~~(2) enhancements to the base-level electronic service-delivery documentation system to~~
 199.24 ~~be implemented by January 1, 2019, or after, with projected operational costs and the costs~~
 199.25 ~~and benefits for system enhancements.~~

199.26 ~~(b) The report must also identify current regulations on service providers that are either~~
 199.27 ~~inefficient, minimally effective, or will be unnecessary with the implementation of an~~
 199.28 ~~electronic service-delivery documentation system.~~

199.29 Sec. 45. **DIRECTION TO COMMISSIONER; SKILLED NURSE VISIT RATES.**

199.30 The commissioner of human services shall ensure that skilled nurse visits reimbursed
 199.31 under Minnesota Statutes, section 256B.0653, are coded, specific to the category of the
 199.32 nurse performing the visit, using code sets compliant with the Health Insurance Portability

200.1 and Accountability Act, Public Law 104-191. "Skilled nurse visit" has the meaning given
200.2 in Minnesota Statutes, section 256B.0653, subdivision 2, paragraph (j).

200.3 Sec. 46. **DIRECTION TO COMMISSIONER; INTERAGENCY AGREEMENTS.**

200.4 By October 1, 2019, the Department of Commerce, Public Utilities Commission, and
200.5 Department of Human Services must amend all interagency agreements necessary to
200.6 implement sections 1 to 10.

200.7 Sec. 47. **DIRECTION TO COMMISSIONER; FEDERAL AUTHORITY FOR**
200.8 **RECONFIGURED WAIVER SERVICES.**

200.9 The commissioner of human services shall seek necessary federal authority to implement
200.10 new and reconfigured waiver services under section 48. The commissioner of human services
200.11 shall notify the revisor of statutes when federal approval is obtained and when new services
200.12 are fully implemented.

200.13 Sec. 48. **DISABILITY WAIVER RECONFIGURATION.**

200.14 Subdivision 1. Intent. It is the intent of the legislature to reform the medical assistance
200.15 waiver programs for people with disabilities to simplify administration of the programs,
200.16 encourage person-centered supports, enhance each person's personal authority over the
200.17 person's service choice, align benefits across waivers, encourage equity across programs
200.18 and populations, and promote long-term sustainability of needed services.

200.19 Subd. 2. Report. By January 15, 2021, the commissioner of human services shall submit
200.20 a report to the members of the legislative committees with jurisdiction over human services
200.21 on any necessary waivers, state plan amendments, requests for new funding or realignment
200.22 of existing funds, any changes to state statute or rule, and any other federal authority
200.23 necessary to implement this section.

200.24 Subd. 3. Proposal. By January 15, 2021, the commissioner shall develop a proposal to
200.25 reconfigure the medical assistance waivers provided in sections 256B.092 and 256B.49.
200.26 The proposal shall include all necessary plans for implementing two home and
200.27 community-based services waiver programs, as authorized under section 1915(c) of the
200.28 Social Security Act that serve persons who are determined to require the levels of care
200.29 provided in a nursing home, a hospital, a neurobehavioral hospital, or an intermediate care
200.30 facility for persons with developmental disabilities.

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

201.1 Sec. 49. **INDIVIDUAL PROVIDERS OF DIRECT SUPPORT SERVICES.**

201.2 The labor agreement between the state of Minnesota and the Service Employees
201.3 International Union Healthcare Minnesota, submitted to the Legislative Coordinating
201.4 Commission on, is ratified.

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

201.6 Sec. 50. **RATE INCREASE FOR DIRECT SUPPORT SERVICES PROVIDERS**
201.7 **WORKFORCE NEGOTIATIONS.**

201.8 (a) Effective July 1, 2019, if the labor agreement between the state of Minnesota and
201.9 the Service Employees International Union Healthcare Minnesota under Minnesota Statutes,
201.10 section 179A.54, is approved pursuant to Minnesota Statutes, section 3.855, the commissioner
201.11 of human services shall:

201.12 (1) increase reimbursement rates, individual budgets, grants, or allocations by 2.37
201.13 percent for services provided on or after July 1, 2019, to implement the minimum hourly
201.14 wage, holiday, and paid time off provisions of that agreement; and

201.15 (2) provide an enhanced rate of 7.5 percent for personal care assistance and community
201.16 first services and supports and an enhanced budget, increased by 7.5 percent for consumer
201.17 directed community supports and the consumer support grant for eligible service recipients.
201.18 Eligible service recipients are people identified by the state through assessment who are
201.19 eligible for at least 12 hours of personal care assistance each day served by workers who
201.20 have completed designated training approved by the commissioner. The enhanced rate and
201.21 enhanced budget includes and is not in addition to any previously implemented enhanced
201.22 rates or enhanced budgets for people identified by the state through assessment who are
201.23 eligible for at least 12 hours of personal care assistance each day.

201.24 (b) The rate changes described in this section apply to direct support services provided
201.25 through a covered program, as defined in Minnesota Statutes, section 256B.0711, subdivision
201.26 1.

201.27 Sec. 51. **REPEALER.**

201.28 (a) Minnesota Statutes 2018, section 256B.0705, is repealed.

201.29 (b) Minnesota Statutes 2018, sections 252.431; and 252.451, are repealed.

201.30 (c) Minnesota Statutes 2018, section 252.41, subdivision 8, is repealed.

202.1 **EFFECTIVE DATE.** Paragraph (a) is effective the day following final enactment.
 202.2 Paragraph (b) is effective September 1, 2019. Paragraph (c) is effective January 1, 2020.

202.3 **ARTICLE 6**

202.4 **CHEMICAL AND MENTAL HEALTH**

202.5 Section 1. Minnesota Statutes 2018, section 245.4889, subdivision 1, is amended to read:

202.6 Subdivision 1. **Establishment and authority.** (a) The commissioner is authorized to
 202.7 make grants from available appropriations to assist:

202.8 (1) counties;

202.9 (2) Indian tribes;

202.10 (3) children's collaboratives under section 124D.23 or 245.493; or

202.11 (4) mental health service providers.

202.12 (b) The following services are eligible for grants under this section:

202.13 (1) services to children with emotional disturbances as defined in section 245.4871,
 202.14 subdivision 15, and their families;

202.15 (2) transition services under section 245.4875, subdivision 8, for young adults under
 202.16 age 21 and their families;

202.17 (3) respite care services for children with severe emotional disturbances who are at risk
 202.18 of out-of-home placement;

202.19 (4) children's mental health crisis services;

202.20 (5) mental health services for people from cultural and ethnic minorities;

202.21 (6) children's mental health screening and follow-up diagnostic assessment and treatment;

202.22 (7) services to promote and develop the capacity of providers to use evidence-based
 202.23 practices in providing children's mental health services;

202.24 (8) school-linked mental health services, ~~including transportation for children receiving~~
 202.25 ~~school-linked mental health services when school is not in session~~ under section 245.4901;

202.26 (9) building evidence-based mental health intervention capacity for children birth to age
 202.27 five;

202.28 (10) suicide prevention and counseling services that use text messaging statewide;

202.29 (11) mental health first aid training;

203.1 (12) training for parents, collaborative partners, and mental health providers on the
 203.2 impact of adverse childhood experiences and trauma and development of an interactive
 203.3 website to share information and strategies to promote resilience and prevent trauma;

203.4 (13) transition age services to develop or expand mental health treatment and supports
 203.5 for adolescents and young adults 26 years of age or younger;

203.6 (14) early childhood mental health consultation;

203.7 (15) evidence-based interventions for youth at risk of developing or experiencing a first
 203.8 episode of psychosis, and a public awareness campaign on the signs and symptoms of
 203.9 psychosis;

203.10 (16) psychiatric consultation for primary care practitioners; and

203.11 (17) providers to begin operations and meet program requirements when establishing a
 203.12 new children's mental health program. These may be start-up grants.

203.13 (c) Services under paragraph (b) must be designed to help each child to function and
 203.14 remain with the child's family in the community and delivered consistent with the child's
 203.15 treatment plan. Transition services to eligible young adults under this paragraph must be
 203.16 designed to foster independent living in the community.

203.17 (d) As a condition of receiving grant funds, a grantee shall obtain all available third-party
 203.18 reimbursement sources, if applicable.

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

203.20 **Sec. 2. [245.4901] SCHOOL-LINKED MENTAL HEALTH GRANTS.**

203.21 Subdivision 1. **Establishment.** The commissioner of human services shall establish a
 203.22 school-linked mental health grant program to provide early identification and intervention
 203.23 for students with mental health needs and to build the capacity of schools to support students
 203.24 with mental health needs in the classroom.

203.25 Subd. 2. **Eligible applicants.** An eligible applicant for school-linked mental health grants
 203.26 is an entity that is:

203.27 (1) certified under Minnesota Rules, parts 9520.0750 to 9520.0870;

203.28 (2) a community mental health center under section 256B.0625, subdivision 5;

203.29 (3) an Indian health service facility or a facility owned and operated by a tribe or tribal
 203.30 organization operating under United States Code, title 25, section 5321;

204.1 (4) a provider of children's therapeutic services and supports as defined in section
204.2 256B.0943; or

204.3 (5) enrolled in medical assistance as a mental health or substance use disorder provider
204.4 agency and employs at least two full-time equivalent mental health professionals qualified
204.5 according to section 245I.16, subdivision 2, or two alcohol and drug counselors licensed or
204.6 exempt from licensure under chapter 148F who are qualified to provide clinical services to
204.7 children and families.

204.8 Subd. 3. **Allowable grant activities and related expenses.** (a) Allowable grant activities
204.9 and related expenses may include but are not limited to:

204.10 (1) identifying and diagnosing mental health conditions of students;

204.11 (2) delivering mental health treatment and services to students and their families,
204.12 including via telemedicine consistent with section 256B.0625, subdivision 3b;

204.13 (3) supporting families in meeting their child's needs, including navigating health care,
204.14 social service, and juvenile justice systems;

204.15 (4) providing transportation for students receiving school-linked mental health services
204.16 when school is not in session;

204.17 (5) building the capacity of schools to meet the needs of students with mental health
204.18 concerns, including school staff development activities for licensed and nonlicensed staff;
204.19 and

204.20 (6) purchasing equipment, connection charges, on-site coordination, set-up fees, and
204.21 site fees in order to deliver school-linked mental health services via telemedicine.

204.22 (b) Grantees shall obtain all available third-party reimbursement sources as a condition
204.23 of receiving a grant. For purposes of this grant program, a third-party reimbursement source
204.24 excludes a public school as defined in section 120A.20, subdivision 1. Grantees shall serve
204.25 students regardless of health coverage status or ability to pay.

204.26 Subd. 4. **Data collection and outcome measurement.** Grantees shall provide data to
204.27 the commissioner for the purpose of evaluating the effectiveness of the school-linked mental
204.28 health grant program.

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

205.1 Sec. 3. Minnesota Statutes 2018, section 245.735, subdivision 3, is amended to read:

205.2 Subd. 3. **Certified community behavioral health clinics.** (a) The commissioner shall
205.3 establish a state certification process for certified community behavioral health clinics
205.4 (CCBHCs) ~~to be eligible for the prospective payment system in paragraph (f).~~ Entities that
205.5 choose to be CCBHCs must:

205.6 (1) comply with the CCBHC criteria published by the United States Department of
205.7 Health and Human Services;

205.8 (2) employ or contract for clinic staff who have backgrounds in diverse disciplines,
205.9 including licensed mental health professionals and licensed alcohol and drug counselors,
205.10 and staff who are culturally and linguistically trained to ~~serve~~ meet the needs of the ~~clinic's~~
205.11 ~~patient~~ population the clinic serves;

205.12 (3) ensure that clinic services are available and accessible to ~~patients~~ individuals and
205.13 families of all ages and genders and that crisis management services are available 24 hours
205.14 per day;

205.15 (4) establish fees for clinic services for ~~nonmedical assistance patients~~ individuals who
205.16 are not enrolled in medical assistance using a sliding fee scale that ensures that services to
205.17 patients are not denied or limited due to ~~a patient's~~ an individual's inability to pay for services;

205.18 (5) comply with quality assurance reporting requirements and other reporting
205.19 requirements, including any required reporting of encounter data, clinical outcomes data,
205.20 and quality data;

205.21 (6) provide crisis mental health and substance use services, withdrawal management
205.22 services, emergency crisis intervention services, and stabilization services; screening,
205.23 assessment, and diagnosis services, including risk assessments and level of care
205.24 ~~patient-centered~~ person- and family-centered treatment planning; outpatient
205.25 mental health and substance use services; targeted case management; psychiatric
205.26 rehabilitation services; peer support and counselor services and family support services;
205.27 and intensive community-based mental health services, including mental health services
205.28 for members of the armed forces and veterans;

205.29 (7) provide coordination of care across settings and providers to ensure seamless
205.30 transitions for ~~patients~~ individuals being served across the full spectrum of health services,
205.31 including acute, chronic, and behavioral needs. Care coordination may be accomplished
205.32 through partnerships or formal contracts with:

206.1 (i) counties, health plans, pharmacists, pharmacies, rural health clinics, federally qualified
206.2 health centers, inpatient psychiatric facilities, substance use and detoxification facilities, or
206.3 community-based mental health providers; and

206.4 (ii) other community services, supports, and providers, including schools, child welfare
206.5 agencies, juvenile and criminal justice agencies, Indian health services clinics, tribally
206.6 licensed health care and mental health facilities, urban Indian health clinics, Department of
206.7 Veterans Affairs medical centers, outpatient clinics, drop-in centers, acute care hospitals,
206.8 and hospital outpatient clinics;

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

206.10 ~~(9) be certified to provide integrated treatment for co-occurring mental illness and~~
206.11 ~~substance use disorders in adults or children under Minnesota Rules, chapter 9533, effective~~
206.12 ~~July 1, 2017;~~

206.13 ~~(10) (9) comply with standards relating to mental health services in Minnesota Rules,~~
206.14 ~~parts 9505.0370 to 9505.0372 chapter 245I and section 256B.0671;~~

206.15 ~~(11) (10) be licensed to provide chemical dependency substance use disorder treatment~~
206.16 ~~under chapter 245G;~~

206.17 ~~(12) (11) be certified to provide children's therapeutic services and supports under section~~
206.18 ~~256B.0943;~~

206.19 ~~(13) (12) be certified to provide adult rehabilitative mental health services under section~~
206.20 ~~256B.0623;~~

206.21 ~~(14) (13) be enrolled to provide mental health crisis response services under section~~
206.22 ~~sections 256B.0624 and 256B.0944;~~

206.23 ~~(15) (14) be enrolled to provide mental health targeted case management under section~~
206.24 ~~256B.0625, subdivision 20;~~

206.25 ~~(16) (15) comply with standards relating to mental health case management in Minnesota~~
206.26 ~~Rules, parts 9520.0900 to 9520.0926; and~~

206.27 ~~(17) (16) provide services that comply with the evidence-based practices described in~~
206.28 ~~paragraph (e); and~~

206.29 (17) comply with standards relating to peer services under sections 256B.0615,
206.30 256B.0616, and 245G.07, subdivision 1, paragraph (a), clause (5), as applicable when peer
206.31 services are provided.

207.1 (b) If an entity is unable to provide one or more of the services listed in paragraph (a),
207.2 clauses (6) to (17), the commissioner may certify the entity as a CCBHC, if the entity has
207.3 a current contract with another entity that has the required authority to provide that service
207.4 and that meets federal CCBHC criteria as a designated collaborating organization, or, to
207.5 the extent allowed by the federal CCBHC criteria, the commissioner may approve a referral
207.6 arrangement. The CCBHC must meet federal requirements regarding the type and scope of
207.7 services to be provided directly by the CCBHC.

207.8 (c) Notwithstanding any other law that requires a county contract or other form of county
207.9 approval for certain services listed in paragraph (a), clause (6), a clinic that otherwise meets
207.10 CCBHC requirements may receive the prospective payment under ~~paragraph (f)~~ section
207.11 256B.0625, subdivision 5m, for those services without a county contract or county approval.
207.12 There is no county share when medical assistance pays the CCBHC prospective payment.
207.13 As part of the certification process in paragraph (a), the commissioner shall require a letter
207.14 of support from the CCBHC's host county confirming that the CCBHC and the county or
207.15 counties it serves have an ongoing relationship to facilitate access and continuity of care,
207.16 especially for individuals who are uninsured or who may go on and off medical assistance.

207.17 (d) When the standards listed in paragraph (a) or other applicable standards conflict or
207.18 address similar issues in duplicative or incompatible ways, the commissioner may grant
207.19 variances to state requirements if the variances do not conflict with federal requirements.
207.20 If standards overlap, the commissioner may substitute all or a part of a licensure or
207.21 certification that is substantially the same as another licensure or certification. The
207.22 commissioner shall consult with stakeholders, as described in subdivision 4, before granting
207.23 variances under this provision. For the CCBHC that is certified but not approved for
207.24 prospective payment under section 256B.0625, subdivision 5m, the commissioner may
207.25 grant a variance under this paragraph if the variance does not increase the state share of
207.26 costs.

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

208.1 ~~(f) The commissioner shall establish standards and methodologies for a prospective~~
208.2 ~~payment system for medical assistance payments for services delivered by certified~~
208.3 ~~community behavioral health clinics, in accordance with guidance issued by the Centers~~
208.4 ~~for Medicare and Medicaid Services. During the operation of the demonstration project,~~
208.5 ~~payments shall comply with federal requirements for an enhanced federal medical assistance~~
208.6 ~~percentage. The commissioner may include quality bonus payment in the prospective~~
208.7 ~~payment system based on federal criteria and on a clinic's provision of the evidence-based~~
208.8 ~~practices in paragraph (e). The prospective payment system does not apply to MinnesotaCare.~~
208.9 ~~Implementation of the prospective payment system is effective July 1, 2017, or upon federal~~
208.10 ~~approval, whichever is later.~~

208.11 ~~(g) The commissioner shall seek federal approval to continue federal financial~~
208.12 ~~participation in payment for CCBHC services after the federal demonstration period ends~~
208.13 ~~for clinics that were certified as CCBHCs during the demonstration period and that continue~~
208.14 ~~to meet the CCBHC certification standards in paragraph (a). Payment for CCBHC services~~
208.15 ~~shall cease effective July 1, 2019, if continued federal financial participation for the payment~~
208.16 ~~of CCBHC services cannot be obtained.~~

208.17 ~~(h) The commissioner may certify at least one CCBHC located in an urban area and at~~
208.18 ~~least one CCBHC located in a rural area, as defined by federal criteria. To the extent allowed~~
208.19 ~~by federal law, the commissioner may limit the number of certified clinics so that the~~
208.20 ~~projected claims for certified clinics will not exceed the funds budgeted for this purpose.~~
208.21 ~~The commissioner shall give preference to clinics that:~~

208.22 ~~(1) provide a comprehensive range of services and evidence-based practices for all age~~
208.23 ~~groups, with services being fully coordinated and integrated; and~~

208.24 ~~(2) enhance the state's ability to meet the federal priorities to be selected as a CCBHC~~
208.25 ~~demonstration state.~~

208.26 ~~(+)~~ (f) The commissioner shall recertify CCBHCs at least every three years. The
208.27 commissioner shall establish a process for decertification and shall require corrective action,
208.28 medical assistance repayment, or decertification of a CCBHC that no longer meets the
208.29 requirements in this section or that fails to meet the standards provided by the commissioner
208.30 in the application and certification process.

208.31 EFFECTIVE DATE. This section is effective July 1, 2019, or upon federal approval,
208.32 whichever is later. The commissioner of human services shall notify the revisor of statutes
208.33 when federal approval is obtained.

209.1 Sec. 4. Minnesota Statutes 2018, section 245F.05, subdivision 2, is amended to read:

209.2 Subd. 2. **Admission criteria.** For an individual to be admitted to a withdrawal
 209.3 management program, the program must make a determination that the program services
 209.4 are appropriate to the needs of the individual. A program may only admit individuals ~~who~~
 209.5 ~~meet the admission criteria and who, at the time of admission;~~ meet the criteria for admission
 209.6 as determined by current American Society of Addiction Medicine standards for appropriate
 209.7 level of withdrawal management.

209.8 ~~(1) are impaired as the result of intoxication;~~

209.9 ~~(2) are experiencing physical, mental, or emotional problems due to intoxication or~~
 209.10 ~~withdrawal from alcohol or other drugs;~~

209.11 ~~(3) are being held under apprehend and hold orders under section 253B.07, subdivision~~
 209.12 ~~2b;~~

209.13 ~~(4) have been committed under chapter 253B and need temporary placement;~~

209.14 ~~(5) are held under emergency holds or peace and health officer holds under section~~
 209.15 ~~253B.05, subdivision 1 or 2; or~~

209.16 ~~(6) need to stay temporarily in a protective environment because of a crisis related to~~
 209.17 ~~substance use disorder. Individuals satisfying this clause may be admitted only at the request~~
 209.18 ~~of the county of fiscal responsibility, as determined according to section 256G.02, subdivision~~
 209.19 ~~4. Individuals admitted according to this clause must not be restricted to the facility.~~

209.20 Sec. 5. Minnesota Statutes 2018, section 254B.02, subdivision 1, is amended to read:

209.21 Subdivision 1. **Chemical dependency treatment allocation.** The chemical dependency
 209.22 treatment appropriation shall be placed in a special revenue account. ~~The commissioner~~
 209.23 ~~shall annually transfer funds from the chemical dependency fund to pay for operation of~~
 209.24 ~~the drug and alcohol abuse normative evaluation system and to pay for all costs incurred~~
 209.25 ~~by adding two positions for licensing of chemical dependency treatment and rehabilitation~~
 209.26 ~~programs located in hospitals for which funds are not otherwise appropriated. The remainder~~
 209.27 ~~of the money in the special revenue account must be used according to the requirements in~~
 209.28 ~~this chapter.~~

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

210.1 Sec. 6. Minnesota Statutes 2018, section 254B.03, subdivision 2, is amended to read:

210.2 Subd. 2. **Chemical dependency fund payment.** (a) Payment from the chemical
210.3 dependency fund is limited to payments for services other than detoxification licensed under
210.4 Minnesota Rules, parts 9530.6510 to 9530.6590, that, if located outside of federally
210.5 recognized tribal lands, would be required to be licensed by the commissioner as a chemical
210.6 dependency treatment or rehabilitation program under sections 245A.01 to 245A.16, and
210.7 services other than detoxification provided in another state that would be required to be
210.8 licensed as a chemical dependency program if the program were in the state. Out of state
210.9 vendors must also provide the commissioner with assurances that the program complies
210.10 substantially with state licensing requirements and possesses all licenses and certifications
210.11 required by the host state to provide chemical dependency treatment. Vendors receiving
210.12 payments from the chemical dependency fund must not require co-payment from a recipient
210.13 of benefits for services provided under this subdivision. The vendor is prohibited from using
210.14 the client's public benefits to offset the cost of services paid under this section. The vendor
210.15 shall not require the client to use public benefits for room or board costs. This includes but
210.16 is not limited to cash assistance benefits under chapters 119B, 256D, and 256J, or SNAP
210.17 benefits. Retention of SNAP benefits is a right of a client receiving services through the
210.18 consolidated chemical dependency treatment fund or through state contracted managed care
210.19 entities. Payment from the chemical dependency fund shall be made for necessary room
210.20 and board costs provided by vendors ~~certified according to~~ meeting the criteria under section
210.21 254B.05, subdivision 1a, or in a community hospital licensed by the commissioner of health
210.22 according to sections 144.50 to 144.56 to a client who is:

210.23 (1) determined to meet the criteria for placement in a residential chemical dependency
210.24 treatment program according to rules adopted under section 254A.03, subdivision 3; and

210.25 (2) concurrently receiving a chemical dependency treatment service in a program licensed
210.26 by the commissioner and reimbursed by the chemical dependency fund.

210.27 (b) A county may, from its own resources, provide chemical dependency services for
210.28 which state payments are not made. A county may elect to use the same invoice procedures
210.29 and obtain the same state payment services as are used for chemical dependency services
210.30 for which state payments are made under this section if county payments are made to the
210.31 state in advance of state payments to vendors. When a county uses the state system for
210.32 payment, the commissioner shall make monthly billings to the county using the most recent
210.33 available information to determine the anticipated services for which payments will be made
210.34 in the coming month. Adjustment of any overestimate or underestimate based on actual

211.1 expenditures shall be made by the state agency by adjusting the estimate for any succeeding
211.2 month.

211.3 (c) The commissioner shall coordinate chemical dependency services and determine
211.4 whether there is a need for any proposed expansion of chemical dependency treatment
211.5 services. The commissioner shall deny vendor certification to any provider that has not
211.6 received prior approval from the commissioner for the creation of new programs or the
211.7 expansion of existing program capacity. The commissioner shall consider the provider's
211.8 capacity to obtain clients from outside the state based on plans, agreements, and previous
211.9 utilization history, when determining the need for new treatment services.

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

211.11 Sec. 7. Minnesota Statutes 2018, section 254B.03, subdivision 4, is amended to read:

211.12 Subd. 4. **Division of costs.** (a) Except for services provided by a county under section
211.13 254B.09, subdivision 1, or services provided under section 256B.69, the county shall, out
211.14 of local money, pay the state for 22.95 percent of the cost of chemical dependency services,
211.15 ~~including except for~~ those services provided to persons ~~eligible for~~ enrolled in medical
211.16 assistance under chapter 256B and room and board services under section 254B.05,
211.17 subdivision 5, paragraph (b), clause (12). Counties may use the indigent hospitalization
211.18 levy for treatment and hospital payments made under this section.

211.19 (b) 22.95 percent of any state collections from private or third-party pay, less 15 percent
211.20 for the cost of payment and collections, must be distributed to the county that paid for a
211.21 portion of the treatment under this section.

211.22 ~~(c) For fiscal year 2017 only, the 22.95 percentages under paragraphs (a) and (b) are~~
211.23 ~~equal to 20.2 percent.~~

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

211.25 Sec. 8. Minnesota Statutes 2018, section 254B.04, subdivision 1, is amended to read:

211.26 Subdivision 1. **Eligibility.** (a) Persons eligible for benefits under Code of Federal
211.27 Regulations, title 25, part 20, ~~and persons eligible for medical assistance benefits under~~
211.28 ~~sections 256B.055, 256B.056, and 256B.057, subdivisions 1, 5, and 6, or who meet the~~
211.29 income standards of section 256B.056, subdivision 4, and are not enrolled in medical
211.30 assistance, are entitled to chemical dependency fund services. State money appropriated
211.31 for this paragraph must be placed in a separate account established for this purpose.

212.1 (b) Persons with dependent children who are determined to be in need of chemical
212.2 dependency treatment pursuant to an assessment under section 626.556, subdivision 10, or
212.3 a case plan under section 260C.201, subdivision 6, or 260C.212, shall be assisted by the
212.4 local agency to access needed treatment services. Treatment services must be appropriate
212.5 for the individual or family, which may include long-term care treatment or treatment in a
212.6 facility that allows the dependent children to stay in the treatment facility. The county shall
212.7 pay for out-of-home placement costs, if applicable.

212.8 (c) Notwithstanding paragraph (a), persons enrolled in medical assistance are eligible
212.9 for room and board services under section 254B.05, subdivision 5, paragraph (b), clause
212.10 (12).

212.11 **EFFECTIVE DATE.** This section is effective September 1, 2019.

212.12 Sec. 9. Minnesota Statutes 2018, section 254B.05, subdivision 1a, is amended to read:

212.13 Subd. 1a. **Room and board provider requirements.** (a) Effective January 1, 2000,
212.14 vendors of room and board are eligible for chemical dependency fund payment if the vendor:

212.15 (1) has rules prohibiting residents bringing chemicals into the facility or using chemicals
212.16 while residing in the facility and provide consequences for infractions of those rules;

212.17 (2) is determined to meet applicable health and safety requirements;

212.18 (3) is not a jail or prison;

212.19 (4) is not concurrently receiving funds under chapter 256I for the recipient;

212.20 (5) admits individuals who are 18 years of age or older;

212.21 (6) is registered as a board and lodging or lodging establishment according to section
212.22 157.17;

212.23 (7) has awake staff on site 24 hours per day;

212.24 (8) has staff who are at least 18 years of age and meet the requirements of section
212.25 245G.11, subdivision 1, paragraph (b);

212.26 (9) has emergency behavioral procedures that meet the requirements of section 245G.16;

212.27 (10) meets the requirements of section 245G.08, subdivision 5, if administering
212.28 medications to clients;

212.29 (11) meets the abuse prevention requirements of section 245A.65, including a policy on
212.30 fraternization and the mandatory reporting requirements of section 626.557;

213.1 (12) documents coordination with the treatment provider to ensure compliance with
213.2 section 254B.03, subdivision 2;

213.3 (13) protects client funds and ensures freedom from exploitation by meeting the
213.4 provisions of section 245A.04, subdivision 13;

213.5 (14) has a grievance procedure that meets the requirements of section 245G.15,
213.6 subdivision 2; and

213.7 (15) has sleeping and bathroom facilities for men and women separated by a door that
213.8 is locked, has an alarm, or is supervised by awake staff.

213.9 (b) Programs licensed according to Minnesota Rules, chapter 2960, are exempt from
213.10 paragraph (a), clauses (5) to (15).

213.11 (c) Licensed programs providing intensive residential treatment services or residential
213.12 crisis stabilization services pursuant to section 256B.0622 or 256B.0624 are eligible vendors
213.13 of room and board and are exempt from paragraph (a), clauses (6) to (15).

213.14 **EFFECTIVE DATE.** This section is effective September 1, 2019.

213.15 Sec. 10. Minnesota Statutes 2018, section 254B.06, subdivision 1, is amended to read:

213.16 Subdivision 1. **State collections.** The commissioner is responsible for all collections
213.17 from persons determined to be partially responsible for the cost of care of an eligible person
213.18 receiving services under Laws 1986, chapter 394, sections 8 to 20. The commissioner may
213.19 initiate, or request the attorney general to initiate, necessary civil action to recover the unpaid
213.20 cost of care. The commissioner may collect all third-party payments for chemical dependency
213.21 services provided under Laws 1986, chapter 394, sections 8 to 20, including private insurance
213.22 and federal Medicaid and Medicare financial participation. ~~The commissioner shall deposit~~
213.23 ~~in a dedicated account a percentage of collections to pay for the cost of operating the chemical~~
213.24 ~~dependency consolidated treatment fund invoice processing and vendor payment system,~~
213.25 ~~billing, and collections.~~ The remaining receipts must be deposited in the chemical dependency
213.26 fund.

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

213.28 Sec. 11. Minnesota Statutes 2018, section 254B.06, subdivision 2, is amended to read:

213.29 Subd. 2. **Allocation of collections.** ~~(a) The commissioner shall allocate all federal~~
213.30 ~~financial participation collections to a special revenue account.~~ The commissioner shall

214.1 allocate 77.05 percent of patient payments and third-party payments to the special revenue
 214.2 account and 22.95 percent to the county financially responsible for the patient.

214.3 ~~(b) For fiscal year 2017 only, the commissioner's allocation to the special revenue account~~
 214.4 ~~shall be increased from 77.05 percent to 79.8 percent and the county financial responsibility~~
 214.5 ~~shall be reduced from 22.95 percent to 20.2 percent.~~

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

214.7 Sec. 12. Minnesota Statutes 2018, section 256.478, is amended to read:

214.8 **256.478 HOME AND COMMUNITY-BASED SERVICES TRANSITIONS**
 214.9 **GRANTS TRANSITION TO COMMUNITY INITIATIVE.**

214.10 Subdivision 1. Eligibility. (a) An individual is eligible for the transition to community
 214.11 initiative if the individual meets the following criteria:

214.12 (1) without the additional resources available through the transitions to community
 214.13 initiative the individual would otherwise remain at the Anoka-Metro Regional Treatment
 214.14 Center, a state-operated community behavioral health hospital, or the Minnesota Security
 214.15 Hospital;

214.16 (2) the individual's discharge would be significantly delayed without the additional
 214.17 resources available through the transitions to community initiative; and

214.18 (3) the individual met treatment objectives and no longer needs hospital-level care or a
 214.19 secure treatment setting.

214.20 (b) An individual who is in a community hospital and on the waiting list for the
 214.21 Anoka-Metro Regional Treatment Center, but for whom alternative community placement
 214.22 would be appropriate is eligible for the transition to community initiative upon the
 214.23 commissioner's approval.

214.24 Subd. 2. Transition grants. The commissioner shall make available ~~home and~~
 214.25 ~~community-based services transition to community grants to serve assist~~ individuals who
 214.26 ~~do not meet eligibility criteria for the medical assistance program under section 256B.056~~
 214.27 ~~or 256B.057, but who otherwise meet the criteria under section 256B.092, subdivision 13,~~
 214.28 ~~or 256B.49, subdivision 24 who met the criteria under subdivision 1.~~

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

215.1 Sec. 13. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision
215.2 to read:

215.3 Subd. 5m. **Certified community behavioral health clinic services.** (a) Medical
215.4 assistance covers certified community behavioral health clinic (CCBHC) services that meet
215.5 the requirements of section 245.735, subdivision 3.

215.6 (b) The commissioner shall establish standards and methodologies for a prospective
215.7 payment system for medical assistance payments for services delivered by a CCBHC, in
215.8 accordance with guidance issued by the Centers for Medicare and Medicaid Services. The
215.9 commissioner shall include a quality bonus payment in the prospective payment system
215.10 based on federal criteria. The prospective payment system does not apply to MinnesotaCare.

215.11 (c) To the extent allowed by federal law, the commissioner may limit the number of
215.12 CCBHCs for the prospective payment system in paragraph (b) to ensure that the projected
215.13 claims do not exceed the money appropriated for this purpose. The commissioner shall
215.14 apply the following priorities, in the order listed, to give preference to clinics that:

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

215.17 (2) are certified as CCBHCs during the federal CCBHC demonstration period;

215.18 (3) receive CCBHC grants from the United States Department of Health and Human
215.19 Services; or

215.20 (4) focus on serving individuals in tribal areas and other underserved communities.

215.21 (d) Unless otherwise indicated in applicable federal requirements, the prospective payment
215.22 system must continue to be based on the federal instructions issued for the federal CCBHC
215.23 demonstration, except:

215.24 (1) the commissioner shall rebase CCBHC rates at least every three years;

215.25 (2) the commissioner shall provide for a 60-day appeals process of the rebasing;

215.26 (3) the prohibition against inclusion of new facilities in the demonstration does not apply
215.27 after the demonstration ends;

215.28 (4) the prospective payment rate under this section does not apply to services rendered
215.29 by CCBHCs to individuals who are dually eligible for Medicare and medical assistance
215.30 when Medicare is the primary payer for the service;

215.31 (5) payments for CCBHC services to individuals enrolled in managed care shall be
215.32 coordinated with the state's phase-out of CCBHC wrap payments;

216.1 (6) initial prospective payment rates for CCBHCs certified after July 1, 2019, shall be
 216.2 based on rates for comparable CCBHCs. If no comparable provider exists, the commissioner
 216.3 shall compute a CCBHC-specific rate based upon the CCBHC's audited costs adjusted for
 216.4 changes in the scope of services; and

216.5 (7) the prospective payment rate for each CCBHC shall be adjusted annually by the
 216.6 Medicare Economic Index as defined for the CCBHC federal demonstration.

216.7 **EFFECTIVE DATE.** Contingent upon federal approval, this section is effective July
 216.8 1, 2019. The commissioner of human services shall notify the revisor of statutes when
 216.9 federal approval is obtained or denied.

216.10 Sec. 14. Minnesota Statutes 2018, section 256B.0625, subdivision 24, is amended to read:

216.11 Subd. 24. **Other medical or remedial care.** Medical assistance covers any other medical
 216.12 or remedial care licensed and recognized under state law unless otherwise prohibited by
 216.13 law, ~~except licensed chemical dependency treatment programs or primary treatment or~~
 216.14 ~~extended care treatment units in hospitals that are covered under chapter 254B. The~~
 216.15 ~~commissioner shall include chemical dependency services in the state medical assistance~~
 216.16 ~~plan for federal reporting purposes, but payment must be made under chapter 254B. The~~
 216.17 commissioner shall publish in the State Register a list of elective surgeries that require a
 216.18 second medical opinion before medical assistance reimbursement, and the criteria and
 216.19 standards for deciding whether an elective surgery should require a second medical opinion.
 216.20 The list and criteria and standards are not subject to the requirements of sections 14.01 to
 216.21 14.69.

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

216.23 Sec. 15. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision
 216.24 to read:

216.25 Subd. 24a. **Substance use disorder services.** Medical assistance covers substance use
 216.26 disorder treatment services according to section 254B.05, subdivision 5, except for room
 216.27 and board.

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

217.1 Sec. 16. Minnesota Statutes 2018, section 256B.0625, subdivision 45a, is amended to
217.2 read:

217.3 Subd. 45a. **Psychiatric residential treatment facility services for persons younger**
217.4 **than 21 years of age.** (a) Medical assistance covers psychiatric residential treatment facility
217.5 services, according to section 256B.0941, for persons younger than 21 years of age.
217.6 Individuals who reach age 21 at the time they are receiving services are eligible to continue
217.7 receiving services until they no longer require services or until they reach age 22, whichever
217.8 occurs first.

217.9 (b) For purposes of this subdivision, "psychiatric residential treatment facility" means
217.10 a facility other than a hospital that provides psychiatric services, as described in Code of
217.11 Federal Regulations, title 42, sections 441.151 to 441.182, to individuals under age 21 in
217.12 an inpatient setting.

217.13 (c) The commissioner shall enroll up to 150 certified psychiatric residential treatment
217.14 facility services beds ~~at up to six sites.~~ The commissioner may enroll an additional 80
217.15 certified psychiatric residential treatment facility services beds beginning July 1, 2020, and
217.16 an additional 70 certified psychiatric residential treatment facility services beds beginning
217.17 July 1, 2023. The commissioner shall select psychiatric residential treatment facility services
217.18 providers through a request for proposals process. Providers of state-operated services may
217.19 respond to the request for proposals. The commissioner shall prioritize programs that
217.20 demonstrate the capacity to serve children and youth with aggressive and risky behaviors
217.21 toward themselves or others, multiple diagnoses, neurodevelopmental disorders, or complex
217.22 trauma related issues.

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

217.24 Sec. 17. Minnesota Statutes 2018, section 256B.0625, subdivision 57, is amended to read:

217.25 Subd. 57. **Payment for Part B Medicare crossover claims.** (a) Effective for services
217.26 provided on or after January 1, 2012, medical assistance payment for an enrollee's
217.27 cost-sharing associated with Medicare Part B is limited to an amount up to the medical
217.28 assistance total allowed, when the medical assistance rate exceeds the amount paid by
217.29 Medicare.

217.30 (b) Excluded from this limitation are payments for mental health services and payments
217.31 for dialysis services provided to end-stage renal disease patients. The exclusion for mental
217.32 health services does not apply to payments for physician services provided by psychiatrists
217.33 and advanced practice nurses with a specialty in mental health.

218.1 (c) Excluded from this limitation are payments to federally qualified health centers ~~and~~₂
 218.2 rural health clinics, and CCBHCs subject to the prospective payment system under
 218.3 subdivision 5m.

218.4 **EFFECTIVE DATE.** Contingent upon federal approval, this section is effective July
 218.5 1, 2019. The commissioner of human services shall notify the revisor of statutes when
 218.6 federal approval is obtained or denied.

218.7 Sec. 18. **[256B.0759] SUBSTANCE USE DISORDER DEMONSTRATION PROJECT.**

218.8 **Subdivision 1. Establishment.** The commissioner shall develop and implement a medical
 218.9 assistance demonstration project to test reforms of Minnesota's substance use disorder
 218.10 treatment system to ensure individuals with substance use disorders have access to a full
 218.11 continuum of high quality care.

218.12 **Subd. 2. Provider participation.** Substance use disorder treatment providers may elect
 218.13 to participate in the demonstration project. To participate, a provider must notify the
 218.14 commissioner of the provider's intent to participate in a format required by the commissioner
 218.15 and enroll as a demonstration project provider.

218.16 **Subd. 3. Provider standards.** (a) The commissioner shall establish requirements for
 218.17 participating providers that meet the federal requirements of the demonstration project.

218.18 (b) A participating provider must obtain applicable licensure under chapters 245F and
 218.19 245G for the services provided and must:

218.20 (1) deliver services in accordance with the American Society of Addiction Medicine
 218.21 (ASAM) standards;

218.22 (2) comply with formal patient referral arrangements with providers delivering step-up
 218.23 or step-down levels of care in accordance with the ASAM standards; and

218.24 (3) provide or arrange for medication-assisted treatment services if requested by a client
 218.25 for whom an effective medication exists.

218.26 (c) If the provider standards under chapter 245G or other applicable standards conflict
 218.27 or are duplicative, the commissioner may grant variances to the standards if the variances
 218.28 do not conflict with federal requirements. The commissioner shall publish service
 218.29 components, service standards, and staffing requirements for participating providers that
 218.30 are consistent with ASAM standards and federal requirements.

218.31 **Subd. 4. Provider payment rates.** (a) Payment rates for participating providers must
 218.32 be increased for services provided to medical assistance enrollees.

219.1 (b) For substance use disorder services under section 254B.05, subdivision 5, paragraph
 219.2 (b), clause (8), payment rates must be increased by 15 percent over the rates in effect on
 219.3 January 1, 2022.

219.4 (c) For substance use disorder services under section 254B.05, subdivision 5, paragraph
 219.5 (b), clauses (1), (6), (7), and (10), payment rates must be increased by ten percent over the
 219.6 rates in effect on January 1, 2022.

219.7 Subd. 5. **Federal approval.** The commissioner shall seek federal approval to implement
 219.8 the demonstration project under this section and to receive federal financial participation.

219.9 Sec. 19. Minnesota Statutes 2018, section 256B.0915, subdivision 3b, is amended to read:

219.10 Subd. 3b. **Cost limits for elderly waiver applicants who reside in a nursing facility**
 219.11 **or another eligible facility.** (a) For a person who is a nursing facility resident at the time
 219.12 of requesting a determination of eligibility for elderly waived services, a monthly
 219.13 conversion budget limit for the cost of elderly waived services may be requested. The
 219.14 monthly conversion budget limit for the cost of elderly waiver services shall be ~~the resident~~
 219.15 ~~class assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, for that resident in~~
 219.16 ~~the nursing facility where the resident currently resides until July 1 of the state fiscal year~~
 219.17 ~~in which the resident assessment system as described in section 256B.438 for nursing home~~
 219.18 ~~rate determination is implemented. Effective on July 1 of the state fiscal year in which the~~
 219.19 ~~resident assessment system as described in section 256B.438 for nursing home rate~~
 219.20 ~~determination is implemented, the monthly conversion budget limit for the cost of elderly~~
 219.21 ~~waiver services shall be based on the per diem nursing facility rate as determined by the~~
 219.22 resident assessment system as described in section ~~256B.438~~ 256R.17 for residents in the
 219.23 nursing facility where the elderly waiver applicant currently resides. The monthly conversion
 219.24 budget limit shall be calculated by multiplying the per diem by 365, divided by 12, and
 219.25 reduced by the recipient's maintenance needs allowance as described in subdivision 1d. The
 219.26 initially approved monthly conversion budget limit shall be adjusted annually as described
 219.27 in subdivision 3a, paragraph (a). The limit under this ~~subdivision~~ paragraph only applies to
 219.28 persons discharged from a nursing facility after a minimum 30-day stay and found eligible
 219.29 for waived services on or after July 1, 1997. For conversions from the nursing home to
 219.30 the elderly waiver with consumer directed community support services, the nursing facility
 219.31 per diem used to calculate the monthly conversion budget limit must be reduced by a
 219.32 percentage equal to the percentage difference between the consumer directed services budget
 219.33 limit that would be assigned according to the federally approved waiver plan and the
 219.34 corresponding community case mix cap, but not to exceed 50 percent.

220.1 (b) A person who meets elderly waiver eligibility criteria and the eligibility criteria under
 220.2 section 256.478, subdivision 1, is eligible for a special monthly budget limit for the cost of
 220.3 elderly waived services up to \$21,610 per month. The special monthly budget limit must
 220.4 be adjusted annually as described in subdivision 3a, paragraphs (a) and (e). For a person
 220.5 using a special monthly budget limit under the elderly waiver with consumer-directed
 220.6 community support services, the special monthly budget limit must be reduced as described
 220.7 in paragraph (a).

220.8 (c) The commissioner may provide an additional payment for documented costs between
 220.9 a threshold determined by the commissioner and the special monthly budget limit to a
 220.10 managed care plan for elderly waiver services provided to a person who is: (1) eligible for
 220.11 a special monthly budget limit under paragraph (b); and (2) enrolled in a managed care plan
 220.12 that provides elderly waiver services under section 256B.69.

220.13 (d) For monthly conversion budget limits under paragraph (a) and special monthly budget
 220.14 limits under paragraph (b), the service rate limits for adult foster care under subdivision 3d
 220.15 and for customized living under subdivision 3e may be exceeded if necessary for the provider
 220.16 to meet identified needs and provide services as approved in the coordinated service and
 220.17 support plan, if the total cost of all services does not exceed the monthly conversion or
 220.18 special monthly budget limit. Service rates must be established using tools provided by the
 220.19 commissioner.

220.20 (e) The following costs must be included in determining the total monthly costs for the
 220.21 waiver client:

220.22 (1) cost of all waived services, including specialized supplies and equipment and
 220.23 environmental accessibility adaptations; and

220.24 (2) cost of skilled nursing, home health aide, and personal care services reimbursable
 220.25 by medical assistance.

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

220.28 Sec. 20. Minnesota Statutes 2018, section 256B.092, subdivision 13, is amended to read:

220.29 Subd. 13. **Waiver allocations for transition populations.** (a) The commissioner shall
 220.30 make available additional waiver allocations and additional necessary resources ~~to assure~~
 220.31 ~~timely discharges from the Anoka Metro Regional Treatment Center and the Minnesota~~
 220.32 ~~Security Hospital in St. Peter~~ for individuals who meet the following eligibility criteria:
 220.33 established under section 256.478, subdivision 1.

221.1 ~~(1) are otherwise eligible for the developmental disabilities waiver under this section;~~

221.2 ~~(2) who would otherwise remain at the Anoka Metro Regional Treatment Center or the~~
 221.3 ~~Minnesota Security Hospital;~~

221.4 ~~(3) whose discharge would be significantly delayed without the available waiver~~
 221.5 ~~allocation; and~~

221.6 ~~(4) who have met treatment objectives and no longer meet hospital level of care.~~

221.7 (b) Additional waiver allocations under this subdivision must meet cost-effectiveness
 221.8 requirements of the federal approved waiver plan.

221.9 (c) Any corporate foster care home developed under this subdivision must be considered
 221.10 an exception under section 245A.03, subdivision 7, paragraph (a).

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

221.12 Sec. 21. Minnesota Statutes 2018, section 256B.49, subdivision 24, is amended to read:

221.13 Subd. 24. **Waiver allocations for transition populations.** (a) The commissioner shall
 221.14 make available additional waiver allocations and additional necessary resources ~~to assure~~
 221.15 ~~timely discharges from the Anoka Metro Regional Treatment Center and the Minnesota~~
 221.16 ~~Security Hospital in St. Peter~~ for individuals who meet the following eligibility criteria:
 221.17 established under section 256.478, subdivision 1.

221.18 ~~(1) are otherwise eligible for the brain injury, community access for disability inclusion,~~
 221.19 ~~or community alternative care waivers under this section;~~

221.20 ~~(2) who would otherwise remain at the Anoka Metro Regional Treatment Center or the~~
 221.21 ~~Minnesota Security Hospital;~~

221.22 ~~(3) whose discharge would be significantly delayed without the available waiver~~
 221.23 ~~allocation; and~~

221.24 ~~(4) who have met treatment objectives and no longer meet hospital level of care.~~

221.25 (b) Additional waiver allocations under this subdivision must meet cost-effectiveness
 221.26 requirements of the federal approved waiver plan.

221.27 (c) Any corporate foster care home developed under this subdivision must be considered
 221.28 an exception under section 245A.03, subdivision 7, paragraph (a).

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

222.1 Sec. 22. Minnesota Statutes 2018, section 256I.04, subdivision 1, is amended to read:

222.2 Subdivision 1. **Individual eligibility requirements.** An individual is eligible for and
222.3 entitled to a housing support payment to be made on the individual's behalf if the agency
222.4 has approved the setting where the individual will receive housing support and the individual
222.5 meets the requirements in paragraph (a), (b), or (c).

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

222.15 (b) The individual meets a category of eligibility under section 256D.05, subdivision 1,
222.16 paragraph (a), clauses (1), (3), (4) to (8), and (13), and paragraph (b), if applicable, and the
222.17 individual's resources are less than the standards specified by section 256P.02, and the
222.18 individual's countable income as determined under section 256P.06, less the medical
222.19 assistance personal needs allowance under section 256B.35 is less than the monthly rate
222.20 specified in the agency's agreement with the provider of housing support in which the
222.21 individual resides.

222.22 (c) ~~The individual receives licensed residential crisis stabilization services under section~~
222.23 ~~256B.0624, subdivision 7, and is receiving medical assistance. The individual may receive~~
222.24 ~~concurrent housing support payments if receiving licensed residential crisis stabilization~~
222.25 ~~services under section 256B.0624, subdivision 7. lacks a fixed, adequate, nighttime residence~~
222.26 ~~upon discharge from a residential behavioral health treatment program, as determined by~~
222.27 ~~treatment staff from the residential behavioral health treatment program. An individual is~~
222.28 ~~eligible under this paragraph for up to three months, including a full or partial month from~~
222.29 ~~the individual's move-in date at a setting approved for housing support following discharge~~
222.30 ~~from treatment, plus two full months.~~

222.31 **EFFECTIVE DATE.** This section is effective September 1, 2019.

223.1 Sec. 23. Minnesota Statutes 2018, section 256I.04, subdivision 2f, is amended to read:

223.2 Subd. 2f. **Required services.** (a) In licensed and registered settings under subdivision
223.3 2a, providers shall ensure that participants have at a minimum:

223.4 (1) food preparation and service for three nutritional meals a day on site;

223.5 (2) a bed, clothing storage, linen, bedding, laundering, and laundry supplies or service;

223.6 (3) housekeeping, including cleaning and lavatory supplies or service; and

223.7 (4) maintenance and operation of the building and grounds, including heat, water, garbage
223.8 removal, electricity, telephone for the site, cooling, supplies, and parts and tools to repair
223.9 and maintain equipment and facilities.

223.10 (b) In addition, when providers serve participants described in subdivision 1, paragraph
223.11 (c), the providers are required to assist the participants in applying for continuing housing
223.12 support payments before the end of the eligibility period.

223.13 **EFFECTIVE DATE.** This section is effective September 1, 2019.

223.14 Sec. 24. Minnesota Statutes 2018, section 256I.06, subdivision 8, is amended to read:

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

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

223.26 (c) For an individual who receives ~~licensed residential crisis stabilization services under~~
223.27 ~~section 256B.0624, subdivision 7,~~ housing support payments under section 256I.04,
223.28 subdivision 1, paragraph (c), the amount of the housing support payment is determined by
223.29 multiplying the housing support rate times the period of time the individual was a resident.

223.30 **EFFECTIVE DATE.** This section is effective September 1, 2019.

224.1 Sec. 25. Laws 2017, First Special Session chapter 6, article 8, section 71, the effective
224.2 date, is amended to read:

224.3 **EFFECTIVE DATE.** This section is effective for services provided on July 1, 2017,
224.4 ~~through April 30, 2019, and expires May 1, 2019~~ and thereafter.

224.5 **EFFECTIVE DATE.** This section is effective April 30, 2019.

224.6 Sec. 26. Laws 2017, First Special Session chapter 6, article 8, section 72, the effective
224.7 date, is amended to read:

224.8 **EFFECTIVE DATE.** This section is effective for services provided on July 1, 2017,
224.9 ~~through April 30, 2019, and expires May 1, 2019~~ and thereafter.

224.10 **EFFECTIVE DATE.** This section is effective April 30, 2019.

224.11 Sec. 27. **COMMUNITY COMPETENCY RESTORATION TASK FORCE.**

224.12 Subdivision 1. **Establishment; purpose.** The Community Competency Restoration Task
224.13 Force is established to evaluate and study community competency restoration programs and
224.14 develop recommendations to address the needs of individuals deemed incompetent to stand
224.15 trial.

224.16 Subd. 2. **Membership.** (a) The Community Competency Restoration Task Force consists
224.17 of the following members, appointed as follows:

224.18 (1) a representative appointed by the governor's office;

224.19 (2) the commissioner of human services or designee;

224.20 (3) the commissioner of corrections or designee;

224.21 (4) a representative from direct care and treatment services with experience in competency
224.22 evaluations, appointed by the commissioner of human services;

224.23 (5) a representative appointed by the designated State Protection and Advocacy system;

224.24 (6) the ombudsman for mental health and developmental disabilities;

224.25 (7) a representative appointed by the Minnesota Hospital Association;

224.26 (8) a representative appointed by the Association of Minnesota Counties;

224.27 (9) two representatives appointed by the Minnesota Association of County Social Service
224.28 Administrators: one from the seven-county metropolitan area, as defined under Minnesota

- 225.1 Statutes, section 473.121, subdivision 2, and one from outside the seven-county metropolitan
225.2 area;
- 225.3 (10) a representative appointed by the Board of Public Defense;
- 225.4 (11) a representative appointed by the Minnesota County Attorney Association;
- 225.5 (12) a representative appointed by the Chiefs of Police;
- 225.6 (13) a representative appointed by the Minnesota Psychiatric Society;
- 225.7 (14) a representative appointed by the Minnesota Psychological Association;
- 225.8 (15) a representative appointed by the State Court Administrator;
- 225.9 (16) a representative appointed by the Minnesota Association of Community Mental
225.10 Health Programs;
- 225.11 (17) a representative appointed by the Minnesota Sheriff's Association;
- 225.12 (18) a representative appointed by the Sentencing Commission;
- 225.13 (19) a jail administrator appointed by the commissioner of corrections;
- 225.14 (20) a representative from an organization providing reentry services appointed by the
225.15 commissioner of corrections;
- 225.16 (21) a representative from a mental health advocacy organization appointed by the
225.17 commissioner of human services;
- 225.18 (22) a person with direct experience with competency restoration appointed by the
225.19 commissioner of human services;
- 225.20 (23) representatives from organizations representing racial and ethnic groups
225.21 overrepresented in the justice system appointed by the commissioner of corrections; and
- 225.22 (24) a crime victim appointed by the commissioner of corrections.
- 225.23 (b) Appointments to the task force must be made no later than July 15, 2019, and members
225.24 of the task force may be compensated as provided under Minnesota Statutes, section 15.059,
225.25 subdivision 3.
- 225.26 Subd. 3. **Duties.** The task force must:
- 225.27 (1) identify current services and resources available for individuals in the criminal justice
225.28 system who have been found incompetent to stand trial;
- 225.29 (2) analyze current trends of competency referrals by county and the impact of any
225.30 diversion projects or stepping-up initiatives;

226.1 (3) analyze selected case reviews and other data to identify risk levels of those individuals,
226.2 service usage, housing status, and health insurance status prior to being jailed;

226.3 (4) research how other states address this issue, including funding and structure of
226.4 community competency restoration programs, and jail-based programs; and

226.5 (5) develop recommendations to address the growing number of individuals deemed
226.6 incompetent to stand trial including increasing prevention and diversion efforts, providing
226.7 a timely process for reducing the amount of time individuals remain in the criminal justice
226.8 system, determining how to provide and fund competency restoration services in the
226.9 community, and defining the role of the counties and state in providing competency
226.10 restoration.

226.11 Subd. 4. **Officers; meetings.** (a) The commissioner of human services shall convene
226.12 the first meeting of the task force no later than August 1, 2019.

226.13 (b) The task force must elect a chair and vice-chair from among its members and may
226.14 elect other officers as necessary.

226.15 (c) The task force is subject to the Minnesota Open Meeting Law under Minnesota
226.16 Statutes, chapter 13D.

226.17 Subd. 5. **Staff.** (a) The commissioner of human services must provide staff assistance
226.18 to support the task force's work.

226.19 (b) The task force may utilize the expertise of the Council of State Governments Justice
226.20 Center.

226.21 Subd. 6. **Report required.** (a) By February 1, 2020, the task force shall submit a report
226.22 on its progress and findings to the chairs and ranking minority members of the legislative
226.23 committees with jurisdiction over mental health and corrections.

226.24 (b) By February 1, 2021, the task force must submit a written report including
226.25 recommendations to address the growing number of individuals deemed incompetent to
226.26 stand trial to the chairs and ranking minority members of the legislative committees with
226.27 jurisdiction over mental health and corrections.

226.28 Subd. 7. **Expiration.** The task force expires upon submission of the report in subdivision
226.29 6, paragraph (b), or February 1, 2021, whichever is later.

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

227.1 Sec. 28. **DIRECTION TO COMMISSIONER; IMPROVING SCHOOL-LINKED**
227.2 **MENTAL HEALTH GRANT PROGRAM.**

227.3 (a) The commissioner of human services, in collaboration with the commissioner of
227.4 education, representatives from the education community, mental health providers, and
227.5 advocates, shall assess the school-linked mental health grant program under Minnesota
227.6 Statutes, section 245.4901, and develop recommendations for improvements. The assessment
227.7 must include but is not limited to the following:

227.8 (1) promoting stability among current grantees and school partners;

227.9 (2) assessing the minimum number of full-time equivalents needed per school site to
227.10 effectively carry out the program;

227.11 (3) developing a funding formula that promotes sustainability and consistency across
227.12 grant cycles;

227.13 (4) reviewing current data collection and evaluation; and

227.14 (5) analyzing the impact on outcomes when a school has a school-linked mental health
227.15 program, a multi-tier system of supports, and sufficient school support personnel to meet
227.16 the needs of students.

227.17 (b) The commissioner shall provide a report of the findings of the assessment and
227.18 recommendations, including any necessary statutory changes, to the legislative committees
227.19 with jurisdiction over mental health and education by January 15, 2020.

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

227.21 Sec. 29. **DIRECTION TO COMMISSIONER; CCBHC RATE METHODOLOGY.**

227.22 (a) The commissioner of human services shall develop recommendations for a rate
227.23 methodology that reflects each CCBHC's reasonable cost of providing the services described
227.24 in Minnesota Statutes, section 245.735, subdivision 3, consistent with applicable federal
227.25 requirements. In developing the rate methodology, the commissioner shall consider guidance
227.26 issued by the Centers for Medicare and Medicaid Services for the Section 223 Demonstration
227.27 Program for CCBHC and costs associated with the following:

227.28 (1) a new CCBHC service that is not incorporated in the baseline prospective payment
227.29 system rate, or a deletion of a CCBHC service that is incorporated in the baseline rate;

227.30 (2) a change in service due to amended regulatory requirements or rules;

228.1 (3) a change in types of services due to a change in applicable technology and medical
228.2 practice utilized by the clinic;

228.3 (4) a change in the scope of a project approved by the commissioner; and

228.4 (5) a Minnesota-specific quality incentive program for CCBHCs that achieve target
228.5 performance on select quality measures. The commissioner shall develop the quality incentive
228.6 program, in consultation with stakeholders, with the following requirements:

228.7 (i) the same terms of performance must apply to all CCBHCs;

228.8 (ii) quality payments must be in addition to the prospective payment rate and must not
228.9 exceed an amount equal to five percent of total medical assistance payments for CCBHC
228.10 services provided during the applicable time period; and

228.11 (iii) the quality measures must be consistent with measures used by the commissioner
228.12 for other health care programs.

228.13 (b) By February 15, 2020, the commissioner of human services shall consult with CCBHC
228.14 providers to develop the rate methodology under paragraph (a). The commissioner shall
228.15 report to the chairs and ranking minority members of the legislative committees with
228.16 jurisdiction over mental health services and medical assistance on the recommendations to
228.17 the CCBHC rate methodology including any necessary statutory updates required for federal
228.18 approval.

228.19 (c) An entity that receives a prospective payment system rate that overlaps with the
228.20 CCBHC rate is not eligible for a CCBHC rate. The commissioner shall consult with CCBHCs
228.21 and other providers receiving a prospective payment system rate to study a rate methodology
228.22 that eliminates potential duplication of payment for CCBHC providers who also receive a
228.23 separate prospective payment system rate. By February 15, 2021, the commissioner shall
228.24 report to the chairs and ranking minority members of the legislative committees with
228.25 jurisdiction over mental health services and medical assistance on findings and
228.26 recommendations related to the rate methodology study under this paragraph, including any
228.27 necessary statutory updates to implement recommendations.

228.28 **Sec. 30. REPEALER.**

228.29 Minnesota Statutes 2018, section 254B.03, subdivision 4a, is repealed.

ARTICLE 7

UNIFORM SERVICE STANDARDS

229.1
229.2
229.3 Section 1. Minnesota Statutes 2018, section 62A.152, subdivision 3, is amended to read:

229.4 Subd. 3. **Provider discrimination prohibited.** All group policies and group subscriber
229.5 contracts that provide benefits for mental or nervous disorder treatments in a hospital must
229.6 provide direct reimbursement for those services if performed by a mental health professional;
229.7 ~~as defined in sections 245.462, subdivision 18, clauses (1) to (5); and 245.4871, subdivision~~
229.8 ~~27, clauses (1) to (5);~~ qualified according to section 245I.16, subdivision 2, to the extent
229.9 that the services and treatment are within the scope of mental health professional licensure.

229.10 This subdivision is intended to provide payment of benefits for mental or nervous disorder
229.11 treatments performed by a licensed mental health professional in a hospital and is not
229.12 intended to change or add benefits for those services provided in policies or contracts to
229.13 which this subdivision applies.

229.14 Sec. 2. Minnesota Statutes 2018, section 62A.3094, subdivision 1, is amended to read:

229.15 Subdivision 1. **Definitions.** (a) For purposes of this section, the terms defined in
229.16 paragraphs (b) to (d) have the meanings given.

229.17 (b) "Autism spectrum disorders" means the conditions as determined by criteria set forth
229.18 in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of
229.19 the American Psychiatric Association.

229.20 (c) "Medically necessary care" means health care services appropriate, in terms of type,
229.21 frequency, level, setting, and duration, to the enrollee's condition, and diagnostic testing
229.22 and preventative services. Medically necessary care must be consistent with generally
229.23 accepted practice parameters as determined by physicians and licensed psychologists who
229.24 typically manage patients who have autism spectrum disorders.

229.25 (d) "Mental health professional" means a mental health professional as ~~defined in section~~
229.26 ~~245.4871, subdivision 27~~ described in section 245I.16, subdivision 2, clause (1), (2), (3),
229.27 (4), or (6), who has training and expertise in autism spectrum disorder and child development.

229.28 Sec. 3. Minnesota Statutes 2018, section 148B.5301, subdivision 2, is amended to read:

229.29 Subd. 2. **Supervision.** (a) To qualify as a LPCC, an applicant must have completed
229.30 4,000 hours of post-master's degree supervised professional practice in the delivery of
229.31 clinical services in the diagnosis and treatment of mental illnesses and disorders in both

230.1 children and adults. The supervised practice shall be conducted according to the requirements
 230.2 in paragraphs (b) to (e).

230.3 (b) The supervision must have been received under a contract that defines clinical practice
 230.4 and supervision from a mental health professional ~~as defined in section 245.462, subdivision~~
 230.5 ~~18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6),~~ qualified according
 230.6 to section 245I.16, subdivision 2, or by a board-approved supervisor, who has at least two
 230.7 years of postlicensure experience in the delivery of clinical services in the diagnosis and
 230.8 treatment of mental illnesses and disorders. All supervisors must meet the supervisor
 230.9 requirements in Minnesota Rules, part 2150.5010.

230.10 (c) The supervision must be obtained at the rate of two hours of supervision per 40 hours
 230.11 of professional practice. The supervision must be evenly distributed over the course of the
 230.12 supervised professional practice. At least 75 percent of the required supervision hours must
 230.13 be received in person. The remaining 25 percent of the required hours may be received by
 230.14 telephone or by audio or audiovisual electronic device. At least 50 percent of the required
 230.15 hours of supervision must be received on an individual basis. The remaining 50 percent
 230.16 may be received in a group setting.

230.17 (d) The supervised practice must include at least 1,800 hours of clinical client contact.

230.18 (e) The supervised practice must be clinical practice. Supervision includes the observation
 230.19 by the supervisor of the successful application of professional counseling knowledge, skills,
 230.20 and values in the differential diagnosis and treatment of psychosocial function, disability,
 230.21 or impairment, including addictions and emotional, mental, and behavioral disorders.

230.22 Sec. 4. Minnesota Statutes 2018, section 148E.0555, subdivision 6, is amended to read:

230.23 Subd. 6. **Qualifications during grandfathering for licensure as LICSW.** (a) To be
 230.24 licensed as a licensed independent clinical social worker, an applicant for licensure under
 230.25 this section must provide evidence satisfactory to the board that the individual has:

230.26 (1) completed a graduate degree in social work from a program accredited by the Council
 230.27 on Social Work Education, the Canadian Association of Schools of Social Work, or a similar
 230.28 accrediting body designated by the board; or

230.29 (2) completed a graduate degree and is a mental health professional according to section
 230.30 ~~245.462, subdivision 18, clauses (1) to (6)~~ 245I.16, subdivision 2.

230.31 (b) To be licensed as a licensed independent clinical social worker, an applicant for
 230.32 licensure under this section must provide evidence satisfactory to the board that the individual
 230.33 has:

231.1 (1) practiced clinical social work as defined in section 148E.010, subdivision 6, including
231.2 both diagnosis and treatment, and has met the supervised practice requirements specified
231.3 in sections 148E.100 to 148E.125, excluding the 1,800 hours of direct clinical client contact
231.4 specified in section 148E.115, subdivision 1, except that supervised practice hours obtained
231.5 prior to August 1, 2011, must meet the requirements in Minnesota Statutes 2010, sections
231.6 148D.100 to 148D.125;

231.7 (2) submitted a completed, signed application and the license fee in section 148E.180;

231.8 (3) for applications submitted electronically, provided an attestation as specified by the
231.9 board;

231.10 (4) submitted the criminal background check fee and a form provided by the board
231.11 authorizing a criminal background check;

231.12 (5) paid the license fee in section 148E.180; and

231.13 (6) not engaged in conduct that was or would be in violation of the standards of practice
231.14 specified in Minnesota Statutes 2010, sections 148D.195 to 148D.240, and sections 148E.195
231.15 to 148E.240. If the applicant has engaged in conduct that was or would be in violation of
231.16 the standards of practice, the board may take action according to sections 148E.255 to
231.17 148E.270.

231.18 (c) An application which is not completed, signed, and accompanied by the correct
231.19 license fee must be returned to the applicant, along with any fee submitted, and is void.

231.20 (d) By submitting an application for licensure, an applicant authorizes the board to
231.21 investigate any information provided or requested in the application. The board may request
231.22 that the applicant provide additional information, verification, or documentation.

231.23 (e) Within one year of the time the board receives an application for licensure, the
231.24 applicant must meet all the requirements and provide all of the information requested by
231.25 the board.

231.26 Sec. 5. Minnesota Statutes 2018, section 148E.120, subdivision 2, is amended to read:

231.27 Subd. 2. **Alternate supervisors.** (a) The board may approve an alternate supervisor as
231.28 determined in this subdivision. The board shall approve up to 25 percent of the required
231.29 supervision hours by a licensed mental health professional who is competent and qualified
231.30 to provide supervision according to the mental health professional's respective licensing
231.31 board, as established by section ~~245.462, subdivision 18, clauses (1) to (6), or 245.4871,~~
231.32 ~~subdivision 27, clauses (1) to (6)~~ 245I.16, subdivision 2.

232.1 (b) The board shall approve up to 100 percent of the required supervision hours by an
232.2 alternate supervisor if the board determines that:

232.3 (1) there are five or fewer supervisors in the county where the licensee practices social
232.4 work who meet the applicable licensure requirements in subdivision 1;

232.5 (2) the supervisor is an unlicensed social worker who is employed in, and provides the
232.6 supervision in, a setting exempt from licensure by section 148E.065, and who has
232.7 qualifications equivalent to the applicable requirements specified in sections 148E.100 to
232.8 148E.115;

232.9 (3) the supervisor is a social worker engaged in authorized social work practice in Iowa,
232.10 Manitoba, North Dakota, Ontario, South Dakota, or Wisconsin, and has the qualifications
232.11 equivalent to the applicable requirements in sections 148E.100 to 148E.115; or

232.12 (4) the applicant or licensee is engaged in nonclinical authorized social work practice
232.13 outside of Minnesota and the supervisor meets the qualifications equivalent to the applicable
232.14 requirements in sections 148E.100 to 148E.115, or the supervisor is an equivalent mental
232.15 health professional, as determined by the board, who is credentialed by a state, territorial,
232.16 provincial, or foreign licensing agency; or

232.17 (5) the applicant or licensee is engaged in clinical authorized social work practice outside
232.18 of Minnesota and the supervisor meets qualifications equivalent to the applicable
232.19 requirements in section 148E.115, or the supervisor is an equivalent mental health
232.20 professional as determined by the board, who is credentialed by a state, territorial, provincial,
232.21 or foreign licensing agency.

232.22 (c) In order for the board to consider an alternate supervisor under this section, the
232.23 licensee must:

232.24 (1) request in the supervision plan and verification submitted according to section
232.25 148E.125 that an alternate supervisor conduct the supervision; and

232.26 (2) describe the proposed supervision and the name and qualifications of the proposed
232.27 alternate supervisor. The board may audit the information provided to determine compliance
232.28 with the requirements of this section.

232.29 Sec. 6. Minnesota Statutes 2018, section 148F.11, subdivision 1, is amended to read:

232.30 Subdivision 1. **Other professionals.** (a) Nothing in this chapter prevents members of
232.31 other professions or occupations from performing functions for which they are qualified or
232.32 licensed. This exception includes, but is not limited to: licensed physicians; registered nurses;

233.1 licensed practical nurses; licensed psychologists and licensed psychological practitioners;
233.2 members of the clergy provided such services are provided within the scope of regular
233.3 ministries; American Indian medicine men and women; licensed attorneys; probation officers;
233.4 licensed marriage and family therapists; licensed social workers; social workers employed
233.5 by city, county, or state agencies; licensed professional counselors; licensed professional
233.6 clinical counselors; licensed school counselors; registered occupational therapists or
233.7 occupational therapy assistants; Upper Midwest Indian Council on Addictive Disorders
233.8 (UMICAD) certified counselors when providing services to Native American people; city,
233.9 county, or state employees when providing assessments or case management under Minnesota
233.10 Rules, chapter 9530; and individuals defined in section 256B.0623, subdivision 5, clauses
233.11 (1) ~~and (2)~~ to (4), providing integrated dual diagnosis treatment in adult mental health
233.12 rehabilitative programs certified by the Department of Human Services under section
233.13 256B.0622 or 256B.0623.

233.14 (b) Nothing in this chapter prohibits technicians and resident managers in programs
233.15 licensed by the Department of Human Services from discharging their duties as provided
233.16 in Minnesota Rules, chapter 9530.

233.17 (c) Any person who is exempt from licensure under this section must not use a title
233.18 incorporating the words "alcohol and drug counselor" or "licensed alcohol and drug
233.19 counselor" or otherwise hold himself or herself out to the public by any title or description
233.20 stating or implying that he or she is engaged in the practice of alcohol and drug counseling,
233.21 or that he or she is licensed to engage in the practice of alcohol and drug counseling, unless
233.22 that person is also licensed as an alcohol and drug counselor. Persons engaged in the practice
233.23 of alcohol and drug counseling are not exempt from the board's jurisdiction solely by the
233.24 use of one of the titles in paragraph (a).

233.25 Sec. 7. Minnesota Statutes 2018, section 245.462, subdivision 6, is amended to read:

233.26 Subd. 6. **Community support services program.** "Community support services program"
233.27 means services, other than inpatient or residential treatment services, provided or coordinated
233.28 by an identified program and staff under the ~~clinical~~ clinical treatment supervision of a mental health
233.29 professional designed to help adults with serious and persistent mental illness to function
233.30 and remain in the community. A community support services program includes:

233.31 (1) client outreach,

233.32 (2) medication monitoring,

233.33 (3) assistance in independent living skills,

- 234.1 (4) development of employability and work-related opportunities,
 234.2 (5) crisis assistance,
 234.3 (6) psychosocial rehabilitation,
 234.4 (7) help in applying for government benefits, and
 234.5 (8) housing support services.

234.6 The community support services program must be coordinated with the case management
 234.7 services specified in section 245.4711.

234.8 Sec. 8. Minnesota Statutes 2018, section 245.462, subdivision 8, is amended to read:

234.9 Subd. 8. **Day treatment services.** "Day treatment," "day treatment services," or "day
 234.10 treatment program" means ~~a structured program of treatment and care provided to an adult~~
 234.11 ~~in or by: (1) a hospital accredited by the joint commission on accreditation of health~~
 234.12 ~~organizations and licensed under sections 144.50 to 144.55; (2) a community mental health~~
 234.13 ~~center under section 245.62; or (3) an entity that is under contract with the county board to~~
 234.14 ~~operate a program that meets the requirements of section 245.4712, subdivision 2, and~~
 234.15 ~~Minnesota Rules, parts 9505.0170 to 9505.0475. Day treatment consists of group~~
 234.16 ~~psychotherapy and other intensive therapeutic services that are provided at least two days~~
 234.17 ~~a week by a multidisciplinary staff under the clinical supervision of a mental health~~
 234.18 ~~professional. Day treatment may include education and consultation provided to families~~
 234.19 ~~and other individuals as part of the treatment process. The services are aimed at stabilizing~~
 234.20 ~~the adult's mental health status, providing mental health services, and developing and~~
 234.21 ~~improving the adult's independent living and socialization skills. The goal of day treatment~~
 234.22 ~~is to reduce or relieve mental illness and to enable the adult to live in the community. Day~~
 234.23 ~~treatment services are not a part of inpatient or residential treatment services. Day treatment~~
 234.24 ~~services are distinguished from day care by their structured therapeutic program of~~
 234.25 ~~psychotherapy services. The commissioner may limit medical assistance reimbursement~~
 234.26 ~~for day treatment to 15 hours per week per person the treatment services described under~~
 234.27 ~~section 256B.0625, subdivision 23.~~

234.28 Sec. 9. Minnesota Statutes 2018, section 245.462, subdivision 9, is amended to read:

234.29 Subd. 9. **Diagnostic assessment.** ~~(a) "Diagnostic assessment" has the meaning given in~~
 234.30 ~~Minnesota Rules, part 9505.0370, subpart 11, and is delivered as provided in Minnesota~~
 234.31 ~~Rules, part 9505.0372, subpart 1, items A, B, C, and E. Diagnostic assessment includes a~~

235.1 ~~standard, extended, or brief diagnostic assessment, or an adult update~~ means the assessment
235.2 described under section 256B.0671, subdivisions 2 to 4.

235.3 ~~(b) A brief diagnostic assessment must include a face-to-face interview with the client~~
235.4 ~~and a written evaluation of the client by a mental health professional or a clinical trainee,~~
235.5 ~~as provided in Minnesota Rules, part 9505.0371, subpart 5, item C. The professional or~~
235.6 ~~clinical trainee must gather initial components of a standard diagnostic assessment, including~~
235.7 ~~the client's:~~

235.8 ~~(1) age;~~

235.9 ~~(2) description of symptoms, including reason for referral;~~

235.10 ~~(3) history of mental health treatment;~~

235.11 ~~(4) cultural influences and their impact on the client; and~~

235.12 ~~(5) mental status examination.~~

235.13 ~~(c) On the basis of the initial components, the professional or clinical trainee must draw~~
235.14 ~~a provisional clinical hypothesis. The clinical hypothesis may be used to address the client's~~
235.15 ~~immediate needs or presenting problem.~~

235.16 ~~(d) Treatment sessions conducted under authorization of a brief assessment may be used~~
235.17 ~~to gather additional information necessary to complete a standard diagnostic assessment or~~
235.18 ~~an extended diagnostic assessment.~~

235.19 ~~(e) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1),~~
235.20 ~~unit (b), prior to completion of a client's initial diagnostic assessment, a client is eligible~~
235.21 ~~for psychological testing as part of the diagnostic process.~~

235.22 ~~(f) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1),~~
235.23 ~~unit (c), prior to completion of a client's initial diagnostic assessment, but in conjunction~~
235.24 ~~with the diagnostic assessment process, a client is eligible for up to three individual or family~~
235.25 ~~psychotherapy sessions or family psychoeducation sessions or a combination of the above~~
235.26 ~~sessions not to exceed three sessions.~~

235.27 ~~(g) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item B, subitem (3),~~
235.28 ~~unit (a), a brief diagnostic assessment may be used for a client's family who requires a~~
235.29 ~~language interpreter to participate in the assessment.~~

236.1 Sec. 10. Minnesota Statutes 2018, section 245.462, subdivision 14, is amended to read:

236.2 Subd. 14. **Individual treatment plan.** "Individual treatment plan" means ~~a written plan~~
 236.3 ~~of intervention, treatment, and services for an adult with mental illness that is developed~~
 236.4 ~~by a service provider under the clinical supervision of a mental health professional on the~~
 236.5 ~~basis of a diagnostic assessment. The plan identifies goals and objectives of treatment,~~
 236.6 ~~treatment strategy, a schedule for accomplishing treatment goals and objectives, and the~~
 236.7 ~~individual responsible for providing treatment to the adult with mental illness~~ the individual
 236.8 treatment plan described under section 256B.0671, subdivisions 5 and 6.

236.9 Sec. 11. Minnesota Statutes 2018, section 245.462, subdivision 17, is amended to read:

236.10 Subd. 17. **Mental health practitioner.** (a) "Mental health practitioner" means a person
 236.11 ~~providing services to adults with mental illness or children with emotional disturbance who~~
 236.12 ~~is qualified in at least one of the ways described in paragraphs (b) to (g). A mental health~~
 236.13 ~~practitioner for a child client must have training working with children. A mental health~~
 236.14 ~~practitioner for an adult client must have training working with adults~~ qualified according
 236.15 to section 245I.16, subdivision 4.

236.16 (b) ~~For purposes of this subdivision, a practitioner is qualified through relevant~~
 236.17 ~~coursework if the practitioner completes at least 30 semester hours or 45 quarter hours in~~
 236.18 ~~behavioral sciences or related fields and:~~

236.19 (1) ~~has at least 2,000 hours of supervised experience in the delivery of services to adults~~
 236.20 ~~or children with:~~

236.21 (i) ~~mental illness, substance use disorder, or emotional disturbance; or~~

236.22 (ii) ~~traumatic brain injury or developmental disabilities and completes training on mental~~
 236.23 ~~illness, recovery from mental illness, mental health de-escalation techniques, co-occurring~~
 236.24 ~~mental illness and substance abuse, and psychotropic medications and side effects;~~

236.25 (2) ~~is fluent in the non-English language of the ethnic group to which at least 50 percent~~
 236.26 ~~of the practitioner's clients belong, completes 40 hours of training in the delivery of services~~
 236.27 ~~to adults with mental illness or children with emotional disturbance, and receives clinical~~
 236.28 ~~supervision from a mental health professional at least once a week until the requirement of~~
 236.29 ~~2,000 hours of supervised experience is met;~~

236.30 (3) ~~is working in a day treatment program under section 245.4712, subdivision 2; or~~

236.31 (4) ~~has completed a practicum or internship that (i) requires direct interaction with adults~~
 236.32 ~~or children served, and (ii) is focused on behavioral sciences or related fields.~~

237.1 ~~(e) For purposes of this subdivision, a practitioner is qualified through work experience~~
237.2 ~~if the person:~~

237.3 ~~(1) has at least 4,000 hours of supervised experience in the delivery of services to adults~~
237.4 ~~or children with:~~

237.5 ~~(i) mental illness, substance use disorder, or emotional disturbance; or~~

237.6 ~~(ii) traumatic brain injury or developmental disabilities and completes training on mental~~
237.7 ~~illness, recovery from mental illness, mental health de-escalation techniques, co-occurring~~
237.8 ~~mental illness and substance abuse, and psychotropic medications and side effects; or~~

237.9 ~~(2) has at least 2,000 hours of supervised experience in the delivery of services to adults~~
237.10 ~~or children with:~~

237.11 ~~(i) mental illness, emotional disturbance, or substance use disorder, and receives clinical~~
237.12 ~~supervision as required by applicable statutes and rules from a mental health professional~~
237.13 ~~at least once a week until the requirement of 4,000 hours of supervised experience is met;~~
237.14 ~~or~~

237.15 ~~(ii) traumatic brain injury or developmental disabilities; completes training on mental~~
237.16 ~~illness, recovery from mental illness, mental health de-escalation techniques, co-occurring~~
237.17 ~~mental illness and substance abuse, and psychotropic medications and side effects; and~~
237.18 ~~receives clinical supervision as required by applicable statutes and rules at least once a week~~
237.19 ~~from a mental health professional until the requirement of 4,000 hours of supervised~~
237.20 ~~experience is met.~~

237.21 ~~(d) For purposes of this subdivision, a practitioner is qualified through a graduate student~~
237.22 ~~internship if the practitioner is a graduate student in behavioral sciences or related fields~~
237.23 ~~and is formally assigned by an accredited college or university to an agency or facility for~~
237.24 ~~clinical training.~~

237.25 ~~(e) For purposes of this subdivision, a practitioner is qualified by a bachelor's or master's~~
237.26 ~~degree if the practitioner:~~

237.27 ~~(1) holds a master's or other graduate degree in behavioral sciences or related fields; or~~

237.28 ~~(2) holds a bachelor's degree in behavioral sciences or related fields and completes a~~
237.29 ~~practicum or internship that (i) requires direct interaction with adults or children served,~~
237.30 ~~and (ii) is focused on behavioral sciences or related fields.~~

238.1 ~~(f) For purposes of this subdivision, a practitioner is qualified as a vendor of medical~~
238.2 ~~care if the practitioner meets the definition of vendor of medical care in section 256B.02,~~
238.3 ~~subdivision 7, paragraphs (b) and (c), and is serving a federally recognized tribe.~~

238.4 ~~(g) For purposes of medical assistance coverage of diagnostic assessments, explanations~~
238.5 ~~of findings, and psychotherapy under section 256B.0625, subdivision 65, a mental health~~
238.6 ~~practitioner working as a clinical trainee means that the practitioner's clinical supervision~~
238.7 ~~experience is helping the practitioner gain knowledge and skills necessary to practice~~
238.8 ~~effectively and independently. This may include supervision of direct practice, treatment~~
238.9 ~~team collaboration, continued professional learning, and job management. The practitioner~~
238.10 ~~must also:~~

238.11 ~~(1) comply with requirements for licensure or board certification as a mental health~~
238.12 ~~professional, according to the qualifications under Minnesota Rules, part 9505.0371, subpart~~
238.13 ~~5, item A, including supervised practice in the delivery of mental health services for the~~
238.14 ~~treatment of mental illness; or~~

238.15 ~~(2) be a student in a bona fide field placement or internship under a program leading to~~
238.16 ~~completion of the requirements for licensure as a mental health professional according to~~
238.17 ~~the qualifications under Minnesota Rules, part 9505.0371, subpart 5, item A.~~

238.18 ~~(h) For purposes of this subdivision, "behavioral sciences or related fields" has the~~
238.19 ~~meaning given in section 256B.0623, subdivision 5, paragraph (d).~~

238.20 ~~(i) Notwithstanding the licensing requirements established by a health-related licensing~~
238.21 ~~board, as defined in section 214.01, subdivision 2, this subdivision supersedes any other~~
238.22 ~~statute or rule.~~

238.23 Sec. 12. Minnesota Statutes 2018, section 245.462, subdivision 18, is amended to read:

238.24 Subd. 18. **Mental health professional.** "Mental health professional" means a person
238.25 providing clinical services in the treatment of mental illness who is qualified in at least one
238.26 of the following ways: qualified according to section 245I.16, subdivision 2.

238.27 ~~(1) in psychiatric nursing: a registered nurse who is licensed under sections 148.171 to~~
238.28 ~~148.285; and:~~

238.29 ~~(i) who is certified as a clinical specialist or as a nurse practitioner in adult or family~~
238.30 ~~psychiatric and mental health nursing by a national nurse certification organization; or~~

238.31 ~~(ii) who has a master's degree in nursing or one of the behavioral sciences or related~~
238.32 ~~fields from an accredited college or university or its equivalent, with at least 4,000 hours~~

239.1 ~~of post-master's supervised experience in the delivery of clinical services in the treatment~~
 239.2 ~~of mental illness;~~

239.3 ~~(2) in clinical social work: a person licensed as an independent clinical social worker~~
 239.4 ~~under chapter 148D, or a person with a master's degree in social work from an accredited~~
 239.5 ~~college or university, with at least 4,000 hours of post-master's supervised experience in~~
 239.6 ~~the delivery of clinical services in the treatment of mental illness;~~

239.7 ~~(3) in psychology: an individual licensed by the Board of Psychology under sections~~
 239.8 ~~148.88 to 148.98 who has stated to the Board of Psychology competencies in the diagnosis~~
 239.9 ~~and treatment of mental illness;~~

239.10 ~~(4) in psychiatry: a physician licensed under chapter 147 and certified by the American~~
 239.11 ~~Board of Psychiatry and Neurology or eligible for board certification in psychiatry, or an~~
 239.12 ~~osteopathic physician licensed under chapter 147 and certified by the American Osteopathic~~
 239.13 ~~Board of Neurology and Psychiatry or eligible for board certification in psychiatry;~~

239.14 ~~(5) in marriage and family therapy: the mental health professional must be a marriage~~
 239.15 ~~and family therapist licensed under sections 148B.29 to 148B.39 with at least two years of~~
 239.16 ~~post-master's supervised experience in the delivery of clinical services in the treatment of~~
 239.17 ~~mental illness;~~

239.18 ~~(6) in licensed professional clinical counseling, the mental health professional shall be~~
 239.19 ~~a licensed professional clinical counselor under section 148B.5301 with at least 4,000 hours~~
 239.20 ~~of post-master's supervised experience in the delivery of clinical services in the treatment~~
 239.21 ~~of mental illness; or~~

239.22 ~~(7) in allied fields: a person with a master's degree from an accredited college or university~~
 239.23 ~~in one of the behavioral sciences or related fields, with at least 4,000 hours of post-master's~~
 239.24 ~~supervised experience in the delivery of clinical services in the treatment of mental illness.~~

239.25 Sec. 13. Minnesota Statutes 2018, section 245.462, subdivision 21, is amended to read:

239.26 Subd. 21. **Outpatient services.** "Outpatient services" means mental health services,
 239.27 excluding day treatment and community support services programs, provided by or under
 239.28 the ~~clinical~~ clinical treatment supervision of a mental health professional to adults with mental
 239.29 illness who live outside a hospital. Outpatient services include clinical activities such as
 239.30 individual, group, and family therapy; individual treatment planning; diagnostic assessments;
 239.31 medication management; and psychological testing.

240.1 Sec. 14. Minnesota Statutes 2018, section 245.462, subdivision 23, is amended to read:

240.2 Subd. 23. **Residential treatment.** "Residential treatment" means a 24-hour-a-day program
240.3 under the ~~clinical treatment~~ supervision of a mental health professional, in a community
240.4 residential setting other than an acute care hospital or regional treatment center inpatient
240.5 unit, that must be licensed as a residential treatment program for adults with mental illness
240.6 under Minnesota Rules, parts 9520.0500 to 9520.0670₂ or other rules adopted by the
240.7 commissioner.

240.8 Sec. 15. Minnesota Statutes 2018, section 245.462, is amended by adding a subdivision
240.9 to read:

240.10 Subd. 27. **Treatment supervision.** "Treatment supervision" means the treatment
240.11 supervision described under section 245I.18.

240.12 Sec. 16. Minnesota Statutes 2018, section 245.467, subdivision 2, is amended to read:

240.13 Subd. 2. **Diagnostic assessment.** ~~All providers of residential, acute care hospital inpatient,~~
240.14 ~~and regional treatment centers must complete a diagnostic assessment for each of their~~
240.15 ~~clients within five days of admission. Providers of day treatment services must complete a~~
240.16 ~~diagnostic assessment within five days after the adult's second visit or within 30 days after~~
240.17 ~~intake, whichever occurs first. In cases where a diagnostic assessment is available and has~~
240.18 ~~been completed within three years preceding admission, only an adult diagnostic assessment~~
240.19 ~~update is necessary. An "adult diagnostic assessment update" means a written summary by~~
240.20 ~~a mental health professional of the adult's current mental health status and service needs~~
240.21 ~~and includes a face-to-face interview with the adult. If the adult's mental health status has~~
240.22 ~~changed markedly since the adult's most recent diagnostic assessment, a new diagnostic~~
240.23 ~~assessment is required. Compliance with the provisions of this subdivision does not ensure~~
240.24 ~~eligibility for medical assistance reimbursement under chapter 256B. Providers of services~~
240.25 governed by this section shall complete a diagnostic assessment according to the standards
240.26 of section 256B.0671, including for services to a person not eligible for medical assistance.

240.27 Sec. 17. Minnesota Statutes 2018, section 245.467, subdivision 3, is amended to read:

240.28 Subd. 3. **Individual treatment plans.** ~~All providers of outpatient services, day treatment~~
240.29 ~~services, residential treatment, acute care hospital inpatient treatment, and all regional~~
240.30 ~~treatment centers must develop an individual treatment plan for each of their adult clients.~~
240.31 ~~The individual treatment plan must be based on a diagnostic assessment. To the extent~~
240.32 ~~possible, the adult client shall be involved in all phases of developing and implementing~~

241.1 ~~the individual treatment plan. Providers of residential treatment and acute care hospital~~
 241.2 ~~inpatient treatment, and all regional treatment centers must develop the individual treatment~~
 241.3 ~~plan within ten days of client intake and must review the individual treatment plan every~~
 241.4 ~~90 days after intake. Providers of day treatment services must develop the individual~~
 241.5 ~~treatment plan before the completion of five working days in which service is provided or~~
 241.6 ~~within 30 days after the diagnostic assessment is completed or obtained, whichever occurs~~
 241.7 ~~first. Providers of outpatient services must develop the individual treatment plan within 30~~
 241.8 ~~days after the diagnostic assessment is completed or obtained or by the end of the second~~
 241.9 ~~session of an outpatient service, not including the session in which the diagnostic assessment~~
 241.10 ~~was provided, whichever occurs first. Outpatient and day treatment services providers must~~
 241.11 ~~review the individual treatment plan every 90 days after intake. Providers of services~~
 241.12 ~~governed by this section shall complete an individual treatment plan according to the~~
 241.13 ~~standards of section 256B.0671, subdivisions 5 and 6, including for services to a person not~~
 241.14 ~~eligible for medical assistance.~~

241.15 Sec. 18. Minnesota Statutes 2018, section 245.469, subdivision 1, is amended to read:

241.16 Subdivision 1. **Availability of emergency services.** ~~By July 1, 1988,~~ County boards
 241.17 must provide or contract for enough emergency services within the county to meet the needs
 241.18 of adults in the county who are experiencing an emotional crisis or mental illness. Clients
 241.19 may be required to pay a fee according to section 245.481. Emergency service providers
 241.20 shall not delay the timely provision of emergency service because of delays in determining
 241.21 this fee or because of the unwillingness or inability of the client to pay the fee. Emergency
 241.22 services must include assessment, crisis intervention, and appropriate case disposition. A
 241.23 tribal authority that accepts crisis grant funding has the same responsibilities as county
 241.24 boards within the tribal authority's designated service area. Emergency services must:

241.25 (1) promote the safety and emotional stability of adults with mental illness or emotional
 241.26 crises;

241.27 (2) minimize further deterioration of adults with mental illness or emotional crises;

241.28 (3) help adults with mental illness or emotional crises to obtain ongoing care and
 241.29 treatment; ~~and~~

241.30 (4) prevent placement in settings that are more intensive, costly, or restrictive than
 241.31 necessary and appropriate to meet client needs; and

241.32 (5) provide support, psychoeducation, and referrals to family members, friends, service
 241.33 providers, or other third parties on behalf of a recipient in need of emergency services.

242.1 Sec. 19. Minnesota Statutes 2018, section 245.469, subdivision 2, is amended to read:

242.2 Subd. 2. **Specific requirements.** (a) The county board shall require that all service
242.3 providers of emergency services to adults with mental illness provide immediate direct
242.4 access to a mental health professional during regular business hours. For evenings, weekends,
242.5 and holidays, the service may be by direct toll-free telephone access to a mental health
242.6 professional, a clinical trainee, or a mental health practitioner, ~~or until January 1, 1991, a~~
242.7 ~~designated person with training in human services who receives clinical supervision from~~
242.8 ~~a mental health professional.~~

242.9 (b) The commissioner may waive the requirement in paragraph (a) that the evening,
242.10 weekend, and holiday service be provided by a mental health professional, clinical trainee,
242.11 or mental health practitioner ~~after January 1, 1991,~~ if the county documents that:

242.12 (1) mental health professionals, clinical trainees, or mental health practitioners are
242.13 unavailable to provide this service;

242.14 (2) services are provided by a designated person with training in human services who
242.15 receives ~~clinical~~ treatment supervision from a mental health professional; and

242.16 (3) the service provider is not also the provider of fire and public safety emergency
242.17 services.

242.18 (c) The commissioner may waive the requirement in paragraph (b), clause (3), that the
242.19 evening, weekend, and holiday service not be provided by the provider of fire and public
242.20 safety emergency services if:

242.21 (1) every person who will be providing the first telephone contact has received at least
242.22 eight hours of training on emergency mental health services reviewed by the state advisory
242.23 council on mental health and then approved by the commissioner;

242.24 (2) every person who will be providing the first telephone contact will annually receive
242.25 at least four hours of continued training on emergency mental health services reviewed by
242.26 the state advisory council on mental health and then approved by the commissioner;

242.27 (3) the local social service agency has provided public education about available
242.28 emergency mental health services and can assure potential users of emergency services that
242.29 their calls will be handled appropriately;

242.30 (4) the local social service agency agrees to provide the commissioner with accurate
242.31 data on the number of emergency mental health service calls received;

243.1 (5) the local social service agency agrees to monitor the frequency and quality of
243.2 emergency services; and

243.3 (6) the local social service agency describes how it will comply with paragraph (d).

243.4 (d) Whenever emergency service during nonbusiness hours is provided by anyone other
243.5 than a mental health professional, a mental health professional must be available on call for
243.6 an emergency assessment and crisis intervention services, and must be available for at least
243.7 telephone consultation within 30 minutes.

243.8 Sec. 20. Minnesota Statutes 2018, section 245.470, subdivision 1, is amended to read:

243.9 Subdivision 1. **Availability of outpatient services.** (a) County boards must provide or
243.10 contract for enough outpatient services within the county to meet the needs of adults with
243.11 mental illness residing in the county. Services may be provided directly by the county
243.12 through county-operated mental health centers or mental health clinics approved by the
243.13 commissioner under section 245.69, subdivision 2; by contract with privately operated
243.14 mental health centers or mental health clinics approved by the commissioner under section
243.15 245.69, subdivision 2; by contract with hospital mental health outpatient programs certified
243.16 by the Joint Commission on Accreditation of Hospital Organizations; or by contract with
243.17 a licensed mental health professional ~~as defined in section 245.462, subdivision 18, clauses~~
243.18 ~~(1) to (6)~~. Clients may be required to pay a fee according to section 245.481. Outpatient
243.19 services include:

243.20 (1) conducting diagnostic assessments;

243.21 (2) conducting psychological testing;

243.22 (3) developing or modifying individual treatment plans;

243.23 (4) making referrals and recommending placements as appropriate;

243.24 (5) treating an adult's mental health needs through therapy;

243.25 (6) prescribing and managing medication and evaluating the effectiveness of prescribed
243.26 medication; and

243.27 (7) preventing placement in settings that are more intensive, costly, or restrictive than
243.28 necessary and appropriate to meet client needs.

243.29 (b) County boards may request a waiver allowing outpatient services to be provided in
243.30 a nearby trade area if it is determined that the client can best be served outside the county.

244.1 Sec. 21. Minnesota Statutes 2018, section 245.4712, subdivision 2, is amended to read:

244.2 Subd. 2. **Day treatment services provided.** (a) Day treatment services must be developed
244.3 as a part of the community support services available to adults with serious and persistent
244.4 mental illness residing in the county. Adults may be required to pay a fee according to
244.5 section 245.481. Day treatment services must be designed to:

244.6 (1) provide a structured environment for treatment;

244.7 (2) provide support for residing in the community;

244.8 (3) prevent placement in settings that are more intensive, costly, or restrictive than
244.9 necessary and appropriate to meet client need;

244.10 (4) coordinate with or be offered in conjunction with a local education agency's special
244.11 education program; and

244.12 (5) operate on a continuous basis throughout the year.

244.13 (b) For purposes of complying with medical assistance requirements, an adult day
244.14 treatment program must comply with the method of clinical treatment supervision specified
244.15 in ~~Minnesota Rules, part 9505.0371, subpart 4~~ section 245I.18. ~~The clinical supervision~~
244.16 ~~must be performed by a qualified supervisor who satisfies the requirements of Minnesota~~
244.17 ~~Rules, part 9505.0371, subpart 5.~~

244.18 A day treatment program must demonstrate compliance with this clinical treatment
244.19 supervision requirement by the commissioner's review and approval of the program according
244.20 to ~~Minnesota Rules, part 9505.0372, subpart 8~~ section 256B.0625, subdivision 23.

244.21 (c) County boards may request a waiver from including day treatment services if they
244.22 can document that:

244.23 (1) an alternative plan of care exists through the county's community support services
244.24 for clients who would otherwise need day treatment services;

244.25 (2) day treatment, if included, would be duplicative of other components of the
244.26 community support services; and

244.27 (3) county demographics and geography make the provision of day treatment services
244.28 cost ineffective and infeasible.

244.29 Sec. 22. Minnesota Statutes 2018, section 245.472, subdivision 2, is amended to read:

244.30 Subd. 2. **Specific requirements.** Providers of residential services must be licensed under
244.31 applicable rules adopted by the commissioner and must ~~be clinically supervised~~ provide

245.1 treatment supervision by a mental health professional. ~~Persons employed in facilities licensed~~
245.2 ~~under Minnesota Rules, parts 9520.0500 to 9520.0670, in the capacity of program director~~
245.3 ~~as of July 1, 1987, in accordance with Minnesota Rules, parts 9520.0500 to 9520.0670, may~~
245.4 ~~be allowed to continue providing clinical supervision within a facility, provided they continue~~
245.5 ~~to be employed as a program director in a facility licensed under Minnesota Rules, parts~~
245.6 ~~9520.0500 to 9520.0670.~~

245.7 Sec. 23. Minnesota Statutes 2018, section 245.4863, is amended to read:

245.8 **245.4863 INTEGRATED CO-OCCURRING DISORDER TREATMENT.**

245.9 (a) The commissioner shall require individuals who perform chemical dependency
245.10 assessments to screen clients for co-occurring mental health disorders, and staff who perform
245.11 mental health diagnostic assessments to screen for co-occurring substance use disorders.
245.12 Screening tools must be approved by the commissioner. If a client screens positive for a
245.13 co-occurring mental health or substance use disorder, the individual performing the screening
245.14 must document what actions will be taken in response to the results and whether further
245.15 assessments must be performed.

245.16 (b) Notwithstanding paragraph (a), screening is not required when:

245.17 (1) the presence of co-occurring disorders was documented for the client in the past 12
245.18 months;

245.19 (2) the client is currently receiving co-occurring disorders treatment;

245.20 (3) the client is being referred for co-occurring disorders treatment; or

245.21 (4) a mental health professional, as ~~defined in Minnesota Rules, part 9505.0370, subpart~~
245.22 ~~18~~ provided by section 245I.16, subdivision 2, who is competent to perform diagnostic
245.23 assessments of co-occurring disorders is performing a diagnostic assessment that meets the
245.24 requirements in Minnesota Rules, part 9533.0090, subpart 5, to identify whether the client
245.25 may have co-occurring mental health and chemical dependency disorders. If an individual
245.26 is identified to have co-occurring mental health and substance use disorders, the assessing
245.27 mental health professional must document what actions will be taken to address the client's
245.28 co-occurring disorders.

245.29 (c) The commissioner shall adopt rules as necessary to implement this section. The
245.30 commissioner shall ensure that the rules are effective on July 1, 2013, thereby establishing
245.31 a certification process for integrated dual disorder treatment providers and a system through
245.32 which individuals receive integrated dual diagnosis treatment if assessed as having both a
245.33 substance use disorder and either a serious mental illness or emotional disturbance.

246.1 (d) The commissioner shall apply for any federal waivers necessary to secure, to the
 246.2 extent allowed by law, federal financial participation for the provision of integrated dual
 246.3 diagnosis treatment to persons with co-occurring disorders.

246.4 Sec. 24. Minnesota Statutes 2018, section 245.4871, subdivision 9a, is amended to read:

246.5 Subd. 9a. **Crisis assistance planning.** "Crisis assistance planning" means ~~assistance to~~
 246.6 ~~the child, the child's family, and all providers of services to the child to:~~ recognize factors
 246.7 ~~precipitating a mental health crisis, identify behaviors related to the crisis, and be informed~~
 246.8 ~~of available resources to resolve the crisis. Crisis assistance requires the development of a~~
 246.9 ~~plan which addresses prevention and intervention strategies to be used in a potential crisis.~~
 246.10 ~~Other interventions include: (1) arranging for admission to acute care hospital inpatient~~
 246.11 ~~treatment; (2) crisis placement; (3) community resources for follow-up; and (4) emotional~~
 246.12 ~~support to the family during crisis. Crisis assistance does not include services designed to~~
 246.13 ~~secure the safety of a child who is at risk of abuse or neglect or necessary emergency services.~~
 246.14 the development of a written plan to assist a child's family with a potential crisis and is
 246.15 distinct from the immediate provision of mental health mobile crisis intervention services
 246.16 as defined in section 256B.0944. The plan must address prevention, de-escalation, and
 246.17 intervention strategies to be used in a crisis. The plan identifies factors that might precipitate
 246.18 a crisis, behaviors related to the emergence of a crisis, and the resources available to resolve
 246.19 a crisis. The plan must include planning for the following potential needs: (1) acute care;
 246.20 (2) crisis placement; (3) community resources for follow-up; and (4) emotional support to
 246.21 the family during crisis. Crisis planning excludes services designed to secure the safety of
 246.22 a child who is at risk of abuse or neglect or necessary emergency services.

246.23 Sec. 25. Minnesota Statutes 2018, section 245.4871, subdivision 10, is amended to read:

246.24 Subd. 10. **Day treatment services.** "Day treatment," "day treatment services," or "day
 246.25 treatment program" means a structured program of treatment and care provided to a child
 246.26 in:

246.27 (1) an outpatient hospital accredited by the Joint Commission on Accreditation of Health
 246.28 Organizations and licensed under sections 144.50 to 144.55;

246.29 (2) a community mental health center under section 245.62;

246.30 (3) an entity that is under contract with the county board to operate a program that meets
 246.31 the requirements of section 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170
 246.32 to 9505.0475; or

247.1 (4) an entity that operates a program that meets the requirements of section 245.4884,
 247.2 subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475, that is under contract
 247.3 with an entity that is under contract with a county board; or

247.4 (5) an entity that operates a program certified under section 256B.0943.

247.5 Day treatment consists of group psychotherapy and other intensive therapeutic services
 247.6 that are provided for a minimum two-hour time block by a multidisciplinary staff under the
 247.7 clinical supervision of a mental health professional. Day treatment may include education
 247.8 and consultation provided to families and other individuals as an extension of the treatment
 247.9 process. The services are aimed at stabilizing the child's mental health status, and developing
 247.10 and improving the child's daily independent living and socialization skills. Day treatment
 247.11 services are distinguished from day care by their structured therapeutic program of
 247.12 psychotherapy services. Day treatment services are not a part of inpatient hospital or
 247.13 residential treatment services.

247.14 A day treatment service must be available to a child up to 15 hours a week throughout
 247.15 the year and must be coordinated with, integrated with, or part of an education program
 247.16 offered by the child's school.

247.17 Sec. 26. Minnesota Statutes 2018, section 245.4871, subdivision 11a, is amended to read:

247.18 Subd. 11a. **Diagnostic assessment.** ~~(a) "Diagnostic assessment" has the meaning given~~
 247.19 ~~in Minnesota Rules, part 9505.0370, subpart 11, and is delivered as provided in Minnesota~~
 247.20 ~~Rules, part 9505.0372, subpart 1, items A, B, C, and E. Diagnostic assessment includes a~~
 247.21 ~~standard, extended, or brief diagnostic assessment, or an adult update. means the assessment~~
 247.22 described under section 256B.0671, subdivisions 2 to 4.

247.23 ~~(b) A brief diagnostic assessment must include a face-to-face interview with the client~~
 247.24 ~~and a written evaluation of the client by a mental health professional or a clinical trainee,~~
 247.25 ~~as provided in Minnesota Rules, part 9505.0371, subpart 5, item C. The professional or~~
 247.26 ~~clinical trainee must gather initial components of a standard diagnostic assessment, including~~
 247.27 ~~the client's:~~

247.28 ~~(1) age;~~

247.29 ~~(2) description of symptoms, including reason for referral;~~

247.30 ~~(3) history of mental health treatment;~~

247.31 ~~(4) cultural influences and their impact on the client; and~~

247.32 ~~(5) mental status examination.~~

248.1 ~~(e) On the basis of the brief components, the professional or clinical trainee must draw~~
248.2 ~~a provisional clinical hypothesis. The clinical hypothesis may be used to address the client's~~
248.3 ~~immediate needs or presenting problem.~~

248.4 ~~(d) Treatment sessions conducted under authorization of a brief assessment may be used~~
248.5 ~~to gather additional information necessary to complete a standard diagnostic assessment or~~
248.6 ~~an extended diagnostic assessment.~~

248.7 ~~(e) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1),~~
248.8 ~~unit (b), prior to completion of a client's initial diagnostic assessment, a client is eligible~~
248.9 ~~for psychological testing as part of the diagnostic process.~~

248.10 ~~(f) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1),~~
248.11 ~~unit (c), prior to completion of a client's initial diagnostic assessment, but in conjunction~~
248.12 ~~with the diagnostic assessment process, a client is eligible for up to three individual or family~~
248.13 ~~psychotherapy sessions or family psychoeducation sessions or a combination of the above~~
248.14 ~~sessions not to exceed three sessions.~~

248.15 Sec. 27. Minnesota Statutes 2018, section 245.4871, subdivision 17, is amended to read:

248.16 Subd. 17. **Family community support services.** "Family community support services"
248.17 means services provided under the ~~clinical~~ treatment supervision of a mental health
248.18 professional and designed to help each child with severe emotional disturbance to function
248.19 and remain with the child's family in the community. Family community support services
248.20 do not include acute care hospital inpatient treatment, residential treatment services, or
248.21 regional treatment center services. Family community support services include:

248.22 (1) client outreach to each child with severe emotional disturbance and the child's family;

248.23 (2) medication monitoring where necessary;

248.24 (3) assistance in developing independent living skills;

248.25 (4) assistance in developing parenting skills necessary to address the needs of the child
248.26 with severe emotional disturbance;

248.27 (5) assistance with leisure and recreational activities;

248.28 (6) crisis assistance, including crisis placement and respite care;

248.29 (7) professional home-based family treatment;

248.30 (8) foster care with therapeutic supports;

248.31 (9) day treatment;

249.1 (10) assistance in locating respite care and special needs day care; and

249.2 (11) assistance in obtaining potential financial resources, including those benefits listed
249.3 in section 245.4884, subdivision 5.

249.4 Sec. 28. Minnesota Statutes 2018, section 245.4871, subdivision 21, is amended to read:

249.5 Subd. 21. **Individual treatment plan.** "Individual treatment plan" means ~~a written plan~~
249.6 ~~of intervention, treatment, and services for a child with an emotional disturbance that is~~
249.7 ~~developed by a service provider under the clinical supervision of a mental health professional~~
249.8 ~~on the basis of a diagnostic assessment. An individual treatment plan for a child must be~~
249.9 ~~developed in conjunction with the family unless clinically inappropriate. The plan identifies~~
249.10 ~~goals and objectives of treatment, treatment strategy, a schedule for accomplishing treatment~~
249.11 ~~goals and objectives, and the individuals responsible for providing treatment to the child~~
249.12 ~~with an emotional disturbance~~ the individual treatment plan described under section
249.13 256B.0671, subdivisions 5 and 6.

249.14 Sec. 29. Minnesota Statutes 2018, section 245.4871, subdivision 26, is amended to read:

249.15 Subd. 26. **Mental health practitioner.** "Mental health practitioner" ~~has the meaning~~
249.16 ~~given in~~ means a person qualified according to section 245.462, subdivision 17 245I.16,
249.17 subdivision 4.

249.18 Sec. 30. Minnesota Statutes 2018, section 245.4871, subdivision 27, is amended to read:

249.19 Subd. 27. **Mental health professional.** "Mental health professional" means a person
249.20 ~~providing clinical services in the diagnosis and treatment of children's emotional disorders.~~
249.21 ~~A mental health professional must have training and experience in working with children~~
249.22 ~~consistent with the age group to which the mental health professional is assigned. A mental~~
249.23 ~~health professional must be qualified in at least one of the following ways: qualified according~~
249.24 to section 245I.16, subdivision 2.

249.25 ~~(1) in psychiatric nursing, the mental health professional must be a registered nurse who~~
249.26 ~~is licensed under sections 148.171 to 148.285 and who is certified as a clinical specialist in~~
249.27 ~~child and adolescent psychiatric or mental health nursing by a national nurse certification~~
249.28 ~~organization or who has a master's degree in nursing or one of the behavioral sciences or~~
249.29 ~~related fields from an accredited college or university or its equivalent, with at least 4,000~~
249.30 ~~hours of post-master's supervised experience in the delivery of clinical services in the~~
249.31 ~~treatment of mental illness;~~

250.1 ~~(2) in clinical social work, the mental health professional must be a person licensed as~~
250.2 ~~an independent clinical social worker under chapter 148D, or a person with a master's degree~~
250.3 ~~in social work from an accredited college or university, with at least 4,000 hours of~~
250.4 ~~post-master's supervised experience in the delivery of clinical services in the treatment of~~
250.5 ~~mental disorders;~~

250.6 ~~(3) in psychology, the mental health professional must be an individual licensed by the~~
250.7 ~~board of psychology under sections 148.88 to 148.98 who has stated to the board of~~
250.8 ~~psychology competencies in the diagnosis and treatment of mental disorders;~~

250.9 ~~(4) in psychiatry, the mental health professional must be a physician licensed under~~
250.10 ~~chapter 147 and certified by the American Board of Psychiatry and Neurology or eligible~~
250.11 ~~for board certification in psychiatry or an osteopathic physician licensed under chapter 147~~
250.12 ~~and certified by the American Osteopathic Board of Neurology and Psychiatry or eligible~~
250.13 ~~for board certification in psychiatry;~~

250.14 ~~(5) in marriage and family therapy, the mental health professional must be a marriage~~
250.15 ~~and family therapist licensed under sections 148B.29 to 148B.39 with at least two years of~~
250.16 ~~post-master's supervised experience in the delivery of clinical services in the treatment of~~
250.17 ~~mental disorders or emotional disturbances;~~

250.18 ~~(6) in licensed professional clinical counseling, the mental health professional shall be~~
250.19 ~~a licensed professional clinical counselor under section 148B.5301 with at least 4,000 hours~~
250.20 ~~of post-master's supervised experience in the delivery of clinical services in the treatment~~
250.21 ~~of mental disorders or emotional disturbances; or~~

250.22 ~~(7) in allied fields, the mental health professional must be a person with a master's degree~~
250.23 ~~from an accredited college or university in one of the behavioral sciences or related fields,~~
250.24 ~~with at least 4,000 hours of post-master's supervised experience in the delivery of clinical~~
250.25 ~~services in the treatment of emotional disturbances.~~

250.26 Sec. 31. Minnesota Statutes 2018, section 245.4871, subdivision 29, is amended to read:

250.27 Subd. 29. **Outpatient services.** "Outpatient services" means mental health services,
250.28 excluding day treatment and community support services programs, provided by or under
250.29 the clinical treatment supervision of a mental health professional to children with emotional
250.30 disturbances who live outside a hospital. Outpatient services include clinical activities such
250.31 as individual, group, and family therapy; individual treatment planning; diagnostic
250.32 assessments; medication management; and psychological testing.

251.1 Sec. 32. Minnesota Statutes 2018, section 245.4871, subdivision 32, is amended to read:

251.2 Subd. 32. **Residential treatment.** "Residential treatment" means a 24-hour-a-day program
251.3 under the ~~clinical~~ treatment supervision of a mental health professional, in a community
251.4 residential setting other than an acute care hospital or regional treatment center inpatient
251.5 unit, that must be licensed as a residential treatment program for children with emotional
251.6 disturbances under Minnesota Rules, parts 2960.0580 to 2960.0700, or other rules adopted
251.7 by the commissioner.

251.8 Sec. 33. Minnesota Statutes 2018, section 245.4871, subdivision 34, is amended to read:

251.9 Subd. 34. **Therapeutic support of foster care.** "Therapeutic support of foster care"
251.10 means the mental health training and mental health support services and ~~clinical~~ treatment
251.11 supervision provided by a mental health professional to foster families caring for children
251.12 with severe emotional disturbance to provide a therapeutic family environment and support
251.13 for the child's improved functioning. Therapeutic support of foster care includes services
251.14 provided under section 256B.0946.

251.15 Sec. 34. Minnesota Statutes 2018, section 245.4876, subdivision 2, is amended to read:

251.16 Subd. 2. **Diagnostic assessment.** ~~All residential treatment facilities and acute care~~
251.17 ~~hospital inpatient treatment facilities that provide mental health services for children must~~
251.18 ~~complete a diagnostic assessment for each of their child clients within five working days~~
251.19 ~~of admission. Providers of day treatment services for children must complete a diagnostic~~
251.20 ~~assessment within five days after the child's second visit or 30 days after intake, whichever~~
251.21 ~~occurs first. In cases where a diagnostic assessment is available and has been completed~~
251.22 ~~within 180 days preceding admission, only updating is necessary. "Updating" means a~~
251.23 ~~written summary by a mental health professional of the child's current mental health status~~
251.24 ~~and service needs. If the child's mental health status has changed markedly since the child's~~
251.25 ~~most recent diagnostic assessment, a new diagnostic assessment is required. Compliance~~
251.26 ~~with the provisions of this subdivision does not ensure eligibility for medical assistance~~
251.27 ~~reimbursement under chapter 256B.~~ Providers of services governed by this section shall
251.28 complete a diagnostic assessment according to the standards of section 256B.0671, including
251.29 for services to a person not eligible for medical assistance.

251.30 Sec. 35. Minnesota Statutes 2018, section 245.4876, subdivision 3, is amended to read:

251.31 Subd. 3. **Individual treatment plans.** ~~All providers of outpatient services, day treatment~~
251.32 ~~services, professional home-based family treatment, residential treatment, and acute care~~

252.1 ~~hospital inpatient treatment, and all regional treatment centers that provide mental health~~
 252.2 ~~services for children must develop an individual treatment plan for each child client. The~~
 252.3 ~~individual treatment plan must be based on a diagnostic assessment. To the extent appropriate,~~
 252.4 ~~the child and the child's family shall be involved in all phases of developing and~~
 252.5 ~~implementing the individual treatment plan. Providers of residential treatment, professional~~
 252.6 ~~home-based family treatment, and acute care hospital inpatient treatment, and regional~~
 252.7 ~~treatment centers must develop the individual treatment plan within ten working days of~~
 252.8 ~~client intake or admission and must review the individual treatment plan every 90 days after~~
 252.9 ~~intake, except that the administrative review of the treatment plan of a child placed in a~~
 252.10 ~~residential facility shall be as specified in sections 260C.203 and 260C.212, subdivision 9.~~
 252.11 ~~Providers of day treatment services must develop the individual treatment plan before the~~
 252.12 ~~completion of five working days in which service is provided or within 30 days after the~~
 252.13 ~~diagnostic assessment is completed or obtained, whichever occurs first. Providers of~~
 252.14 ~~outpatient services must develop the individual treatment plan within 30 days after the~~
 252.15 ~~diagnostic assessment is completed or obtained or by the end of the second session of an~~
 252.16 ~~outpatient service, not including the session in which the diagnostic assessment was provided,~~
 252.17 ~~whichever occurs first. Providers of outpatient and day treatment services must review the~~
 252.18 ~~individual treatment plan every 90 days after intake. Providers of services governed by this~~
 252.19 ~~section shall complete an individual treatment plan according to the standards of section~~
 252.20 ~~256B.0671, subdivisions 5 and 6, including for services to a person not eligible for medical~~
 252.21 ~~assistance.~~

252.22 Sec. 36. Minnesota Statutes 2018, section 245.4879, subdivision 1, is amended to read:

252.23 Subdivision 1. **Availability of emergency services.** County boards must provide or
 252.24 contract for enough mental health emergency services within the county to meet the needs
 252.25 of children, and children's families when clinically appropriate, in the county who are
 252.26 experiencing an emotional crisis or emotional disturbance. The county board shall ensure
 252.27 that parents, providers, and county residents are informed about when and how to access
 252.28 emergency mental health services for children. A child or the child's parent may be required
 252.29 to pay a fee according to section 245.481. Emergency service providers shall not delay the
 252.30 timely provision of emergency service because of delays in determining this fee or because
 252.31 of the unwillingness or inability of the parent to pay the fee. Emergency services must
 252.32 include assessment, crisis intervention, and appropriate case disposition. A tribal authority
 252.33 that accepts crisis grant funding has the same responsibilities as county boards within the
 252.34 tribal authority's designated service area. Emergency services must:

253.1 (1) promote the safety and emotional stability of children with emotional disturbances
253.2 or emotional crises;

253.3 (2) minimize further deterioration of the child with emotional disturbance or emotional
253.4 crisis;

253.5 (3) help each child with an emotional disturbance or emotional crisis to obtain ongoing
253.6 care and treatment; ~~and~~

253.7 (4) prevent placement in settings that are more intensive, costly, or restrictive than
253.8 necessary and appropriate to meet the child's needs; and

253.9 (5) provide support, psychoeducation, and referrals to family members, service providers,
253.10 or other third parties on behalf of a client in need of emergency services.

253.11 Sec. 37. Minnesota Statutes 2018, section 245.4879, subdivision 2, is amended to read:

253.12 Subd. 2. **Specific requirements.** (a) The county board shall require that all service
253.13 providers of emergency services to the child with an emotional disturbance provide immediate
253.14 direct access to a mental health professional during regular business hours. For evenings,
253.15 weekends, and holidays, the service may be by direct toll-free telephone access to a mental
253.16 health professional, a clinical trainee, or a mental health practitioner, ~~or until January 1,~~
253.17 ~~1991, a designated person with training in human services who receives clinical supervision~~
253.18 ~~from a mental health professional.~~

253.19 (b) The commissioner may waive the requirement in paragraph (a) that the evening,
253.20 weekend, and holiday service be provided by a mental health professional, clinical trainee,
253.21 or mental health practitioner ~~after January 1, 1991~~, if the county documents that:

253.22 (1) mental health professionals, clinical trainees, or mental health practitioners are
253.23 unavailable to provide this service;

253.24 (2) services are provided by a designated person with training in human services who
253.25 receives clinical treatment supervision from a mental health professional; and

253.26 (3) the service provider is not also the provider of fire and public safety emergency
253.27 services.

253.28 (c) The commissioner may waive the requirement in paragraph (b), clause (3), that the
253.29 evening, weekend, and holiday service not be provided by the provider of fire and public
253.30 safety emergency services if:

254.1 (1) every person who will be providing the first telephone contact has received at least
254.2 eight hours of training on emergency mental health services reviewed by the state advisory
254.3 council on mental health and then approved by the commissioner;

254.4 (2) every person who will be providing the first telephone contact will annually receive
254.5 at least four hours of continued training on emergency mental health services reviewed by
254.6 the state advisory council on mental health and then approved by the commissioner;

254.7 (3) the local social service agency has provided public education about available
254.8 emergency mental health services and can assure potential users of emergency services that
254.9 their calls will be handled appropriately;

254.10 (4) the local social service agency agrees to provide the commissioner with accurate
254.11 data on the number of emergency mental health service calls received;

254.12 (5) the local social service agency agrees to monitor the frequency and quality of
254.13 emergency services; and

254.14 (6) the local social service agency describes how it will comply with paragraph (d).

254.15 (d) When emergency service during nonbusiness hours is provided by anyone other than
254.16 a mental health professional, a mental health professional must be available on call for an
254.17 emergency assessment and crisis intervention services, and must be available for at least
254.18 telephone consultation within 30 minutes.

254.19 Sec. 38. Minnesota Statutes 2018, section 245.488, subdivision 1, is amended to read:

254.20 Subdivision 1. **Availability of outpatient services.** (a) County boards must provide or
254.21 contract for enough outpatient services within the county to meet the needs of each child
254.22 with emotional disturbance residing in the county and the child's family. Services may be
254.23 provided directly by the county through county-operated mental health centers or mental
254.24 health clinics approved by the commissioner under section 245.69, subdivision 2; by contract
254.25 with privately operated mental health centers or mental health clinics approved by the
254.26 commissioner under section 245.69, subdivision 2; by contract with hospital mental health
254.27 outpatient programs certified by the Joint Commission on Accreditation of Hospital
254.28 Organizations; or by contract with a licensed mental health professional as defined in section
254.29 ~~245.4871, subdivision 27, clauses (1) to (6).~~ A child or a child's parent may be required to
254.30 pay a fee based in accordance with section 245.481. Outpatient services include:

254.31 (1) conducting diagnostic assessments;

254.32 (2) conducting psychological testing;

- 255.1 (3) developing or modifying individual treatment plans;
- 255.2 (4) making referrals and recommending placements as appropriate;
- 255.3 (5) treating the child's mental health needs through therapy; and
- 255.4 (6) prescribing and managing medication and evaluating the effectiveness of prescribed
- 255.5 medication.

255.6 (b) County boards may request a waiver allowing outpatient services to be provided in

255.7 a nearby trade area if it is determined that the child requires necessary and appropriate

255.8 services that are only available outside the county.

255.9 (c) Outpatient services offered by the county board to prevent placement must be at the

255.10 level of treatment appropriate to the child's diagnostic assessment.

255.11 Sec. 39. Minnesota Statutes 2018, section 245.696, is amended by adding a subdivision

255.12 to read:

255.13 Subd. 3. **Certification of mental health peer specialists and mental health family**

255.14 **peer specialists.** The commissioner shall develop a process to certify mental health peer

255.15 specialists and mental health family peer specialists according to federal guidelines and

255.16 section 245I.16, subdivisions 10 to 13, for a provider entity to bill for reimbursable services.

255.17 The training and certification curriculum must teach individuals specific skills relevant to

255.18 providing peer support as appropriate for individual or family peers.

255.19 Sec. 40. **[245I.01] PURPOSE AND CITATION.**

255.20 Subdivision 1. **Citation.** This chapter may be cited as the "Mental Health Uniform

255.21 Service Standards Act."

255.22 Subd. 2. **Purpose.** In accordance with sections 245.461 and 245.487, to create a system

255.23 of mental health care that is unified, accountable, and comprehensive, and to promote the

255.24 recovery of Minnesotans from mental illnesses, the state's public policy is to support quality

255.25 outpatient and residential mental health services reimbursable by public and private health

255.26 insurance programs. Further, the state's public policy is to ensure the safety, rights, and

255.27 well-being of individuals served in these programs.

255.28 Subd. 3. **Variations.** If the conditions in section 245A.04, subdivision 9, are met, the

255.29 commissioner may grant variations to the requirements in this chapter that do not affect a

255.30 client's health or safety.

256.1 Sec. 41. **[245I.02] DEFINITIONS.**

256.2 **Subdivision 1. Scope.** For purposes of this chapter the terms in this section have the
256.3 meanings given them.

256.4 **Subd. 2. Approval.** "Approval" means the documented review of, opportunity to request
256.5 changes to, and agreement with a treatment document by a treatment supervisor or by a
256.6 client. Approval may be demonstrated by written signature, secure electronic signature, or
256.7 documented oral approval.

256.8 **Subd. 3. Behavioral sciences or related fields.** "Behavioral sciences or related fields"
256.9 means an education from an accredited college or university in a field including but not
256.10 limited to social work, psychology, sociology, community counseling, family social science,
256.11 child development, child psychology, community mental health, addiction counseling,
256.12 counseling and guidance, special education, and other similar fields as approved by the
256.13 commissioner.

256.14 **Subd. 4. Certified rehabilitation specialist.** "Certified rehabilitation specialist" means
256.15 a staff person qualified according to section 245I.16, subdivision 8.

256.16 **Subd. 5. Child.** "Child" means a client under 18 years of age, or a client under 21 years
256.17 of age who is eligible for a service otherwise provided to persons under 18 years of age.

256.18 **Subd. 6. Client.** "Client" means a person who is seeking or receiving services regulated
256.19 under this chapter. For the purpose of consent to services, this term includes a parent,
256.20 guardian, or other individual authorized to consent to services by law.

256.21 **Subd. 7. Clinical trainee.** "Clinical trainee" means a staff person qualified according
256.22 to section 245I.16, subdivision 6.

256.23 **Subd. 8. Clinician.** "Clinician" means a mental health professional or clinical trainee
256.24 who is performing diagnostic assessment, testing, or psychotherapy.

256.25 **Subd. 9. Commissioner.** "Commissioner" means the commissioner of human services
256.26 or the commissioner's designee.

256.27 **Subd. 10. Diagnostic assessment.** "Diagnostic assessment" means the evaluation and
256.28 report of a client's potential diagnoses conducted by a clinician. For a client receiving
256.29 publicly funded services, a diagnostic assessment must meet the standards of section
256.30 256B.0671, subdivisions 2 to 4.

256.31 **Subd. 11. Diagnostic formulation.** "Diagnostic formulation" means a written analysis
256.32 and explanation of the information obtained from a clinical assessment to develop a

257.1 hypothesis about the cause and nature of the presenting problems and identify a framework
257.2 for developing the most suitable treatment approach.

257.3 Subd. 12. **Individual treatment plan.** "Individual treatment plan" means the formulation
257.4 of planned services that are responsive to the needs and goals of a client. For a client receiving
257.5 publicly funded services, an individual treatment plan must meet the standards of section
257.6 256B.0671, subdivisions 5 and 6.

257.7 Subd. 13. **Mental health behavioral aide.** "Mental health behavioral aide" means a
257.8 staff person qualified according to section 245I.16, subdivision 16.

257.9 Subd. 14. **Mental health certified family peer specialist.** "Mental health certified
257.10 family peer specialist" means a staff person qualified according to section 245I.16,
257.11 subdivision 12.

257.12 Subd. 15. **Mental health certified peer specialist.** "Mental health certified peer
257.13 specialist" means a staff person qualified according to section 245I.16, subdivision 10.

257.14 Subd. 16. **Mental health practitioner.** "Mental health practitioner" means a staff person
257.15 qualified according to section 245I.16, subdivision 4.

257.16 Subd. 17. **Mental health professional.** "Mental health professional" means a staff person
257.17 qualified according to section 245I.16, subdivision 2.

257.18 Subd. 18. **Mental health rehabilitation worker.** "Mental health rehabilitation worker"
257.19 means a staff person qualified according to section 245I.16, subdivision 14.

257.20 Subd. 19. **Personnel file.** "Personnel file" means the set of records under section 245I.13,
257.21 paragraph (a). Personnel files excludes information related to a person's employment not
257.22 enumerated in section 245I.13.

257.23 Subd. 20. **Provider entity.** "Provider entity" means the organization, governmental unit,
257.24 corporation, or other legal body that is enrolled, certified, licensed, or otherwise authorized
257.25 by the commissioner to provide the services described in this chapter.

257.26 Subd. 21. **Responsivity factors.** "Responsivity factors" means the factors other than the
257.27 diagnostic formulation that may modify an individual's treatment needs. This includes
257.28 learning style, ability, cognitive function, cultural background, and personal circumstance.
257.29 Documentation of responsivity factors includes an analysis of how an individual's strengths
257.30 may be reflected in the planned delivery of services.

257.31 Subd. 22. **Risk factors.** "Risk factors" means factors that predispose a client to engage
257.32 in potentially harmful behaviors to themselves or others.

258.1 Subd. 23. **Strengths.** "Strengths" means inner characteristics, virtues, external
258.2 relationships, activities, and connections to resources that contribute to resilience and core
258.3 competencies and can be built on to support recovery.

258.4 Subd. 24. **Trauma.** "Trauma" means an event, series of events, or set of circumstances
258.5 that is experienced by an individual as physically or emotionally harmful or life threatening
258.6 and has lasting adverse effects on the individual's functioning and mental, physical, social,
258.7 emotional, or spiritual well-being. Trauma includes the cumulative emotional or
258.8 psychological harm of group traumatic experiences, transmitted across generations within
258.9 a community, often associated with racial and ethnic population groups in the country who
258.10 have suffered major intergenerational losses.

258.11 Subd. 25. **Treatment supervision.** "Treatment supervision" means the direction and
258.12 evaluation of individual assessment, treatment planning, and service delivery for each client
258.13 when services are delivered by an individual who is not a licensed mental health professional
258.14 or certified rehabilitation specialist as provided by section 245I.18.

258.15 **Sec. 42. [245I.10] TRAINING REQUIRED.**

258.16 Subdivision 1. **Training plan.** A provider entity must develop a plan to ensure that staff
258.17 persons receive orientation and ongoing training. The plan must include:

258.18 (1) a formal process to evaluate the training needs of each staff person. An annual
258.19 performance evaluation satisfies this requirement;

258.20 (2) a description of how the provider entity conducts annual training, including whether
258.21 annual training is based on a staff person's hire date or a specified annual cycle determined
258.22 by the program; and

258.23 (3) a description of how the provider entity determines when a staff person needs
258.24 additional training, including the timelines in which the additional training is provided.

258.25 Subd. 2. **Documentation of orientation and training.** (a) The provider entity must
258.26 provide training in accordance with the training plan and must document that orientation
258.27 and training was provided. All training programs and materials used by the provider entity
258.28 must be available for review by regulatory agencies. The documentation must include the
258.29 following:

258.30 (1) topic covered in the training;

258.31 (2) identification of the trainee;

258.32 (3) name and credentials of the trainer;

- 259.1 (4) method of evaluating competency upon completion of training;
- 259.2 (5) date of training; and
- 259.3 (6) length of training, in hours.
- 259.4 (b) Documentation of a continuing education credit accepted by the governing
- 259.5 health-related licensing board is sufficient for purposes of this subdivision.
- 259.6 Subd. 3. **Orientation.** (a) Before providing direct contact services, a staff person must
- 259.7 receive orientation on:
- 259.8 (1) patient rights as identified in section 144.651;
- 259.9 (2) vulnerable adult and minor maltreatment requirements in sections 245A.65,
- 259.10 subdivision 3; 626.556, subdivisions 2, 3, and 7; 626.557; and 626.5572;
- 259.11 (3) the Minnesota Health Records Act, including confidentiality, family engagement
- 259.12 according to section 144.294, and client privacy;
- 259.13 (4) program policies and procedures;
- 259.14 (5) emergency procedures appropriate to the position, including but not limited to fires,
- 259.15 inclement weather, missing persons, and medical emergencies;
- 259.16 (6) professional boundaries;
- 259.17 (7) behavior management, crisis intervention, and stabilization techniques;
- 259.18 (8) specific needs of individuals served by the program, including but not limited to
- 259.19 developmental status, cognitive functioning, and physical and mental abilities; and
- 259.20 (9) training related to the specific activities and job functions for which the staff person
- 259.21 is responsible to carry out, including documentation of the delivery of services.
- 259.22 (b) A staff person must receive orientation on the following topics within 90 calendar
- 259.23 days of a staff person first providing direct contact services:
- 259.24 (1) trauma-informed care;
- 259.25 (2) family- and person-centered individual treatment plans, seeking partnership with
- 259.26 parents and identified supports, and shared decision making and engagement;
- 259.27 (3) treatment for co-occurring substance use problems, including the definitions of
- 259.28 co-occurring disorders, prevalence of co-occurring disorders, common signs and symptoms
- 259.29 of co-occurring disorders, and the etiology of co-occurring disorders;
- 259.30 (4) psychotropic medications, side effects, and safe medication management;

260.1 (5) family systems and promoting culturally appropriate support networks;

260.2 (6) culturally responsive treatment practices;

260.3 (7) recovery concepts and principles;

260.4 (8) building resiliency through a strength-based approach;

260.5 (9) person-centered planning and positive support strategies; and

260.6 (10) other training relevant to the staff person's role and responsibilities.

260.7 (c) A provider entity may deem a staff person to have met an orientation requirement
260.8 in paragraph (b) if the staff person has received equivalent postsecondary education in the
260.9 previous four years or training experience in the previous two years. The training plan must
260.10 describe the process and location for verification and documentation of previous training
260.11 experience.

260.12 (d) A provider entity may deem a mental health professional to have met a requirement
260.13 of paragraph (a), clauses (6) to (9), and paragraph (b) after an evaluation of the mental health
260.14 professional's competency, including by interview.

260.15 Subd. 4. **Annual training.** (a) A provider entity shall ensure that staff persons who are
260.16 not licensed mental health professionals receive 15 hours of training each year after the first
260.17 year of employment.

260.18 (b) A licensed mental health professional must follow specific training requirements as
260.19 determined by the professional's governing health-related licensing board.

260.20 (c) All staff persons, including licensed mental health professionals, must receive annual
260.21 training on the topics in subdivision 3, paragraph (a), clauses (2) and (5).

260.22 (d) The selection of additional training topics must be based on program needs and staff
260.23 persons' competency.

260.24 Subd. 5. **Training for services provided to children.** (a) Training and orientation
260.25 required under this section for a staff person working with children must be aligned to the
260.26 developmental characteristics of the children served in the program and address the needs
260.27 of children in the context of the family, support system, and culture. This includes orientation
260.28 under subdivision 3 on the following topics: (1) child development; (2) working with children
260.29 and children's support systems; (3) adverse childhood experiences, cognitive functioning,
260.30 and physical and mental abilities; and (4) understanding family perspective.

260.31 (b) For a mental health behavioral aide, orientation in the first 90 days of service must
260.32 include a parent team training utilizing a curriculum approved by the commissioner.

261.1 Sec. 43. **[245I.13] PERSONNEL FILES.**

261.2 (a) For each staff person, a provider entity shall maintain a personnel file that includes:

261.3 (1) verification of the staff person's qualifications including training, education, and
261.4 licensure;

261.5 (2) documentation related to the staff person's background study;

261.6 (3) the date of hire;

261.7 (4) the effective date of specific duties and responsibilities including the date that the
261.8 staff person begins direct contact with a client;

261.9 (5) documentation of orientation;

261.10 (6) records of training, license renewal, and educational activities completed during the
261.11 staff person's employment;

261.12 (7) annual job performance evaluations; and

261.13 (8) records of clinical supervision, if applicable.

261.14 (b) Personnel files must be made accessible to the commissioner upon request. Personnel
261.15 files must be readily accessible for review but need not be kept in a single location.

261.16 Sec. 44. **[245I.16] PROVIDER QUALIFICATIONS AND SCOPE OF PRACTICE.**

261.17 Subdivision 1. Tribal providers. For purposes of this section, a tribal entity may
261.18 credential an individual under section 256B.02, subdivision 7, paragraphs (b) and (c).

261.19 Subd. 2. Mental health professional qualifications. The following individuals may
261.20 provide services as a mental health professional:

261.21 (1) a registered nurse who is licensed under sections 148.171 to 148.285 and is certified
261.22 as a (i) clinical nurse specialist in child or adolescent, family, or adult psychiatric and mental
261.23 health nursing by a national certification organization, or (ii) nurse practitioner in adult or
261.24 family psychiatric and mental health nursing by a national nurse certification organization;

261.25 (2) a licensed independent clinical social worker as defined in section 148E.050,
261.26 subdivision 5;

261.27 (3) a psychologist licensed by the Board of Psychology under sections 148.88 to 148.98;

261.28 (4) a physician licensed under chapter 147 if the physician is: (i) certified by the American
261.29 Board of Psychiatry and Neurology; (ii) certified by the American Osteopathic Board of
261.30 Neurology and Psychiatry; or (iii) eligible for board certification in psychiatry;

262.1 (5) a marriage and family therapist licensed under sections 148B.29 to 148B.39; or

262.2 (6) a licensed professional clinical counselor licensed under section 148B.5301.

262.3 Subd. 3. **Mental health professional scope of practice.** A mental health professional
262.4 shall maintain a valid license with the mental health professional's governing health-related
262.5 licensing board and shall only provide services within the scope of practice as determined
262.6 by the health-related licensing board.

262.7 Subd. 4. **Mental health practitioner qualifications.** (a) An individual who is qualified
262.8 in at least one of the ways described in paragraphs (b) to (d) may serve as a mental health
262.9 practitioner.

262.10 (b) An individual is qualified through relevant coursework if the individual completes
262.11 at least 30 semester hours or 45 quarter hours in behavioral sciences or related fields and:

262.12 (1) has at least 2,000 hours of supervised experience in the delivery of services to adults
262.13 or children with: (i) mental illness, substance use disorder, or emotional disturbance; or (ii)
262.14 traumatic brain injury or developmental disabilities and completes training on mental illness,
262.15 recovery from mental illness, mental health de-escalation techniques, co-occurring mental
262.16 illness and substance use disorder, and psychotropic medications and side effects;

262.17 (2) is fluent in the non-English language of the ethnic group to which at least 50 percent
262.18 of the individual's clients belong, completes 40 hours of training in the delivery of services
262.19 to adults with mental illness or children with emotional disturbance, and receives treatment
262.20 supervision from a mental health professional at least once per week until the requirement
262.21 of 2,000 hours of supervised experience is met;

262.22 (3) is working in a day treatment program under section 245.4712, subdivision 2; or

262.23 (4) has completed a practicum or internship that (i) requires direct interaction with adults
262.24 or children served, and (ii) is focused on behavioral sciences or related fields.

262.25 (c) An individual is qualified through work experience if the individual:

262.26 (1) has at least 4,000 hours of supervised experience in the delivery of services to adults
262.27 or children with: (i) mental illness, substance use disorder, or emotional disturbance; or (ii)
262.28 traumatic brain injury or developmental disabilities and completes training on mental illness,
262.29 recovery from mental illness, mental health de-escalation techniques, co-occurring mental
262.30 illness and substance use disorder, and psychotropic medications and side effects; or

262.31 (2) has at least 2,000 hours of supervised experience in the delivery of services to adults
262.32 or children with: (i) mental illness, emotional disturbance, or substance use disorder, and

263.1 receives treatment supervision as required by applicable statutes and rules from a mental
263.2 health professional at least once per week until the requirement of 4,000 hours of supervised
263.3 experience is met; or (ii) traumatic brain injury or developmental disabilities, completes
263.4 training on mental illness, recovery from mental illness, mental health de-escalation
263.5 techniques, co-occurring mental illness and substance use disorder, and psychotropic
263.6 medications and side effects, and receives treatment supervision as required by applicable
263.7 statutes and rules at least once per week from a mental health professional until the
263.8 requirement of 4,000 hours of supervised experience is met.

263.9 (d) An individual is qualified by a bachelor's or master's degree if the individual: (1)
263.10 holds a master's or other graduate degree in behavioral sciences or related fields; or (2)
263.11 holds a bachelor's degree in behavioral sciences or related fields and completes a practicum
263.12 or internship that (i) requires direct interaction with adults or children served, and (ii) is
263.13 focused on behavioral sciences or related fields.

263.14 Subd. 5. **Mental health practitioner scope of practice.** (a) A mental health practitioner
263.15 must perform services under the treatment supervision of a mental health professional.

263.16 (b) A mental health practitioner may perform client education, functional assessments
263.17 for adult clients, level of care assessments, rehabilitative interventions, and skills building;
263.18 provide direction to a mental health rehabilitation worker or mental health behavioral aide;
263.19 and propose individual treatment plans.

263.20 (c) A mental health practitioner who provides services according to section 256B.0624
263.21 or 256B.0944 may perform crisis assessment and intervention.

263.22 Subd. 6. **Clinical trainee qualifications.** (a) A clinical trainee is a staff person who is
263.23 enrolled in or has completed an accredited graduate program of study intended to prepare
263.24 the individual for independent licensure as a mental health professional and who: (1)
263.25 participates in a practicum or internship supervised by a mental health professional; or (2)
263.26 is completing postgraduate hours, according to the requirements of a health-related licensing
263.27 board.

263.28 (b) A clinical trainee is responsible for notifying and applying to a health-related licensing
263.29 board to ensure the requirements of the health-related licensing board are met. As permitted
263.30 by a health-related licensing board, treatment supervision under this chapter may be integrated
263.31 into a plan to meet the supervisory requirements of the health-related licensing board but
263.32 does not supersede those requirements.

263.33 Subd. 7. **Clinical trainee scope of practice.** (a) A clinical trainee, under treatment
263.34 supervision of a mental health professional, may perform psychotherapy, diagnostic

264.1 assessments, and services that a mental health practitioner may deliver. A clinical trainee
264.2 shall not provide treatment supervision. A clinical trainee may provide direction to a mental
264.3 health behavioral aide or mental health rehabilitation worker.

264.4 (b) A psychological clinical trainee under the treatment supervision of a psychologist
264.5 may perform psychological testing.

264.6 (c) A clinical trainee shall not deliver services in violation of the practice act of a
264.7 health-related licensing board, including failure to obtain licensure, if required.

264.8 Subd. 8. **Certified rehabilitation specialist qualifications.** A certified rehabilitation
264.9 specialist shall have:

264.10 (1) a master's degree from an accredited college or university in behavioral sciences or
264.11 related fields as defined in section 245I.02, subdivision 3;

264.12 (2) at least 4,000 hours of postmaster's supervised experience in the delivery of mental
264.13 health services; and

264.14 (3) a valid national certification as a certified rehabilitation counselor or certified
264.15 psychosocial rehabilitation practitioner.

264.16 Subd. 9. **Certified rehabilitation specialist scope of practice.** A certified rehabilitation
264.17 specialist shall provide services based on a client's diagnostic assessment. A certified
264.18 rehabilitation specialist may provide supervision for mental health certified peer specialists,
264.19 mental health practitioners, and mental health rehabilitation workers, but is prohibited from
264.20 performing a diagnostic assessment.

264.21 Subd. 10. **Mental health certified peer specialist qualifications.** A mental health
264.22 certified peer specialist shall:

264.23 (1) be 21 years of age or older;

264.24 (2) have been diagnosed with a mental illness;

264.25 (3) be a current or former mental health services client; and

264.26 (4) have a valid certification as a mental health certified peer specialist according to
264.27 section 245.696, subdivision 3.

264.28 Subd. 11. **Mental health certified peer specialist scope of practice.** A mental health
264.29 certified peer specialist shall:

264.30 (1) provide peer support that is individualized to the client;

265.1 (2) promote recovery goals, self-sufficiency, self-advocacy, and the development of
265.2 natural supports; and

265.3 (3) support the maintenance of skills learned in other services.

265.4 Subd. 12. **Mental health certified family peer specialist qualifications.** A mental
265.5 health certified family peer specialist shall:

265.6 (1) be 21 years of age or older;

265.7 (2) have raised or be currently raising a child with a mental illness;

265.8 (3) have experience navigating the children's mental health system; and

265.9 (4) have a valid certification as a mental health certified family peer specialist according
265.10 to section 245.696, subdivision 3.

265.11 Subd. 13. **Mental health certified family peer specialist scope of practice.** A mental
265.12 health certified family peer specialist shall provide services to increase the child's ability to
265.13 function better within the child's home, school, and community. The mental health certified
265.14 family peer specialist shall:

265.15 (1) provide family peer support, to build on strengths of families and help families
265.16 achieve desired outcomes;

265.17 (2) provide nonadversarial advocacy that encourages partnership and promotes positive
265.18 change and growth;

265.19 (3) support families to advocate for culturally appropriate services for a child in each
265.20 treatment setting;

265.21 (4) promote resiliency, self-advocacy, and development of natural supports;

265.22 (5) support the maintenance of skills learned in other services;

265.23 (6) establish and lead parent support groups;

265.24 (7) assist parents to develop coping and problem-solving skills; and

265.25 (8) educate parents on community resources, including resources that connect parents
265.26 with similar experiences.

265.27 Subd. 14. **Mental health rehabilitation worker qualifications.** (a) A mental health
265.28 rehabilitation worker shall (1) be 21 years of age or older; (2) have a high school diploma
265.29 or equivalent; and (3) meet the qualification requirements in paragraph (b).

266.1 (b) In addition to the requirements of paragraph (a), a mental health rehabilitation worker
266.2 shall also:

266.3 (1) be fluent in the non-English language or competent in the culture of the ethnic group
266.4 to which at least 20 percent of the mental health rehabilitation worker's clients belong;

266.5 (2) have an associate of arts degree;

266.6 (3) have two years of full-time postsecondary education or a total of 15 semester hours
266.7 or 23 quarter hours in behavioral sciences or related fields;

266.8 (4) be a registered nurse;

266.9 (5) have within the previous ten years three years of personal life experience with mental
266.10 illness;

266.11 (6) have within the previous ten years three years of life experience as a primary caregiver
266.12 to an adult with a mental illness, traumatic brain injury, substance use disorder, or
266.13 developmental disability; or

266.14 (7) have within the previous ten years 2,000 hours of supervised work experience in
266.15 delivering mental health services to adults with a mental illness, traumatic brain injury,
266.16 substance use disorder, or developmental disability.

266.17 (c) If the mental health rehabilitation worker provides crisis residential services, intensive
266.18 residential treatment services, partial hospitalization, or day treatment services, the mental
266.19 health rehabilitation worker shall: (1) satisfy paragraph (b), clause (1); and (2) have 40 hours
266.20 of additional continuing education on mental health topics during the first year of
266.21 employment.

266.22 Subd. 15. **Mental health rehabilitation worker scope of practice.** (a) A mental health
266.23 rehabilitation worker under supervision of a mental health practitioner or mental health
266.24 professional may provide rehabilitative mental health services identified in the client's
266.25 individual treatment plan and individual behavior plan.

266.26 (b) A mental health rehabilitation worker who solely acts and is scheduled as overnight
266.27 staff is exempt from the additional qualification requirements in subdivision 14, paragraphs
266.28 (a), clause (3), and (b).

266.29 Subd. 16. **Mental health behavioral aide qualifications.** (a) A level 1 mental health
266.30 behavioral aide shall:

266.31 (1) be 18 years of age or older; and

267.1 (2) have a high school diploma or commissioner of education-selected high school
267.2 equivalency certification; or two years of experience as a primary caregiver to a child with
267.3 severe emotional disturbance within the previous ten years.

267.4 (b) A level 2 mental health behavioral aide shall:

267.5 (1) be 18 years of age or older; and

267.6 (2) have an associate or bachelor's degree or be certified by a program under section
267.7 256B.0943, subdivision 8a.

267.8 Subd. 17. **Mental health behavioral aide scope of practice.** The mental health
267.9 behavioral aide under supervision of a mental health professional may provide rehabilitative
267.10 mental health services identified in the client's individual treatment plan and individual
267.11 behavior plan.

267.12 Sec. 45. **[245L.18] TREATMENT SUPERVISION.**

267.13 Subdivision 1. **Generally.** (a) A provider entity shall ensure that a mental health
267.14 professional provides treatment supervision for each staff person who provides services to
267.15 a client and who is not a mental health professional or certified rehabilitation specialist.
267.16 Treatment supervision shall be based on a staff person's written treatment supervision plan.

267.17 (b) Treatment supervision must focus on the client's treatment needs and the ability of
267.18 the staff person receiving treatment supervision to provide services, including:

267.19 (1) review and evaluation of the interventions delivered;

267.20 (2) instruction on alternative strategies if a client is not achieving treatment goals;

267.21 (3) review and evaluation of assessments, treatment plans, and progress notes for accuracy
267.22 and appropriateness;

267.23 (4) approval of diagnostic assessments and individual treatment plans within five business
267.24 days of initial completion by the supervisee;

267.25 (5) instruction on the cultural norms or values of the clients and communities served by
267.26 the provider entity and any impact on treatment;

267.27 (6) evaluation of and feedback on the competencies of direct service staff persons; and

267.28 (7) coaching, teaching, and practicing skills with staff persons.

267.29 (c) A treatment supervisor's responsibility for a supervisee is limited to services provided
267.30 by the associated provider entity. If a supervisee is employed by multiple provider entities,
267.31 each entity is responsible for furnishing the necessary treatment supervision.

268.1 Subd. 2. Permitted modalities. (a) Treatment supervision must be conducted face-to-face,
268.2 including telemedicine, according to the Minnesota Telemedicine Act, sections 62A.67 to
268.3 62A.672.

268.4 (b) Treatment supervision may be conducted using individual, small group, or team
268.5 modalities. "Individual supervision" means one or more mental health professionals and
268.6 one staff person receiving treatment supervision. "Small group supervision" means one or
268.7 more mental health professionals and two to six staff persons receiving treatment supervision.
268.8 "Team supervision" is defined by the service lines for which it may be used.

268.9 Subd. 3. Treatment supervision planning. (a) A written treatment supervision plan
268.10 shall be developed by a mental health professional who is qualified to provide treatment
268.11 supervision and the staff person receiving the treatment supervision. The treatment
268.12 supervision plan must be completed and implemented within 30 days of a new staff person's
268.13 employment. The treatment supervision plan must be reviewed and updated at least annually.

268.14 (b) The treatment supervision plan must include:

268.15 (1) the name and qualifications of the staff person receiving treatment supervision;

268.16 (2) the name of the provider entity under which the staff person is receiving treatment
268.17 supervision;

268.18 (3) the name and licensure of a mental health professional providing treatment
268.19 supervision;

268.20 (4) the number of hours of individual and group supervision the staff person receiving
268.21 treatment supervision must complete and the location of the record if the record is kept
268.22 outside of an individual personnel file;

268.23 (5) procedures that the staff person receiving treatment supervision shall use to respond
268.24 to client emergencies; and

268.25 (6) the authorized scope of practice for the staff person receiving treatment supervision,
268.26 including a description of responsibilities with the provider entity, a description of client
268.27 population, and treatment methods and modalities.

268.28 Subd. 4. Treatment supervision record. (a) A provider entity shall ensure treatment
268.29 supervision is documented in each staff person's treatment supervision record.

268.30 (b) The treatment supervision record must include:

268.31 (1) the date and duration of the supervision;

268.32 (2) identification of the supervision type as individual, small group, or team supervision;

269.1 (3) the name of the mental health professional providing treatment supervision;

269.2 (4) subsequent actions that the staff person receiving treatment supervision shall take;

269.3 and

269.4 (5) the date and signature of the mental health professional providing treatment

269.5 supervision.

269.6 Subd. 5. **Supervision and direct observation of mental health rehabilitation workers**

269.7 and behavioral aides. (a) A mental health practitioner, clinical trainee, or mental health

269.8 professional shall directly observe a mental health behavioral aide or a mental health

269.9 rehabilitation worker while the mental health behavioral aide or mental health rehabilitation

269.10 worker provides services to clients. The amount of direct observation shall be no less than

269.11 twice per month for the first six months and once per month thereafter. The staff performing

269.12 the observation shall approve the progress note for the service observed.

269.13 (b) For a rehabilitation worker qualified under section 245I.16, subdivision 14, paragraph

269.14 (b), clause (1), the treatment supervision in the first 2,000 hours of work shall be no less

269.15 than:

269.16 (1) monthly individual treatment supervision; and

269.17 (2) twice per month direct observation.

269.18 Sec. 46. **[245I.32] CLIENT FILES.**

269.19 Subdivision 1. **Generally.** A provider entity must maintain a file of current and accurate

269.20 client records on the premises where the service is provided or coordinated. Each entry in

269.21 the record must be signed and dated by the staff person making the entry.

269.22 Subd. 2. **Record retention.** A provider entity must retain client records of a discharged

269.23 client for a minimum of seven years from the date of discharge. A provider entity that ceases

269.24 to provide treatment service must retain client records for a minimum of seven years from

269.25 the date the provider entity stopped providing the service and must notify the commissioner

269.26 of the location of the client records and the name of the individual responsible for maintaining

269.27 the client records.

269.28 Subd. 3. **Contents.** Client files must contain the following, as applicable:

269.29 (1) diagnostic assessments;

269.30 (2) functional assessments;

269.31 (3) individual treatment plans;

- 270.1 (4) individual abuse prevention plans;
- 270.2 (5) crisis plans;
- 270.3 (6) documentation of releases of information;
- 270.4 (7) emergency contacts for the client;
- 270.5 (8) documentation of the date of service; signature of the person providing the service;
- 270.6 nature, extent, and units of service; and place of service delivery;
- 270.7 (9) record of all medication prescribed or administered by staff;
- 270.8 (10) documentation of any contact made with the client's other mental health providers,
- 270.9 case manager, family members, primary caregiver, or legal representative or the reason the
- 270.10 provider did not contact the client's family members or primary caregiver;
- 270.11 (11) documentation of any contact made with other persons interested in the client,
- 270.12 including representatives of the courts, corrections systems, or schools;
- 270.13 (12) written information by the client that the client requests be included in the file;
- 270.14 (13) health care directive; and
- 270.15 (14) the date and reason the provider entity's services are discontinued.

270.16 Sec. 47. **[245I.33] DOCUMENTATION STANDARDS.**

270.17 Subdivision 1. **Generally.** As a condition of payment, a provider entity must ensure that

270.18 documentation complies with this section and Minnesota Rules, parts 9505.2175 and

270.19 9505.2197. The department must recover medical assistance payments for a service not

270.20 documented in a client file according to this section.

270.21 Subd. 2. **Documentation standards.** A provider entity must ensure that all documentation

270.22 required under this chapter:

- 270.23 (1) is typed or legible, if handwritten;
- 270.24 (2) identifies the client or staff person on each page, as applicable;
- 270.25 (3) is signed and dated by the staff person who completes the documentation, including
- 270.26 the staff person's credentials; and
- 270.27 (4) is cosigned and dated by the staff person providing treatment supervision as required
- 270.28 under this chapter, including the staff person's credentials.

271.1 Subd. 3. **Progress notes.** A provider entity shall use a progress note to promptly document
 271.2 each occurrence of a mental health service provided to a client. A progress note must include
 271.3 the following:

271.4 (1) the type of service;

271.5 (2) the date of service, including the start and stop time;

271.6 (3) the location of service;

271.7 (4) the scope of service, including: (i) the goal and objective targeted; (ii) the intervention
 271.8 delivered and the methods used; (iii) the client's response or reaction to intervention; (iv)
 271.9 the plan for the next session; and (v) the service modality;

271.10 (5) the signature and the printed name and credentials of the staff person who provided
 271.11 the service;

271.12 (6) the mental health provider travel documentation requirements under section
 271.13 256B.0625, if applicable; and

271.14 (7) other significant observations, including (i) current risk factors the client may be
 271.15 experiencing; (ii) emergency interventions; (iii) consultations with or referrals to other
 271.16 professionals, family, or significant others; (iv) a summary of the effectiveness of treatment,
 271.17 prognosis, or discharge planning; (v) test results and medications; or (vi) changes in mental
 271.18 or physical symptoms.

271.19 Sec. 48. Minnesota Statutes 2018, section 254B.05, subdivision 5, is amended to read:

271.20 **Subd. 5. Rate requirements.** (a) The commissioner shall establish rates for substance
 271.21 use disorder services and service enhancements funded under this chapter.

271.22 (b) Eligible substance use disorder treatment services include:

271.23 (1) outpatient treatment services that are licensed according to sections 245G.01 to
 271.24 245G.17, or applicable tribal license;

271.25 (2) on July 1, 2018, or upon federal approval, whichever is later, comprehensive
 271.26 assessments provided according to sections 245.4863, paragraph (a), and 245G.05, ~~and~~
 271.27 ~~Minnesota Rules, part 9530.6422;~~

271.28 (3) on July 1, 2018, or upon federal approval, whichever is later, care coordination
 271.29 services provided according to section 245G.07, subdivision 1, paragraph (a), clause (6);

271.30 (4) on July 1, 2018, or upon federal approval, whichever is later, peer recovery support
 271.31 services provided according to section 245G.07, subdivision 1, paragraph (a), clause (5);

272.1 (5) on July 1, 2019, or upon federal approval, whichever is later, withdrawal management
272.2 services provided according to chapter 245F;

272.3 (6) medication-assisted therapy services that are licensed according to sections 245G.01
272.4 to 245G.17 and 245G.22, or applicable tribal license;

272.5 (7) medication-assisted therapy plus enhanced treatment services that meet the
272.6 requirements of clause (6) and provide nine hours of clinical services each week;

272.7 (8) high, medium, and low intensity residential treatment services that are licensed
272.8 according to sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license which
272.9 provide, respectively, 30, 15, and five hours of clinical services each week;

272.10 (9) hospital-based treatment services that are licensed according to sections 245G.01 to
272.11 245G.17 or applicable tribal license and licensed as a hospital under sections 144.50 to
272.12 144.56;

272.13 (10) adolescent treatment programs that are licensed as outpatient treatment programs
272.14 according to sections 245G.01 to 245G.18 or as residential treatment programs according
272.15 to Minnesota Rules, parts 2960.0010 to 2960.0220, and 2960.0430 to 2960.0490, or
272.16 applicable tribal license;

272.17 (11) high-intensity residential treatment services that are licensed according to sections
272.18 245G.01 to 245G.17 and 245G.21 or applicable tribal license, which provide 30 hours of
272.19 clinical services each week provided by a state-operated vendor or to clients who have been
272.20 civilly committed to the commissioner, present the most complex and difficult care needs,
272.21 and are a potential threat to the community; and

272.22 (12) room and board facilities that meet the requirements of subdivision 1a.

272.23 (c) The commissioner shall establish higher rates for programs that meet the requirements
272.24 of paragraph (b) and one of the following additional requirements:

272.25 (1) programs that serve parents with their children if the program:

272.26 (i) provides on-site child care during the hours of treatment activity that:

272.27 (A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter
272.28 9503; or

272.29 (B) meets the licensure exclusion criteria of section 245A.03, subdivision 2, paragraph
272.30 (a), clause (6), and meets the requirements under section 245G.19, subdivision 4; or

272.31 (ii) arranges for off-site child care during hours of treatment activity at a facility that is
272.32 licensed under chapter 245A as:

- 273.1 (A) a child care center under Minnesota Rules, chapter 9503; or
- 273.2 (B) a family child care home under Minnesota Rules, chapter 9502;
- 273.3 (2) culturally specific programs as defined in section 254B.01, subdivision 4a, or
- 273.4 programs or subprograms serving special populations, if the program or subprogram meets
- 273.5 the following requirements:
- 273.6 (i) is designed to address the unique needs of individuals who share a common language,
- 273.7 racial, ethnic, or social background;
- 273.8 (ii) is governed with significant input from individuals of that specific background; and
- 273.9 (iii) employs individuals to provide individual or group therapy, at least 50 percent of
- 273.10 whom are of that specific background, except when the common social background of the
- 273.11 individuals served is a traumatic brain injury or cognitive disability and the program employs
- 273.12 treatment staff who have the necessary professional training, as approved by the
- 273.13 commissioner, to serve clients with the specific disabilities that the program is designed to
- 273.14 serve;
- 273.15 (3) programs that offer medical services delivered by appropriately credentialed health
- 273.16 care staff in an amount equal to two hours per client per week if the medical needs of the
- 273.17 client and the nature and provision of any medical services provided are documented in the
- 273.18 client file; and
- 273.19 (4) programs that offer services to individuals with co-occurring mental health and
- 273.20 chemical dependency problems if:
- 273.21 (i) the program meets the co-occurring requirements in section 245G.20;
- 273.22 (ii) 25 percent of the counseling staff are licensed mental health professionals, ~~as defined~~
- 273.23 ~~in section 245.462, subdivision 18, clauses (1) to (6),~~ qualified according to section 245I.16,
- 273.24 subdivision 2, or are students or licensing candidates under the supervision of a licensed
- 273.25 alcohol and drug counselor supervisor and licensed mental health professional, except that
- 273.26 no more than 50 percent of the mental health staff may be students or licensing candidates
- 273.27 with time documented to be directly related to provisions of co-occurring services;
- 273.28 (iii) clients scoring positive on a standardized mental health screen receive a mental
- 273.29 health diagnostic assessment within ten days of admission;
- 273.30 (iv) the program has standards for multidisciplinary case review that include a monthly
- 273.31 review for each client that, at a minimum, includes a licensed mental health professional
- 273.32 and licensed alcohol and drug counselor, and their involvement in the review is documented;

274.1 (v) family education is offered that addresses mental health and substance abuse disorders
274.2 and the interaction between the two; and

274.3 (vi) co-occurring counseling staff shall receive eight hours of co-occurring disorder
274.4 training annually.

274.5 (d) In order to be eligible for a higher rate under paragraph (c), clause (1), a program
274.6 that provides arrangements for off-site child care must maintain current documentation at
274.7 the chemical dependency facility of the child care provider's current licensure to provide
274.8 child care services. Programs that provide child care according to paragraph (c), clause (1),
274.9 must be deemed in compliance with the licensing requirements in section 245G.19.

274.10 (e) Adolescent residential programs that meet the requirements of Minnesota Rules,
274.11 parts 2960.0430 to 2960.0490 and 2960.0580 to 2960.0690, are exempt from the requirements
274.12 in paragraph (c), clause (4), items (i) to (iv).

274.13 (f) Subject to federal approval, chemical dependency services that are otherwise covered
274.14 as direct face-to-face services may be provided via two-way interactive video. The use of
274.15 two-way interactive video must be medically appropriate to the condition and needs of the
274.16 person being served. Reimbursement shall be at the same rates and under the same conditions
274.17 that would otherwise apply to direct face-to-face services. The interactive video equipment
274.18 and connection must comply with Medicare standards in effect at the time the service is
274.19 provided.

274.20 Sec. 49. Minnesota Statutes 2018, section 256B.0615, subdivision 1, is amended to read:

274.21 Subdivision 1. **Scope.** Medical assistance covers mental health certified peer specialist
274.22 services, ~~as established in subdivision 2, subject to federal approval, if provided to recipients~~
274.23 ~~who are eligible for services under sections 256B.0622, 256B.0623, and 256B.0624 and~~
274.24 ~~are provided by a certified peer specialist who has completed the training under subdivision~~
274.25 ~~5 is qualified according to section 245I.16, subdivision 10.~~

274.26 Sec. 50. Minnesota Statutes 2018, section 256B.0616, subdivision 1, is amended to read:

274.27 Subdivision 1. **Scope.** Medical assistance covers mental health certified family peer
274.28 specialists services, ~~as established in subdivision 2, subject to federal approval, if provided~~
274.29 ~~to recipients who have an emotional disturbance or severe emotional disturbance under~~
274.30 ~~chapter 245, and are provided by a certified family peer specialist who has completed the~~
274.31 ~~training under subdivision 5 is qualified according to section 245I.16, subdivision 12.~~ A
274.32 family peer specialist cannot provide services to the peer specialist's family.

275.1 Sec. 51. Minnesota Statutes 2018, section 256B.0616, subdivision 3, is amended to read:

275.2 Subd. 3. **Eligibility.** Family peer support services may be ~~located in~~ provided to recipients
 275.3 of inpatient hospitalization, partial hospitalization, residential treatment, intensive treatment
 275.4 in foster care, day treatment, children's therapeutic services and supports, or crisis services.

275.5 Sec. 52. Minnesota Statutes 2018, section 256B.0622, subdivision 1, is amended to read:

275.6 Subdivision 1. **Scope.** ~~Subject to federal approval,~~ Medical assistance covers medically
 275.7 necessary, assertive community treatment for clients as defined in subdivision 2a and
 275.8 intensive residential treatment services for clients as defined in subdivision 3, when the
 275.9 services are provided by an entity meeting the standards in this section.

275.10 Sec. 53. Minnesota Statutes 2018, section 256B.0622, subdivision 2, is amended to read:

275.11 Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the
 275.12 meanings given them.

275.13 (b) "ACT team" means the group of interdisciplinary mental health staff who work as
 275.14 a team to provide assertive community treatment.

275.15 (c) "Assertive community treatment" means intensive nonresidential treatment and
 275.16 rehabilitative mental health services provided according to the assertive community treatment
 275.17 model. Assertive community treatment provides a single, fixed point of responsibility for
 275.18 treatment, rehabilitation, and support needs for clients. Services are offered 24 hours per
 275.19 day, seven days per week, in a community-based setting.

275.20 ~~(d) "Individual treatment plan" means the document that results from a person-centered~~
 275.21 ~~planning process of determining real-life outcomes with clients and developing strategies~~
 275.22 ~~to achieve those outcomes.~~

275.23 ~~(e) "Assertive engagement" means the use of collaborative strategies to engage clients~~
 275.24 ~~to receive services.~~

275.25 ~~(f) "Benefits and finance support" means assisting clients in capably managing financial~~
 275.26 ~~affairs. Services include, but are not limited to, assisting clients in applying for benefits;~~
 275.27 ~~assisting with redetermination of benefits; providing financial crisis management; teaching~~
 275.28 ~~and supporting budgeting skills and asset development; and coordinating with a client's~~
 275.29 ~~representative payee, if applicable.~~

275.30 (d) "Clinical trainee" means a staff person qualified according to section 245I.16,
 275.31 subdivision 6.

276.1 ~~(g)~~ (e) "Co-occurring disorder treatment" means the treatment of co-occurring mental
276.2 illness and substance use disorders and is characterized by assertive outreach, stage-wise
276.3 comprehensive treatment, treatment goal setting, and flexibility to work within each stage
276.4 of treatment. Services include, but are not limited to, assessing and tracking clients' stages
276.5 of change readiness and treatment; applying the appropriate treatment based on stages of
276.6 change, such as outreach and motivational interviewing techniques to work with clients in
276.7 earlier stages of change readiness and cognitive behavioral approaches and relapse prevention
276.8 to work with clients in later stages of change; and facilitating access to community supports.

276.9 ~~(h)~~ (f) "Crisis assessment and intervention" means mental health crisis response services
276.10 as defined in section 256B.0624, subdivision 2, paragraphs (c) to (e).

276.11 ~~(i) "Employment services" means assisting clients to work at jobs of their choosing.
276.12 Services must follow the principles of the individual placement and support (IPS)
276.13 employment model, including focusing on competitive employment; emphasizing individual
276.14 client preferences and strengths; ensuring employment services are integrated with mental
276.15 health services; conducting rapid job searches and systematic job development according
276.16 to client preferences and choices; providing benefits counseling; and offering all services
276.17 in an individualized and time-unlimited manner. Services shall also include educating clients
276.18 about opportunities and benefits of work and school and assisting the client in learning job
276.19 skills, navigating the work place, and managing work relationships.~~

276.20 ~~(j) "Family psychoeducation and support" means services provided to the client's family
276.21 and other natural supports to restore and strengthen the client's unique social and family
276.22 relationships. Services include, but are not limited to, individualized psychoeducation about
276.23 the client's illness and the role of the family and other significant people in the therapeutic
276.24 process; family intervention to restore contact, resolve conflict, and maintain relationships
276.25 with family and other significant people in the client's life; ongoing communication and
276.26 collaboration between the ACT team and the family; introduction and referral to family
276.27 self-help programs and advocacy organizations that promote recovery and family
276.28 engagement, individual supportive counseling, parenting training, and service coordination
276.29 to help clients fulfill parenting responsibilities; coordinating services for the child and
276.30 restoring relationships with children who are not in the client's custody; and coordinating
276.31 with child welfare and family agencies, if applicable. These services must be provided with
276.32 the client's agreement and consent.~~

276.33 ~~(k) "Housing access support" means assisting clients to find, obtain, retain, and move
276.34 to safe and adequate housing of their choice. Housing access support includes, but is not
276.35 limited to, locating housing options with a focus on integrated independent settings; applying~~

277.1 ~~for housing subsidies, programs, or resources; assisting the client in developing relationships~~
 277.2 ~~with local landlords; providing tenancy support and advocacy for the individual's tenancy~~
 277.3 ~~rights at the client's home; and assisting with relocation.~~

277.4 (g) "Individual treatment plan" means a plan described under section 256B.0671,
 277.5 subdivisions 5 and 6.

277.6 ~~(h)~~ (h) "Individual treatment team" means a minimum of three members of the ACT
 277.7 team who are responsible for consistently carrying out most of a client's assertive community
 277.8 treatment services.

277.9 ~~(m)~~ (i) "Intensive residential treatment services treatment team" means all staff who
 277.10 provide intensive residential treatment services under this section to clients. ~~At a minimum,~~
 277.11 ~~this includes the clinical supervisor; mental health professionals as defined in section 245.462,~~
 277.12 ~~subdivision 18, clauses (1) to (6); mental health practitioners as defined in section 245.462,~~
 277.13 ~~subdivision 17; mental health rehabilitation workers under section 256B.0623, subdivision~~
 277.14 ~~5, paragraph (a), clause (4); and mental health certified peer specialists under section~~
 277.15 ~~256B.0615.~~

277.16 ~~(n)~~ (j) "Intensive residential treatment services" means short-term, time-limited services
 277.17 provided in a residential setting to clients who are in need of more restrictive settings and
 277.18 are at risk of significant functional deterioration if they do not receive these services. Services
 277.19 are designed to develop and enhance psychiatric stability, personal and emotional adjustment,
 277.20 self-sufficiency, and skills to live in a more independent setting. Services must be directed
 277.21 toward a targeted discharge date with specified client outcomes.

277.22 ~~(o) "Medication assistance and support" means assisting clients in accessing medication,~~
 277.23 ~~developing the ability to take medications with greater independence, and providing~~
 277.24 ~~medication setup. This includes the prescription, administration, and order of medication~~
 277.25 ~~by appropriate medical staff.~~

277.26 ~~(p) "Medication education" means educating clients on the role and effects of medications~~
 277.27 ~~in treating symptoms of mental illness and the side effects of medications.~~

277.28 (k) "Mental health certified peer specialist" means a staff person qualified according to
 277.29 section 245I.16, subdivision 10.

277.30 (l) "Mental health practitioner" means a staff person qualified according to section
 277.31 245I.16, subdivision 4.

277.32 (m) "Mental health professional" means a staff person qualified according to section
 277.33 245I.16, subdivision 2.

278.1 (n) "Mental health rehabilitation worker" means a staff person qualified according to
278.2 section 245I.16, subdivision 14.

278.3 ~~(q)~~ (o) "Overnight staff" means a member of the intensive residential treatment services
278.4 team who is responsible during hours when clients are typically asleep.

278.5 ~~(r) "Mental health certified peer specialist services" has the meaning given in section~~
278.6 ~~256B.0615.~~

278.7 ~~(s)~~ (p) "Physical health services" means any service or treatment to meet the physical
278.8 health needs of the client to support the client's mental health recovery. Services include,
278.9 but are not limited to, education on primary health issues, including wellness education;
278.10 medication administration and monitoring; providing and coordinating medical screening
278.11 and follow-up; scheduling routine and acute medical and dental care visits; tobacco cessation
278.12 strategies; assisting clients in attending appointments; communicating with other providers;
278.13 and integrating all physical and mental health treatment.

278.14 ~~(t)~~ (q) "Primary team member" means the person who leads and coordinates the activities
278.15 of the individual treatment team and is the individual treatment team member who has
278.16 primary responsibility for establishing and maintaining a therapeutic relationship with the
278.17 client on a continuing basis.

278.18 ~~(u)~~ (r) "Rehabilitative mental health services" means mental health services that are
278.19 rehabilitative and enable the client to develop and enhance psychiatric stability, social
278.20 competencies, personal and emotional adjustment, independent living, parenting skills, and
278.21 community skills, when these abilities are impaired by the symptoms of mental illness.

278.22 ~~(v)~~ (s) "Symptom management" means supporting clients in identifying and targeting
278.23 the symptoms and occurrence patterns of their mental illness and developing strategies to
278.24 reduce the impact of those symptoms.

278.25 ~~(w)~~ (t) "Therapeutic interventions" means empirically supported techniques to address
278.26 specific symptoms and behaviors such as anxiety, psychotic symptoms, emotional
278.27 dysregulation, and trauma symptoms. Interventions include empirically supported
278.28 psychotherapies including, but not limited to, cognitive behavioral therapy, exposure therapy,
278.29 acceptance and commitment therapy, interpersonal therapy, and motivational interviewing.

278.30 ~~(x)~~ (u) "Wellness self-management and prevention" means a combination of approaches
278.31 to working with the client to build and apply skills related to recovery, and to support the
278.32 client in participating in leisure and recreational activities, civic participation, and meaningful
278.33 structure.

279.1 Sec. 54. Minnesota Statutes 2018, section 256B.0622, subdivision 3a, is amended to read:

279.2 Subd. 3a. **Provider certification and contract requirements for assertive community**
 279.3 **treatment.** (a) The assertive community treatment provider must:

279.4 (1) have a contract with the host county to provide assertive community treatment
 279.5 services; and

279.6 (2) have each ACT team be certified by the state following the certification process and
 279.7 procedures developed by the commissioner. The certification process determines whether
 279.8 the ACT team meets the standards for assertive community treatment under this section as
 279.9 ~~well as, chapter 245I, and~~ minimum program fidelity standards as measured by a nationally
 279.10 recognized fidelity tool approved by the commissioner. Recertification must occur at least
 279.11 every three years.

279.12 (b) An ACT team certified under this subdivision must meet the following standards:

279.13 (1) have capacity to recruit, hire, manage, and train required ACT team members;

279.14 (2) have adequate administrative ability to ensure availability of services;

279.15 ~~(3) ensure adequate preservice and ongoing training for staff;~~

279.16 ~~(4) ensure that staff is capable of implementing culturally specific services that are~~
 279.17 ~~culturally responsive and appropriate as determined by the client's culture, beliefs, values,~~
 279.18 ~~and language as identified in the individual treatment plan;~~

279.19 ~~(5)~~ (3) ensure flexibility in service delivery to respond to the changing and intermittent
 279.20 care needs of a client as identified by the client and the individual treatment plan;

279.21 ~~(6) develop and maintain client files, individual treatment plans, and contact charting;~~

279.22 ~~(7) develop and maintain staff training and personnel files;~~

279.23 ~~(8)~~ (4) submit information as required by the state;

279.24 ~~(9)~~ (5) keep all necessary records required by law;

279.25 ~~(10) comply with all applicable laws;~~

279.26 ~~(11)~~ (6) be an enrolled Medicaid provider;

279.27 ~~(12)~~ (7) establish and maintain a quality assurance plan to determine specific service
 279.28 outcomes and the client's satisfaction with services; and

279.29 ~~(13)~~ (8) develop and maintain written policies and procedures regarding service provision
 279.30 and administration of the provider entity.

280.1 (c) The commissioner may intervene at any time and decertify an ACT team with cause.
280.2 The commissioner shall establish a process for decertification of an ACT team and shall
280.3 require corrective action, medical assistance repayment, or decertification of an ACT team
280.4 that no longer meets the requirements in this section or that fails to meet the clinical quality
280.5 standards or administrative standards provided by the commissioner in the application and
280.6 certification process. The decertification is subject to appeal to the state.

280.7 Sec. 55. Minnesota Statutes 2018, section 256B.0622, subdivision 4, is amended to read:

280.8 Subd. 4. **Provider entity licensure and contract requirements for intensive residential**
280.9 **treatment services.** (a) The intensive residential treatment services provider entity must:

280.10 (1) be licensed under Minnesota Rules, parts 9520.0500 to 9520.0670;

280.11 (2) not exceed 16 beds per site; and

280.12 (3) comply with the additional standards in this section and chapter 245I.

280.13 (b) The commissioner shall develop procedures for counties and providers to submit
280.14 other documentation as needed to allow the commissioner to determine whether the standards
280.15 in this section are met.

280.16 (c) A provider entity must specify in the provider entity's application what geographic
280.17 area and populations will be served by the proposed program. A provider entity must
280.18 document that the capacity or program specialties of existing programs are not sufficient
280.19 to meet the service needs of the target population. A provider entity must submit evidence
280.20 of ongoing relationships with other providers and levels of care to facilitate referrals to and
280.21 from the proposed program.

280.22 (d) A provider entity must submit documentation that the provider entity requested a
280.23 statement of need from each county board and tribal authority that serves as a local mental
280.24 health authority in the proposed service area. The statement of need must specify if the local
280.25 mental health authority supports or does not support the need for the proposed program and
280.26 the basis for this determination. If a local mental health authority does not respond within
280.27 60 days of the receipt of the request, the commissioner shall determine the need for the
280.28 program based on the documentation submitted by the provider entity.

280.29 Sec. 56. Minnesota Statutes 2018, section 256B.0622, subdivision 5a, is amended to read:

280.30 Subd. 5a. **Standards for intensive residential rehabilitative mental health services.** (a)

280.31 The standards in this subdivision apply to intensive residential mental health services.

281.1 (b) The provider of intensive residential treatment services must have sufficient staff to
281.2 provide 24-hour-per-day coverage to deliver the rehabilitative services described in the
281.3 treatment plan and to safely supervise and direct the activities of clients, given the client's
281.4 level of behavioral and psychiatric stability, cultural needs, and vulnerability. The provider
281.5 must have the capacity within the facility to provide integrated services for chemical
281.6 dependency, illness management services, and family education, when appropriate.

281.7 (c) At a minimum:

281.8 (1) staff must provide direction and supervision whenever clients are present in the
281.9 facility;

281.10 (2) staff must remain awake during all work hours;

281.11 (3) there must be a staffing ratio of at least one to nine clients for each day and evening
281.12 shift. If more than nine clients are present at the residential site, there must be a minimum
281.13 of two staff during day and evening shifts, one of whom must be a mental health practitioner
281.14 or mental health professional;

281.15 (4) if services are provided to clients who need the services of a medical professional,
281.16 the provider shall ensure that these services are provided either by the provider's own medical
281.17 staff or through referral to a medical professional; and

281.18 (5) the provider must ensure the timely availability of a licensed registered nurse, either
281.19 directly employed or under contract, who is responsible for ensuring the effectiveness and
281.20 safety of medication administration in the facility and assessing clients for medication side
281.21 effects and drug interactions.

281.22 (d) Services must be provided by qualified staff as defined in section 256B.0623,
281.23 subdivision 5, ~~who are trained and supervised according to section 256B.0623, subdivision~~
281.24 ~~6, except that mental health rehabilitation workers acting as overnight staff are not required~~
281.25 ~~to comply with section 256B.0623, subdivision 5, paragraph (a), clause (4), item (iv).~~

281.26 (e) The ~~clinical~~ clinical treatment supervisor must be an active member of the intensive residential
281.27 services treatment team. The team must meet with the ~~clinical~~ clinical treatment supervisor at least
281.28 weekly to discuss clients' progress and make rapid adjustments to meet clients' needs. The
281.29 team meeting shall include client-specific case reviews and general treatment discussions
281.30 among team members. Client-specific case reviews and planning must be documented in
281.31 the client's treatment record.

281.32 (f) Treatment staff must have prompt access in person or by telephone to a mental health
281.33 practitioner or mental health professional. The provider must have the capacity to promptly

282.1 and appropriately respond to emergent needs and make any necessary staffing adjustments
282.2 to ensure the health and safety of clients.

282.3 (g) The initial functional assessment must be completed within ten days of intake and
282.4 updated at least every 30 days, or prior to discharge from the service, whichever comes
282.5 first.

282.6 (h) The initial individual treatment plan must be completed within 24 hours of admission.
282.7 Within ten days of admission, the initial treatment plan must be refined and further developed,
282.8 except for providers certified according to Minnesota Rules, parts 9533.0010 to 9533.0180.
282.9 The individual treatment plan must be reviewed with the client and updated at least monthly.

282.10 Sec. 57. Minnesota Statutes 2018, section 256B.0622, subdivision 7, is amended to read:

282.11 Subd. 7. **Assertive community treatment service standards.** (a) ACT teams must
282.12 offer and have the capacity to directly provide the following services:

282.13 (1) assertive engagement using collaborative strategies to encourage clients to receive
282.14 services;

282.15 (2) benefits and finance support; that assists clients to capably manage financial affairs.
282.16 Services include but are not limited to assisting clients in applying for benefits, assisting
282.17 with redetermination of benefits, providing financial crisis management, teaching and
282.18 supporting budgeting skills and asset development, and coordinating with a client's
282.19 representative payee, if applicable;

282.20 (3) co-occurring disorder treatment;

282.21 (4) crisis assessment and intervention;

282.22 (5) employment services; that assists clients to work at jobs of their choosing. Services
282.23 must follow the principles of the individual placement and support employment model,
282.24 including focusing on competitive employment, emphasizing individual client preferences
282.25 and strengths, ensuring employment services are integrated with mental health services,
282.26 conducting rapid job searches and systematic job development according to client preferences
282.27 and choices, providing benefits counseling, and offering all services in an individualized
282.28 and time-unlimited manner. Services must also include educating clients about opportunities
282.29 and benefits of work and school and assisting the client in learning job skills, navigating
282.30 the workplace, and managing work relationships;

282.31 (6) family psychoeducation and support; provided to the client's family and other natural
282.32 supports to restore and strengthen the client's unique social and family relationships. Services

283.1 include but are not limited to individualized psychoeducation about the client's illness and
283.2 the role of the family and other significant people in the therapeutic process; family
283.3 intervention to restore contact, resolve conflict, and maintain relationships with family and
283.4 other significant people in the client's life; ongoing communication and collaboration between
283.5 the ACT team and the family; introduction and referral to family self-help programs and
283.6 advocacy organizations that promote recovery and family engagement, individual supportive
283.7 counseling, parenting training, and service coordination to help clients fulfill parenting
283.8 responsibilities; coordinating services for the child and restoring relationships with children
283.9 who are not in the client's custody; and coordinating with child welfare and family agencies,
283.10 if applicable. These services must be provided with the client's agreement and consent;

283.11 (7) housing access support; that assists clients to find, obtain, retain, and move to safe
283.12 and adequate housing of their choice. Housing access support includes but is not limited to
283.13 locating housing options with a focus on integrated independent settings; applying for
283.14 housing subsidies, programs, or resources; assisting the client in developing relationships
283.15 with local landlords; providing tenancy support and advocacy for the individual's tenancy
283.16 rights at the client's home; and assisting with relocation;

283.17 (8) medication assistance and support; that assists clients in accessing medication,
283.18 developing the ability to take medications with greater independence, and providing
283.19 medication setup. Medication assistance and support includes assisting the client with the
283.20 prescription, administration, and ordering of medication by appropriate medical staff;

283.21 (9) medication education; that educates clients on the role and effects of medications in
283.22 treating symptoms of mental illness and the side effects of medications;

283.23 (10) mental health certified peer specialists services;

283.24 (11) physical health services;

283.25 (12) rehabilitative mental health services;

283.26 (13) symptom management;

283.27 (14) therapeutic interventions;

283.28 (15) wellness self-management and prevention; and

283.29 (16) other services based on client needs as identified in a client's assertive community
283.30 treatment individual treatment plan.

283.31 (b) ACT teams must ensure the provision of all services necessary to meet a client's
283.32 needs as identified in the client's individual treatment plan.

284.1 Sec. 58. Minnesota Statutes 2018, section 256B.0622, subdivision 7a, is amended to read:

284.2 Subd. 7a. **Assertive community treatment team staff requirements and roles.** (a)

284.3 The required treatment staff qualifications and roles for an ACT team are:

284.4 (1) the team leader:

284.5 (i) shall be a ~~licensed~~ mental health professional ~~who is qualified under Minnesota Rules,~~
284.6 ~~part 9505.0371, subpart 5, item A.~~ Individuals who are not licensed but who are eligible
284.7 for licensure and are otherwise qualified may also fulfill this role but must obtain full
284.8 licensure within 24 months of assuming the role of team leader;

284.9 (ii) must be an active member of the ACT team and provide some direct services to
284.10 clients;

284.11 (iii) must be a single full-time staff member, dedicated to the ACT team, who is
284.12 responsible for overseeing the administrative operations of the team, providing ~~clinical~~
284.13 ~~oversight~~ treatment supervision of services in conjunction with the psychiatrist or psychiatric
284.14 care provider, and supervising team members to ensure delivery of best and ethical practices;
284.15 and

284.16 (iv) must be available to provide overall ~~clinical oversight~~ treatment supervision to the
284.17 ACT team after regular business hours and on weekends and holidays. The team leader may
284.18 delegate this duty to another qualified member of the ACT team;

284.19 (2) the psychiatric care provider:

284.20 (i) must be a ~~licensed psychiatrist certified by the American Board of Psychiatry and~~
284.21 ~~Neurology or eligible for board certification or certified by the American Osteopathic Board~~
284.22 ~~of Neurology and Psychiatry or eligible for board certification, or a psychiatric nurse who~~
284.23 ~~is qualified under Minnesota Rules, part 9505.0371, subpart 5, item A~~ mental health
284.24 professional permitted to prescribe psychiatric medications as part of the professional's
284.25 scope of practice. The psychiatric care provider must have demonstrated clinical experience
284.26 working with individuals with serious and persistent mental illness;

284.27 (ii) shall collaborate with the team leader in sharing overall clinical responsibility for
284.28 screening and admitting clients; monitoring clients' treatment and team member service
284.29 delivery; educating staff on psychiatric and nonpsychiatric medications, their side effects,
284.30 and health-related conditions; actively collaborating with nurses; and helping provide ~~clinical~~
284.31 treatment supervision to the team;

284.32 (iii) shall fulfill the following functions for assertive community treatment clients:
284.33 provide assessment and treatment of clients' symptoms and response to medications, including

285.1 side effects; provide brief therapy to clients; provide diagnostic and medication education
285.2 to clients, with medication decisions based on shared decision making; monitor clients'
285.3 nonpsychiatric medical conditions and nonpsychiatric medications; and conduct home and
285.4 community visits;

285.5 (iv) shall serve as the point of contact for psychiatric treatment if a client is hospitalized
285.6 for mental health treatment and shall communicate directly with the client's inpatient
285.7 psychiatric care providers to ensure continuity of care;

285.8 (v) shall have a minimum full-time equivalency that is prorated at a rate of 16 hours per
285.9 50 clients. Part-time psychiatric care providers shall have designated hours to work on the
285.10 team, with sufficient blocks of time on consistent days to carry out the provider's clinical,
285.11 supervisory, and administrative responsibilities. No more than two psychiatric care providers
285.12 may share this role;

285.13 (vi) may not provide specific roles and responsibilities by telemedicine unless approved
285.14 by the commissioner; and

285.15 (vii) shall provide psychiatric backup to the program after regular business hours and
285.16 on weekends and holidays. The psychiatric care provider may delegate this duty to another
285.17 qualified psychiatric provider;

285.18 (3) the nursing staff:

285.19 (i) shall consist of one to three registered nurses or advanced practice registered nurses,
285.20 of whom at least one has a minimum of one-year experience working with adults with
285.21 serious mental illness and a working knowledge of psychiatric medications. No more than
285.22 two individuals can share a full-time equivalent position;

285.23 (ii) are responsible for managing medication, administering and documenting medication
285.24 treatment, and managing a secure medication room; and

285.25 (iii) shall develop strategies, in collaboration with clients, to maximize taking medications
285.26 as prescribed; screen and monitor clients' mental and physical health conditions and
285.27 medication side effects; engage in health promotion, prevention, and education activities;
285.28 communicate and coordinate services with other medical providers; facilitate the development
285.29 of the individual treatment plan for clients assigned; and educate the ACT team in monitoring
285.30 psychiatric and physical health symptoms and medication side effects;

285.31 (4) the co-occurring disorder specialist:

285.32 (i) shall be a full-time equivalent co-occurring disorder specialist who has received
285.33 specific training on co-occurring disorders that is consistent with national evidence-based

286.1 practices. The training must include practical knowledge of common substances and how
286.2 they affect mental illnesses, the ability to assess substance use disorders and the client's
286.3 stage of treatment, motivational interviewing, and skills necessary to provide counseling to
286.4 clients at all different stages of change and treatment. The co-occurring disorder specialist
286.5 may also be an individual who is a licensed alcohol and drug counselor as described in
286.6 section 148F.01, subdivision 5, or a counselor who otherwise meets the training, experience,
286.7 and other requirements in section 245G.11, subdivision 5. No more than two co-occurring
286.8 disorder specialists may occupy this role; and

286.9 (ii) shall provide or facilitate the provision of co-occurring disorder treatment to clients.
286.10 The co-occurring disorder specialist shall serve as a consultant and educator to fellow ACT
286.11 team members on co-occurring disorders;

286.12 (5) the vocational specialist:

286.13 (i) shall be a full-time vocational specialist who has at least one-year experience providing
286.14 employment services or advanced education that involved field training in vocational services
286.15 to individuals with mental illness. An individual who does not meet these qualifications
286.16 may also serve as the vocational specialist upon completing a training plan approved by the
286.17 commissioner;

286.18 (ii) shall provide or facilitate the provision of vocational services to clients. The vocational
286.19 specialist serves as a consultant and educator to fellow ACT team members on these services;
286.20 and

286.21 (iii) ~~shall~~ shall not refer individuals to receive any type of vocational services or linkage
286.22 by providers outside of the ACT team;

286.23 (6) the mental health certified peer specialist:

286.24 (i) shall be a full-time equivalent ~~mental health certified peer specialist as defined in~~
286.25 ~~section 256B.0615~~. No more than two individuals can share this position. The mental health
286.26 certified peer specialist is a fully integrated team member who provides highly individualized
286.27 services in the community and promotes the self-determination and shared decision-making
286.28 abilities of clients. This requirement may be waived due to workforce shortages upon
286.29 approval of the commissioner;

286.30 (ii) must provide coaching, mentoring, and consultation to the clients to promote recovery,
286.31 self-advocacy, and self-direction, promote wellness management strategies, and assist clients
286.32 in developing advance directives; and

287.1 (iii) must model recovery values, attitudes, beliefs, and personal action to encourage
287.2 wellness and resilience, provide consultation to team members, promote a culture where
287.3 the clients' points of view and preferences are recognized, understood, respected, and
287.4 integrated into treatment, and serve in a manner equivalent to other team members;

287.5 (7) the program administrative assistant shall be a full-time office-based program
287.6 administrative assistant position assigned to solely work with the ACT team, providing a
287.7 range of supports to the team, clients, and families; and

287.8 (8) additional staff:

287.9 (i) shall be based on team size. Additional treatment team staff may include licensed
287.10 mental health professionals as defined in Minnesota Rules, part 9505.0371, subpart 5, item
287.11 A; mental health practitioners as defined in section 245.462, subdivision 17; a mental health
287.12 practitioner working as a clinical trainee according to Minnesota Rules, part 9505.0371,
287.13 subpart 5, item C trainees; or mental health rehabilitation workers as defined in section
287.14 256B.0623, subdivision 5, paragraph (a), clause (4). These individuals shall have the
287.15 knowledge, skills, and abilities required by the population served to carry out rehabilitation
287.16 and support functions; and

287.17 (ii) shall be selected based on specific program needs or the population served.

287.18 (b) Each ACT team must clearly document schedules for all ACT team members.

287.19 (c) Each ACT team member must serve as a primary team member for clients assigned
287.20 by the team leader and are responsible for facilitating the individual treatment plan process
287.21 for those clients. The primary team member for a client is the responsible team member
287.22 knowledgeable about the client's life and circumstances and writes the individual treatment
287.23 plan. The primary team member provides individual supportive therapy or counseling, and
287.24 provides primary support and education to the client's family and support system.

287.25 (d) Members of the ACT team must have strong clinical skills, professional qualifications,
287.26 experience, and competency to provide a full breadth of rehabilitation services. Each staff
287.27 member shall be proficient in their respective discipline and be able to work collaboratively
287.28 as a member of a multidisciplinary team to deliver the majority of the treatment,
287.29 rehabilitation, and support services clients require to fully benefit from receiving assertive
287.30 community treatment.

287.31 (e) Each ACT team member must fulfill training requirements established by the
287.32 commissioner.

288.1 Sec. 59. Minnesota Statutes 2018, section 256B.0622, subdivision 7b, is amended to read:

288.2 Subd. 7b. **Assertive community treatment program size and opportunities.** (a) Each
288.3 ACT team shall maintain an annual average caseload that does not exceed 100 clients.

288.4 Staff-to-client ratios shall be based on team size as follows:

288.5 (1) a small ACT team must:

288.6 (i) employ at least six but no more than seven full-time treatment team staff, excluding
288.7 the program assistant and the psychiatric care provider;

288.8 (ii) serve an annual average maximum of no more than 50 clients;

288.9 (iii) ensure at least one full-time equivalent position for every eight clients served;

288.10 (iv) schedule ACT team staff for at least eight-hour shift coverage on weekdays and
288.11 on-call duty to provide crisis services and deliver services after hours when staff are not
288.12 working;

288.13 (v) provide crisis services during business hours if the small ACT team does not have
288.14 sufficient staff numbers to operate an after-hours on-call system. During all other hours,
288.15 the ACT team may arrange for coverage for crisis assessment and intervention services
288.16 through a reliable crisis-intervention provider as long as there is a mechanism by which the
288.17 ACT team communicates routinely with the crisis-intervention provider and the on-call
288.18 ACT team staff are available to see clients face-to-face when necessary or if requested by
288.19 the crisis-intervention services provider;

288.20 (vi) adjust schedules and provide staff to carry out the needed service activities in the
288.21 evenings or on weekend days or holidays, when necessary;

288.22 (vii) arrange for and provide psychiatric backup during all hours the psychiatric care
288.23 provider is not regularly scheduled to work. If availability of the ACT team's psychiatric
288.24 care provider during all hours is not feasible, alternative psychiatric prescriber backup must
288.25 be arranged and a mechanism of timely communication and coordination established in
288.26 writing; and

288.27 (viii) be composed of, at minimum, one full-time team leader, at least 16 hours each
288.28 week per 50 clients of psychiatric provider time, or equivalent if fewer clients, one full-time
288.29 equivalent nursing, one full-time substance abuse specialist, one full-time equivalent mental
288.30 health certified peer specialist, one full-time vocational specialist, one full-time program
288.31 assistant, and at least one additional full-time ACT team member who has mental health
288.32 professional, clinical trainee, or mental health practitioner status; and

289.1 (2) a midsize ACT team shall:

289.2 (i) be composed of, at minimum, one full-time team leader, at least 16 hours of psychiatry
289.3 time for 51 clients, with an additional two hours for every six clients added to the team, 1.5
289.4 to two full-time equivalent nursing staff, one full-time substance abuse specialist, one
289.5 full-time equivalent mental health certified peer specialist, one full-time vocational specialist,
289.6 one full-time program assistant, and at least 1.5 to two additional full-time equivalent ACT
289.7 members, with at least one dedicated full-time staff member with mental health professional
289.8 status. Remaining team members may have mental health professional, clinical trainee, or
289.9 mental health practitioner status;

289.10 (ii) employ seven or more treatment team full-time equivalents, excluding the program
289.11 assistant and the psychiatric care provider;

289.12 (iii) serve an annual average maximum caseload of 51 to 74 clients;

289.13 (iv) ensure at least one full-time equivalent position for every nine clients served;

289.14 (v) schedule ACT team staff for a minimum of ten-hour shift coverage on weekdays
289.15 and six- to eight-hour shift coverage on weekends and holidays. In addition to these minimum
289.16 specifications, staff are regularly scheduled to provide the necessary services on a
289.17 client-by-client basis in the evenings and on weekends and holidays;

289.18 (vi) schedule ACT team staff on-call duty to provide crisis services and deliver services
289.19 when staff are not working;

289.20 (vii) have the authority to arrange for coverage for crisis assessment and intervention
289.21 services through a reliable crisis-intervention provider as long as there is a mechanism by
289.22 which the ACT team communicates routinely with the crisis-intervention provider and the
289.23 on-call ACT team staff are available to see clients face-to-face when necessary or if requested
289.24 by the crisis-intervention services provider; and

289.25 (viii) arrange for and provide psychiatric backup during all hours the psychiatric care
289.26 provider is not regularly scheduled to work. If availability of the psychiatric care provider
289.27 during all hours is not feasible, alternative psychiatric prescriber backup must be arranged
289.28 and a mechanism of timely communication and coordination established in writing;

289.29 (3) a large ACT team must:

289.30 (i) be composed of, at minimum, one full-time team leader, at least 32 hours each week
289.31 per 100 clients, or equivalent of psychiatry time, three full-time equivalent nursing staff,
289.32 one full-time substance abuse specialist, one full-time equivalent mental health certified
289.33 peer specialist, one full-time vocational specialist, one full-time program assistant, and at

- 290.1 least two additional full-time equivalent ACT team members, with at least one dedicated
290.2 full-time staff member with mental health professional status. Remaining team members
290.3 may have mental health professional, clinical trainee, or mental health practitioner status;
- 290.4 (ii) employ nine or more treatment team full-time equivalents, excluding the program
290.5 assistant and psychiatric care provider;
- 290.6 (iii) serve an annual average maximum caseload of 75 to 100 clients;
- 290.7 (iv) ensure at least one full-time equivalent position for every nine individuals served;
- 290.8 (v) schedule staff to work two eight-hour shifts, with a minimum of two staff on the
290.9 second shift providing services at least 12 hours per day weekdays. For weekends and
290.10 holidays, the team must operate and schedule ACT team staff to work one eight-hour shift,
290.11 with a minimum of two staff each weekend day and every holiday;
- 290.12 (vi) schedule ACT team staff on-call duty to provide crisis services and deliver services
290.13 when staff are not working; and
- 290.14 (vii) arrange for and provide psychiatric backup during all hours the psychiatric care
290.15 provider is not regularly scheduled to work. If availability of the ACT team psychiatric care
290.16 provider during all hours is not feasible, alternative psychiatric backup must be arranged
290.17 and a mechanism of timely communication and coordination established in writing.
- 290.18 (b) An ACT team of any size may have a staff-to-client ratio that is lower than the
290.19 requirements described in paragraph (a) upon approval by the commissioner, but may not
290.20 exceed a one-to-ten staff-to-client ratio.

290.21 Sec. 60. Minnesota Statutes 2018, section 256B.0622, subdivision 7d, is amended to read:

290.22 Subd. 7d. **Assertive community treatment assessment and individual treatment**
290.23 **plan.** (a) An initial assessment, including a diagnostic assessment that meets the requirements
290.24 of ~~Minnesota Rules, part 9505.0372, subpart 1,~~ section 256B.0671, subdivisions 2 and 3,
290.25 and a 30-day treatment plan shall be completed the day of the client's admission to assertive
290.26 community treatment by the ACT team leader or the psychiatric care provider, with
290.27 participation by designated ACT team members and the client. The team leader, psychiatric
290.28 care provider, or other mental health professional designated by the team leader or psychiatric
290.29 care provider, must update the client's diagnostic assessment at least annually.

290.30 (b) An initial functional assessment must be completed within ten days of intake and
290.31 updated every six months for assertive community treatment, or prior to discharge from the
290.32 service, whichever comes first.

291.1 (c) Within 30 days of the client's assertive community treatment admission, the ACT
291.2 team shall complete an in-depth assessment of the domains listed under section 245.462,
291.3 subdivision 11a.

291.4 (d) Each part of the in-depth assessment areas shall be completed by each respective
291.5 team specialist or an ACT team member with skill and knowledge in the area being assessed.
291.6 The assessments are based upon all available information, including that from client interview
291.7 family and identified natural supports, and written summaries from other agencies, including
291.8 police, courts, county social service agencies, outpatient facilities, and inpatient facilities,
291.9 where applicable.

291.10 (e) Between 30 and 45 days after the client's admission to assertive community treatment,
291.11 the entire ACT team must hold a comprehensive case conference, where all team members,
291.12 including the psychiatric provider, present information discovered from the completed
291.13 in-depth assessments and provide treatment recommendations. The conference must serve
291.14 as the basis for the first six-month treatment plan, which must be written by the primary
291.15 team member.

291.16 (f) The client's psychiatric care provider, primary team member, and individual treatment
291.17 team members shall assume responsibility for preparing the written narrative of the results
291.18 from the psychiatric and social functioning history timeline and the comprehensive
291.19 assessment.

291.20 (g) The primary team member and individual treatment team members shall be assigned
291.21 by the team leader in collaboration with the psychiatric care provider by the time of the first
291.22 treatment planning meeting or 30 days after admission, whichever occurs first.

291.23 (h) Individual treatment plans must be developed through the following treatment
291.24 planning process:

291.25 (1) The individual treatment plan shall be developed in collaboration with the client and
291.26 the client's preferred natural supports, and guardian, if applicable and appropriate. The ACT
291.27 team shall evaluate, together with each client, the client's needs, strengths, and preferences
291.28 and develop the individual treatment plan collaboratively. The ACT team shall make every
291.29 effort to ensure that the client and the client's family and natural supports, with the client's
291.30 consent, are in attendance at the treatment planning meeting, are involved in ongoing
291.31 meetings related to treatment, and have the necessary supports to fully participate. The
291.32 client's participation in the development of the individual treatment plan shall be documented.

291.33 (2) The client and the ACT team shall work together to formulate and prioritize the
291.34 issues, set goals, research approaches and interventions, and establish the plan. The plan is

292.1 individually tailored so that the treatment, rehabilitation, and support approaches and
 292.2 interventions achieve optimum symptom reduction, help fulfill the personal needs and
 292.3 aspirations of the client, take into account the cultural beliefs and realities of the individual,
 292.4 and improve all the aspects of psychosocial functioning that are important to the client. The
 292.5 process supports strengths, rehabilitation, and recovery.

292.6 (3) Each client's individual treatment plan shall identify service needs, strengths and
 292.7 capacities, and barriers, and set specific and measurable short- and long-term goals for each
 292.8 service need. The individual treatment plan must clearly specify the approaches and
 292.9 interventions necessary for the client to achieve the individual goals, when the interventions
 292.10 shall happen, and identify which ACT team member shall carry out the approaches and
 292.11 interventions.

292.12 (4) The primary team member and the individual treatment team, together with the client
 292.13 and the client's family and natural supports with the client's consent, are responsible for
 292.14 reviewing and rewriting the treatment goals and individual treatment plan whenever there
 292.15 is a major decision point in the client's course of treatment or at least every six months.

292.16 (5) The primary team member shall prepare a summary that thoroughly describes in
 292.17 writing the client's and the individual treatment team's evaluation of the client's progress
 292.18 and goal attainment, the effectiveness of the interventions, and the satisfaction with services
 292.19 since the last individual treatment plan. The client's most recent diagnostic assessment must
 292.20 be included with the treatment plan summary.

292.21 (6) The individual treatment plan and review must be ~~signed~~ approved or acknowledged
 292.22 by the client, the primary team member, the team leader, the psychiatric care provider, and
 292.23 all individual treatment team members. A copy of the ~~signed~~ individual treatment plan is
 292.24 made available to the client.

292.25 Sec. 61. Minnesota Statutes 2018, section 256B.0623, subdivision 1, is amended to read:

292.26 Subdivision 1. **Scope.** Medical assistance covers adult rehabilitative mental health
 292.27 services as defined in subdivision 2, ~~subject to federal approval~~, if provided to recipients
 292.28 as defined in subdivision 3 and provided by a qualified provider entity meeting the standards
 292.29 in this section and by a qualified individual provider working within the provider's scope
 292.30 of practice and identified in the recipient's individual treatment plan ~~as defined~~ described
 292.31 in section ~~245.462, subdivision 14~~ 256B.0671, subdivisions 5 and 6, and if determined to
 292.32 be medically necessary according to section 62Q.53.

293.1 Sec. 62. Minnesota Statutes 2018, section 256B.0623, subdivision 2, is amended to read:

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

293.4 (a) "Adult rehabilitative mental health services" means mental health services which are
293.5 rehabilitative and enable the recipient to develop and enhance psychiatric stability, social
293.6 competencies, personal and emotional adjustment, independent living, parenting skills, and
293.7 community skills, when these abilities are impaired by the symptoms of mental illness.

293.8 ~~Adult rehabilitative mental health services are also appropriate when provided to enable a~~
293.9 ~~recipient to retain stability and functioning, if the recipient would be at risk of significant~~
293.10 ~~functional decompensation or more restrictive service settings without these services.~~

293.11 ~~(1) Adult rehabilitative mental health services instruct, assist, and support the recipient~~
293.12 ~~in areas such as: interpersonal communication skills, community resource utilization and~~
293.13 ~~integration skills, crisis assistance, relapse prevention skills, health care directives, budgeting~~
293.14 ~~and shopping skills, healthy lifestyle skills and practices, cooking and nutrition skills,~~
293.15 ~~transportation skills, medication education and monitoring, mental illness symptom~~
293.16 ~~management skills, household management skills, employment-related skills, parenting~~
293.17 ~~skills, and transition to community living services.~~

293.18 ~~(2) These services shall be provided to the recipient on a one-to-one basis in the recipient's~~
293.19 ~~home or another community setting or in groups.~~

293.20 (b) "Medication education services" means services provided individually or in groups
293.21 which focus on educating the recipient about mental illness and symptoms; the role and
293.22 effects of medications in treating symptoms of mental illness; and the side effects of
293.23 medications. Medication education is coordinated with medication management services
293.24 and does not duplicate it. Medication education services are provided by physicians,
293.25 pharmacists, physician assistants, or registered nurses.

293.26 (c) "Transition to community living services" means services which maintain continuity
293.27 of contact between the rehabilitation services provider and the recipient and which facilitate
293.28 discharge from a hospital, residential treatment program under Minnesota Rules, chapter
293.29 9505, board and lodging facility, or nursing home. Transition to community living services
293.30 are not intended to provide other areas of adult rehabilitative mental health services.

293.31 Sec. 63. Minnesota Statutes 2018, section 256B.0623, subdivision 3, is amended to read:

293.32 Subd. 3. **Eligibility.** An eligible recipient is an individual who:

293.33 (1) is age 18 or older;

294.1 (2) is diagnosed with a medical condition, such as mental illness or traumatic brain
 294.2 injury, for which adult rehabilitative mental health services are needed;

294.3 (3) has substantial disability and functional impairment in three or more of the areas
 294.4 listed in section 245.462, subdivision 11a, so that self-sufficiency is markedly reduced; and

294.5 (4) has had a recent diagnostic assessment ~~or an adult diagnostic assessment update~~ by
 294.6 a qualified professional that documents adult rehabilitative mental health services are
 294.7 medically necessary to address identified disability and functional impairments and individual
 294.8 recipient goals.

294.9 Sec. 64. Minnesota Statutes 2018, section 256B.0623, subdivision 4, is amended to read:

294.10 Subd. 4. **Provider entity standards.** (a) The provider entity must be certified by the
 294.11 state following the certification process and procedures developed by the commissioner.

294.12 (b) The certification process is a determination as to whether the entity meets the standards
 294.13 in this subdivision and chapter 245I. The certification must specify which adult rehabilitative
 294.14 mental health services the entity is qualified to provide.

294.15 (c) A noncounty provider entity must obtain additional certification from each county
 294.16 in which it will provide services. The additional certification must be based on the adequacy
 294.17 of the entity's knowledge of that county's local health and human service system, and the
 294.18 ability of the entity to coordinate its services with the other services available in that county.
 294.19 A county-operated entity must obtain this additional certification from any other county in
 294.20 which it will provide services.

294.21 (d) State-level recertification must occur at least every three years.

294.22 (e) The commissioner may intervene at any time and decertify providers with cause.
 294.23 The decertification is subject to appeal to the state. A county board may recommend that
 294.24 the state decertify a provider for cause.

294.25 (f) The adult rehabilitative mental health services provider entity must meet the following
 294.26 standards:

294.27 (1) have capacity to recruit, hire, manage, and train ~~mental health professionals, mental~~
 294.28 ~~health practitioners, and mental health rehabilitation workers~~ qualified staff;

294.29 (2) have adequate administrative ability to ensure availability of services;

294.30 ~~(3) ensure adequate preservice and inservice and ongoing training for staff;~~

295.1 ~~(4)~~ (3) ensure that ~~mental health professionals, mental health practitioners, and mental~~
295.2 ~~health rehabilitation workers~~ staff are skilled in the delivery of the specific adult rehabilitative
295.3 mental health services provided to the individual eligible recipient;

295.4 ~~(5) ensure that staff is capable of implementing culturally specific services that are~~
295.5 ~~culturally competent and appropriate as determined by the recipient's culture, beliefs, values,~~
295.6 ~~and language as identified in the individual treatment plan;~~

295.7 ~~(6)~~ (4) ensure enough flexibility in service delivery to respond to the changing and
295.8 intermittent care needs of a recipient as identified by the recipient and the individual treatment
295.9 plan;

295.10 ~~(7) ensure that the mental health professional or mental health practitioner, who is under~~
295.11 ~~the clinical supervision of a mental health professional, involved in a recipient's services~~
295.12 ~~participates in the development of the individual treatment plan;~~

295.13 ~~(8)~~ (5) assist the recipient in arranging needed crisis assessment, intervention, and
295.14 stabilization services;

295.15 ~~(9)~~ (6) ensure that services are coordinated with other recipient mental health services
295.16 providers and the county mental health authority and the federally recognized American
295.17 Indian authority and necessary others after obtaining the consent of the recipient. Services
295.18 must also be coordinated with the recipient's case manager or care coordinator if the recipient
295.19 is receiving case management or care coordination services;

295.20 ~~(10) develop and maintain recipient files, individual treatment plans, and contact charting;~~

295.21 ~~(11) develop and maintain staff training and personnel files;~~

295.22 ~~(12)~~ (7) submit information as required by the state;

295.23 ~~(13) establish and maintain a quality assurance plan to evaluate the outcome of services~~
295.24 ~~provided;~~

295.25 ~~(14)~~ (8) keep all necessary records required by law;

295.26 ~~(15)~~ (9) deliver services as required by section 245.461;

295.27 ~~(16) comply with all applicable laws;~~

295.28 ~~(17)~~ (10) be an enrolled Medicaid provider;

295.29 ~~(18)~~ (11) maintain a quality assurance plan to determine specific service outcomes and
295.30 the recipient's satisfaction with services; and

296.1 ~~(19)~~ (12) develop and maintain written policies and procedures regarding service
 296.2 provision and administration of the provider entity.

296.3 Sec. 65. Minnesota Statutes 2018, section 256B.0623, subdivision 5, is amended to read:

296.4 Subd. 5. **Qualifications of provider staff.** ~~(a)~~ Adult rehabilitative mental health services
 296.5 must be provided by qualified individual provider staff of a certified provider entity.

296.6 Individual provider staff must be qualified ~~under~~ as one of the following ~~criteria~~ providers:

296.7 ~~(1) a mental health professional as defined in section 245.462, subdivision 18, clauses~~
 296.8 ~~(1) to (6). If the recipient has a current diagnostic assessment by a licensed mental health~~
 296.9 ~~professional as defined in section 245.462, subdivision 18, clauses (1) to (6), recommending~~
 296.10 ~~receipt of adult mental health rehabilitative services, the definition of mental health~~
 296.11 ~~professional for purposes of this section includes a person who is qualified under section~~
 296.12 ~~245.462, subdivision 18, clause (7), and who holds a current and valid national certification~~
 296.13 ~~as a certified rehabilitation counselor or certified psychosocial rehabilitation practitioner~~
 296.14 qualified according to section 245I.16, subdivision 2;

296.15 (2) a certified rehabilitation specialist qualified according to section 245I.16, subdivision
 296.16 8;

296.17 (3) a clinical trainee qualified according to section 245I.16, subdivision 6;

296.18 ~~(2)~~ (4) a mental health practitioner as defined in section 245.462, subdivision 17. The
 296.19 mental health practitioner must work under the clinical supervision of a mental health
 296.20 professional qualified according to section 245I.16, subdivision 4;

296.21 ~~(3)~~ (5) a mental health certified peer specialist ~~under section 256B.0615. The certified~~
 296.22 ~~peer specialist must work under the clinical supervision of a mental health professional~~
 296.23 qualified according to section 245I.16, subdivision 10; or

296.24 ~~(4)~~ (6) a mental health rehabilitation worker qualified according to section 245I.16,
 296.25 subdivision 14. A mental health rehabilitation worker means a staff person working under
 296.26 the direction of a mental health practitioner or mental health professional and under the
 296.27 clinical supervision of a mental health professional in the implementation of rehabilitative
 296.28 mental health services as identified in the recipient's individual treatment plan who:

296.29 (i) is at least 21 years of age;

296.30 (ii) has a high school diploma or equivalent;

296.31 ~~(iii) has successfully completed 30 hours of training during the two years immediately~~
 296.32 ~~prior to the date of hire, or before provision of direct services, in all of the following areas:~~

297.1 ~~recovery from mental illness, mental health de-escalation techniques, recipient rights,~~
 297.2 ~~recipient-centered individual treatment planning, behavioral terminology, mental illness,~~
 297.3 ~~co-occurring mental illness and substance abuse, psychotropic medications and side effects,~~
 297.4 ~~functional assessment, local community resources, adult vulnerability, recipient~~
 297.5 ~~confidentiality; and~~

297.6 ~~(iv) meets the qualifications in paragraph (b).~~

297.7 ~~(b) In addition to the requirements in paragraph (a), a mental health rehabilitation worker~~
 297.8 ~~must also meet the qualifications in clause (1), (2), or (3):~~

297.9 ~~(1) has an associates of arts degree, two years of full-time postsecondary education, or~~
 297.10 ~~a total of 15 semester hours or 23 quarter hours in behavioral sciences or related fields; is~~
 297.11 ~~a registered nurse; or within the previous ten years has:~~

297.12 ~~(i) three years of personal life experience with serious mental illness;~~

297.13 ~~(ii) three years of life experience as a primary caregiver to an adult with a serious mental~~
 297.14 ~~illness, traumatic brain injury, substance use disorder, or developmental disability; or~~

297.15 ~~(iii) 2,000 hours of supervised work experience in the delivery of mental health services~~
 297.16 ~~to adults with a serious mental illness, traumatic brain injury, substance use disorder, or~~
 297.17 ~~developmental disability;~~

297.18 ~~(2)(i) is fluent in the non-English language or competent in the culture of the ethnic~~
 297.19 ~~group to which at least 20 percent of the mental health rehabilitation worker's clients belong;~~

297.20 ~~(ii) receives during the first 2,000 hours of work, monthly documented individual clinical~~
 297.21 ~~supervision by a mental health professional;~~

297.22 ~~(iii) has 18 hours of documented field supervision by a mental health professional or~~
 297.23 ~~mental health practitioner during the first 160 hours of contact work with recipients, and at~~
 297.24 ~~least six hours of field supervision quarterly during the following year;~~

297.25 ~~(iv) has review and cosignature of charting of recipient contacts during field supervision~~
 297.26 ~~by a mental health professional or mental health practitioner; and~~

297.27 ~~(v) has 15 hours of additional continuing education on mental health topics during the~~
 297.28 ~~first year of employment and 15 hours during every additional year of employment; or~~

297.29 ~~(3) for providers of crisis residential services, intensive residential treatment services,~~
 297.30 ~~partial hospitalization, and day treatment services:~~

297.31 ~~(i) satisfies clause (2), items (ii) to (iv); and~~

298.1 ~~(ii) has 40 hours of additional continuing education on mental health topics during the~~
 298.2 ~~first year of employment.~~

298.3 ~~(c) A mental health rehabilitation worker who solely acts and is scheduled as overnight~~
 298.4 ~~staff is not required to comply with paragraph (a), clause (4), item (iv).~~

298.5 ~~(d) For purposes of this subdivision, "behavioral sciences or related fields" means an~~
 298.6 ~~education from an accredited college or university and includes but is not limited to social~~
 298.7 ~~work, psychology, sociology, community counseling, family social science, child~~
 298.8 ~~development, child psychology, community mental health, addiction counseling, counseling~~
 298.9 ~~and guidance, special education, and other fields as approved by the commissioner.~~

298.10 Sec. 66. Minnesota Statutes 2018, section 256B.0623, subdivision 6, is amended to read:

298.11 **Subd. 6. Required training and supervision.** ~~(a) Mental health rehabilitation workers~~
 298.12 ~~must receive ongoing continuing education training of at least 30 hours every two years in~~
 298.13 ~~areas of mental illness and mental health services and other areas specific to the population~~
 298.14 ~~being served. Mental health rehabilitation workers must also be subject to the ongoing~~
 298.15 ~~direction and clinical supervision standards in paragraphs (c) and (d) Staff must receive~~
 298.16 ~~training in accordance with section 245I.10.~~

298.17 ~~(b) Mental health practitioners must receive ongoing continuing education training as~~
 298.18 ~~required by their professional license; or if the practitioner is not licensed, the practitioner~~
 298.19 ~~must receive ongoing continuing education training of at least 30 hours every two years in~~
 298.20 ~~areas of mental illness and mental health services. Mental health practitioners must meet~~
 298.21 ~~the ongoing clinical supervision standards in paragraph (c).~~

298.22 ~~(c) Clinical supervision may be provided by a full- or part-time qualified professional~~
 298.23 ~~employed by or under contract with the provider entity. Clinical supervision may be provided~~
 298.24 ~~by interactive videoconferencing according to procedures developed by the commissioner.~~

298.25 (b) Treatment supervision must be provided according to section 245I.18. A mental health
 298.26 professional providing clinical treatment supervision of staff delivering adult rehabilitative
 298.27 mental health services must provide the following guidance:

298.28 ~~(1) review the information in the recipient's file;~~

298.29 ~~(2) review and approve initial and updates of individual treatment plans;~~

298.30 ~~(3) (1) meet with mental health rehabilitation workers and practitioners, individually or~~
 298.31 ~~in small groups, staff receiving direction at least monthly to discuss treatment topics of~~
 298.32 ~~interest to the workers and practitioners;~~

299.1 ~~(4) meet with mental health rehabilitation workers and practitioners, individually or in~~
 299.2 ~~small groups, at least monthly to~~ (2) discuss treatment plans of recipients, ~~and approve by~~
 299.3 ~~signature and document in the recipient's file any resulting plan updates;~~

299.4 ~~(5) meet at least monthly with the directing mental health practitioner, if there is one,~~
 299.5 ~~to~~ (3) review needs of the adult rehabilitative mental health services program, review staff
 299.6 on-site observations and evaluate mental health rehabilitation workers, plan staff training,
 299.7 and review program evaluation and development, ~~and consult with the directing practitioner;~~
 299.8 ~~and;~~

299.9 ~~(6) be available for urgent consultation as the individual recipient needs or the situation~~
 299.10 ~~necessitates.~~

299.11 ~~(d) An adult rehabilitative mental health services provider entity must have a treatment~~
 299.12 ~~director who is a mental health practitioner or mental health professional. The treatment~~
 299.13 ~~director must ensure the following:~~

299.14 ~~(1) while delivering direct services to recipients, a newly hired mental health rehabilitation~~
 299.15 ~~worker must be directly observed delivering services to recipients by a mental health~~
 299.16 ~~practitioner or mental health professional for at least six hours per 40 hours worked during~~
 299.17 ~~the first 160 hours that the mental health rehabilitation worker works;~~

299.18 ~~(2) the mental health rehabilitation worker must receive ongoing on-site direct service~~
 299.19 ~~observation by a mental health professional or mental health practitioner for at least six~~
 299.20 ~~hours for every six months of employment;~~

299.21 ~~(3)~~ (4) review progress notes ~~are reviewed~~ from on-site service observation prepared by
 299.22 the mental health rehabilitation worker and mental health practitioner for accuracy and
 299.23 consistency with actual recipient contact and the individual treatment plan and goals;

299.24 ~~(4)~~ (5) ensure immediate availability by phone or in person for consultation by a mental
 299.25 health professional or a mental health practitioner to the mental health rehabilitation services
 299.26 worker during service provision; and

299.27 ~~(5) oversee the identification of changes in individual recipient treatment strategies,~~
 299.28 ~~revise the plan, and communicate treatment instructions and methodologies as appropriate~~
 299.29 ~~to ensure that treatment is implemented correctly;~~

299.30 ~~(6) model service practices which: respect the recipient, include the recipient in planning~~
 299.31 ~~and implementation of the individual treatment plan, recognize the recipient's strengths,~~
 299.32 ~~collaborate and coordinate with other involved parties and providers;~~

300.1 ~~(7)~~ (6) ensure that mental health practitioners and mental health rehabilitation workers
 300.2 are able to effectively communicate with the recipients, significant others, and providers;
 300.3 ~~and.~~

300.4 ~~(8) oversee the record of the results of on-site observation and charting evaluation and~~
 300.5 ~~corrective actions taken to modify the work of the mental health practitioners and mental~~
 300.6 ~~health rehabilitation workers.~~

300.7 ~~(e) A mental health practitioner who is providing treatment direction for a provider entity~~
 300.8 ~~must receive supervision at least monthly from a mental health professional to:~~

300.9 ~~(1) identify and plan for general needs of the recipient population served;~~

300.10 ~~(2) identify and plan to address provider entity program needs and effectiveness;~~

300.11 ~~(3) identify and plan provider entity staff training and personnel needs and issues; and~~

300.12 ~~(4) plan, implement, and evaluate provider entity quality improvement programs.~~

300.13 Sec. 67. Minnesota Statutes 2018, section 256B.0623, subdivision 7, is amended to read:

300.14 Subd. 7. **Personnel file.** The adult rehabilitative mental health services provider entity
 300.15 must maintain a personnel file on each staff in accordance with section 245I.13. ~~Each file~~
 300.16 ~~must contain:~~

300.17 ~~(1) an annual performance review;~~

300.18 ~~(2) a summary of on-site service observations and charting review;~~

300.19 ~~(3) a criminal background check of all direct service staff;~~

300.20 ~~(4) evidence of academic degree and qualifications;~~

300.21 ~~(5) a copy of professional license;~~

300.22 ~~(6) any job performance recognition and disciplinary actions;~~

300.23 ~~(7) any individual staff written input into own personnel file;~~

300.24 ~~(8) all clinical supervision provided; and~~

300.25 ~~(9) documentation of compliance with continuing education requirements.~~

300.26 Sec. 68. Minnesota Statutes 2018, section 256B.0623, subdivision 8, is amended to read:

300.27 Subd. 8. **Diagnostic assessment.** Providers of adult rehabilitative mental health services
 300.28 must obtain or complete a diagnostic assessment as defined in according to section 245.462,
 300.29 ~~subdivision 9, within five days after the recipient's second visit or within 30 days after~~

301.1 ~~intake, whichever occurs first. In cases where a diagnostic assessment is available that~~
301.2 ~~reflects the recipient's current status, and has been completed within three years preceding~~
301.3 ~~admission, an adult diagnostic assessment update must be completed. An update shall include~~
301.4 ~~a face-to-face interview with the recipient and a written summary by a mental health~~
301.5 ~~professional of the recipient's current mental health status and service needs. If the recipient's~~
301.6 ~~mental health status has changed significantly since the adult's most recent diagnostic~~
301.7 ~~assessment, a new diagnostic assessment is required 256B.0671, subdivisions 2 and 3.~~

301.8 Sec. 69. Minnesota Statutes 2018, section 256B.0623, subdivision 10, is amended to read:

301.9 Subd. 10. **Individual treatment plan.** All providers of adult rehabilitative mental health
301.10 services must develop and implement an individual treatment plan for each recipient. ~~The~~
301.11 ~~provisions in clauses (1) and (2) apply; according to section 256B.0671, subdivisions 5 and~~
301.12 6.

301.13 ~~(1) Individual treatment plan means a plan of intervention, treatment, and services for~~
301.14 ~~an individual recipient written by a mental health professional or by a mental health~~
301.15 ~~practitioner under the clinical supervision of a mental health professional. The individual~~
301.16 ~~treatment plan must be based on diagnostic and functional assessments. To the extent~~
301.17 ~~possible, the development and implementation of a treatment plan must be a collaborative~~
301.18 ~~process involving the recipient, and with the permission of the recipient, the recipient's~~
301.19 ~~family and others in the recipient's support system. Providers of adult rehabilitative mental~~
301.20 ~~health services must develop the individual treatment plan within 30 calendar days of intake.~~
301.21 The treatment plan must be updated at least every six months thereafter, or more often when
301.22 there is significant change in the recipient's situation or functioning, or in services or service
301.23 methods to be used, or at the request of the recipient or the recipient's legal guardian.

301.24 ~~(2) The individual treatment plan must include:~~

301.25 ~~(i) a list of problems identified in the assessment;~~

301.26 ~~(ii) the recipient's strengths and resources;~~

301.27 ~~(iii) concrete, measurable goals to be achieved, including time frames for achievement;~~

301.28 ~~(iv) specific objectives directed toward the achievement of each one of the goals;~~

301.29 ~~(v) documentation of participants in the treatment planning. The recipient, if possible,~~
301.30 ~~must be a participant. The recipient or the recipient's legal guardian must sign the treatment~~
301.31 ~~plan, or documentation must be provided why this was not possible. A copy of the plan~~
301.32 ~~must be given to the recipient or legal guardian. Referral to formal services must be arranged,~~
301.33 ~~including specific providers where applicable;~~

302.1 ~~(vi) cultural considerations, resources, and needs of the recipient must be included;~~

302.2 ~~(vii) planned frequency and type of services must be initiated; and~~

302.3 ~~(viii) clear progress notes on outcome of goals.~~

302.4 ~~(3) The individual community support plan defined in section 245.462, subdivision 12,~~
302.5 ~~may serve as the individual treatment plan if there is involvement of a mental health case~~
302.6 ~~manager, and with the approval of the recipient. The individual community support plan~~
302.7 ~~must include the criteria in clause (2).~~

302.8 Sec. 70. Minnesota Statutes 2018, section 256B.0623, subdivision 11, is amended to read:

302.9 Subd. 11. **Recipient file.** Providers of adult rehabilitative mental health services must
302.10 maintain a file for each recipient ~~that contains the following information:~~ according to
302.11 section 245I.32.

302.12 ~~(1) diagnostic assessment or verification of its location that is current and that was~~
302.13 ~~reviewed by a mental health professional who is employed by or under contract with the~~
302.14 ~~provider entity;~~

302.15 ~~(2) functional assessments;~~

302.16 ~~(3) individual treatment plans signed by the recipient and the mental health professional,~~
302.17 ~~or if the recipient refused to sign the plan, the date and reason stated by the recipient as to~~
302.18 ~~why the recipient would not sign the plan;~~

302.19 ~~(4) recipient history;~~

302.20 ~~(5) signed release forms;~~

302.21 ~~(6) recipient health information and current medications;~~

302.22 ~~(7) emergency contacts for the recipient;~~

302.23 ~~(8) case records which document the date of service, the place of service delivery,~~
302.24 ~~signature of the person providing the service, nature, extent and units of service, and place~~
302.25 ~~of service delivery;~~

302.26 ~~(9) contacts, direct or by telephone, with recipient's family or others, other providers,~~
302.27 ~~or other resources for service coordination;~~

302.28 ~~(10) summary of recipient case reviews by staff; and~~

302.29 ~~(11) written information by the recipient that the recipient requests be included in the~~
302.30 ~~file.~~

303.1 Sec. 71. Minnesota Statutes 2018, section 256B.0623, subdivision 12, is amended to read:

303.2 Subd. 12. **Additional requirements.** (a) Providers of adult rehabilitative mental health
303.3 services must comply with the requirements relating to referrals for case management in
303.4 section 245.467, subdivision 4.

303.5 (b) Adult rehabilitative mental health services are provided for most recipients in the
303.6 recipient's home and community. Services may also be provided at the home of a relative
303.7 or significant other, job site, psychosocial clubhouse, drop-in center, social setting, classroom,
303.8 or other places in the community. Except for "transition to community services," the place
303.9 of service does not include a regional treatment center, nursing home, residential treatment
303.10 facility licensed under Minnesota Rules, parts 9520.0500 to 9520.0670 (Rule 36), or an
303.11 acute care hospital.

303.12 (c) Adult rehabilitative mental health services may be provided in group settings if
303.13 appropriate to each participating recipient's needs and treatment plan. A group is defined
303.14 as two to ten clients, at least one of whom is a recipient, who is concurrently receiving a
303.15 service which is identified in this section. The service and group must be specified in the
303.16 recipient's treatment plan. No more than two qualified staff may bill Medicaid for services
303.17 provided to the same group of recipients. If two adult rehabilitative mental health workers
303.18 bill for recipients in the same group session, they must each bill for different recipients.

303.19 (d) Adult rehabilitative mental health services are appropriate if provided to enable a
303.20 recipient to retain stability and functioning, when the recipient is at risk of significant
303.21 functional decompensation or requiring more restrictive service settings without these
303.22 services.

303.23 (e) Adult rehabilitative mental health services instruct, assist, and support the recipient
303.24 in areas including: interpersonal communication skills, community resource utilization and
303.25 integration skills, crisis planning, relapse prevention skills, health care directives, budgeting
303.26 and shopping skills, healthy lifestyle skills and practices, cooking and nutrition skills,
303.27 transportation skills, medication education and monitoring, mental illness symptom
303.28 management skills, household management skills, employment-related skills, parenting
303.29 skills, and transition to community living services.

303.30 (f) Community intervention, including consultation with relatives, guardians, friends,
303.31 employers, treatment providers, and other significant individuals, is appropriate when
303.32 directed exclusively to the treatment of the client.

304.1 Sec. 72. Minnesota Statutes 2018, section 256B.0624, subdivision 2, is amended to read:

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

304.4 (a) "Mental health crisis" is an adult behavioral, emotional, or psychiatric situation
304.5 which, but for the provision of crisis response services, would likely result in significantly
304.6 reduced levels of functioning in primary activities of daily living, or in an emergency
304.7 situation, or in the placement of the recipient in a more restrictive setting, including, but
304.8 not limited to, inpatient hospitalization.

304.9 (b) "Mental health emergency" is an adult behavioral, emotional, or psychiatric situation
304.10 which causes an immediate need for mental health services and is consistent with section
304.11 62Q.55.

304.12 A mental health crisis or emergency is determined for medical assistance service
304.13 reimbursement by a physician, a mental health professional, or ~~crisis mental health~~
304.14 ~~practitioner~~ qualified member of a crisis team with input from the recipient whenever
304.15 possible.

304.16 (c) "Mental health crisis assessment" means an immediate face-to-face assessment by
304.17 a physician, a mental health professional, or ~~mental health practitioner under the clinical~~
304.18 ~~supervision of a mental health professional,~~ qualified member of a crisis team following a
304.19 screening that suggests that the adult may be experiencing a mental health crisis or mental
304.20 health emergency situation. It includes, when feasible, assessing whether the person might
304.21 be willing to voluntarily accept treatment, determining whether the person has an advance
304.22 directive, and obtaining information and history from involved family members or caretakers.

304.23 (d) "Mental health mobile crisis intervention services" means face-to-face, short-term
304.24 intensive mental health services initiated during a mental health crisis or mental health
304.25 emergency to help the recipient cope with immediate stressors, identify and utilize available
304.26 resources and strengths, engage in voluntary treatment, and begin to return to the recipient's
304.27 baseline level of functioning. The services, including screening and treatment plan
304.28 recommendations, must be culturally and linguistically appropriate.

304.29 (1) This service is provided on site by a mobile crisis intervention team outside of an
304.30 inpatient hospital setting. Mental health mobile crisis intervention services must be available
304.31 24 hours a day, seven days a week.

304.32 (2) The initial screening must consider other available services to determine which
304.33 service intervention would best address the recipient's needs and circumstances.

305.1 (3) The mobile crisis intervention team must be available to meet promptly face-to-face
305.2 with a person in mental health crisis or emergency in a community setting or hospital
305.3 emergency room.

305.4 (4) The intervention must consist of a mental health crisis assessment and a crisis
305.5 treatment plan.

305.6 (5) The team must be available to individuals who are experiencing a co-occurring
305.7 substance use disorder, who do not need the level of care provided in a detoxification facility.

305.8 (6) The treatment plan must include recommendations for any needed crisis stabilization
305.9 services for the recipient, including engagement in treatment planning and family
305.10 psychoeducation.

305.11 (e) "Mental health crisis stabilization services" means individualized mental health
305.12 services provided to a recipient following crisis intervention services which are designed
305.13 to restore the recipient to the recipient's prior functional level. Mental health crisis
305.14 stabilization services may be provided in the recipient's home, the home of a family member
305.15 or friend of the recipient, another community setting, or a short-term supervised, licensed
305.16 residential program. Mental health crisis stabilization does not include partial hospitalization
305.17 or day treatment. Mental health crisis stabilization services includes family psychoeducation.

305.18 (f) "Clinical trainee" means a person qualified according to section 245I.16, subdivision
305.19 6.

305.20 (g) "Mental health certified family peer specialist" means a person qualified according
305.21 to section 245I.16, subdivision 12.

305.22 (h) "Mental health certified peer specialist" means a person qualified according to section
305.23 245I.16, subdivision 10.

305.24 (i) "Mental health practitioner" means a person qualified according to section 245I.16,
305.25 subdivision 4.

305.26 (j) "Mental health professional" means a person qualified according to section 245I.16,
305.27 subdivision 2.

305.28 (k) "Mental health rehabilitation worker" means a person qualified according to section
305.29 245I.16, subdivision 14.

305.30 Sec. 73. Minnesota Statutes 2018, section 256B.0624, subdivision 4, is amended to read:

305.31 Subd. 4. **Provider entity standards.** (a) A provider entity is an entity that meets the
305.32 standards listed in paragraph (c) and:

306.1 (1) is a county board operated entity; ~~or~~

306.2 (2) is an Indian health service facility or facility owned and operated by a tribe or a tribal
 306.3 organization operating under United States Code, title 25, section 450f; or

306.4 (3) is a provider entity that is under contract with the county board in the county where
 306.5 the potential crisis or emergency is occurring. To provide services under this section, the
 306.6 provider entity must directly provide the services; or if services are subcontracted, the
 306.7 provider entity must maintain responsibility for services and billing.

306.8 (b) A provider entity that provides crisis stabilization services in a residential setting
 306.9 under subdivision 7 is not required to meet the requirements of paragraph (a), clauses (1)
 306.10 ~~and (2)~~ to (3), and paragraph (c), clauses (9), (20), and (21), but must meet all other
 306.11 requirements of this subdivision. Upon approval by the commissioner, a residential crisis
 306.12 services provider meeting relevant standards for supervision and assessment may allow a
 306.13 practitioner to perform a crisis assessment to establish eligibility for admission to the
 306.14 program. A provider performing an assessment under this paragraph shall not bill separately
 306.15 beyond the daily rate for the residential stabilization program.

306.16 (c) The adult mental health crisis response services provider entity must have the capacity
 306.17 to meet and carry out the requirements in chapter 245I and the following standards:

306.18 (1) has the capacity to recruit, hire, and manage and train ~~mental health professionals,~~
 306.19 ~~practitioners, and rehabilitation workers~~ qualified staff;

306.20 (2) has adequate administrative ability to ensure availability of services;

306.21 (3) is able to ensure adequate preservice and in-service training;

306.22 (4) is able to ensure that staff providing these services are skilled in the delivery of
 306.23 mental health crisis response services to recipients;

306.24 (5) is able to ensure that staff are capable of implementing culturally specific treatment
 306.25 identified in the individual treatment plan that is meaningful and appropriate as determined
 306.26 by the recipient's culture, beliefs, values, and language;

306.27 (6) is able to ensure enough flexibility to respond to the changing intervention and care
 306.28 needs of a recipient as identified by the recipient during the service partnership between
 306.29 the recipient and providers;

306.30 (7) is able to ensure that ~~mental health professionals and mental health practitioners~~ staff
 306.31 have the communication tools and procedures to communicate and consult promptly about
 306.32 crisis assessment and interventions as services occur;

307.1 (8) is able to coordinate these services with county emergency services, community
307.2 hospitals, ambulance, transportation services, social services, law enforcement, and mental
307.3 health crisis services through regularly scheduled interagency meetings;

307.4 (9) is able to ensure that mental health crisis assessment and mobile crisis intervention
307.5 services are available 24 hours a day, seven days a week;

307.6 (10) is able to ensure that services are coordinated with other mental health service
307.7 providers, county mental health authorities, or federally recognized American Indian
307.8 authorities and others as necessary, with the consent of the adult. Services must also be
307.9 coordinated with the recipient's case manager if the adult is receiving case management
307.10 services;

307.11 (11) is able to coordinate services with detoxification according to Minnesota Rules,
307.12 parts 9530.6605 to 9530.6655, or withdrawal management according to chapter 245F to
307.13 ensure a recipient receives care that is responsive to the recipient's chemical and mental
307.14 health needs;

307.15 (12) is able to ensure that crisis intervention services are provided in a manner consistent
307.16 with sections 245.461 to 245.486;

307.17 ~~(12)~~ (13) is able to submit information as required by the state;

307.18 ~~(13)~~ (14) maintains staff training and personnel files, including documentation of staff
307.19 completion of required training modules;

307.20 ~~(14)~~ (15) is able to establish and maintain a quality assurance and evaluation plan to
307.21 evaluate the outcomes of services and recipient satisfaction, including notifying recipients
307.22 of the process by which the provider, county, or tribe accepts and responds to concerns;

307.23 ~~(15)~~ (16) is able to keep records as required by applicable laws;

307.24 ~~(16)~~ (17) is able to comply with all applicable laws and statutes;

307.25 ~~(17)~~ (18) is an enrolled medical assistance provider; ~~and~~

307.26 ~~(18)~~ (19) develops and maintains written policies and procedures regarding service
307.27 provision and administration of the provider entity, including safety of staff and recipients
307.28 in high-risk situations;

307.29 (20) is able to respond to a call for crisis services in a designated service area or according
307.30 to a written agreement with the local mental health authority for an adjacent area; and

307.31 (21) documents protocol used when delivering services by telemedicine, according to
307.32 sections 62A.67 to 62A.672, including responsibilities of the originating site, means to

308.1 promote recipient safety, timeliness for connection and response, and steps to take in the
308.2 event of a lost connection.

308.3 Sec. 74. Minnesota Statutes 2018, section 256B.0624, subdivision 5, is amended to read:

308.4 Subd. 5. **Mobile crisis intervention staff qualifications.** ~~For provision of adult mental~~
308.5 ~~health mobile crisis intervention services, a mobile crisis intervention team is comprised of~~
308.6 ~~at least two mental health professionals as defined in section 245.462, subdivision 18, clauses~~
308.7 ~~(1) to (6), or a combination of at least one mental health professional and one mental health~~
308.8 ~~practitioner as defined in section 245.462, subdivision 17, with the required mental health~~
308.9 ~~crisis training and under the clinical supervision of a mental health professional on the team.~~

308.10 (a) Mobile crisis intervention team staff must be qualified to provide services as mental
308.11 health professionals, mental health practitioners, clinical trainees, mental health certified
308.12 family peer specialists, or mental health certified peer specialists.

308.13 (b) A mobile crisis intervention team is comprised of at least two members, one of whom
308.14 must be qualified as a mental health professional. A second member must be qualified as
308.15 a mental health professional, clinical trainee, or mental health practitioner. A provider entity
308.16 must consider the needs of the area served when adding staff.

308.17 (c) Mental health crisis assessment and intervention services must be led by a mental
308.18 health professional, or under the supervision of a mental health professional according to
308.19 subdivision 9, by a clinical trainee or mental health practitioner.

308.20 (d) The team must have at least two people with at least one member providing on-site
308.21 crisis intervention services when needed. Team members must be experienced in mental
308.22 health assessment, crisis intervention techniques, treatment engagement strategies, working
308.23 with families, and clinical decision-making under emergency conditions and have knowledge
308.24 of local services and resources. The team must recommend and coordinate the team's services
308.25 with appropriate local resources such as the county social services agency, mental health
308.26 services, and local law enforcement when necessary.

308.27 Sec. 75. Minnesota Statutes 2018, section 256B.0624, subdivision 6, is amended to read:

308.28 Subd. 6. **Crisis assessment and mobile intervention treatment planning.** (a) Prior to
308.29 initiating mobile crisis intervention services, a screening of the potential crisis situation
308.30 must be conducted. The screening may use the resources of crisis assistance and emergency
308.31 services as defined in sections 245.462, subdivision 6, and 245.469, subdivisions 1 and 2.

309.1 The screening must gather information, determine whether a crisis situation exists, identify
309.2 parties involved, and determine an appropriate response.

309.3 (b) In conducting the screening, a provider shall:

309.4 (1) employ evidence-based practices as identified by the commissioner in collaboration
309.5 with the commissioner of health to reduce the risk of the recipient's suicide and self-injurious
309.6 behavior;

309.7 (2) work with the recipient to establish a plan and time frame for responding to the crisis,
309.8 including immediate needs for support by telephone or text message until a face-to-face
309.9 response arrives;

309.10 (3) document significant factors related to the determination of a crisis, including prior
309.11 calls to the crisis team, recent presentation at an emergency department, known calls to 911
309.12 or law enforcement, or the presence of third parties with knowledge of a potential recipient's
309.13 history or current needs;

309.14 (4) screen for the needs of a third-party caller, including a recipient who primarily
309.15 identifies as a family member or a caregiver but also presents signs of a crisis; and

309.16 (5) provide psychoeducation, including education on the available means for reducing
309.17 self-harm, to relevant third parties, including family members or other persons living in the
309.18 home.

309.19 (c) A provider entity shall consider the following to indicate a positive screening unless
309.20 the provider entity documents specific evidence to show why crisis response was clinically
309.21 inappropriate:

309.22 (1) the recipient presented in an emergency department or urgent care setting, and the
309.23 health care team at that location requested crisis services; or

309.24 (2) a peace officer requested crisis services for a recipient who may be subject to
309.25 transportation under section 253B.05 for a mental health crisis.

309.26 ~~(b)~~ (d) If a crisis exists, a crisis assessment must be completed. A crisis assessment
309.27 evaluates any immediate needs for which emergency services are needed and, as time
309.28 permits, the recipient's current life situation, health information including current medications,
309.29 sources of stress, mental health problems and symptoms, strengths, cultural considerations,
309.30 support network, vulnerabilities, current functioning, and the recipient's preferences as
309.31 communicated directly by the recipient, or as communicated in a health care directive as
309.32 described in chapters 145C and 253B, the treatment plan described under paragraph (d), a
309.33 crisis prevention plan, or a wellness recovery action plan.

310.1 ~~(e)~~ (e) If the crisis assessment determines mobile crisis intervention services are needed,
310.2 the intervention services must be provided promptly. As opportunity presents during the
310.3 intervention, at least two members of the mobile crisis intervention team must confer directly
310.4 or by telephone about the assessment, treatment plan, and actions taken and needed. At least
310.5 one of the team members must be on site providing crisis intervention services. If providing
310.6 on-site crisis intervention services, a mental health practitioner must seek ~~clinical~~ clinical treatment
310.7 supervision as required in subdivision 9.

310.8 (f) Direct contact with the recipient is not required before initiating a crisis assessment
310.9 or intervention service. A crisis team may gather relevant information from a third party at
310.10 the scene to establish the need for services and potential safety factors. A crisis assessment
310.11 is provided face-to-face by a mobile crisis intervention team outside of an inpatient hospital
310.12 setting. A service must be provided promptly and respond to the recipient's location whenever
310.13 possible, including community or clinical settings. As clinically appropriate, a mobile crisis
310.14 intervention team must coordinate a response with other health care providers if a recipient
310.15 requires detoxification, withdrawal management, or medical stabilization services in addition
310.16 to crisis services.

310.17 ~~(d)~~ (g) The mobile crisis intervention team must develop an initial, brief crisis treatment
310.18 plan as soon as appropriate but no later than 24 hours after the initial face-to-face intervention.
310.19 The plan must address the needs and problems noted in the crisis assessment and include
310.20 measurable short-term goals, cultural considerations, and frequency and type of services to
310.21 be provided to achieve the goals and reduce or eliminate the crisis. The treatment plan must
310.22 be updated as needed to reflect current goals and services.

310.23 ~~(e)~~ (h) The team must document which short-term goals have been met and when no
310.24 further crisis intervention services are required. If after an assessment a crisis provider entity
310.25 refers a recipient to an intensive setting, including an emergency department, in-patient
310.26 hospitalization, or crisis residential treatment, one of the crisis team members who performed
310.27 or conferred on the assessment must immediately contact the provider entity and consult
310.28 with the triage nurse or other staff responsible for intake. The crisis team member must
310.29 convey key findings or concerns that led to the referral. The consultation shall occur with
310.30 the recipient's consent, the recipient's legal guardian's consent, or as allowed by section
310.31 144.293, subdivision 5. Any available written documentation, including a crisis treatment
310.32 plan, must be sent no later than the next business day.

310.33 ~~(f)~~ (i) If the recipient's crisis is stabilized, but the recipient needs a referral to other
310.34 services, the team must provide referrals to these services. If the recipient has a case manager,
310.35 planning for other services must be coordinated with the case manager. If the recipient is

311.1 unable to follow up on the referral, the team must link the recipient to the service and follow
311.2 up to ensure the recipient is receiving the service.

311.3 ~~(g)~~ (j) If the recipient's crisis is stabilized and the recipient does not have an advance
311.4 directive, the case manager or crisis team shall offer to work with the recipient to develop
311.5 one.

311.6 (k) If an intervention service is provided without the recipient present, the provider shall
311.7 document the reasons why the service is more effective without the recipient present.

311.8 Sec. 76. Minnesota Statutes 2018, section 256B.0624, subdivision 7, is amended to read:

311.9 **Subd. 7. Crisis stabilization services.** (a) Crisis stabilization services must be provided
311.10 by qualified staff of a crisis stabilization services provider entity and must meet the following
311.11 standards:

311.12 (1) a crisis stabilization treatment plan must be developed which meets the criteria in
311.13 subdivision 11;

311.14 (2) staff must be qualified as defined in subdivision 8; ~~and~~

311.15 (3) services must be delivered according to the treatment plan and include face-to-face
311.16 contact with the recipient by qualified staff for further assessment, help with referrals,
311.17 updating of the crisis stabilization treatment plan, supportive counseling, skills training,
311.18 and collaboration with other service providers in the community; and

311.19 (4) if a stabilization service is provided without the recipient present, the provider shall
311.20 document the reasons why the service is more effective without the recipient present.

311.21 (b) If crisis stabilization services are provided in a supervised, licensed residential setting,
311.22 the recipient must be contacted face-to-face daily by a qualified mental health practitioner
311.23 or mental health professional. The program must have 24-hour-a-day residential staffing
311.24 which may include staff who do not meet the qualifications in subdivision 8. The residential
311.25 staff must have 24-hour-a-day immediate direct or telephone access to a qualified mental
311.26 health professional or practitioner.

311.27 (c) If crisis stabilization services are provided in a supervised, licensed residential setting
311.28 that serves no more than four adult residents, and one or more individuals are present at the
311.29 setting to receive residential crisis stabilization services, the residential staff must include,
311.30 for at least eight hours per day, at least one individual who meets the qualifications in
311.31 subdivision 8, paragraph (a), clause (1) or (2).

312.1 (d) If crisis stabilization services are provided in a supervised, licensed residential setting
 312.2 that serves more than four adult residents, and one or more are recipients of crisis stabilization
 312.3 services, the residential staff must include, for 24 hours a day, at least one individual who
 312.4 meets the qualifications in subdivision 8. When more than four residents are present at the
 312.5 setting during the first 48 hours that a recipient is in the residential program, the residential
 312.6 program must have at least two staff working 24 hours a day. Staffing levels may be adjusted
 312.7 thereafter according to the needs of the recipient as specified in the crisis stabilization
 312.8 treatment plan.

312.9 Sec. 77. Minnesota Statutes 2018, section 256B.0624, subdivision 8, is amended to read:

312.10 Subd. 8. **Adult crisis stabilization staff qualifications.** ~~(a)~~ Adult mental health crisis
 312.11 stabilization services must be provided by qualified individual staff of a qualified provider
 312.12 entity. Individual provider staff must ~~have the following qualifications~~ be:

312.13 (1) ~~be a mental health professional as defined in section 245.462, subdivision 18, clauses~~
 312.14 ~~(1) to (6);~~

312.15 (2) ~~be a mental health practitioner as defined in section 245.462, subdivision 17. The~~
 312.16 ~~mental health practitioner must work under the clinical supervision of a mental health~~
 312.17 ~~professional;~~

312.18 (3) ~~be a mental health certified peer specialist under section 256B.0615. The certified~~
 312.19 ~~peer specialist must work under the clinical supervision of a mental health professional; or~~

312.20 (4) ~~be a mental health rehabilitation worker who meets the criteria in section 256B.0623,~~
 312.21 ~~subdivision 5, paragraph (a), clause (4); works under the direction of a mental health~~
 312.22 ~~practitioner as defined in section 245.462, subdivision 17, or under direction of a mental~~
 312.23 ~~health professional; and works under the clinical supervision of a mental health professional.~~

312.24 ~~(b) Mental health practitioners and mental health rehabilitation workers must have~~
 312.25 ~~completed at least 30 hours of training in crisis intervention and stabilization during the~~
 312.26 ~~past two years.~~

312.27 Sec. 78. Minnesota Statutes 2018, section 256B.0624, subdivision 9, is amended to read:

312.28 Subd. 9. **Supervision.** Mental health practitioners or clinical trainees may provide crisis
 312.29 assessment and mobile crisis intervention services if the following clinical treatment
 312.30 supervision requirements are met:

312.31 (1) the mental health provider entity must accept full responsibility for the services
 312.32 provided;

313.1 (2) the mental health professional of the provider entity, who is an employee or under
 313.2 contract with the provider entity, must be immediately available by phone or in person for
 313.3 clinical supervision;

313.4 (3) the mental health professional is consulted, in person or by phone, during the first
 313.5 three hours when a mental health practitioner or clinical trainee provides on-site service;

313.6 (4) the mental health professional must:

313.7 (i) review and approve of the tentative crisis assessment and crisis treatment plan;

313.8 (ii) document the consultation; and

313.9 (iii) sign the crisis assessment and treatment plan within the next business day; and

313.10 ~~(5) if the mobile crisis intervention services continue into a second calendar day, a mental~~
 313.11 ~~health professional must contact the recipient face-to-face on the second day to provide~~
 313.12 ~~services and update the crisis treatment plan; and~~

313.13 ~~(6)~~ (5) the on-site observation must be documented in the recipient's record and signed
 313.14 by the mental health professional.

313.15 Sec. 79. Minnesota Statutes 2018, section 256B.0624, subdivision 11, is amended to read:

313.16 Subd. 11. **Treatment plan.** The individual crisis stabilization treatment plan must include,
 313.17 at a minimum:

313.18 (1) a list of problems identified in the assessment;

313.19 (2) a list of the recipient's strengths and resources;

313.20 (3) concrete, measurable short-term goals and tasks to be achieved, including time frames
 313.21 for achievement;

313.22 (4) specific objectives directed toward the achievement of each one of the goals;

313.23 (5) documentation of the participants involved in the service planning. The recipient, if
 313.24 possible, must be a participant. The recipient or the recipient's legal guardian must sign the
 313.25 service plan or documentation must be provided why this was not possible. A copy of the
 313.26 plan must be given to the recipient and the recipient's legal guardian. The plan should include
 313.27 services arranged, including specific providers where applicable;

313.28 (6) planned frequency and type of services initiated;

313.29 (7) a crisis response action plan if a crisis should occur;

313.30 (8) clear progress notes on outcome of goals;

314.1 (9) a written plan must be completed within 24 hours of beginning services with the
314.2 recipient; and

314.3 (10) a treatment plan must be developed by a mental health professional, clinical trainee,
314.4 or mental health practitioner ~~under the clinical supervision of a mental health professional~~.
314.5 The mental health professional must approve and sign all treatment plans.

314.6 Sec. 80. Minnesota Statutes 2018, section 256B.0625, subdivision 3b, is amended to read:

314.7 Subd. 3b. **Telemedicine services.** (a) Medical assistance covers medically necessary
314.8 services and consultations delivered by a licensed health care provider via telemedicine in
314.9 the same manner as if the service or consultation was delivered in person. Coverage is
314.10 limited to three telemedicine services per enrollee per calendar week. Telemedicine services
314.11 shall be paid at the full allowable rate.

314.12 (b) The commissioner shall establish criteria that a health care provider must attest to
314.13 in order to demonstrate the safety or efficacy of delivering a particular service via
314.14 telemedicine. The attestation may include that the health care provider:

314.15 (1) has identified the categories or types of services the health care provider will provide
314.16 via telemedicine;

314.17 (2) has written policies and procedures specific to telemedicine services that are regularly
314.18 reviewed and updated;

314.19 (3) has policies and procedures that adequately address patient safety before, during,
314.20 and after the telemedicine service is rendered;

314.21 (4) has established protocols addressing how and when to discontinue telemedicine
314.22 services; and

314.23 (5) has an established quality assurance process related to telemedicine services.

314.24 (c) As a condition of payment, a licensed health care provider must document each
314.25 occurrence of a health service provided by telemedicine to a medical assistance enrollee.
314.26 Health care service records for services provided by telemedicine must meet the requirements
314.27 set forth in Minnesota Rules, part 9505.2175, subparts 1 and 2, and must document:

314.28 (1) the type of service provided by telemedicine;

314.29 (2) the time the service began and the time the service ended, including an a.m. and p.m.
314.30 designation;

315.1 (3) the licensed health care provider's basis for determining that telemedicine is an
315.2 appropriate and effective means for delivering the service to the enrollee;

315.3 (4) the mode of transmission of the telemedicine service and records evidencing that a
315.4 particular mode of transmission was utilized;

315.5 (5) the location of the originating site and the distant site;

315.6 (6) if the claim for payment is based on a physician's telemedicine consultation with
315.7 another physician, the written opinion from the consulting physician providing the
315.8 telemedicine consultation; and

315.9 (7) compliance with the criteria attested to by the health care provider in accordance
315.10 with paragraph (b).

315.11 (d) For purposes of this subdivision, unless otherwise covered under this chapter,
315.12 "telemedicine" is defined as the delivery of health care services or consultations while the
315.13 patient is at an originating site and the licensed health care provider is at a distant site. A
315.14 communication between licensed health care providers, or a licensed health care provider
315.15 and a patient that consists solely of a telephone conversation, e-mail, or facsimile transmission
315.16 does not constitute telemedicine consultations or services. Telemedicine may be provided
315.17 by means of real-time two-way, interactive audio and visual communications, including the
315.18 application of secure video conferencing or store-and-forward technology to provide or
315.19 support health care delivery, which facilitate the assessment, diagnosis, consultation,
315.20 treatment, education, and care management of a patient's health care.

315.21 (e) For purposes of this section, "licensed health care provider" means a licensed health
315.22 care provider under section 62A.671, subdivision 6, a clinical trainee, and a mental health
315.23 practitioner defined under section 245.462, subdivision 17, ~~or 245.4871, subdivision 26~~,
315.24 working under the general supervision of a mental health professional; "health care provider"
315.25 is defined under section 62A.671, subdivision 3; and "originating site" is defined under
315.26 section 62A.671, subdivision 7.

315.27 Sec. 81. Minnesota Statutes 2018, section 256B.0625, subdivision 5, is amended to read:

315.28 Subd. 5. **Community mental health center services.** Medical assistance covers
315.29 community mental health center services provided by a community mental health center
315.30 that meets the requirements in paragraphs (a) to (j).

315.31 (a) The provider is licensed under Minnesota Rules, parts 9520.0750 to 9520.0870, and
315.32 in compliance with requirements under chapter 245I and section 256B.0671.

316.1 (b) The provider provides mental health services under the ~~clinical~~ treatment supervision
316.2 of a mental health professional who is licensed for independent practice at the doctoral level
316.3 or by a board-certified psychiatrist or a psychiatrist who is eligible for board certification.
316.4 ~~Clinical supervision has the meaning given in Minnesota Rules, part 9505.0370, subpart 6.~~
316.5 Treatment supervision means the treatment supervision described under section 245I.18.

316.6 (c) The provider must be a private nonprofit corporation or a governmental agency and
316.7 have a community board of directors as specified by section 245.66.

316.8 (d) The provider must have a sliding fee scale that meets the requirements in section
316.9 245.481, and agree to serve within the limits of its capacity all individuals residing in its
316.10 service delivery area.

316.11 (e) At a minimum, the provider must provide the following outpatient mental health
316.12 services: diagnostic assessment; explanation of findings; and family, group, and individual
316.13 psychotherapy, including crisis intervention psychotherapy services, ~~multiple family group~~
316.14 ~~psychotherapy~~, psychological testing, and medication management. In addition, the provider
316.15 must provide or be capable of providing upon request of the local mental health authority
316.16 day treatment services, multiple family group psychotherapy, and professional home-based
316.17 mental health services. The provider must have the capacity to provide such services to
316.18 specialized populations such as the elderly, families with children, persons who are seriously
316.19 and persistently mentally ill, and children who are seriously emotionally disturbed.

316.20 (f) The provider must be capable of providing the services specified in paragraph (e) to
316.21 individuals who are dually diagnosed with ~~both~~ a mental illness or emotional disturbance,
316.22 ~~and chemical dependency~~ substance use disorder, and to individuals who are dually diagnosed
316.23 with a mental illness or emotional disturbance and developmental disability.

316.24 (g) The provider must provide 24-hour emergency care services or demonstrate the
316.25 capacity to assist recipients in need of such services to access such services on a 24-hour
316.26 basis.

316.27 (h) The provider must have a contract with the local mental health authority to provide
316.28 one or more of the services specified in paragraph (e).

316.29 (i) The provider must agree, upon request of the local mental health authority, to enter
316.30 into a contract with the county to provide mental health services not reimbursable under
316.31 the medical assistance program.

316.32 (j) The provider may not be enrolled with the medical assistance program as both a
316.33 hospital and a community mental health center. The community mental health center's

317.1 administrative, organizational, and financial structure must be separate and distinct from
317.2 that of the hospital.

317.3 Sec. 82. Minnesota Statutes 2018, section 256B.0625, subdivision 51, is amended to read:

317.4 Subd. 51. **Intensive mental health outpatient treatment.** (a) Medical assistance covers
317.5 intensive mental health outpatient treatment for dialectical behavioral therapy for adults.
317.6 The commissioner shall establish:

317.7 (1) certification procedures to ensure that providers of these services are qualified and
317.8 meet the standards in chapter 245I; and

317.9 (2) treatment protocols including required service components and criteria for admission,
317.10 continued treatment, and discharge.

317.11 (b) "Dialectical behavior therapy" means an evidence-based treatment approach provided
317.12 in an intensive outpatient treatment program using a combination of individualized
317.13 rehabilitative and psychotherapeutic interventions. A dialectical behavior therapy program
317.14 involves the following service components: individual dialectical behavior therapy, group
317.15 skills training, telephone coaching, and team consultation meetings.

317.16 (c) To be eligible for dialectical behavior therapy a client must:

317.17 (1) be 18 years of age or older;

317.18 (2) have mental health needs that cannot be met with other available community-based
317.19 services or that must be provided concurrently with other community-based services;

317.20 (3) meet one of the following criteria:

317.21 (i) have a diagnosis of borderline personality disorder; or

317.22 (ii) have multiple mental health diagnoses, exhibit behaviors characterized by impulsivity
317.23 or intentional self-harm, and be at significant risk of death, morbidity, disability, or severe
317.24 dysfunction across multiple life areas;

317.25 (4) understand and be cognitively capable of participating in dialectical behavior therapy
317.26 as an intensive therapy program and be able and willing to follow program policies and
317.27 rules ensuring safety of self and others; and

317.28 (5) be at significant risk of one or more of the following if dialectical behavior therapy
317.29 is not provided:

317.30 (i) having a mental health crisis;

317.31 (ii) requiring a more restrictive setting including hospitalization;

318.1 (iii) decompensation; or

318.2 (iv) engaging in intentional self-harm behavior.

318.3 (d) Individual dialectical behavior therapy combines individualized rehabilitative and
318.4 psychotherapeutic interventions to treat suicidal and other dysfunctional behaviors and
318.5 reinforce the use of adaptive skillful behaviors. Individual dialectical behavior therapy must
318.6 be provided by a mental health professional or a clinical trainee. The mental health
318.7 professional or clinical trainee must:

318.8 (1) identify, prioritize, and sequence behavioral targets;

318.9 (2) treat behavioral targets;

318.10 (3) generalize dialectical behavior therapy skills to the client's natural environment
318.11 through telephone coaching outside of the treatment session;

318.12 (4) measure the client's progress toward dialectical behavior therapy targets;

318.13 (5) help the client manage mental health crises and life-threatening behaviors; and

318.14 (6) help the client learn and apply effective behaviors when working with other treatment
318.15 providers.

318.16 (e) Group skills training combines individualized psychotherapeutic and psychiatric
318.17 rehabilitative interventions conducted in a group setting to reduce the client's suicidal and
318.18 other dysfunctional coping behaviors and restore function. Group skills training must teach
318.19 the client adaptive skills in the following areas:

318.20 (1) mindfulness;

318.21 (2) interpersonal effectiveness;

318.22 (3) emotional regulation; and

318.23 (4) distress tolerance.

318.24 (f) Group skills training must be provided by two mental health professionals, or by a
318.25 mental health professional co-facilitating with a clinical trainee or a mental health practitioner
318.26 as specified in section 245I.16, subdivision 4. Individual skills training must be provided
318.27 by a mental health professional, a clinical trainee, or a mental health practitioner as specified
318.28 in section 245I.16, subdivision 4.

318.29 (g) A program must be certified by the commissioner as a dialectical behavior therapy
318.30 provider. To qualify for certification, a provider must:

319.1 (1) hold current accreditation as a dialectical behavior therapy program from a nationally
319.2 recognized certification body approved by the commissioner;

319.3 (2) submit to the commissioner's inspection;

319.4 (3) provide evidence that the dialectical behavior therapy program's policies, procedures,
319.5 and practices continuously meet the requirements of this subdivision;

319.6 (4) be enrolled as a MHCP provider;

319.7 (5) collect and report client outcomes as specified by the commissioner; and

319.8 (6) have a manual that outlines the dialectical behavior therapy program's policies,
319.9 procedures, and practices that meet the requirements of this subdivision.

319.10 Sec. 83. Minnesota Statutes 2018, section 256B.0625, subdivision 19c, is amended to
319.11 read:

319.12 Subd. 19c. **Personal care.** Medical assistance covers personal care assistance services
319.13 provided by an individual who is qualified to provide the services according to subdivision
319.14 19a and sections 256B.0651 to 256B.0654, provided in accordance with a plan, and
319.15 supervised by a qualified professional.

319.16 "Qualified professional" means a mental health professional ~~as defined in section 245.462,~~
319.17 ~~subdivision 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6);~~ a registered
319.18 nurse as defined in sections 148.171 to 148.285, a licensed social worker as defined in
319.19 sections 148E.010 and 148E.055, or a qualified designated coordinator under section
319.20 245D.081, subdivision 2. The qualified professional shall perform the duties required in
319.21 section 256B.0659.

319.22 Sec. 84. Minnesota Statutes 2018, section 256B.0625, subdivision 23, is amended to read:

319.23 Subd. 23. **Adult day treatment services.** (a) Medical assistance covers adult day
319.24 treatment services as specified in sections 245.462, subdivision 8, and 245.4871, subdivision
319.25 10, that are provided under contract with the county board. The commissioner may set
319.26 authorization thresholds for day treatment for adults according to subdivision 25. Medical
319.27 assistance covers day treatment services for children as specified under section 256B.0943.
319.28 Adult day treatment payment is limited to the conditions in paragraphs (b) to (e).

319.29 (b) Adult day treatment is an intensive psychotherapeutic treatment to reduce or relieve
319.30 the effects of mental illness to enable the client to benefit from a lower level of care and to
319.31 live and function more independently in the community. Adult day treatment services must

320.1 stabilize the client's mental health status and develop and improve the client's independent
320.2 living and socialization skills. Adult day treatment must consist of at least one hour of group
320.3 psychotherapy and must include group time focused on rehabilitative interventions or other
320.4 therapeutic services that are provided by a multidisciplinary staff person. Adult day treatment
320.5 services are not a part of inpatient or residential treatment services.

320.6 (c) To be eligible for medical assistance payment, an adult day treatment service must:

320.7 (1) be reviewed by and approved by the commissioner;

320.8 (2) be provided to a group of clients by a multidisciplinary staff person under the
320.9 treatment supervision of a mental health professional as described under section 245I.18;

320.10 (3) be available to the client at least two days a week for at least three consecutive hours
320.11 per day. The adult day treatment may be longer than three hours per day, but medical
320.12 assistance must not reimburse a provider for more than 15 hours per week;

320.13 (4) include group psychotherapy by a mental health professional or clinical trainee and
320.14 daily rehabilitative interventions by a mental health professional qualified according to
320.15 section 245I.16, subdivision 2, clinical trainee qualified according to section 245I.16,
320.16 subdivision 6, or mental health practitioner qualified according to section 245I.16, subdivision
320.17 4;

320.18 (5) be included in the client's individual treatment plan as described under section
320.19 256B.0671, subdivisions 5 and 6, as appropriate. The individual treatment plan must include
320.20 attainable, measurable goals related to services and must be completed before the first adult
320.21 day treatment session. The vendor must review the client's progress and update the treatment
320.22 plan at least every 30 days until the client is discharged and include an available discharge
320.23 plan for the client in the treatment plan; and

320.24 (6) document the daily interventions provided and the client's response according to
320.25 section 245I.33.

320.26 (d) To be eligible for adult day treatment, a client must:

320.27 (1) be 18 years of age or older;

320.28 (2) not be residing in a nursing facility, hospital, institute of mental disease, or regional
320.29 treatment center unless the client has an active discharge plan that indicates a move to an
320.30 independent living arrangement within 180 days;

320.31 (3) have a diagnosis of mental illness as determined by a diagnostic assessment;

321.1 (4) have the capacity to engage in the rehabilitative nature, the structured setting, and
 321.2 the therapeutic parts of psychotherapy and skills activities of an adult day treatment program
 321.3 and demonstrate measurable improvements in the client's functioning related to the client's
 321.4 mental illness that would result from participating in the adult day treatment program;

321.5 (5) have at least three areas of functional impairment as determined by a functional
 321.6 assessment with the domains prescribed by section 245.462, subdivision 11a;

321.7 (6) have a level of care determination that supports the need for the level of intensity
 321.8 and duration of an adult day treatment program; and

321.9 (7) be determined to need adult day treatment services by a mental health professional
 321.10 who must deem the adult day treatment services medically necessary.

321.11 (e) The following services are not covered by medical assistance as an adult day treatment
 321.12 service:

321.13 (1) a service that is primarily recreation-oriented or that is provided in a setting that is
 321.14 not medically supervised. This includes sports activities, exercise groups, craft hours, leisure
 321.15 time, social hours, meal or snack time, trips to community activities, and tours;

321.16 (2) a social or educational service that does not have or cannot reasonably be expected
 321.17 to have a therapeutic outcome related to the client's mental illness;

321.18 (3) consultation with other providers or service agency staff persons about the care or
 321.19 progress of a client;

321.20 (4) prevention or education programs provided to the community;

321.21 (5) day treatment for clients with primary diagnoses of alcohol or other drug abuse;

321.22 (6) day treatment provided in the client's home;

321.23 (7) psychotherapy for more than two hours per day; and

321.24 (8) participation in meal preparation and eating that is not part of a clinical treatment
 321.25 plan to address the client's eating disorder.

321.26 Sec. 85. Minnesota Statutes 2018, section 256B.0625, subdivision 42, is amended to read:

321.27 Subd. 42. **Mental health professional.** Notwithstanding Minnesota Rules, part
 321.28 9505.0175, subpart 28, the definition of a mental health professional shall include a person
 321.29 who is qualified as specified in section ~~245.462, subdivision 18, clauses (1) to (6); or~~
 321.30 ~~245.4871, subdivision 27, clauses (1) to (6);~~ 245I.16, subdivision 2, for the purpose of this
 321.31 section and Minnesota Rules, parts 9505.0170 to 9505.0475.

322.1 Sec. 86. Minnesota Statutes 2018, section 256B.0625, subdivision 48, is amended to read:

322.2 Subd. 48. **Psychiatric consultation to primary care practitioners.** Medical assistance
 322.3 covers consultation provided by a ~~psychiatrist, a psychologist, an advanced practice registered~~
 322.4 ~~nurse certified in psychiatric mental health, a licensed independent clinical social worker,~~
 322.5 ~~as defined in section 245.462, subdivision 18, clause (2), or a licensed marriage and family~~
 322.6 ~~therapist, as defined in section 245.462, subdivision 18, clause (5),~~ mental health professional
 322.7 except one licensed under section 148B.5301 via telephone, e-mail, facsimile, or other
 322.8 means of communication to primary care practitioners, including pediatricians. The need
 322.9 for consultation and the receipt of the consultation must be documented in the patient record
 322.10 maintained by the primary care practitioner. If the patient consents, and subject to federal
 322.11 limitations and data privacy provisions, the consultation may be provided without the patient
 322.12 present.

322.13 Sec. 87. Minnesota Statutes 2018, section 256B.0625, subdivision 49, is amended to read:

322.14 Subd. 49. **Community health worker.** (a) Medical assistance covers the care
 322.15 coordination and patient education services provided by a community health worker if the
 322.16 community health worker has: ~~(1) received a certificate from the Minnesota State Colleges~~
 322.17 ~~and Universities System approved community health worker curriculum; or,~~

322.18 ~~(2) at least five years of supervised experience with an enrolled physician, registered~~
 322.19 ~~nurse, advanced practice registered nurse, mental health professional as defined in section~~
 322.20 ~~245.462, subdivision 18, clauses (1) to (6), and section 245.4871, subdivision 27, clauses~~
 322.21 ~~(1) to (5), or dentist, or at least five years of supervised experience by a certified public~~
 322.22 ~~health nurse operating under the direct authority of an enrolled unit of government.~~

322.23 ~~Community health workers eligible for payment under clause (2) must complete the~~
 322.24 ~~certification program by January 1, 2010, to continue to be eligible for payment.~~

322.25 (b) Community health workers must work under the supervision of a medical assistance
 322.26 enrolled physician, registered nurse, advanced practice registered nurse, mental health
 322.27 professional ~~as defined in section 245.462, subdivision 18, clauses (1) to (6), and section~~
 322.28 ~~245.4871, subdivision 27, clauses (1) to (5), or dentist, or work under the supervision of a~~
 322.29 ~~certified public health nurse operating under the direct authority of an enrolled unit of~~
 322.30 ~~government.~~

322.31 (c) Care coordination and patient education services covered under this subdivision
 322.32 include, but are not limited to, services relating to oral health and dental care.

323.1 Sec. 88. Minnesota Statutes 2018, section 256B.0625, subdivision 56a, is amended to
323.2 read:

323.3 Subd. 56a. **Post-arrest community-based service coordination.** (a) Medical assistance
323.4 covers post-arrest community-based service coordination for an individual who:

323.5 (1) has been identified as having a mental illness or substance use disorder using a
323.6 screening tool approved by the commissioner;

323.7 (2) does not require the security of a public detention facility and is not considered an
323.8 inmate of a public institution as defined in Code of Federal Regulations, title 42, section
323.9 435.1010;

323.10 (3) meets the eligibility requirements in section 256B.056; and

323.11 (4) has agreed to participate in post-arrest community-based service coordination through
323.12 a diversion contract in lieu of incarceration.

323.13 (b) Post-arrest community-based service coordination means navigating services to
323.14 address a client's mental health, chemical health, social, economic, and housing needs, or
323.15 any other activity targeted at reducing the incidence of jail utilization and connecting
323.16 individuals with existing covered services available to them, including, but not limited to,
323.17 targeted case management, waiver case management, or care coordination.

323.18 (c) Post-arrest community-based service coordination must be provided by an individual
323.19 who is an employee of a county or is under contract with a county to provide post-arrest
323.20 community-based coordination and is qualified under one of the following criteria:

323.21 (1) a licensed mental health professional ~~as defined in section 245.462, subdivision 18,~~
323.22 ~~clauses (1) to (6);~~

323.23 (2) a mental health practitioner as defined in section 245.462, subdivision 17, working
323.24 under the clinical treatment supervision of a mental health professional; ~~or~~

323.25 (3) a certified peer specialist under section 256B.0615, working under the clinical
323.26 treatment supervision of a mental health professional; or

323.27 (4) a clinical trainee.

323.28 (d) Reimbursement is allowed for up to 60 days following the initial determination of
323.29 eligibility.

323.30 (e) Providers of post-arrest community-based service coordination shall annually report
323.31 to the commissioner on the number of individuals served, and number of the
323.32 community-based services that were accessed by recipients. The commissioner shall ensure

324.1 that services and payments provided under post-arrest community-based service coordination
 324.2 do not duplicate services or payments provided under section 256B.0625, subdivision 20,
 324.3 256B.0753, 256B.0755, or 256B.0757.

324.4 (f) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of cost for
 324.5 post-arrest community-based service coordination services shall be provided by the county
 324.6 providing the services, from sources other than federal funds or funds used to match other
 324.7 federal funds.

324.8 Sec. 89. Minnesota Statutes 2018, section 256B.0625, subdivision 61, is amended to read:

324.9 Subd. 61. **Family psychoeducation services.** ~~Effective July 1, 2013, or upon federal~~
 324.10 ~~approval, whichever is later,~~ Medical assistance covers family psychoeducation services
 324.11 provided to a child up to age 21 with a diagnosed mental health condition when identified
 324.12 in the child's individual treatment plan and provided by a licensed mental health professional,
 324.13 ~~as defined in Minnesota Rules, part 9505.0371, subpart 5, item A,~~ or a clinical trainee, ~~as~~
 324.14 ~~defined in Minnesota Rules, part 9505.0371, subpart 5, item C,~~ who has determined it
 324.15 medically necessary to involve family members in the child's care. For the purposes of this
 324.16 subdivision, "family psychoeducation services" means information or demonstration provided
 324.17 to an individual or family as part of an individual, family, multifamily group, or peer group
 324.18 session to explain, educate, and support the child and family in understanding a child's
 324.19 symptoms of mental illness, the impact on the child's development, and needed components
 324.20 of treatment and skill development so that the individual, family, or group can help the child
 324.21 to prevent relapse, prevent the acquisition of comorbid disorders, and achieve optimal mental
 324.22 health and long-term resilience.

324.23 Sec. 90. Minnesota Statutes 2018, section 256B.0625, subdivision 62, is amended to read:

324.24 Subd. 62. **Mental health clinical care consultation.** ~~Effective July 1, 2013, or upon~~
 324.25 ~~federal approval, whichever is later,~~ Medical assistance covers clinical care consultation
 324.26 for a person up to age 21 who is diagnosed with a complex mental health condition or a
 324.27 mental health condition that co-occurs with other complex and chronic conditions, when
 324.28 described in the person's individual treatment plan and provided by a licensed mental health
 324.29 professional, ~~as defined in Minnesota Rules, part 9505.0371, subpart 5, item A,~~ or a clinical
 324.30 trainee, ~~as defined in Minnesota Rules, part 9505.0371, subpart 5, item C.~~ For the purposes
 324.31 of this subdivision, "clinical care consultation" means communication from a treating mental
 324.32 health professional to other providers or educators not under the clinical supervision of the
 324.33 treating mental health professional who are working with the same client to inform, inquire,

325.1 and instruct regarding the client's symptoms; strategies for effective engagement, care, and
325.2 intervention needs; and treatment expectations across service settings; and to direct and
325.3 coordinate clinical service components provided to the client and family.

325.4 Sec. 91. Minnesota Statutes 2018, section 256B.0625, subdivision 65, is amended to read:

325.5 Subd. 65. **Outpatient mental health services.** For the purposes of this section, "clinical
325.6 trainee" has the meaning given in section 245I.16, subdivision 6. Medical assistance covers
325.7 diagnostic assessment, explanation of findings, and psychotherapy according to Minnesota
325.8 Rules, part 9505.0372, subdivision 69 and section 256B.0671 when the mental health
325.9 services are performed by a mental health practitioner working as a clinical trainee according
325.10 to section 245.462, subdivision 17, paragraph (g).

325.11 Sec. 92. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision
325.12 to read:

325.13 Subd. 66. **Neuropsychological assessment.** (a) "Neuropsychological assessment" means
325.14 a specialized clinical assessment of the client's underlying cognitive abilities related to
325.15 thinking, reasoning, and judgment that is conducted by a qualified neuropsychologist. A
325.16 neuropsychological assessment must include a face-to-face interview with the client,
325.17 interpretation of the test results, and preparation and completion of a report.

325.18 (b) A client is eligible for a neuropsychological assessment if at least one of the following
325.19 criteria is met:

325.20 (1) there is a known or strongly suspected brain disorder based on medical history or
325.21 neurological evaluation, including a history of significant head trauma, brain tumor, stroke,
325.22 seizure disorder, multiple sclerosis, neurodegenerative disorder, significant exposure to
325.23 neurotoxins, central nervous system infection, metabolic or toxic encephalopathy, fetal
325.24 alcohol syndrome, or congenital malformation of the brain; or

325.25 (2) there are cognitive or behavioral symptoms that suggest that the client has an organic
325.26 condition that cannot be readily attributed to functional psychopathology or suspected
325.27 neuropsychological impairment in addition to functional psychopathology. This includes:

325.28 (i) poor memory or impaired problem solving;

325.29 (ii) change in mental status evidenced by lethargy, confusion, or disorientation;

325.30 (iii) deterioration in level of functioning;

325.31 (iv) marked behavioral or personality change;

326.1 (v) in children or adolescents, significant delays in academic skill acquisition or poor
326.2 attention relative to peers;

326.3 (vi) in children or adolescents, significant plateau in expected development of cognitive,
326.4 social, emotional, or physical function relative to peers; and

326.5 (vii) in children or adolescents, significant inability to develop expected knowledge,
326.6 skills, or abilities as required to adapt to new or changing cognitive, social, emotional, or
326.7 physical demands.

326.8 (c) The neuropsychological assessment must be conducted by a neuropsychologist
326.9 competent in the area of neuropsychological assessment who:

326.10 (1) was awarded a diploma by the American Board of Clinical Neuropsychology, the
326.11 American Board of Professional Neuropsychology, or the American Board of Pediatric
326.12 Neuropsychology;

326.13 (2) earned a doctoral degree in psychology from an accredited university training program
326.14 and:

326.15 (i) completed an internship or its equivalent in a clinically relevant area of professional
326.16 psychology;

326.17 (ii) completed the equivalent of two full-time years of experience and specialized training,
326.18 at least one of which is at the postdoctoral level, supervised by a clinical neuropsychologist
326.19 in the study and practice of clinical neuropsychology and related neurosciences; and

326.20 (iii) holds a current license to practice psychology independently according to sections
326.21 144.88 to 144.98;

326.22 (3) is licensed or credentialed by another state's board of psychology examiners in the
326.23 specialty of neuropsychology using requirements equivalent to requirements specified by
326.24 one of the boards named in clause (1); or

326.25 (4) was approved by the commissioner as an eligible provider of neuropsychological
326.26 assessment prior to December 31, 2010.

326.27 Sec. 93. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision
326.28 to read:

326.29 Subd. 67. **Neuropsychological testing.** (a) "Neuropsychological testing" means
326.30 administering standardized tests and measures designed to evaluate the client's ability to
326.31 attend to, process, interpret, comprehend, communicate, learn, and recall information and
326.32 use problem solving and judgment.

- 327.1 (b) Medical assistance covers neuropsychological testing when the client:
- 327.2 (1) has a significant mental status change that is not a result of a metabolic disorder and
- 327.3 that has failed to respond to treatment;
- 327.4 (2) is a child or adolescent with a significant plateau in expected development of
- 327.5 cognitive, social, emotional, or physical function relative to peers;
- 327.6 (3) is a child or adolescent with a significant inability to develop expected knowledge,
- 327.7 skills, or abilities as required to adapt to new or changing cognitive, social, physical, or
- 327.8 emotional demands; or
- 327.9 (4) has a significant behavioral change, memory loss, or suspected neuropsychological
- 327.10 impairment in addition to functional psychopathology, or other organic brain injury or one
- 327.11 of the following:
- 327.12 (i) traumatic brain injury;
- 327.13 (ii) stroke;
- 327.14 (iii) brain tumor;
- 327.15 (iv) substance use disorder;
- 327.16 (v) cerebral anoxic or hypoxic episode;
- 327.17 (vi) central nervous system infection or other infectious disease;
- 327.18 (vii) neoplasms or vascular injury of the central nervous system;
- 327.19 (viii) neurodegenerative disorders;
- 327.20 (ix) demyelinating disease;
- 327.21 (x) extrapyramidal disease;
- 327.22 (xi) exposure to systemic or intrathecal agents or cranial radiation known to be associated
- 327.23 with cerebral dysfunction;
- 327.24 (xii) systemic medical conditions known to be associated with cerebral dysfunction,
- 327.25 including renal disease, hepatic encephalopathy, cardiac anomaly, sickle cell disease, and
- 327.26 related hematologic anomalies, and autoimmune disorders, including lupus, erythematosis,
- 327.27 or celiac disease;
- 327.28 (xiii) congenital genetic or metabolic disorders known to be associated with cerebral
- 327.29 dysfunction, including phenylketonuria, craniofacial syndromes, or congenital hydrocephalus;
- 327.30 (xiv) severe or prolonged nutrition or malabsorption syndromes; or

328.1 (xv) a condition presenting in a manner difficult for a clinician to distinguish between
328.2 the neurocognitive effects of a neurogenic syndrome, including dementia or encephalopathy;
328.3 and a major depressive disorder when adequate treatment for major depressive disorder has
328.4 not resulted in improvement in neurocognitive function; or another disorder, including
328.5 autism, selective mutism, anxiety disorder, or reactive attachment disorder.

328.6 (c) Neuropsychological testing must be administered or clinically supervised by a
328.7 neuropsychologist qualified as defined in subdivision 66, paragraph (c).

328.8 (d) Neuropsychological testing is not covered when performed: (1) primarily for
328.9 educational purposes; (2) primarily for vocational counseling or training; (3) for personnel
328.10 or employment testing; (4) as a routine battery of psychological tests given at inpatient
328.11 admission or during a continued stay; or (5) for legal or forensic purposes.

328.12 Sec. 94. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision
328.13 to read:

328.14 Subd. 68. **Psychological testing.** (a) "Psychological testing" means the use of tests or
328.15 other psychometric instruments to determine the status of the client's mental, intellectual,
328.16 and emotional functioning.

328.17 (b) The psychological testing must:

328.18 (1) be administered or clinically supervised by a licensed psychologist qualified according
328.19 to section 245I.16, subdivision 2, clause (3), competent in the area of psychological testing;
328.20 and

328.21 (2) be validated in a face-to-face interview between the client and a licensed psychologist
328.22 or a clinical psychology trainee qualified according to section 245I.16, subdivision 6, under
328.23 the treatment supervision of a licensed psychologist according to section 245I.18.

328.24 (c) The administration, scoring, and interpretation of the psychological tests must be
328.25 done under the treatment supervision of a licensed psychologist when performed by a clinical
328.26 psychology trainee, technician, psychometrist, or psychological assistant or as part of a
328.27 computer-assisted psychological testing program. The report resulting from the psychological
328.28 testing must be signed by the psychologist conducting the face-to-face interview, placed in
328.29 the client's record, and released to each person authorized by the client.

329.1 Sec. 95. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision
329.2 to read:

329.3 Subd. 69. **Psychotherapy.** (a) "Psychotherapy" means treatment of a client with mental
329.4 illness that applies to the most appropriate psychological, psychiatric, psychosocial, or
329.5 interpersonal method that conforms to prevailing community standards of professional
329.6 practice to meet the mental health needs of the client. Medical assistance covers
329.7 psychotherapy if conducted by a mental health professional qualified according to section
329.8 245I.16, subdivision 2, or a clinical trainee qualified according to section 245I.16, subdivision
329.9 6.

329.10 (b) Individual psychotherapy is psychotherapy designed for one client.

329.11 (c) Family psychotherapy is designed for the client and one or more family members or
329.12 the client's primary caregiver whose participation is necessary to accomplish the client's
329.13 treatment goals. Family members or primary caregivers participating in a therapy session
329.14 do not need to be eligible for medical assistance. For purposes of this paragraph, "primary
329.15 caregiver whose participation is necessary to accomplish the client's treatment goals" excludes
329.16 shift or facility staff persons at the client's residence. Medical assistance payment for family
329.17 psychotherapy is limited to face-to-face sessions at which the client is present throughout
329.18 the family psychotherapy session unless the mental health professional believes the client's
329.19 absence from the family psychotherapy session is necessary to carry out the client's individual
329.20 treatment plan. If the client is excluded, the mental health professional must document the
329.21 reason for and the length of time of the exclusion. The mental health professional must also
329.22 document any reason a member of the client's family is excluded.

329.23 (d) Group psychotherapy is appropriate for a client who, because of the nature of the
329.24 client's emotional, behavioral, or social dysfunctions, can derive mutual benefit from
329.25 treatment in a group setting. For a group of three to eight persons, one mental health
329.26 professional or clinical trainee is required to conduct the group. For a group of nine to 12
329.27 persons, a team of at least two mental health professionals or two clinical trainees or one
329.28 mental health professional and one clinical trainee is required to co-conduct the group.
329.29 Medical assistance payment is limited to a group of no more than 12 persons.

329.30 (e) A multiple-family group psychotherapy session is eligible for medical assistance
329.31 payment if the psychotherapy session is designed for at least two but not more than five
329.32 families. Multiple-family group psychotherapy is clearly directed toward meeting the
329.33 identified treatment needs of each client as indicated in each client's treatment plan. If the
329.34 client is excluded, the mental health professional or clinical trainee must document the

330.1 reason for and the length of time of the exclusion. The mental health professional or clinical
 330.2 trainee must document any reason a member of the client's family is excluded.

330.3 Sec. 96. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision
 330.4 to read:

330.5 Subd. 70. **Partial hospitalization.** "Partial hospitalization" means a provider's
 330.6 time-limited, structured program of psychotherapy and other therapeutic services, as defined
 330.7 in United States Code, title 42, chapter 7, subchapter XVIII, part E, section 1395x(ff), that
 330.8 is provided in an outpatient hospital facility or community mental health center that meets
 330.9 Medicare requirements to provide partial hospitalization services. Partial hospitalization is
 330.10 a covered service when it is an appropriate alternative to inpatient hospitalization for a client
 330.11 who is experiencing an acute episode of mental illness that meets the criteria for an inpatient
 330.12 hospital admission under Minnesota Rules, part 9505.0520, subpart 1, and who has the
 330.13 family and community resources necessary and appropriate to support the client's residence
 330.14 in the community. Partial hospitalization consists of multiple intensive short-term therapeutic
 330.15 services provided by a multidisciplinary staff person to treat the client's mental illness.

330.16 Sec. 97. **[256B.0671] CLIENT ELIGIBILITY FOR MENTAL HEALTH SERVICES.**

330.17 Subdivision 1. **Definitions.** For the purposes of this section, the definitions in section
 330.18 245I.02 apply.

330.19 Subd. 1a. **Generally.** (a) The provider must use a diagnostic assessment or crisis
 330.20 assessment to determine a client's eligibility for mental health services, except as provided
 330.21 in this section.

330.22 (b) Prior to completion of a client's initial diagnostic assessment, a client is eligible for:

330.23 (1) one explanation of findings;

330.24 (2) one psychological testing;

330.25 (3) any combination of individual psychotherapy sessions, family psychotherapy sessions,
 330.26 group psychotherapy sessions, and individual or family psychoeducation sessions not to
 330.27 exceed three sessions; and

330.28 (4) crisis assessment and intervention services provided according to section 256B.0624
 330.29 or 256B.0944.

330.30 (c) Based on the needs identified in a crisis assessment as specified in section 256B.0624
 330.31 or 256B.0944, a client may receive: (1) crisis stabilization services; and (2) any combination

331.1 of individual psychotherapy sessions, family psychotherapy sessions, or family
331.2 psychoeducation sessions not to exceed ten sessions within a 12-month period without prior
331.3 authorization.

331.4 (d) Based on the needs identified in a brief diagnostic assessment, a client may receive
331.5 a combination of individual psychotherapy sessions, family psychotherapy sessions, or
331.6 family psychoeducation sessions not to exceed ten sessions within a 12-month period without
331.7 prior authorization for any new client or for an existing client who is projected to need fewer
331.8 than ten sessions in the next 12 months.

331.9 (e) If the amount of services or intensity required by the client exceeds the coverage
331.10 limits in this section, a provider shall complete a standard diagnostic assessment.

331.11 (f) A new standard diagnostic assessment must be completed:

331.12 (1) when the client requires services of a greater number or intensity than those permitted
331.13 by paragraphs (b) to (d);

331.14 (2) at least annually following the initial diagnostic assessment if additional services are
331.15 needed and the client does not meet the criteria for brief assessment.

331.16 (3) when the client's mental health condition has changed markedly since the client's
331.17 most recent diagnostic assessment; or

331.18 (4) when the client's current mental health condition does not meet the criteria of the
331.19 client's current diagnosis.

331.20 (g) For an existing client, a new standard diagnostic assessment shall include a written
331.21 update of the parts where significant new or changed information exists, and documentation
331.22 where there has not been significant change, including discussion with the client about
331.23 changes in the client's life situation, functioning, presenting problems, and progress on
331.24 treatment goals since the last diagnostic assessment was completed.

331.25 Subd. 1b. **Continuity of services.** (a) For any client served with a diagnostic assessment
331.26 completed under Minnesota Rules, parts 9505.0370 to 9505.0372, before the effective date,
331.27 the diagnostic assessment is valid for purposes of authorizing treatment and billing for one
331.28 calendar year after completion.

331.29 (b) For any client served with an individual treatment plan completed under section
331.30 256B.0622, 256B.0623, 256B.0943, 256B.0946, or 256B.0947 or Minnesota Rules, parts
331.31 9505.0370 to 9505.0372, the individual treatment plan is valid for purposes of authorizing
331.32 treatment and billing until its expiration date.

332.1 (c) This subdivision expires July 1, 2021.

332.2 Subd. 2. **Diagnostic assessment.** To be eligible for medical assistance payment, a
332.3 diagnostic assessment must (1) identify at least one mental health diagnosis and recommend
332.4 mental health services to develop the client's mental health services and treatment plan, or
332.5 (2) include a finding that the client does not meet the criteria for a mental health disorder.

332.6 Subd. 3. **Standard diagnostic assessment requirements.** (a) A standard diagnostic
332.7 assessment must include a face-to-face interview with the client and contain a written
332.8 evaluation of a client by a mental health professional or clinical trainee. The standard
332.9 diagnostic assessment must be completed within the cultural context of the client.

332.10 (b) The clinician shall gather and document information related to the client's current
332.11 life situation and the client's:

332.12 (1) age;

332.13 (2) current living situation, including household membership and housing status;

332.14 (3) basic needs status;

332.15 (4) education level and employment status;

332.16 (5) family and other significant personal relationships, including the client's evaluation
332.17 of relationship quality;

332.18 (6) strengths and resources, including the extent and quality of social networks;

332.19 (7) belief systems;

332.20 (8) current medications; and

332.21 (9) immediate risks to health and safety.

332.22 (c) The clinician shall gather and document information related to the elements of the
332.23 assessment, including the client's:

332.24 (1) perceptions of the client's condition;

332.25 (2) description of symptoms, including reason for referral;

332.26 (3) history of mental health treatment; and

332.27 (4) cultural influences and the impact on the client.

332.28 (d) A clinician completing a diagnostic assessment shall use professional judgment in
332.29 making inquiries under this paragraph. If information cannot be obtained without
332.30 retraumatizing the client or harming the client's willingness to engage in treatment, the

333.1 clinician shall document which topics require further attention in the course of treatment.

333.2 A clinician must, as clinically appropriate, include the following information related to a
333.3 client in a diagnostic assessment:

333.4 (1) important developmental incidents;

333.5 (2) maltreatment, trauma, potential brain injuries, or abuse issues;

333.6 (3) history of alcohol and drug usage and treatment; and

333.7 (4) health history and family health history, including physical, chemical, and mental
333.8 health history.

333.9 (e) The clinician must perform and document the following components of the
333.10 assessment:

333.11 (1) the client's mental status examination;

333.12 (2) information gathered concerning the client's baseline measurements; symptoms;

333.13 behavior; skills; abilities; resources; vulnerabilities; safety needs, including client data

333.14 adequate to support findings based on the current edition of the Diagnostic and Statistical

333.15 Manual of Mental Disorders, published by the American Psychiatric Association; and any

333.16 differential diagnosis;

333.17 (3) for a child younger than 6 years of age, a clinician may use the current edition of the

333.18 DC: 0-5 Diagnostic Classification of Mental Health and Development Disorders of Infancy

333.19 and Early Childhood instead of the Diagnostic and Statistical Manual of Mental Disorders;

333.20 (4) the screenings used to determine the client's substance use, abuse, or dependency

333.21 and other standardized screening instruments determined by the commissioner;

333.22 (5) use of standardized outcome measurements by the provider as determined and

333.23 periodically updated by the commissioner; and

333.24 (6) a case conceptualization that explains: (i) the diagnostic formulation made based on

333.25 the information gathered through the interview, assessment, available psychological testing,

333.26 and collateral information; (ii) the needs of the client; (iii) risk factors; (iv) strengths; and

333.27 (v) responsivity factors.

333.28 (f) The diagnostic assessment must include recommendations, client and family

333.29 participation in assessment and service preferences, and referrals to services required by

333.30 law.

333.31 Subd. 4. **Brief diagnostic assessment requirements.** (a) A brief diagnostic assessment

333.32 must include a face-to-face interview with the client and a written evaluation of the client

334.1 by a mental health professional or a clinical trainee. The mental health professional or
334.2 clinical trainee must gather initial components of a standard diagnostic assessment, including
334.3 the client's:

334.4 (1) age;

334.5 (2) description of symptoms, including reason for referral;

334.6 (3) history of mental health treatment;

334.7 (4) cultural influences and their impact on the client; and

334.8 (5) mental status examination.

334.9 (b) On the basis of the initial components, the mental health professional or clinical
334.10 trainee must draw a provisional diagnostic formulation. The diagnostic formulation may be
334.11 used to address the client's immediate needs or presenting problem.

334.12 (c) Treatment sessions conducted under authorization of a brief diagnostic assessment
334.13 may be used to gather additional information necessary to complete a standard diagnostic
334.14 assessment if coverage limits in subdivision 1 will be exceeded.

334.15 Subd. 5. **Individual treatment plan.** Medical assistance payment is available only for
334.16 mental health services provided in accordance with the client's written individual treatment
334.17 plan, with the following exceptions: (1) services that do not require a standard diagnostic
334.18 assessment prior to service delivery; (2) service plan development; and (3) re-engagement
334.19 of a client as described in subdivision 6, clause (6).

334.20 Subd. 6. **Individual treatment plan; required elements.** An individual treatment plan
334.21 must:

334.22 (1) be based on the information in the client's diagnostic assessment and baselines;

334.23 (2) identify goals and objectives of treatment, the treatment strategy, the schedule for
334.24 accomplishing treatment goals and measurable objectives, and the individuals responsible
334.25 for providing treatment services and supports;

334.26 (3) be developed after completion of the client's diagnostic assessment, within three
334.27 visits unless otherwise specified by a service line;

334.28 (4) for a child client, be developed through a child-centered, family-driven, culturally
334.29 appropriate planning process, including allowing parents and guardians to observe or
334.30 participate in individual and family treatment services, assessment, and treatment planning.

334.31 For an adult client, the individual treatment plan must be developed through a

335.1 person-centered, culturally appropriate planning process, including allowing identified
 335.2 supports to observe or participate in treatment services, assessment, and treatment planning;
 335.3 (5) be reviewed at least every 90 days unless otherwise specified by the requirements
 335.4 of a service line and revised to document treatment progress on each treatment objective
 335.5 and next goals or, if progress is not documented, to document changes in treatment; and
 335.6 (6) be approved by the client, the client's parent, or other person authorized by law to
 335.7 consent to mental health services for the client. If approval cannot be obtained, a mental
 335.8 health professional shall make efforts to obtain approval from an authorized person for a
 335.9 period of 30 days following the date the previous individual treatment plan expired. A client
 335.10 shall not be denied service in this time period solely on the basis of an unapproved individual
 335.11 treatment plan. A provider entity may continue to bill for otherwise eligible services during
 335.12 a period of re-engagement.

335.13 Sec. 98. Minnesota Statutes 2018, section 256B.0757, subdivision 2, is amended to read:

335.14 Subd. 2. **Eligible individual.** An individual is eligible for health home services under
 335.15 this section if the individual is eligible for medical assistance under this chapter and has at
 335.16 least:

335.17 (1) two chronic conditions;

335.18 (2) one chronic condition and is at risk of having a second chronic condition;

335.19 (3) one serious and persistent mental health condition; or

335.20 (4) a condition that meets the definition in section 245.462, subdivision 20, paragraph
 335.21 (a), or 245.4871, subdivision 15, clause (2); and has a current diagnostic assessment as
 335.22 ~~defined in Minnesota Rules, part 9505.0372, subpart 1, item B or C~~ that meets the
 335.23 requirements of section 256B.0671, subdivisions 2 and 3, as performed or reviewed by a
 335.24 mental health professional employed by or under contract with the behavioral health home.
 335.25 The commissioner shall establish criteria for determining continued eligibility.

335.26 Sec. 99. Minnesota Statutes 2018, section 256B.0941, subdivision 1, is amended to read:

335.27 Subdivision 1. **Eligibility.** (a) An individual who is eligible for mental health treatment
 335.28 services in a psychiatric residential treatment facility must meet all of the following criteria:

335.29 (1) before admission, services are determined to be medically necessary by the state's
 335.30 medical review agent according to Code of Federal Regulations, title 42, section 441.152;

336.1 (2) is younger than 21 years of age at the time of admission. Services may continue until
336.2 the individual meets criteria for discharge or reaches 22 years of age, whichever occurs
336.3 first;

336.4 (3) has a mental health diagnosis as defined in the most recent edition of the Diagnostic
336.5 and Statistical Manual for Mental Disorders, as well as clinical evidence of severe aggression,
336.6 or a finding that the individual is a risk to self or others;

336.7 (4) has functional impairment and a history of difficulty in functioning safely and
336.8 successfully in the community, school, home, or job; an inability to adequately care for
336.9 one's physical needs; or caregivers, guardians, or family members are unable to safely fulfill
336.10 the individual's needs;

336.11 (5) requires psychiatric residential treatment under the direction of a physician to improve
336.12 the individual's condition or prevent further regression so that services will no longer be
336.13 needed;

336.14 (6) utilized and exhausted other community-based mental health services, or clinical
336.15 evidence indicates that such services cannot provide the level of care needed; and

336.16 (7) was referred for treatment in a psychiatric residential treatment facility by a qualified
336.17 mental health professional ~~licensed as defined in section 245.4871, subdivision 27, clauses~~
336.18 ~~(4) to (6)~~ qualified according to section 245I.16, subdivision 2.

336.19 (b) A mental health professional making a referral shall submit documentation to the
336.20 state's medical review agent containing all information necessary to determine medical
336.21 necessity, including a standard diagnostic assessment completed within 180 days of the
336.22 individual's admission. Documentation shall include evidence of family participation in the
336.23 individual's treatment planning and signed consent for services.

336.24 Sec. 100. Minnesota Statutes 2018, section 256B.0943, subdivision 1, is amended to read:

336.25 Subdivision 1. **Definitions.** For purposes of this section, the following terms have the
336.26 meanings given them.

336.27 (a) "Children's therapeutic services and supports" means the flexible package of mental
336.28 health services for children who require varying therapeutic and rehabilitative levels of
336.29 intervention to treat a diagnosed emotional disturbance, ~~as defined in section 245.4871,~~
336.30 ~~subdivision 15, or a diagnosed mental illness, as defined in section 245.462, subdivision~~
336.31 ~~20.~~ The services are time-limited interventions that are delivered using various treatment
336.32 modalities and combinations of services designed to reach treatment outcomes identified
336.33 in the individual treatment plan.

337.1 ~~(b) "Clinical supervision" means the overall responsibility of the mental health~~
337.2 ~~professional for the control and direction of individualized treatment planning, service~~
337.3 ~~delivery, and treatment review for each client. A mental health professional who is an~~
337.4 ~~enrolled Minnesota health care program provider accepts full professional responsibility~~
337.5 ~~for a supervisee's actions and decisions, instructs the supervisee in the supervisee's work,~~
337.6 ~~and oversees or directs the supervisee's work.~~

337.7 ~~(e)~~ (b) "Clinical trainee" means a mental health practitioner who meets the qualifications
337.8 specified in Minnesota Rules, part 9505.0371, subpart 5, item C means a staff person
337.9 qualified according to section 245I.16, subdivision 6.

337.10 ~~(d) "Crisis assistance" has the meaning given in section 245.4871, subdivision 9a. Crisis~~
337.11 ~~assistance entails the development of a written plan to assist a child's family to contend with~~
337.12 ~~a potential crisis and is distinct from the immediate provision of crisis intervention services.~~

337.13 (c) "Crisis planning" means the support and planning activities described under section
337.14 245.4871, subdivision 9a.

337.15 ~~(e)~~ (d) "Culturally competent provider" means a provider who understands and can
337.16 utilize to a client's benefit the client's culture when providing services to the client. A provider
337.17 may be culturally competent because the provider is of the same cultural or ethnic group
337.18 as the client or the provider has developed the knowledge and skills through training and
337.19 experience to provide services to culturally diverse clients.

337.20 ~~(f)~~ (e) "Day treatment program" for children means a site-based structured mental health
337.21 program consisting of psychotherapy for three or more individuals and individual or group
337.22 skills training provided by a multidisciplinary treatment team, under the clinical treatment
337.23 supervision of a mental health professional.

337.24 ~~(g)~~ (f) "Diagnostic assessment" has the meaning given in Minnesota Rules, part
337.25 9505.0372, subpart 1 means the assessment described under section 256B.0671, subdivisions
337.26 2 and 3.

337.27 ~~(h)~~ (g) "Direct service time" means the time that a mental health professional, clinical
337.28 trainee, mental health practitioner, or mental health behavioral aide spends face-to-face with
337.29 a client and the client's family or providing covered telemedicine services. Direct service
337.30 time includes time in which the provider obtains a client's history, develops a client's
337.31 treatment plan, records individual treatment outcomes, or provides service components of
337.32 children's therapeutic services and supports. Direct service time does not include time doing
337.33 work before and after providing direct services, including scheduling or maintaining clinical
337.34 records.

338.1 ~~(h)~~ (h) "Direction of mental health behavioral aide" means the activities of a mental
338.2 health professional, clinical trainee, or mental health practitioner in guiding the mental
338.3 health behavioral aide in providing services to a client. The direction of a mental health
338.4 behavioral aide must be based on the client's individualized treatment plan and meet the
338.5 requirements in subdivision 6, paragraph (b), clause (5).

338.6 ~~(i)~~ (i) "Emotional disturbance" has the meaning given in section 245.4871, subdivision
338.7 15.

338.8 ~~(j)~~ (j) "Individual behavioral plan" means a plan of intervention, treatment, and services
338.9 for a child written by a mental health professional, clinical trainee, or mental health
338.10 practitioner, under the ~~clinical~~ treatment supervision of a mental health professional, to
338.11 guide the work of the mental health behavioral aide. The individual behavioral plan may
338.12 be incorporated into the child's individual treatment plan so long as the behavioral plan is
338.13 separately communicable to the mental health behavioral aide.

338.14 ~~(k)~~ (k) "Individual treatment plan" ~~has the meaning given in Minnesota Rules, part~~
338.15 ~~9505.0371, subpart 7~~ means the plan described under section 256B.0671, subdivisions 5
338.16 and 6.

338.17 ~~(l)~~ (l) "Mental health behavioral aide services" means medically necessary ~~one-on-one~~
338.18 activities performed by a trained paraprofessional ~~qualified as provided in subdivision 7,~~
338.19 ~~paragraph (b), clause (3),~~ to assist a child retain or generalize psychosocial skills as previously
338.20 trained by a mental health professional, clinical trainee, or mental health practitioner and
338.21 as described in the child's individual treatment plan and individual behavior plan. Activities
338.22 involve working directly with the child or child's family as provided in subdivision 9,
338.23 paragraph (b), clause (4).

338.24 (m) "Mental health certified family peer specialist" means a staff person qualified
338.25 according to section 245I.16, subdivision 12.

338.26 (n) "Mental health practitioner" ~~has the meaning given in~~ means a staff person qualified
338.27 according to section 245.462, subdivision 17, except that a practitioner working in a day
338.28 treatment setting may qualify as a mental health practitioner if the practitioner holds a
338.29 bachelor's degree in one of the behavioral sciences or related fields from an accredited
338.30 college or university, and: (1) has at least 2,000 hours of clinically supervised experience
338.31 in the delivery of mental health services to clients with mental illness; (2) is fluent in the
338.32 language, other than English, of the cultural group that makes up at least 50 percent of the
338.33 practitioner's clients, completes 40 hours of training on the delivery of services to clients
338.34 with mental illness, and receives clinical supervision from a mental health professional at

339.1 ~~least once per week until meeting the required 2,000 hours of supervised experience; or (3)~~
339.2 ~~receives 40 hours of training on the delivery of services to clients with mental illness within~~
339.3 ~~six months of employment, and clinical supervision from a mental health professional at~~
339.4 ~~least once per week until meeting the required 2,000 hours of supervised experience~~ 245I.16,
339.5 subdivision 4.

339.6 (o) "Mental health professional" means ~~an individual as defined in Minnesota Rules,~~
339.7 ~~part 9505.0370, subpart 18~~ a staff person qualified according to section 245I.16, subdivision
339.8 2.

339.9 (p) "Mental health service plan development" includes:

339.10 (1) the development, review, and revision of a child's individual treatment plan, as
339.11 ~~provided in Minnesota Rules, part 9505.0371, subpart 7~~ according to section 256B.0671,
339.12 subdivisions 5 and 6, including involvement of the client or client's parents, primary
339.13 caregiver, or other person authorized to consent to mental health services for the client, and
339.14 including arrangement of treatment and support activities specified in the individual treatment
339.15 plan; and

339.16 (2) administering standardized outcome measurement instruments, determined and
339.17 updated by the commissioner, as periodically needed to evaluate the effectiveness of
339.18 treatment for children receiving clinical services and reporting outcome measures, as required
339.19 by the commissioner.

339.20 (q) "Mental illness," for persons at least age 18 but under age 21, has the meaning given
339.21 in section 245.462, subdivision 20, paragraph (a).

339.22 (r) "Psychotherapy" means the treatment of mental or emotional disorders or
339.23 maladjustment by psychological means. Psychotherapy may be provided in many modalities
339.24 ~~in accordance with Minnesota Rules, part 9505.0372, subpart 6,~~ including patient and/or
339.25 family psychotherapy; family psychotherapy; psychotherapy for crisis; group psychotherapy;
339.26 or multiple-family psychotherapy. ~~Beginning with the American Medical Association's~~
339.27 ~~Current Procedural Terminology, standard edition, 2014, the procedure "individual~~
339.28 ~~psychotherapy" is replaced with "patient and/or family psychotherapy," a substantive change~~
339.29 ~~that permits the therapist to work with the client's family without the client present to obtain~~
339.30 ~~information about the client or to explain the client's treatment plan to the family.~~
339.31 Psychotherapy for crisis is appropriate for crisis response when a child has become
339.32 dysregulated or experienced new trauma since the diagnostic assessment was completed
339.33 and needs psychotherapy to address issues not currently included in the child's individual
339.34 treatment plan.

340.1 (s) "Rehabilitative services" or "psychiatric rehabilitation services" means ~~a series of~~
340.2 ~~multidisciplinary combination of psychiatric and psychosocial~~ interventions to: (1) restore
340.3 a child or adolescent to an age-appropriate developmental trajectory that had been disrupted
340.4 by a psychiatric illness; or (2) enable the child to self-monitor, compensate for, cope with,
340.5 counteract, or replace psychosocial skills deficits or maladaptive skills acquired over the
340.6 course of a psychiatric illness. Psychiatric rehabilitation services for children combine
340.7 coordinated psychotherapy to address internal psychological, emotional, and intellectual
340.8 processing deficits, and skills training to restore personal and social functioning. Psychiatric
340.9 rehabilitation services establish a progressive series of goals with each achievement building
340.10 upon a prior achievement. ~~Continuing progress toward goals is expected, and rehabilitative~~
340.11 ~~potential ceases when successive improvement is not observable over a period of time.~~

340.12 (t) "Skills training" means individual, family, or group training, delivered by or under
340.13 the supervision of a mental health professional, designed to facilitate the acquisition of
340.14 psychosocial skills that are medically necessary to rehabilitate the child to an age-appropriate
340.15 developmental trajectory heretofore disrupted by a psychiatric illness or to enable the child
340.16 to self-monitor, compensate for, cope with, counteract, or replace skills deficits or
340.17 maladaptive skills acquired over the course of a psychiatric illness. Skills training is subject
340.18 to the service delivery requirements under subdivision 9, paragraph (b), clause (2).

340.19 (u) "Treatment supervision" means the supervision described under section 245I.18.

340.20 Sec. 101. Minnesota Statutes 2018, section 256B.0943, subdivision 2, is amended to read:

340.21 Subd. 2. **Covered service components of children's therapeutic services and**
340.22 **supports.** (a) ~~Subject to federal approval,~~ Medical assistance covers medically necessary
340.23 children's therapeutic services and supports as defined in this section that an eligible provider
340.24 entity certified under subdivision 4 provides to a client eligible under subdivision 3.

340.25 (b) The service components of children's therapeutic services and supports are:

340.26 (1) patient and/or family psychotherapy, family psychotherapy, psychotherapy for crisis,
340.27 and group psychotherapy;

340.28 (2) individual, family, or group skills training provided by a mental health professional
340.29 or mental health practitioner;

340.30 (3) crisis ~~assistance~~ planning;

340.31 (4) mental health behavioral aide services;

340.32 (5) direction of a mental health behavioral aide;

341.1 (6) mental health service plan development; and

341.2 (7) children's day treatment.

341.3 Sec. 102. Minnesota Statutes 2018, section 256B.0943, subdivision 3, is amended to read:

341.4 Subd. 3. **Determination of client eligibility.** A client's eligibility to receive children's
 341.5 therapeutic services and supports under this section shall be determined based on a diagnostic
 341.6 assessment by a mental health professional or ~~a mental health practitioner who meets the~~
 341.7 ~~requirements of a clinical trainee as defined in Minnesota Rules, part 9505.0371, subpart~~
 341.8 ~~5, item C,~~ that is performed within one year before the initial start of service. The diagnostic
 341.9 assessment must meet the requirements for a standard ~~or extended~~ diagnostic assessment
 341.10 ~~as defined in Minnesota Rules, part 9505.0372, subpart 1, items B and C,~~ and:

341.11 ~~(1) include current diagnoses, including any differential diagnosis, in accordance with~~
 341.12 ~~all criteria for a complete diagnosis and diagnostic profile as specified in the current edition~~
 341.13 ~~of the Diagnostic and Statistical Manual of the American Psychiatric Association, or, for~~
 341.14 ~~children under age five, as six, follow the requirements~~ specified in the current edition of
 341.15 the Diagnostic Classification of Mental Health Disorders of Infancy and Early Childhood;

341.16 (2) determine whether a child under age 18 has a diagnosis of emotional disturbance or,
 341.17 if the person is between the ages of 18 and 21, whether the person has a mental illness;

341.18 (3) document children's therapeutic services and supports as medically necessary to
 341.19 address an identified disability, functional impairment, and the individual client's needs and
 341.20 goals; and

341.21 (4) be used in the development of the individualized treatment plan; and.

341.22 ~~(5) be completed annually until age 18. For individuals between age 18 and 21, unless~~
 341.23 ~~a client's mental health condition has changed markedly since the client's most recent~~
 341.24 ~~diagnostic assessment, annual updating is necessary. For the purpose of this section,~~
 341.25 ~~"updating" means an adult diagnostic update as defined in Minnesota Rules, part 9505.0371,~~
 341.26 ~~subpart 2, item E.~~

341.27 Sec. 103. Minnesota Statutes 2018, section 256B.0943, subdivision 4, is amended to read:

341.28 Subd. 4. **Provider entity certification.** (a) The commissioner shall establish an initial
 341.29 provider entity application and certification process and recertification process to determine
 341.30 whether a provider entity has an administrative and clinical infrastructure that meets the
 341.31 requirements in subdivisions 5 and 6. A provider entity must be certified for the three core
 341.32 rehabilitation services of psychotherapy, skills training, and crisis assistance planning. The

342.1 commissioner shall recertify a provider entity at least every three years. The commissioner
342.2 shall establish a process for decertification of a provider entity and shall require corrective
342.3 action, medical assistance repayment, or decertification of a provider entity that no longer
342.4 meets the requirements in this section or that fails to meet the clinical quality standards or
342.5 administrative standards provided by the commissioner in the application and certification
342.6 process.

342.7 (b) For purposes of this section, a provider entity must meet all requirements in chapter
342.8 245I and be:

342.9 (1) an Indian health services facility or a facility owned and operated by a tribe or tribal
342.10 organization operating as a 638 facility under Public Law 93-638 certified by the state;

342.11 (2) a county-operated entity certified by the state; or

342.12 (3) a noncounty entity certified by the state.

342.13 Sec. 104. Minnesota Statutes 2018, section 256B.0943, subdivision 5, is amended to read:

342.14 Subd. 5. **Provider entity administrative infrastructure requirements.** (a) To be an
342.15 eligible provider entity under this section, a provider entity must have an administrative
342.16 infrastructure that establishes authority and accountability for decision making and oversight
342.17 of functions, including finance, personnel, system management, clinical practice, and
342.18 individual treatment outcomes measurement. An eligible provider entity shall demonstrate
342.19 the availability, by means of employment or contract, of at least one backup mental health
342.20 professional in the event of the primary mental health professional's absence. The provider
342.21 must have written policies and procedures that it reviews and updates every three years and
342.22 distributes to staff initially and upon each subsequent update.

342.23 (b) The administrative infrastructure written policies and procedures must be in
342.24 accordance with sections 245I.10 and 245I.13 and must include:

342.25 (1) personnel procedures, including a process for: (i) recruiting, hiring, training, and
342.26 retention of culturally and linguistically competent providers; (ii) conducting a criminal
342.27 background check on all direct service providers and volunteers; (iii) investigating, reporting,
342.28 and acting on violations of ethical conduct standards; (iv) investigating, reporting, and acting
342.29 on violations of data privacy policies that are compliant with federal and state laws; (v)
342.30 utilizing volunteers, including screening applicants, training and supervising volunteers,
342.31 and providing liability coverage for volunteers; and (vi) documenting that each ~~mental~~
342.32 ~~health professional, mental health practitioner, or mental health behavioral aide meets the~~
342.33 ~~applicable provider qualification criteria~~ staff person meets the applicable qualifications

343.1 ~~under section 245I.16, training criteria under subdivision 8 section 245I.10, and clinical~~
 343.2 ~~treatment supervision or direction of a mental health behavioral aide requirements under~~
 343.3 ~~subdivision 6 section 245I.18;~~

343.4 (2) fiscal procedures, including internal fiscal control practices and a process for collecting
 343.5 revenue that is compliant with federal and state laws;

343.6 (3) a client-specific treatment outcomes measurement system, including baseline
 343.7 measures, to measure a client's progress toward achieving mental health rehabilitation goals.
 343.8 ~~Effective July 1, 2017,~~ To be eligible for medical assistance payment, a provider entity must
 343.9 report individual client outcomes to the commissioner, using instruments and protocols
 343.10 approved by the commissioner; and

343.11 (4) a process to establish and maintain individual client records in accordance with
 343.12 section 245I.32. ~~The client's records must include:~~

343.13 ~~(i) the client's personal information;~~

343.14 ~~(ii) forms applicable to data privacy;~~

343.15 ~~(iii) the client's diagnostic assessment, updates, results of tests, individual treatment~~
 343.16 ~~plan, and individual behavior plan, if necessary;~~

343.17 ~~(iv) documentation of service delivery as specified under subdivision 6;~~

343.18 ~~(v) telephone contacts;~~

343.19 ~~(vi) discharge plan; and~~

343.20 ~~(vii) if applicable, insurance information.~~

343.21 (c) A provider entity that uses a restrictive procedure with a client must meet the
 343.22 requirements of section 245.8261.

343.23 Sec. 105. Minnesota Statutes 2018, section 256B.0943, subdivision 6, is amended to read:

343.24 **Subd. 6. Provider entity clinical infrastructure requirements.** (a) To be an eligible
 343.25 provider entity under this section, a provider entity must have a clinical infrastructure that
 343.26 utilizes diagnostic assessment, individualized treatment plans, service delivery, and individual
 343.27 treatment plan review that are culturally competent, child-centered, and family-driven to
 343.28 achieve maximum benefit for the client. The provider entity must review, and update as
 343.29 necessary, the clinical policies and procedures every three years, must distribute the policies
 343.30 and procedures to staff initially and upon each subsequent update, and must train staff
 343.31 accordingly.

344.1 (b) The clinical infrastructure written policies and procedures must include policies and
344.2 procedures for:

344.3 (1) providing or obtaining a client's diagnostic assessment, including a diagnostic
344.4 assessment performed by an outside or independent clinician, that identifies acute and
344.5 chronic clinical disorders, co-occurring medical conditions, and sources of psychological
344.6 and environmental problems, including baselines, and a functional assessment. The functional
344.7 assessment component must clearly summarize the client's individual strengths and needs.
344.8 When required components of the diagnostic assessment, such as baseline measures, are
344.9 not provided in an outside or independent assessment or when baseline measures cannot be
344.10 attained in a ~~one-session~~ standard diagnostic assessment, the provider entity must determine
344.11 the missing information within 30 days and amend the child's diagnostic assessment or
344.12 incorporate the baselines into the child's individual treatment plan;

344.13 (2) developing an individual treatment plan ~~that~~: according to section 256B.0671,
344.14 subdivisions 5 and 6;

344.15 ~~(i) is based on the information in the client's diagnostic assessment and baselines;~~

344.16 ~~(ii) identified goals and objectives of treatment, treatment strategy, schedule for~~
344.17 ~~accomplishing treatment goals and objectives, and the individuals responsible for providing~~
344.18 ~~treatment services and supports;~~

344.19 ~~(iii) is developed after completion of the client's diagnostic assessment by a mental health~~
344.20 ~~professional or clinical trainee and before the provision of children's therapeutic services~~
344.21 ~~and supports;~~

344.22 ~~(iv) is developed through a child-centered, family-driven, culturally appropriate planning~~
344.23 ~~process, including allowing parents and guardians to observe or participate in individual~~
344.24 ~~and family treatment services, assessment, and treatment planning;~~

344.25 ~~(v) is reviewed at least once every 90 days and revised to document treatment progress~~
344.26 ~~on each treatment objective and next goals or, if progress is not documented, to document~~
344.27 ~~changes in treatment; and~~

344.28 ~~(vi) is signed by the clinical supervisor and by the client or by the client's parent or other~~
344.29 ~~person authorized by statute to consent to mental health services for the client. A client's~~
344.30 ~~parent may approve the client's individual treatment plan by secure electronic signature or~~
344.31 ~~by documented oral approval that is later verified by written signature;~~

345.1 (3) developing an individual behavior plan that documents ~~treatment strategies~~ and
345.2 describes interventions to be provided by the mental health behavioral aide. The individual
345.3 behavior plan must include:

345.4 (i) detailed instructions on the ~~treatment strategies to be provided~~ psychosocial skills to
345.5 be practiced;

345.6 (ii) time allocated to each ~~treatment strategy~~ intervention;

345.7 (iii) methods of documenting the child's behavior;

345.8 (iv) methods of monitoring the child's progress in reaching objectives; and

345.9 (v) goals to increase or decrease targeted behavior as identified in the individual treatment
345.10 plan;

345.11 (4) providing ~~clinical~~ treatment supervision plans for mental health practitioners and
345.12 mental health behavioral aides according to section 245I.18. A mental health professional
345.13 must document the clinical supervision the professional provides by cosigning individual
345.14 treatment plans and making entries in the client's record on supervisory activities. The
345.15 clinical supervisor also shall document supervisee-specific supervision in the supervisee's
345.16 personnel file. Clinical Treatment supervision does not include the authority to make or
345.17 terminate court-ordered placements of the child. A clinical supervisor must be available for
345.18 urgent consultation as required by the individual client's needs or the situation. Clinical
345.19 supervision may occur individually or in a small group to discuss treatment and review
345.20 progress toward goals. The focus of clinical supervision must be the client's treatment needs
345.21 and progress and the mental health practitioner's or behavioral aide's ability to provide
345.22 services;

345.23 (4a) meeting day treatment program conditions in items (i) to (iii):

345.24 (i) the ~~clinical~~ treatment supervisor must be present and available on the premises more
345.25 than 50 percent of the time in a provider's standard working week during which the supervisee
345.26 is providing a mental health service;

345.27 (ii) the treatment supervisor must review and approve the client's diagnosis and the
345.28 client's individual treatment plan or a change in the diagnosis or individual treatment plan
345.29 ~~must be made by or reviewed, approved, and signed by the clinical supervisor~~; and

345.30 (iii) every 30 days, the ~~clinical~~ treatment supervisor must review and sign the record
345.31 indicating the supervisor has reviewed the client's care for all activities in the preceding
345.32 30-day period;

346.1 (4b) meeting the ~~clinical~~ treatment supervision standards in items (i) ~~to (iv)~~ and (ii) for
346.2 all other services provided under CTSS:

346.3 ~~(i) medical assistance shall reimburse for services provided by a mental health practitioner~~
346.4 ~~who is delivering services that fall within the scope of the practitioner's practice and who~~
346.5 ~~is supervised by a mental health professional who accepts full professional responsibility;~~

346.6 ~~(ii) medical assistance shall reimburse for services provided by a mental health behavioral~~
346.7 ~~aide who is delivering services that fall within the scope of the aide's practice and who is~~
346.8 ~~supervised by a mental health professional who accepts full professional responsibility and~~
346.9 ~~has an approved plan for clinical supervision of the behavioral aide. Plans must be developed~~
346.10 ~~in accordance with supervision standards defined in Minnesota Rules, part 9505.0371,~~
346.11 ~~subpart 4, items A to D;~~

346.12 ~~(iii)~~ (i) the mental health professional is required to be present at the site of service
346.13 delivery for observation as clinically appropriate when the mental health practitioner or
346.14 mental health behavioral aide is providing CTSS services; and

346.15 ~~(iv)~~ (ii) when conducted, the on-site presence of the mental health professional must be
346.16 documented in the child's record and signed by the mental health professional who accepts
346.17 full professional responsibility;

346.18 (5) providing direction to a mental health behavioral aide. For entities that employ mental
346.19 health behavioral aides, the ~~clinical~~ treatment supervisor must be employed by the provider
346.20 entity or other provider certified to provide mental health behavioral aide services to ensure
346.21 necessary and appropriate oversight for the client's treatment and continuity of care. The
346.22 ~~mental health professional or mental health practitioner~~ staff giving direction must begin
346.23 with the goals on the individualized treatment plan, and instruct the mental health behavioral
346.24 aide on how to implement therapeutic activities and interventions that will lead to goal
346.25 attainment. The ~~professional or practitioner~~ staff giving direction must also instruct the
346.26 mental health behavioral aide about the client's diagnosis, functional status, and other
346.27 characteristics that are likely to affect service delivery. Direction must also include
346.28 determining that the mental health behavioral aide has the skills to interact with the client
346.29 and the client's family in ways that convey personal and cultural respect and that the aide
346.30 actively solicits information relevant to treatment from the family. The aide must be able
346.31 to clearly explain or demonstrate the activities the aide is doing with the client and the
346.32 activities' relationship to treatment goals. Direction is more didactic than is supervision and
346.33 requires the ~~professional or practitioner~~ staff providing it to continuously evaluate the mental
346.34 health behavioral aide's ability to carry out the activities of the individualized treatment

347.1 plan and the individualized behavior plan. When providing direction, the professional or
 347.2 practitioner staff must:

347.3 (i) review progress notes prepared by the mental health behavioral aide for accuracy and
 347.4 consistency with diagnostic assessment, treatment plan, and behavior goals and the
 347.5 professional or practitioner must approve and sign the progress notes;

347.6 (ii) identify changes in treatment strategies, revise the individual behavior plan, and
 347.7 communicate treatment instructions and methodologies as appropriate to ensure that treatment
 347.8 is implemented correctly;

347.9 (iii) demonstrate family-friendly behaviors that support healthy collaboration among
 347.10 the child, the child's family, and providers as treatment is planned and implemented;

347.11 (iv) ensure that the mental health behavioral aide is able to effectively communicate
 347.12 with the child, the child's family, and the provider; and

347.13 (v) record the results of any evaluation and corrective actions taken to modify the work
 347.14 of the mental health behavioral aide;

347.15 (6) providing service delivery that implements the individual treatment plan and meets
 347.16 the requirements under subdivision 9; and

347.17 (7) individual treatment plan review. The review must determine the extent to which
 347.18 the services have met each of the goals and objectives in the treatment plan. The review
 347.19 must assess the client's progress and ensure that services and treatment goals continue to
 347.20 be necessary and appropriate to the client and the client's family or foster family. ~~Revision~~
 347.21 ~~of the individual treatment plan does not require a new diagnostic assessment unless the~~
 347.22 ~~client's mental health status has changed markedly. The updated treatment plan must be~~
 347.23 ~~signed by the clinical supervisor and by the client, if appropriate, and by the client's parent~~
 347.24 ~~or other person authorized by statute to give consent to the mental health services for the~~
 347.25 ~~child.~~

347.26 Sec. 106. Minnesota Statutes 2018, section 256B.0943, subdivision 7, is amended to read:

347.27 Subd. 7. **Qualifications of individual and team providers.** (a) An individual or team
 347.28 provider working within the scope of the provider's practice or qualifications may provide
 347.29 service components of children's therapeutic services and supports that are identified as
 347.30 medically necessary in a client's individual treatment plan.

347.31 (b) An individual provider must be qualified as:

347.32 (1) a mental health professional as defined in subdivision 1, paragraph (o); or

348.1 (2) a mental health practitioner or clinical trainee. ~~The mental health practitioner or~~
 348.2 ~~clinical trainee must work under the clinical supervision of a mental health professional; or~~

348.3 (3) a mental health behavioral aide ~~working under the clinical supervision of a mental~~
 348.4 ~~health professional to implement the rehabilitative mental health services previously~~
 348.5 ~~introduced by a mental health professional or practitioner and identified in the client's~~
 348.6 ~~individual treatment plan and individual behavior plan.; or~~

348.7 (4) a mental health certified family peer specialist.

348.8 ~~(A) A level I mental health behavioral aide must:~~

348.9 ~~(i) be at least 18 years old;~~

348.10 ~~(ii) have a high school diploma or commissioner of education-selected high school~~
 348.11 ~~equivalency certification or two years of experience as a primary caregiver to a child with~~
 348.12 ~~severe emotional disturbance within the previous ten years; and~~

348.13 ~~(iii) meet preservice and continuing education requirements under subdivision 8.~~

348.14 ~~(B) A level II mental health behavioral aide must:~~

348.15 ~~(i) be at least 18 years old;~~

348.16 ~~(ii) have an associate or bachelor's degree or 4,000 hours of experience in delivering~~
 348.17 ~~clinical services in the treatment of mental illness concerning children or adolescents or~~
 348.18 ~~complete a certificate program established under subdivision 8a; and~~

348.19 ~~(iii) meet preservice and continuing education requirements in subdivision 8.~~

348.20 ~~(e) A day treatment multidisciplinary team must include at least one mental health~~
 348.21 ~~professional or clinical trainee and one mental health practitioner.~~

348.22 Sec. 107. Minnesota Statutes 2018, section 256B.0943, subdivision 8, is amended to read:

348.23 Subd. 8. **Required preservice and continuing education.** ~~(a)~~ A provider entity shall
 348.24 establish a plan to provide preservice and continuing education for staff according to section
 348.25 245I.10. ~~The plan must clearly describe the type of training necessary to maintain current~~
 348.26 ~~skills and obtain new skills and that relates to the provider entity's goals and objectives for~~
 348.27 ~~services offered.~~

348.28 ~~(b) A provider that employs a mental health behavioral aide under this section must~~
 348.29 ~~require the mental health behavioral aide to complete 30 hours of preservice training. The~~
 348.30 ~~preservice training must include parent team training. The preservice training must include~~
 348.31 ~~15 hours of in-person training of a mental health behavioral aide in mental health services~~

349.1 ~~delivery and eight hours of parent team training. Curricula for parent team training must be~~
 349.2 ~~approved in advance by the commissioner. Components of parent team training include:~~

349.3 ~~(1) partnering with parents;~~

349.4 ~~(2) fundamentals of family support;~~

349.5 ~~(3) fundamentals of policy and decision-making;~~

349.6 ~~(4) defining equal partnership;~~

349.7 ~~(5) complexities of the parent and service provider partnership in multiple service delivery~~
 349.8 ~~systems due to system strengths and weaknesses;~~

349.9 ~~(6) sibling impacts;~~

349.10 ~~(7) support networks; and~~

349.11 ~~(8) community resources.~~

349.12 ~~(c) A provider entity that employs a mental health practitioner and a mental health~~
 349.13 ~~behavioral aide to provide children's therapeutic services and supports under this section~~
 349.14 ~~must require the mental health practitioner and mental health behavioral aide to complete~~
 349.15 ~~20 hours of continuing education every two calendar years. The continuing education must~~
 349.16 ~~be related to serving the needs of a child with emotional disturbance in the child's home~~
 349.17 ~~environment and the child's family.~~

349.18 ~~(d) The provider entity must document the mental health practitioner's or mental health~~
 349.19 ~~behavioral aide's annual completion of the required continuing education. The documentation~~
 349.20 ~~must include the date, subject, and number of hours of the continuing education, and~~
 349.21 ~~attendance records, as verified by the staff member's signature, job title, and the instructor's~~
 349.22 ~~name. The provider entity must keep documentation for each employee, including records~~
 349.23 ~~of attendance at professional workshops and conferences, at a central location and in the~~
 349.24 ~~employee's personnel file.~~

349.25 Sec. 108. Minnesota Statutes 2018, section 256B.0943, subdivision 9, is amended to read:

349.26 Subd. 9. **Service delivery criteria.** (a) In delivering services under this section, a certified
 349.27 provider entity must ensure that:

349.28 (1) ~~each individual provider's caseload size permits the provider to deliver services to~~
 349.29 ~~both clients with severe, complex needs and clients with less intensive needs. the provider's~~
 349.30 ~~caseload size should reasonably enable~~ enables the provider to play an active role in service

350.1 planning, monitoring, and delivering services to meet the client's and client's family's needs,
350.2 as specified in each client's individual treatment plan;

350.3 (2) site-based programs, including day treatment programs, provide staffing and facilities
350.4 to ensure the client's health, safety, and protection of rights, and that the programs are able
350.5 to implement each client's individual treatment plan; and

350.6 (3) a day treatment program is provided to a group of clients by a ~~multidisciplinary~~ team
350.7 under the ~~clinical~~ treatment supervision of a mental health professional. The day treatment
350.8 program must be provided in and by: (i) an outpatient hospital accredited by the Joint
350.9 Commission on Accreditation of Health Organizations and licensed under sections 144.50
350.10 to 144.55; (ii) a community mental health center under section 245.62; or (iii) an entity that
350.11 is certified under subdivision 4 to operate a program that meets the requirements of section
350.12 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475. The day
350.13 treatment program must stabilize the client's mental health status while developing and
350.14 improving the client's independent living and socialization skills. The goal of the day
350.15 treatment program must be to reduce or relieve the effects of mental illness and provide
350.16 training to enable the client to live in the community. The program must be available
350.17 year-round at least three to five days per week, two or three hours per day, unless the normal
350.18 five-day school week is shortened by a holiday, weather-related cancellation, or other
350.19 districtwide reduction in a school week. A child transitioning into or out of day treatment
350.20 must receive a minimum treatment of one day a week for a two-hour time block. The
350.21 two-hour time block must include at least one hour of patient and/or family or group
350.22 psychotherapy. The remainder of the structured treatment program may include patient
350.23 and/or family or group psychotherapy, and individual or group skills training, if included
350.24 in the client's individual treatment plan. Day treatment programs are not part of inpatient
350.25 or residential treatment services. When a day treatment group that meets the minimum group
350.26 size requirement temporarily falls below the minimum group size because of a member's
350.27 temporary absence, medical assistance covers a group session conducted for the group
350.28 members in attendance. A day treatment program may provide fewer than the minimally
350.29 required hours for a particular child during a billing period in which the child is transitioning
350.30 into, or out of, the program.

350.31 (b) To be eligible for medical assistance payment, a provider entity must deliver the
350.32 service components of children's therapeutic services and supports in compliance with the
350.33 following requirements:

350.34 (1) patient and/or family, family, and group psychotherapy must be delivered as specified
350.35 in ~~Minnesota Rules, part 9505.0372, subpart 6~~ section 256B.0625, subdivision 69.

351.1 Psychotherapy to address the child's underlying mental health disorder must be documented
351.2 as part of the child's ongoing treatment. A provider must deliver, or arrange for, medically
351.3 necessary psychotherapy, unless the child's parent or caregiver chooses not to receive it.

351.4 When a provider delivering other services to a child under this section deems it not medically
351.5 necessary to provide psychotherapy to the child for a period of 90 days or longer, the provider
351.6 entity must document the medical reasons why psychotherapy is not necessary. When a
351.7 provider determines that a child needs psychotherapy but psychotherapy cannot be delivered
351.8 due to a shortage of licensed mental health professionals in the child's community, the
351.9 provider must document the lack of access in the child's medical record;

351.10 (2) individual, family, or group skills training ~~must be provided by a mental health~~
351.11 ~~professional or a mental health practitioner who is delivering services that fall within the~~
351.12 ~~scope of the provider's practice and is supervised by a mental health professional who~~
351.13 ~~accepts full professional responsibility for the training.~~ Skills training is subject to the
351.14 following requirements:

351.15 (i) a mental health professional, clinical trainee, or mental health practitioner shall provide
351.16 skills training;

351.17 (ii) skills training delivered to a child or the child's family must be targeted to the specific
351.18 deficits or maladaptations of the child's mental health disorder and must be prescribed in
351.19 the child's individual treatment plan;

351.20 (iii) the mental health professional delivering or supervising the delivery of skills training
351.21 must document any underlying psychiatric condition and must document how skills training
351.22 is being used in conjunction with psychotherapy to address the underlying condition;

351.23 (iv) skills training delivered to the child's family must teach skills needed by parents or
351.24 primary caregivers to enhance the child's skill development, to help the child utilize daily
351.25 life skills taught by a mental health professional, clinical trainee, or mental health practitioner,
351.26 and to develop or maintain a home environment that supports the child's progressive use of
351.27 skills;

351.28 (v) group skills training may be provided to multiple recipients who, because of the
351.29 nature of their emotional, behavioral, or social dysfunction, can derive mutual benefit from
351.30 interaction in a group setting, which must be staffed as follows:

351.31 (A) one mental health professional or one clinical trainee or mental health practitioner
351.32 ~~under supervision of a licensed mental health professional~~ must work with a group of three
351.33 to eight clients; or

352.1 (B) any combination of two mental health professionals, two clinical trainees, or mental
352.2 health practitioners under supervision of a licensed mental health professional, or one mental
352.3 health professional or clinical trainee and one mental health practitioner must work with a
352.4 group of nine to 12 clients;

352.5 (vi) a mental health professional, clinical trainee, or mental health practitioner must have
352.6 taught the psychosocial skill before a mental health behavioral aide may practice that skill
352.7 with the client; and

352.8 (vii) for group skills training, when a skills group that meets the minimum group size
352.9 requirement temporarily falls below the minimum group size because of a group member's
352.10 temporary absence, the provider may conduct the session for the group members in
352.11 attendance;

352.12 (3) crisis ~~assistance~~ planning to a child and family must include development of a written
352.13 plan that anticipates the particular factors specific to the child that may precipitate a
352.14 psychiatric crisis for the child in the near future. The written plan must document actions
352.15 that the family should be prepared to take to resolve or stabilize a crisis, such as advance
352.16 arrangements for direct intervention and support services to the child and the child's family.
352.17 Crisis ~~assistance~~ planning must include preparing resources designed to address abrupt or
352.18 substantial changes in the functioning of the child or the child's family when sudden change
352.19 in behavior or a loss of usual coping mechanisms is observed, or the child begins to present
352.20 a danger to self or others;

352.21 (4) mental health behavioral aide services must be medically necessary treatment services,
352.22 identified in the child's individual treatment plan and individual behavior plan, ~~which are~~
352.23 ~~performed minimally by a paraprofessional qualified according to subdivision 7, paragraph~~
352.24 ~~(b), clause (3), and~~ which are designed to improve the functioning of the child in the
352.25 progressive use of developmentally appropriate psychosocial skills. Activities involve
352.26 working directly with the child, child-peer groupings, or child-family groupings to practice,
352.27 repeat, reintroduce, and master the skills defined in subdivision 1, paragraph (t), as previously
352.28 taught by a mental health professional, clinical trainee, or mental health practitioner including:

352.29 (i) providing cues or prompts in skill-building peer-to-peer or parent-child interactions
352.30 so that the child progressively recognizes and responds to the cues independently;

352.31 (ii) performing as a practice partner or role-play partner;

352.32 (iii) reinforcing the child's accomplishments;

352.33 (iv) generalizing skill-building activities in the child's multiple natural settings;

353.1 (v) assigning further practice activities; and

353.2 (vi) intervening as necessary to redirect the child's target behavior and to de-escalate
353.3 behavior that puts the child or other person at risk of injury.

353.4 To be eligible for medical assistance payment, mental health behavioral aide services must
353.5 be delivered to a child who has been diagnosed with an emotional disturbance or a mental
353.6 illness, as provided in subdivision 1, paragraph (a). The mental health behavioral aide must
353.7 implement treatment strategies in the individual treatment plan and the individual behavior
353.8 plan as developed by the mental health professional, clinical trainee, or mental health
353.9 practitioner providing direction for the mental health behavioral aide. The mental health
353.10 behavioral aide must document the delivery of services in written progress notes. Progress
353.11 notes must reflect implementation of the treatment strategies, as performed by the mental
353.12 health behavioral aide and the child's responses to the treatment strategies;

353.13 (5) direction of a mental health behavioral aide must include ~~the following:~~

353.14 ~~(i) ongoing face-to-face observation of the mental health behavioral aide delivering~~
353.15 ~~services to a child by a mental health professional or mental health practitioner for at least~~
353.16 ~~a total of one hour during every 40 hours of service provided to a child; and~~

353.17 ~~(ii) immediate accessibility of the mental health professional, clinical trainee, or mental~~
353.18 ~~health practitioner to the mental health behavioral aide during service provision; and~~

353.19 (6) mental health service plan development must be performed in consultation with the
353.20 child's family and, when appropriate, with other key participants in the child's life by the
353.21 child's treating mental health professional or clinical trainee or by a mental health practitioner
353.22 and approved by the treating mental health professional. Treatment plan drafting consists
353.23 of development, review, and revision by face-to-face or electronic communication. The
353.24 provider must document events, including the time spent with the family and other key
353.25 participants in the child's life to ~~review, revise, and sign~~ approve the individual treatment
353.26 plan. ~~Notwithstanding Minnesota Rules, part 9505.0371, subpart 7, medical assistance~~
353.27 ~~covers service plan development before completion of the child's individual treatment plan.~~
353.28 Service plan development is covered only if a treatment plan is completed for the child. If
353.29 upon review it is determined that a treatment plan was not completed for the child, the
353.30 commissioner shall recover the payment for the service plan development; ~~and.~~

353.31 ~~(7) to be eligible for payment, a diagnostic assessment must be complete with regard to~~
353.32 ~~all required components, including multiple assessment appointments required for an~~
353.33 ~~extended diagnostic assessment and the written report. Dates of the multiple assessment~~
353.34 ~~appointments must be noted in the client's clinical record.~~

354.1 Sec. 109. Minnesota Statutes 2018, section 256B.0943, subdivision 11, is amended to
354.2 read:

354.3 Subd. 11. **Documentation and billing.** (a) A provider entity must document the services
354.4 it provides under this section according to section 245I.33. ~~The provider entity must ensure~~
354.5 ~~that documentation complies with Minnesota Rules, parts 9505.2175 and 9505.2197. Services~~
354.6 ~~billed under this section that are not documented according to this subdivision shall be~~
354.7 ~~subject to monetary recovery by the commissioner. Billing for covered service components~~
354.8 ~~under subdivision 2, paragraph (b), must not include anything other than direct service time.~~

354.9 (b) ~~An individual mental health provider must promptly document the following in a~~
354.10 ~~client's record after providing services to the client:~~

354.11 (1) ~~each occurrence of the client's mental health service, including the date, type, start~~
354.12 ~~and stop times, scope of the service as described in the child's individual treatment plan,~~
354.13 ~~and outcome of the service compared to baselines and objectives;~~

354.14 (2) ~~the name, dated signature, and credentials of the person who delivered the service;~~

354.15 (3) ~~contact made with other persons interested in the client, including representatives~~
354.16 ~~of the courts, corrections systems, or schools. The provider must document the name and~~
354.17 ~~date of each contact;~~

354.18 (4) ~~any contact made with the client's other mental health providers, case manager,~~
354.19 ~~family members, primary caregiver, legal representative, or the reason the provider did not~~
354.20 ~~contact the client's family members, primary caregiver, or legal representative, if applicable;~~

354.21 (5) ~~required clinical supervision directly related to the identified client's services and~~
354.22 ~~needs, as appropriate, with co-signatures of the supervisor and supervisee; and~~

354.23 (6) ~~the date when services are discontinued and reasons for discontinuation of services.~~

354.24 Sec. 110. Minnesota Statutes 2018, section 256B.0944, subdivision 1, is amended to read:

354.25 Subdivision 1. **Definitions.** For purposes of this section, the following terms have the
354.26 meanings given them.

354.27 (a) "Mental health crisis" means a child's behavioral, emotional, or psychiatric situation
354.28 that, but for the provision of crisis response services to the child, would likely result in
354.29 significantly reduced levels of functioning in primary activities of daily living, an emergency
354.30 situation, or the child's placement in a more restrictive setting, including, but not limited
354.31 to, inpatient hospitalization.

355.1 (b) "Mental health emergency" means a child's behavioral, emotional, or psychiatric
355.2 situation that causes an immediate need for mental health services and is consistent with
355.3 section 62Q.55. A physician, mental health professional, or ~~crisis mental health practitioner~~
355.4 qualified member of a crisis team determines a mental health crisis or emergency for medical
355.5 assistance reimbursement with input from the client and the client's family, if possible.

355.6 (c) "Mental health crisis assessment" means an immediate face-to-face assessment by
355.7 a physician, mental health professional, or ~~mental health practitioner under the clinical~~
355.8 ~~supervision of a mental health professional~~ qualified member of a crisis team, following a
355.9 screening that suggests the child may be experiencing a mental health crisis or mental health
355.10 emergency situation.

355.11 (d) "Mental health mobile crisis intervention services" means face-to-face, short-term
355.12 intensive mental health services initiated during a mental health crisis or mental health
355.13 emergency. Mental health mobile crisis services must help the recipient cope with immediate
355.14 stressors, identify and utilize available resources and strengths, and begin to return to the
355.15 recipient's baseline level of functioning. Mental health mobile services ~~must be provided~~
355.16 ~~on site by a mobile crisis intervention team outside of an emergency room, urgent care, or~~
355.17 ~~an inpatient hospital setting.~~ including screening and treatment plan recommendations,
355.18 must be culturally and linguistically appropriate.

355.19 (e) "Mental health crisis stabilization services" means individualized mental health
355.20 services provided to a recipient following crisis intervention services that are designed to
355.21 restore the recipient to the recipient's prior functional level. The individual treatment plan
355.22 recommending mental health crisis stabilization must be completed by the intervention team
355.23 or by staff after an inpatient or urgent care visit. Mental health crisis stabilization services
355.24 may be provided in the recipient's home, the home of a family member or friend of the
355.25 recipient, schools, another community setting, or a short-term supervised, licensed residential
355.26 program if the service is not included in the facility's cost pool or per diem. Mental health
355.27 crisis stabilization is not reimbursable when provided as part of a partial hospitalization or
355.28 day treatment program.

355.29 (f) "Clinical trainee" means a person qualified according to section 245I.16, subdivision
355.30 6.

355.31 (g) "Mental health certified family peer specialist" means a person qualified according
355.32 to section 245I.16, subdivision 12.

355.33 (h) "Mental health practitioner" means a person qualified according to section 245I.16,
355.34 subdivision 4.

356.1 (i) "Mental health professional" means a person qualified according to section 245I.16,
356.2 subdivision 2.

356.3 Sec. 111. Minnesota Statutes 2018, section 256B.0944, subdivision 3, is amended to read:

356.4 Subd. 3. **Eligibility.** An eligible recipient is an individual who:

356.5 (1) is eligible for medical assistance;

356.6 (2) is under age 18 or between the ages of 18 and 21;

356.7 (3) is screened as possibly experiencing a mental health crisis or mental health emergency
356.8 where a mental health crisis assessment is needed; and

356.9 (4) is assessed as experiencing a mental health crisis or mental health emergency, and
356.10 mental health mobile crisis intervention or mental health crisis stabilization services are
356.11 determined to be medically necessary; and.

356.12 ~~(5) meets the criteria for emotional disturbance or mental illness.~~

356.13 Sec. 112. Minnesota Statutes 2018, section 256B.0944, subdivision 4, is amended to read:

356.14 Subd. 4. **Provider entity standards.** (a) A crisis intervention and crisis stabilization
356.15 provider entity must meet the administrative and clinical standards specified in ~~section~~
356.16 ~~256B.0943, subdivisions 5 and 6, chapter 245I,~~ meet the standards listed in paragraph (b),
356.17 and be:

356.18 (1) an Indian health service facility or facility owned and operated by a tribe or a tribal
356.19 organization operating under ~~Public Law 93-638 as a 638 facility~~ United States Code, title
356.20 25, section 450f;

356.21 (2) a county board-operated entity; or

356.22 (3) a provider entity that is under contract with the county board in the county where
356.23 the potential crisis or emergency is occurring.

356.24 (b) The children's mental health crisis response services provider entity must:

356.25 (1) ensure that mental health crisis assessment and mobile crisis intervention services
356.26 are available 24 hours a day, seven days a week;

356.27 (2) coordinate with detoxification according to Minnesota Rules, parts 9530.6605 to
356.28 9530.6655, or withdrawal management according to chapter 245F to ensure a recipient
356.29 receives care that is responsive to the recipient's chemical and mental health needs;

357.1 (3) directly provide the services or, if services are subcontracted, the provider entity
 357.2 must maintain clinical responsibility for services and billing;

357.3 ~~(3)~~ (4) ensure that crisis intervention services are provided in a manner consistent with
 357.4 sections 245.487 to 245.4889; ~~and~~

357.5 (5) maintain staff training, documentation, and personnel files, including documentation
 357.6 of staff completion of required training modules according to sections 245I.32 and 245I.33;

357.7 (6) establish and maintain a quality assurance and evaluation plan to evaluate the
 357.8 outcomes of services and recipient satisfaction, including notifying recipients of the process
 357.9 by which the provider, county, or tribe accepts and responds to concerns;

357.10 ~~(4)~~ (7) develop and maintain written policies and procedures regarding service provision
 357.11 that include safety of staff and recipients in high-risk situations;

357.12 (8) respond to a call for crisis services in a designated service area, or according to a
 357.13 written agreement with the local mental health authority for an adjacent area; and

357.14 (9) document protocol used when delivering services by telemedicine, according to
 357.15 sections 62A.67 to 62A.672, including responsibilities of the originating site, the means to
 357.16 promote recipient safety, the timelines for connection and response, and the steps to take
 357.17 in the event of a lost connection.

357.18 Sec. 113. Minnesota Statutes 2018, section 256B.0944, subdivision 5, is amended to read:

357.19 Subd. 5. **Mobile crisis intervention staff qualifications.** ~~(a) To provide children's~~
 357.20 ~~mental health mobile crisis intervention services, a mobile crisis intervention team must~~
 357.21 ~~include:~~

357.22 ~~(1) at least two mental health professionals as defined in section 256B.0943, subdivision~~
 357.23 ~~1, paragraph (o); or~~

357.24 ~~(2) a combination of at least one mental health professional and one mental health~~
 357.25 ~~practitioner as defined in section 245.4871, subdivision 26, with the required mental health~~
 357.26 ~~crisis training and under the clinical supervision of a mental health professional on the team.~~

357.27 (a) Mobile crisis intervention team staff must be qualified to provide services as mental
 357.28 health professionals, mental health practitioners, clinical trainees, or mental health certified
 357.29 family peer specialists.

357.30 (b) A mobile crisis intervention team is comprised of at least two members, one of whom
 357.31 must be qualified as a mental health professional. A second member must be qualified as

358.1 a mental health professional, clinical trainee, or mental health practitioner. Additional staff
358.2 must be added to reflect the needs of the area served.

358.3 (c) Mental health crisis assessment and intervention services must be led by a mental
358.4 health professional, or under the supervision of a mental health professional according to
358.5 subdivision 9, by a clinical trainee or mental health practitioner.

358.6 ~~(b)~~ (d) The team must have ~~at least two people with~~ at least one member providing
358.7 on-site crisis intervention services when needed. Team members must be experienced in
358.8 mental health assessment, crisis intervention techniques, and clinical decision making under
358.9 emergency conditions and have knowledge of local services and resources. The team must
358.10 recommend and coordinate the team's services with appropriate local resources, including
358.11 the county social services agency, mental health service providers, and local law enforcement,
358.12 if necessary.

358.13 Sec. 114. Minnesota Statutes 2018, section 256B.0944, subdivision 6, is amended to read:

358.14 **Subd. 6. Initial screening and crisis assessment planning.** (a) Before initiating mobile
358.15 crisis intervention services, a screening of the potential crisis situation must be conducted.
358.16 The screening may use the resources of crisis assistance and emergency services as defined
358.17 in sections 245.4871, subdivision 14, and 245.4879, subdivisions 1 and 2. The screening
358.18 must gather information, determine whether a crisis situation exists, identify the parties
358.19 involved, and determine an appropriate response.

358.20 (b) In conducting the screening, a provider shall:

358.21 (1) employ evidence-based practices as identified by the commissioner in collaboration
358.22 with the commissioner of health to reduce the risk of the recipient's suicide and self-injurious
358.23 behavior;

358.24 (2) work with the recipient to establish a plan and time frame for responding to the crisis,
358.25 including immediate needs for support by telephone or text message until a face-to-face
358.26 response arrives;

358.27 (3) document significant factors related to the determination of a crisis, including prior
358.28 calls to the crisis team, recent presentation at an emergency department, known calls to 911
358.29 or law enforcement, or the presence of third parties with knowledge of a potential recipient's
358.30 history or current needs;

358.31 (4) screen for the needs of a third-party caller, including a recipient who primarily
358.32 identifies as a family member or a caregiver but also presents signs of a crisis; and

359.1 (5) provide psychoeducation, including education on the available means for reducing
359.2 self-harm, to relevant third parties, including family members or other persons living in the
359.3 home.

359.4 (c) A provider entity shall consider the following to indicate a positive screening unless
359.5 the provider entity documents specific evidence to show why crisis response was clinically
359.6 inappropriate:

359.7 (1) the recipient presented in an emergency department or urgent care setting, and the
359.8 health care team at that location requested crisis services;

359.9 (2) a peace officer requested crisis services for a recipient who may be subject to
359.10 transportation under section 253B.05 for a mental health crisis.

359.11 ~~(b)~~ (d) If a crisis exists, a crisis assessment must be completed. A crisis assessment must
359.12 evaluate any immediate needs for which emergency services are needed and, as time permits,
359.13 the recipient's current life situation, health information including current medications, sources
359.14 of stress, mental health problems and symptoms, strengths, cultural considerations, support
359.15 network, vulnerabilities, and current functioning.

359.16 ~~(e)~~ (e) If the crisis assessment determines mobile crisis intervention services are needed,
359.17 the intervention services must be provided promptly. As the opportunity presents itself
359.18 during the intervention, at least two members of the mobile crisis intervention team must
359.19 confer directly or by telephone about the assessment, treatment plan, and actions taken and
359.20 needed. At least one of the team members must be on site providing crisis intervention
359.21 services. If providing on-site crisis intervention services, a mental health practitioner must
359.22 seek ~~clinical~~ clinical treatment supervision as required under subdivision 9.

359.23 (f) Direct contact with the recipient is not required before initiating a crisis assessment
359.24 or intervention service. A crisis team may gather relevant information from a third party at
359.25 the scene to establish the need for services and potential safety factors. A crisis assessment
359.26 is provided face-to-face by a mobile crisis intervention team outside of an inpatient hospital
359.27 setting. A service must be provided promptly and respond to the recipient's location whenever
359.28 possible, including community or clinical settings. As clinically appropriate, a mobile crisis
359.29 intervention team must coordinate a response with other health care providers if a recipient
359.30 requires detoxification, withdrawal management, or medical stabilization services in addition
359.31 to crisis services.

359.32 ~~(d)~~ (g) The mobile crisis intervention team must develop an initial, brief crisis treatment
359.33 plan as soon as appropriate but no later than 24 hours after the initial face-to-face intervention.
359.34 The plan must address the needs and problems noted in the crisis assessment and include

360.1 measurable short-term goals, cultural considerations, and frequency and type of services to
 360.2 be provided to achieve the goals and reduce or eliminate the crisis. The crisis treatment plan
 360.3 must be updated as needed to reflect current goals and services. The team must involve the
 360.4 client and the client's family in developing and implementing the plan.

360.5 ~~(e)~~ (h) The team must document in progress notes which short-term goals have been
 360.6 met and when no further crisis intervention services are required. If after an assessment a
 360.7 crisis provider entity refers a recipient to an intensive setting, including an emergency
 360.8 department, in-patient hospitalization, or residential treatment, one of the crisis team members
 360.9 who performed or conferred on the assessment must immediately contact the provider entity
 360.10 and consult with the triage nurse or other staff responsible for intake. The crisis team member
 360.11 must convey key findings or concerns that led to the referral. The consultation must occur
 360.12 with the recipient's consent, the recipient's legal guardian's consent, or as allowed by section
 360.13 144.293, subdivision 5. Any available written documentation, including a crisis treatment
 360.14 plan, must be sent no later than the next business day.

360.15 ~~(f)~~ (i) If the client's crisis is stabilized, but the client needs a referral for mental health
 360.16 crisis stabilization services or to other services, the team must provide a referral to these
 360.17 services. If the recipient has a case manager, planning for other services must be coordinated
 360.18 with the case manager.

360.19 (j) If an intervention service is provided without the recipient present, the provider shall
 360.20 document the reasons why the service is more effective without the recipient present.

360.21 Sec. 115. Minnesota Statutes 2018, section 256B.0944, subdivision 7, is amended to read:

360.22 Subd. 7. **Crisis stabilization services.** Crisis stabilization services ~~must be provided by~~
 360.23 ~~a mental health professional or a mental health practitioner, as defined in section 245.462,~~
 360.24 ~~subdivision 17, who works under the clinical supervision of a mental health professional~~
 360.25 ~~and for a crisis stabilization services provider entity and must meet the following standards:~~

360.26 (1) a crisis stabilization treatment plan must be developed which meets the criteria in
 360.27 subdivision 8;

360.28 (2) services must be delivered according to the treatment plan and include face-to-face
 360.29 contact with the recipient by qualified staff for further assessment, help with referrals,
 360.30 updating the crisis stabilization treatment plan, supportive counseling, skills training, and
 360.31 collaboration with other service providers in the community; and

360.32 ~~(3) mental health practitioners must have completed at least 30 hours of training in crisis~~
 360.33 ~~intervention and stabilization during the past two years.~~

361.1 (3) if an intervention is provided without the recipient present, the provider shall
361.2 document the reasons why the intervention is more effective without the recipient present.

361.3 Sec. 116. Minnesota Statutes 2018, section 256B.0944, subdivision 8, is amended to read:

361.4 Subd. 8. **Treatment plan.** (a) The individual crisis stabilization treatment plan must
361.5 include, at a minimum:

361.6 (1) a list of problems identified in the assessment;

361.7 (2) a list of the recipient's strengths and resources;

361.8 (3) concrete, measurable short-term goals and tasks to be achieved, including time frames
361.9 for achievement of the goals;

361.10 (4) specific objectives directed toward the achievement of each goal;

361.11 (5) documentation of the participants involved in the service planning;

361.12 (6) planned frequency and type of services initiated;

361.13 (7) a crisis response action plan if a crisis should occur; and

361.14 (8) clear progress notes on the outcome of goals.

361.15 (b) The client, if clinically appropriate, must be a participant in the development of the
361.16 crisis stabilization treatment plan. The client or the client's legal guardian must sign the
361.17 service plan or documentation must be provided why this was not possible. A copy of the
361.18 plan must be given to the client and the client's legal guardian. The plan should include
361.19 services arranged, including specific providers where applicable.

361.20 (c) A treatment plan must be developed by a mental health professional, clinical trainee,
361.21 or mental health practitioner under the clinical supervision of a mental health professional.
361.22 A written plan must be completed within 24 hours of beginning services with the client.

361.23 Sec. 117. Minnesota Statutes 2018, section 256B.0944, subdivision 9, is amended to read:

361.24 Subd. 9. **Supervision.** ~~(a)~~ A mental health practitioner or clinical trainee may provide
361.25 crisis assessment and mobile crisis intervention services if the following ~~clinical~~ treatment
361.26 supervision requirements are met:

361.27 (1) the mental health provider entity must accept full responsibility for the services
361.28 provided;

362.1 (2) the mental health professional of the provider entity, who is an employee or under
 362.2 contract with the provider entity, must be immediately available by telephone or in person
 362.3 for ~~clinical~~ treatment supervision;

362.4 (3) the mental health professional is consulted, in person or by telephone, during the
 362.5 first three hours when a mental health practitioner provides on-site service; and

362.6 (4) the mental health professional must review and approve the tentative crisis assessment
 362.7 and crisis treatment plan, document the consultation, and sign the crisis assessment and
 362.8 treatment plan within the next business day.

362.9 ~~(b) If the mobile crisis intervention services continue into a second calendar day, a mental~~
 362.10 ~~health professional must contact the client face-to-face on the second day to provide services~~
 362.11 ~~and update the crisis treatment plan. The on-site observation must be documented in the~~
 362.12 ~~client's record and signed by the mental health professional.~~

362.13 Sec. 118. Minnesota Statutes 2018, section 256B.0946, subdivision 1, is amended to read:

362.14 Subdivision 1. **Required covered service components.** (a) ~~Effective May 23, 2013,~~
 362.15 ~~and subject to federal approval,~~ Medical assistance covers medically necessary intensive
 362.16 treatment services described under paragraph (b) that are provided by a provider entity
 362.17 eligible under subdivision 3 to a client eligible under subdivision 2 who is placed in a foster
 362.18 home licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or placed in a foster
 362.19 home licensed under the regulations established by a federally recognized Minnesota tribe.

362.20 (b) Intensive treatment services to children with mental illness residing in foster family
 362.21 settings that comprise specific required service components provided in clauses (1) to (5)
 362.22 are reimbursed by medical assistance when they meet the following standards:

362.23 (1) psychotherapy provided by a mental health professional ~~as defined in Minnesota~~
 362.24 ~~Rules, part 9505.0371, subpart 5, item A,~~ or a clinical trainee, ~~as defined in Minnesota~~
 362.25 ~~Rules, part 9505.0371, subpart 5, item C;~~

362.26 (2) crisis ~~assistance~~ planning provided according to standards for children's therapeutic
 362.27 services and supports in section 256B.0943;

362.28 (3) individual, family, and group psychoeducation services, defined in subdivision 1a,
 362.29 paragraph ~~(e)~~ (o), provided by a mental health professional or a clinical trainee;

362.30 (4) clinical care consultation, as defined in subdivision 1a, and provided by a mental
 362.31 health professional or a clinical trainee; and

362.32 (5) service delivery payment requirements as provided under subdivision 4.

363.1 Sec. 119. Minnesota Statutes 2018, section 256B.0946, subdivision 1a, is amended to
363.2 read:

363.3 Subd. 1a. **Definitions.** For the purposes of this section, the following terms have the
363.4 meanings given them.

363.5 (a) "Clinical care consultation" means communication from a treating clinician to other
363.6 providers working with the same client to inform, inquire, and instruct regarding the client's
363.7 symptoms, strategies for effective engagement, care and intervention needs, and treatment
363.8 expectations across service settings, including but not limited to the client's school, social
363.9 services, day care, probation, home, primary care, medication prescribers, disabilities
363.10 services, and other mental health providers and to direct and coordinate clinical service
363.11 components provided to the client and family.

363.12 ~~(b) "Clinical supervision" means the documented time a clinical supervisor and supervisee~~
363.13 ~~spend together to discuss the supervisee's work, to review individual client cases, and for~~
363.14 ~~the supervisee's professional development. It includes the documented oversight and~~
363.15 ~~supervision responsibility for planning, implementation, and evaluation of services for a~~
363.16 ~~client's mental health treatment.~~

363.17 ~~(c) "Clinical supervisor" means the mental health professional who is responsible for~~
363.18 ~~clinical supervision.~~

363.19 ~~(d) (b) "Clinical trainee" has the meaning given in Minnesota Rules, part 9505.0371,~~
363.20 ~~subpart 5, item C means a staff person qualified according to section 245I.16, subdivision~~
363.21 ~~6;~~

363.22 ~~(e) (c) "Crisis assistance planning" has the meaning given in section 245.4871, subdivision~~
363.23 ~~9a, including the development of a plan that addresses prevention and intervention strategies~~
363.24 ~~to be used in a potential crisis, but does not include actual crisis intervention.~~

363.25 ~~(f) (d) "Culturally appropriate" means providing mental health services in a manner that~~
363.26 ~~incorporates the child's cultural influences, as defined in Minnesota Rules, part 9505.0370,~~
363.27 ~~subpart 9, into interventions as a way to maximize resiliency factors and utilize cultural~~
363.28 ~~strengths and resources to promote overall wellness.~~

363.29 ~~(g) (e) "Culture" means the distinct ways of living and understanding the world that are~~
363.30 ~~used by a group of people and are transmitted from one generation to another or adopted~~
363.31 ~~by an individual.~~

364.1 ~~(h)~~ (f) "Diagnostic assessment" ~~has the meaning given in Minnesota Rules, part~~
364.2 ~~9505.0370, subpart 11~~ means an assessment described under section 256B.0671, subdivisions
364.3 2 and 3.

364.4 ~~(i)~~ (g) "Family" means a person who is identified by the client or the client's parent or
364.5 guardian as being important to the client's mental health treatment. Family may include,
364.6 but is not limited to, parents, foster parents, children, spouse, committed partners, former
364.7 spouses, persons related by blood or adoption, persons who are a part of the client's
364.8 permanency plan, or persons who are presently residing together as a family unit.

364.9 ~~(j)~~ (h) "Foster care" has the meaning given in section 260C.007, subdivision 18.

364.10 ~~(k)~~ (i) "Foster family setting" means the foster home in which the license holder resides.

364.11 ~~(l)~~ (j) "Individual treatment plan" ~~has the meaning given in Minnesota Rules, part~~
364.12 ~~9505.0370, subpart 15~~ means the plan described under section 256B.0671, subdivisions 5
364.13 and 6.

364.14 ~~(m)~~ "Mental health practitioner" ~~has the meaning given in section 245.462, subdivision~~
364.15 ~~17, and a mental health practitioner working as a clinical trainee according to Minnesota~~
364.16 ~~Rules, part 9505.0371, subpart 5, item C.~~

364.17 (k) "Mental health certified family peer specialist" means a staff person qualified
364.18 according to section 245I.16, subdivision 12.

364.19 ~~(n)~~ (1) "Mental health professional" ~~has the meaning given in Minnesota Rules, part~~
364.20 ~~9505.0370, subpart 18~~ means a staff person qualified according to section 245I.16,
364.21 subdivision 2.

364.22 ~~(o)~~ (m) "Mental illness" has the meaning given in ~~Minnesota Rules, part 9505.0370,~~
364.23 ~~subpart 20~~ section 245.462, subdivision 20, paragraph (a), and includes emotional disturbance
364.24 as defined in section 245.4871, subdivision 15.

364.25 ~~(p)~~ (n) "Parent" has the meaning given in section 260C.007, subdivision 25.

364.26 ~~(q)~~ (o) "Psychoeducation services" means information or demonstration provided to an
364.27 individual, family, or group to explain, educate, and support the individual, family, or group
364.28 in understanding a child's symptoms of mental illness, the impact on the child's development,
364.29 and needed components of treatment and skill development so that the individual, family,
364.30 or group can help the child to prevent relapse, prevent the acquisition of comorbid disorders,
364.31 and achieve optimal mental health and long-term resilience.

365.1 ~~(r)~~ (p) "Psychotherapy" has the meaning given in ~~Minnesota Rules, part 9505.0370,~~
 365.2 ~~subpart 27~~ section 256B.0625, subdivision 69.

365.3 ~~(s)~~ (q) "Team consultation and treatment planning" means the coordination of treatment
 365.4 plans and consultation among providers in a group concerning the treatment needs of the
 365.5 child, including disseminating the child's treatment service schedule to all members of the
 365.6 service team. Team members must include all mental health professionals working with the
 365.7 child, a parent, the child unless the team lead or parent deem it clinically inappropriate, and
 365.8 at least two of the following: an individualized education program case manager; probation
 365.9 agent; children's mental health case manager; child welfare worker, including adoption or
 365.10 guardianship worker; primary care provider; foster parent; and any other member of the
 365.11 child's service team.

365.12 (r) "Trauma" has the meaning given in section 245I.02, subdivision 24.

365.13 (s) "Treatment supervision" means the supervision described under section 245I.18.

365.14 (t) "Treatment supervisor" means the mental health professional who is responsible for
 365.15 treatment supervision.

365.16 Sec. 120. Minnesota Statutes 2018, section 256B.0946, subdivision 2, is amended to read:

365.17 Subd. 2. **Determination of client eligibility.** (a) An eligible recipient is an individual,
 365.18 from birth through age 20, who is currently placed in a foster home licensed under Minnesota
 365.19 Rules, parts 2960.3000 to 2960.3340, and has received a diagnostic assessment and an
 365.20 evaluation of level of care needed, as defined in paragraphs ~~(a)~~ (b) and ~~(b)~~ (c).

365.21 ~~(a)~~ (b) The diagnostic assessment must:

365.22 ~~(1) meet criteria described in Minnesota Rules, part 9505.0372, subpart 1, and be~~
 365.23 ~~conducted by a mental health professional or a clinical trainee;~~

365.24 ~~(2) determine whether or not a child meets the criteria for mental illness, as defined in~~
 365.25 ~~Minnesota Rules, part 9505.0370, subpart 20;~~

365.26 ~~(3)~~ (1) document that intensive treatment services are medically necessary within a foster
 365.27 family setting to ameliorate identified symptoms and functional impairments; and

365.28 ~~(4)~~ (2) be performed within 180 days before the start of service; ~~and~~.

365.29 ~~(5) be completed as either a standard or extended diagnostic assessment annually to~~
 365.30 ~~determine continued eligibility for the service.~~

366.1 ~~(b)~~ (c) The evaluation of level of care must be conducted by the placing county, tribe,
366.2 or case manager in conjunction with the diagnostic assessment ~~as described by Minnesota~~
366.3 ~~Rules, part 9505.0372, subpart 1, item B,~~ using a validated tool approved by the
366.4 commissioner of human services and not subject to the rulemaking process, consistent with
366.5 section 245.4885, subdivision 1, paragraph (d), the result of which evaluation demonstrates
366.6 that the child requires intensive intervention without 24-hour medical monitoring. The
366.7 commissioner shall update the list of approved level of care tools annually and publish on
366.8 the department's website.

366.9 Sec. 121. Minnesota Statutes 2018, section 256B.0946, subdivision 3, is amended to read:

366.10 Subd. 3. **Eligible mental health services providers.** (a) Eligible providers for intensive
366.11 children's mental health services in a foster family setting must be certified by the state and
366.12 have a service provision contract with a county board or a reservation tribal council and
366.13 must be able to demonstrate the ability to provide all of the services required in this section
366.14 and meet the requirements under chapter 245I.

366.15 (b) For purposes of this section, a provider agency must be:

366.16 (1) a county-operated entity certified by the state;

366.17 (2) an Indian Health Services facility operated by a tribe or tribal organization under
366.18 funding authorized by United States Code, title 25, sections 450f to 450n, or title 3 of the
366.19 Indian Self-Determination Act, Public Law 93-638, section 638 (facilities or providers); or

366.20 (3) a noncounty entity.

366.21 (c) Certified providers that do not meet the service delivery standards required in this
366.22 section shall be subject to a decertification process.

366.23 (d) For the purposes of this section, all services delivered to a client must be provided
366.24 by a mental health professional ~~or~~ a clinical trainee, or a mental health certified family peer
366.25 specialist.

366.26 Sec. 122. Minnesota Statutes 2018, section 256B.0946, subdivision 4, is amended to read:

366.27 Subd. 4. **Service delivery payment requirements.** (a) To be eligible for payment under
366.28 this section, a provider must develop and practice written policies and procedures for
366.29 intensive treatment in foster care, consistent with subdivision 1, paragraph (b), and comply
366.30 with the following requirements in paragraphs (b) to ~~(n)~~ (m).

367.1 ~~(b) A qualified clinical supervisor, as defined in and performing in compliance with~~
367.2 ~~Minnesota Rules, part 9505.0371, subpart 5, item D, must supervise the treatment and~~
367.3 ~~provision of services described in this section.~~

367.4 ~~(c) Each client receiving treatment services must receive an extended diagnostic~~
367.5 ~~assessment, as described in Minnesota Rules, part 9505.0372, subpart 1, item C, within 30~~
367.6 ~~days of enrollment in this service unless the client has a previous extended diagnostic~~
367.7 ~~assessment that the client, parent, and mental health professional agree still accurately~~
367.8 ~~describes the client's current mental health functioning.~~

367.9 (b) For children under age six, each client must receive a diagnostic assessment according
367.10 to the requirements in the current edition of the Diagnostic Classification of Mental Health
367.11 Disorders of Infancy and Early Childhood.

367.12 ~~(d)~~ (c) Each previous and current mental health, school, and physical health treatment
367.13 provider must be contacted to request documentation of treatment and assessments that the
367.14 eligible client has received. This information must be reviewed and incorporated into the
367.15 diagnostic assessment and team consultation and treatment planning review process.

367.16 ~~(e)~~ (d) Each client receiving treatment must be assessed for a trauma history, and the
367.17 client's treatment plan must document how the results of the assessment will be incorporated
367.18 into treatment.

367.19 ~~(f)~~ (e) Each client receiving treatment services must have an individual treatment plan
367.20 that is reviewed, evaluated, and ~~signed~~ approved every 90 days using the team consultation
367.21 and treatment planning process, as defined in subdivision 1a, paragraph ~~(s)~~ (p).

367.22 ~~(g)~~ (f) Clinical care consultation, as defined in subdivision 1a, paragraph (a), must be
367.23 provided in accordance with the client's individual treatment plan.

367.24 ~~(h)~~ (g) Each client must have a crisis ~~assistance~~ plan within ten days of initiating services
367.25 and must have access to clinical phone support 24 hours per day, seven days per week,
367.26 during the course of treatment. The crisis plan must demonstrate coordination with the local
367.27 or regional mobile crisis intervention team.

367.28 ~~(i)~~ (h) Services must be delivered and documented at least three days per week, equaling
367.29 at least six hours of treatment per week, unless reduced units of service are specified on the
367.30 treatment plan as part of transition or on a discharge plan to another service or level of care.
367.31 ~~Documentation must comply with Minnesota Rules, parts 9505.2175 and 9505.2197.~~

368.1 ~~(i)~~ (i) Location of service delivery must be in the client's home, day care setting, school,
 368.2 or other community-based setting that is specified on the client's individualized treatment
 368.3 plan.

368.4 ~~(j)~~ (j) Treatment must be developmentally and culturally appropriate for the client.

368.5 ~~(k)~~ (k) Services must be delivered in continual collaboration and consultation with the
 368.6 client's medical providers and, in particular, with prescribers of psychotropic medications,
 368.7 including those prescribed on an off-label basis. Members of the service team must be aware
 368.8 of the medication regimen and potential side effects.

368.9 ~~(l)~~ (l) Parents, siblings, foster parents, and members of the child's permanency plan
 368.10 must be involved in treatment and service delivery unless otherwise noted in the treatment
 368.11 plan.

368.12 ~~(m)~~ (m) Transition planning for the child must be conducted starting with the first
 368.13 treatment plan and must be addressed throughout treatment to support the child's permanency
 368.14 plan and postdischarge mental health service needs.

368.15 Sec. 123. Minnesota Statutes 2018, section 256B.0946, subdivision 6, is amended to read:

368.16 Subd. 6. **Excluded services.** (a) Services in clauses (1) to (7) are not covered under this
 368.17 section and are not eligible for medical assistance payment as components of intensive
 368.18 treatment in foster care services, but may be billed separately:

368.19 (1) inpatient psychiatric hospital treatment;

368.20 (2) mental health targeted case management;

368.21 (3) partial hospitalization;

368.22 (4) medication management;

368.23 (5) children's mental health day treatment services;

368.24 (6) crisis response services under section 256B.0944; and

368.25 (7) transportation.

368.26 (b) Children receiving intensive treatment in foster care services are not eligible for
 368.27 medical assistance reimbursement for the following services while receiving intensive
 368.28 treatment in foster care:

368.29 (1) psychotherapy and skills training components of children's therapeutic services and
 368.30 supports under section 256B.0625, subdivision 35b;

369.1 (2) mental health behavioral aide services as defined in section 256B.0943, subdivision
369.2 1, paragraph ~~(m)~~ (l);

369.3 (3) home and community-based waiver services;

369.4 (4) mental health residential treatment; and

369.5 (5) room and board costs as defined in section 256I.03, subdivision 6.

369.6 Sec. 124. Minnesota Statutes 2018, section 256B.0947, subdivision 1, is amended to read:

369.7 Subdivision 1. **Scope.** ~~Effective November 1, 2011, and subject to federal approval,~~
369.8 Medical assistance covers medically necessary, intensive nonresidential rehabilitative mental
369.9 health services as defined in subdivision 2, for recipients as defined in subdivision 3, when
369.10 the services are provided by an entity meeting the standards in this section.

369.11 Sec. 125. Minnesota Statutes 2018, section 256B.0947, subdivision 2, is amended to read:

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

369.14 (a) "Intensive nonresidential rehabilitative mental health services" means child
369.15 rehabilitative mental health services as defined in section 256B.0943, except that these
369.16 services are provided by a multidisciplinary staff using ~~a total team~~ an approach consistent
369.17 with assertive community treatment, as adapted for youth, and are directed to recipients
369.18 ~~ages 16, 17, 18, 19, or 20 with a serious mental illness or co-occurring mental illness and~~
369.19 ~~substance abuse addiction~~ who require intensive services to prevent admission to an inpatient
369.20 psychiatric hospital or placement in a residential treatment facility or who require intensive
369.21 services to step down from inpatient or residential care to community-based care.

369.22 (b) "Co-occurring mental illness and substance abuse addiction" means a dual diagnosis
369.23 of at least one form of mental illness and at least one substance use disorder. Substance use
369.24 disorders include alcohol or drug abuse or dependence, excluding nicotine use.

369.25 (c) "Diagnostic assessment" ~~has the meaning given to it in Minnesota Rules, part~~
369.26 ~~9505.0370, subpart 11. A diagnostic assessment must be provided according to Minnesota~~
369.27 ~~Rules, part 9505.0372, subpart 1,~~ means the assessment described under section 256B.0671,
369.28 subdivisions 2 and 3, and for this section must incorporate a determination of the youth's
369.29 necessary level of care using a standardized functional assessment instrument approved and
369.30 periodically updated by the commissioner.

370.1 (d) "Education specialist" means an individual with knowledge and experience working
 370.2 with youth regarding special education requirements and goals, special education plans,
 370.3 and coordination of educational activities with health care activities.

370.4 (e) "Housing access support" means an ancillary activity to help an individual find,
 370.5 obtain, retain, and move to safe and adequate housing. Housing access support does not
 370.6 provide monetary assistance for rent, damage deposits, or application fees.

370.7 (f) "Integrated dual disorders treatment" means the integrated treatment of co-occurring
 370.8 mental illness and substance use disorders by a team of cross-trained clinicians within the
 370.9 same program, and is characterized by assertive outreach, stage-wise comprehensive
 370.10 treatment, treatment goal setting, and flexibility to work within each stage of treatment.

370.11 (g) "Medication education services" means services provided individually or in groups,
 370.12 which focus on:

370.13 (1) educating the client and client's family or significant nonfamilial supporters about
 370.14 mental illness and symptoms;

370.15 (2) the role and effects of medications in treating symptoms of mental illness; and

370.16 (3) the side effects of medications.

370.17 Medication education is coordinated with medication management services and does not
 370.18 duplicate it. Medication education services are provided by physicians, pharmacists, or
 370.19 registered nurses with certification in psychiatric and mental health care.

370.20 (h) "Peer specialist" means an employed team member who is a mental health certified
 370.21 peer specialist according to section 256B.0615 and also a former children's mental health
 370.22 consumer who:

370.23 ~~(1) provides direct services to clients including social, emotional, and instrumental~~
 370.24 ~~support and outreach;~~

370.25 ~~(2) assists younger peers to identify and achieve specific life goals;~~

370.26 ~~(3) works directly with clients to promote the client's self-determination, personal~~
 370.27 ~~responsibility, and empowerment;~~

370.28 ~~(4) assists youth with mental illness to regain control over their lives and their~~
 370.29 ~~developmental process in order to move effectively into adulthood;~~

370.30 ~~(5) provides training and education to other team members, consumer advocacy~~
 370.31 ~~organizations, and clients on resiliency and peer support; and~~

371.1 ~~(6) meets the following criteria:~~

371.2 ~~(i) is at least 22 years of age;~~

371.3 ~~(ii) has had a diagnosis of mental illness, as defined in Minnesota Rules, part 9505.0370,~~
371.4 ~~subpart 20, or co-occurring mental illness and substance abuse addiction;~~

371.5 ~~(iii) is a former consumer of child and adolescent mental health services, or a former or~~
371.6 ~~current consumer of adult mental health services for a period of at least two years;~~

371.7 ~~(iv) has at least a high school diploma or equivalent;~~

371.8 ~~(v) has successfully completed training requirements determined and periodically updated~~
371.9 ~~by the commissioner;~~

371.10 ~~(vi) is willing to disclose the individual's own mental health history to team members~~
371.11 ~~and clients; and~~

371.12 ~~(vii) must be free of substance use problems for at least one year.~~

371.13 ~~(i) "Provider agency" means a for-profit or nonprofit organization established to~~
371.14 ~~administer an assertive community treatment for youth team.~~

371.15 ~~(j)~~ (i) "Substance use disorders" means one or more of the disorders defined in the
371.16 Diagnostic and Statistical Manual of Mental Disorders, current edition.

371.17 ~~(k)~~ (j) "Transition services" means:

371.18 (1) activities, materials, consultation, and coordination that ensures continuity of the
371.19 client's care in advance of and in preparation for the client's move from one stage of care
371.20 or life to another by maintaining contact with the client and assisting the client to establish
371.21 provider relationships;

371.22 (2) providing the client with knowledge and skills needed posttransition;

371.23 (3) establishing communication between sending and receiving entities;

371.24 (4) supporting a client's request for service authorization and enrollment; and

371.25 (5) establishing and enforcing procedures and schedules.

371.26 A youth's transition from the children's mental health system and services to the adult
371.27 mental health system and services and return to the client's home and entry or re-entry into
371.28 community-based mental health services following discharge from an out-of-home placement
371.29 or inpatient hospital stay.

372.1 ~~(j)~~ (k) "Treatment team" means all staff who provide services to recipients under this
372.2 section.

372.3 Sec. 126. Minnesota Statutes 2018, section 256B.0947, subdivision 3, is amended to read:

372.4 Subd. 3. **Client eligibility.** An eligible recipient is an individual who:

372.5 (1) is age 16, 17, 18, 19, or 20; and

372.6 (2) is diagnosed with a serious mental illness or co-occurring mental illness and substance
372.7 abuse addiction, for which intensive nonresidential rehabilitative mental health services are
372.8 needed;

372.9 (3) has received a level-of-care determination, using an instrument approved by the
372.10 commissioner, that indicates a need for intensive integrated intervention without 24-hour
372.11 medical monitoring and a need for extensive collaboration among multiple providers;

372.12 (4) has a functional impairment and a history of difficulty in functioning safely and
372.13 successfully in the community, school, home, or job; or who is likely to need services from
372.14 the adult mental health system within the next two years; and

372.15 (5) has had a recent diagnostic assessment, ~~as provided in Minnesota Rules, part~~
372.16 ~~9505.0372, subpart 1, by a mental health professional who is qualified under Minnesota~~
372.17 ~~Rules, part 9505.0371, subpart 5, item A,~~ that documents that intensive nonresidential
372.18 rehabilitative mental health services are medically necessary to ameliorate identified
372.19 symptoms and functional impairments and to achieve individual transition goals.

372.20 Sec. 127. Minnesota Statutes 2018, section 256B.0947, subdivision 3a, is amended to
372.21 read:

372.22 Subd. 3a. **Required service components.** ~~(a) Subject to federal approval, medical~~
372.23 ~~assistance covers all medically necessary intensive nonresidential rehabilitative mental~~
372.24 ~~health services and supports, as defined in this section, under a single daily rate per client.~~
372.25 ~~Services and supports must be delivered by an eligible provider under subdivision 5 to an~~
372.26 ~~eligible client under subdivision 3.~~

372.27 ~~(b)~~ (a) Intensive nonresidential rehabilitative mental health services, supports, and
372.28 ancillary activities covered by the single daily rate per client must include the following,
372.29 as needed by the individual client:

372.30 (1) individual, family, and group psychotherapy;

373.1 (2) individual, family, and group skills training, as defined in section 256B.0943,
373.2 subdivision 1, paragraph (t);

373.3 (3) ~~crisis assistance planning~~ as defined in section ~~245.4871, subdivision 9a, which~~
373.4 ~~includes recognition of factors precipitating a mental health crisis, identification of behaviors~~
373.5 ~~related to the crisis, and the development of a plan to address prevention, intervention, and~~
373.6 ~~follow-up strategies to be used in the lead-up to or onset of, and conclusion of, a mental~~
373.7 ~~health crisis; crisis assistance does not mean crisis response services or crisis intervention~~
373.8 ~~services provided in section 256B.0944~~ 256B.0943, subdivision 1, paragraph (c);

373.9 (4) medication management provided by a physician or an advanced practice registered
373.10 nurse with certification in psychiatric and mental health care;

373.11 (5) mental health case management as provided in section 256B.0625, subdivision 20;

373.12 (6) medication education services ~~as defined in this section;~~

373.13 (7) care coordination by a client-specific lead worker assigned by and responsible to the
373.14 treatment team;

373.15 (8) psychoeducation of and consultation and coordination with the client's biological,
373.16 adoptive, or foster family and, in the case of a youth living independently, the client's
373.17 immediate nonfamilial support network;

373.18 (9) clinical consultation to a client's employer or school or to other service agencies or
373.19 to the courts to assist in managing the mental illness or co-occurring disorder and to develop
373.20 client support systems;

373.21 (10) coordination with, or performance of, crisis intervention and stabilization services
373.22 as defined in section 256B.0944;

373.23 (11) assessment of a client's treatment progress and effectiveness of services using
373.24 standardized outcome measures published by the commissioner;

373.25 (12) transition services as defined in this section;

373.26 (13) integrated dual disorders treatment as defined in this section; and

373.27 (14) housing access support.

373.28 ~~(e)~~ (b) The provider shall ensure and document the following by means of performing
373.29 the required function or by contracting with a qualified person or entity:

373.30 (1) client access to crisis intervention services, as defined in section 256B.0944, and
373.31 available 24 hours per day and seven days per week; and

374.1 ~~(2) completion of an extended diagnostic assessment, as defined in Minnesota Rules,~~
374.2 ~~part 9505.0372, subpart 1, item C; and~~

374.3 ~~(3) (2) determination of the client's needed level of care using an instrument approved~~
374.4 ~~and periodically updated by the commissioner.~~

374.5 Sec. 128. Minnesota Statutes 2018, section 256B.0947, subdivision 5, is amended to read:

374.6 Subd. 5. **Standards for intensive nonresidential rehabilitative providers.** (a) Services
374.7 must be provided by a provider entity as provided in subdivision 4.

374.8 (b) The treatment team for intensive nonresidential rehabilitative mental health services
374.9 comprises both permanently employed core team members and client-specific team members
374.10 as follows:

374.11 ~~(1) The core treatment team is an entity that operates under the direction of an~~
374.12 ~~independently licensed mental health professional, who is qualified under Minnesota Rules,~~
374.13 ~~part 9505.0371, subpart 5, item A, and that assumes comprehensive clinical responsibility~~
374.14 ~~for clients. Based on professional qualifications and client needs, clinically qualified core~~
374.15 ~~team members are assigned on a rotating basis as the client's lead worker to coordinate a~~
374.16 ~~client's care. The core team must comprise at least four full-time equivalent direct care staff~~
374.17 ~~and must include, but is not limited to at a minimum:~~

374.18 ~~(i) an independently licensed a mental health professional, qualified under Minnesota~~
374.19 ~~Rules, part 9505.0371, subpart 5, item A, who serves as team leader to provide administrative~~
374.20 ~~direction and clinical treatment supervision to the team;~~

374.21 ~~(ii) an advanced-practice registered nurse with certification in psychiatric or mental~~
374.22 ~~health care or a board-certified child and adolescent psychiatrist, either of which must be~~
374.23 ~~credentialed to prescribe medications;~~

374.24 ~~(iii) a licensed alcohol and drug counselor who is also trained in mental health~~
374.25 ~~interventions; and~~

374.26 ~~(iv) a peer specialist as defined in subdivision 2, paragraph (h).~~

374.27 (2) The core team may also include any of the following:

374.28 (i) additional mental health professionals;

374.29 (ii) a vocational specialist;

374.30 (iii) an educational specialist;

374.31 (iv) a child and adolescent psychiatrist who may be retained on a consultant basis;

375.1 (v) a mental health practitioner, ~~as defined in~~ qualified according to section 245.4871,
375.2 ~~subdivision 26~~ 245I.16, subdivision 4;

375.3 (vi) a mental health manager, as defined in section 245.4871, subdivision 4; ~~and~~

375.4 (vii) a housing access specialist; and

375.5 (viii) a clinical trainee qualified according to section 245I.16, subdivision 6.

375.6 (3) A treatment team may include, in addition to those in ~~clause~~ clauses (1) ~~or~~ and (2),
375.7 ad hoc members not employed by the team who consult on a specific client and who must
375.8 accept overall clinical direction from the treatment team for the duration of the client's
375.9 placement with the treatment team and must be paid by the provider ~~agency at the rate for~~
375.10 ~~a typical session by that provider with that client or at a rate negotiated with the client-specific~~
375.11 ~~member~~ entity. Client-specific treatment team members may include:

375.12 (i) the mental health professional treating the client prior to placement with the treatment
375.13 team;

375.14 (ii) the client's current substance abuse counselor, if applicable;

375.15 (iii) a lead member of the client's individualized education program team or school-based
375.16 mental health provider, if applicable;

375.17 (iv) a representative from the client's health care home or primary care clinic, as needed
375.18 to ensure integration of medical and behavioral health care;

375.19 (v) the client's probation officer or other juvenile justice representative, if applicable;
375.20 and

375.21 (vi) the client's current vocational or employment counselor, if applicable.

375.22 (c) The ~~clinical~~ treatment supervisor shall be an active member of the treatment team
375.23 and shall function as a practicing clinician at least on a part-time basis. The treatment team
375.24 shall meet with the ~~clinical~~ treatment supervisor at least weekly to discuss recipients' progress
375.25 and make rapid adjustments to meet recipients' needs. The team meeting must include
375.26 client-specific case reviews and general treatment discussions among team members.
375.27 Client-specific case reviews and planning must be documented in the individual client's
375.28 treatment record.

375.29 (d) The staffing ratio must not exceed ten clients to one full-time equivalent treatment
375.30 team position.

376.1 (e) The treatment team shall serve no more than 80 clients at any one time. Should local
376.2 demand exceed the team's capacity, an additional team must be established rather than
376.3 exceed this limit.

376.4 (f) Nonclinical staff shall have prompt access in person or by telephone to a mental
376.5 health practitioner or mental health professional. The provider shall have the capacity to
376.6 promptly and appropriately respond to emergent needs and make any necessary staffing
376.7 adjustments to assure the health and safety of clients.

376.8 (g) The intensive nonresidential rehabilitative mental health services provider shall
376.9 participate in evaluation of the assertive community treatment for youth (Youth ACT) model
376.10 as conducted by the commissioner, including the collection and reporting of data and the
376.11 reporting of performance measures as specified by contract with the commissioner.

376.12 (h) A regional treatment team may serve multiple counties.

376.13 Sec. 129. Minnesota Statutes 2018, section 256B.0947, subdivision 6, is amended to read:

376.14 Subd. 6. **Service standards.** The standards in this subdivision apply to intensive
376.15 nonresidential rehabilitative mental health services.

376.16 (a) The treatment team shall use team treatment, not an individual treatment model.

376.17 (b) Services must be available at times that meet client needs.

376.18 (c) The initial functional assessment must be completed within ten days of intake and
376.19 updated at least every three months or prior to discharge from the service, whichever comes
376.20 first.

376.21 (d) An individual treatment plan must be completed for each client, according to criteria
376.22 specified in section ~~256B.0943, subdivision 6, paragraph (b), clause (2)~~ 256B.0671,
376.23 subdivisions 5 and 6, and, additionally, must:

376.24 (1) be completed in consultation with the client's current therapist and key providers and
376.25 provide for ongoing consultation with the client's current therapist to ensure therapeutic
376.26 continuity and to facilitate the client's return to the community;

376.27 (2) if a need for substance use disorder treatment is indicated by validated assessment;

376.28 (i) identify goals, objectives, and strategies of substance use disorder treatment; develop
376.29 a schedule for accomplishing treatment goals and objectives; and identify the individuals
376.30 responsible for providing treatment services and supports; and

376.31 ~~(ii) be reviewed at least once every 90 days and revised, if necessary;~~

377.1 ~~(3) be signed by the clinical supervisor and by the client and, if the client is a minor, by~~
377.2 ~~the client's parent or other person authorized by statute to consent to mental health treatment~~
377.3 ~~and substance use disorder treatment for the client; and~~

377.4 ~~(4)~~ (3) provide for the client's transition out of intensive nonresidential rehabilitative
377.5 mental health services by defining the team's actions to assist the client and subsequent
377.6 providers in the transition to less intensive or "stepped down" services.

377.7 (e) The treatment team shall actively and assertively engage the client's family members
377.8 and significant others by establishing communication and collaboration with the family and
377.9 significant others and educating the family and significant others about the client's mental
377.10 illness, symptom management, and the family's role in treatment, unless the team knows or
377.11 has reason to suspect that the client has suffered or faces a threat of suffering any physical
377.12 or mental injury, abuse, or neglect from a family member or significant other.

377.13 (f) For a client age 18 or older, the treatment team may disclose to a family member,
377.14 other relative, or a close personal friend of the client, or other person identified by the client,
377.15 the protected health information directly relevant to such person's involvement with the
377.16 client's care, as provided in Code of Federal Regulations, title 45, part 164.502(b). If the
377.17 client is present, the treatment team shall obtain the client's agreement, provide the client
377.18 with an opportunity to object, or reasonably infer from the circumstances, based on the
377.19 exercise of professional judgment, that the client does not object. If the client is not present
377.20 or is unable, by incapacity or emergency circumstances, to agree or object, the treatment
377.21 team may, in the exercise of professional judgment, determine whether the disclosure is in
377.22 the best interests of the client and, if so, disclose only the protected health information that
377.23 is directly relevant to the family member's, relative's, friend's, or client-identified person's
377.24 involvement with the client's health care. The client may orally agree or object to the
377.25 disclosure and may prohibit or restrict disclosure to specific individuals.

377.26 (g) The treatment team shall provide interventions to promote positive interpersonal
377.27 relationships.

377.28 Sec. 130. Minnesota Statutes 2018, section 256B.0947, subdivision 7a, is amended to
377.29 read:

377.30 Subd. 7a. **Noncovered services.** (a) The rate for intensive rehabilitative mental health
377.31 services does not include medical assistance payment for services in clauses (1) to (7).
377.32 Services not covered under this paragraph may be billed separately:

377.33 (1) inpatient psychiatric hospital treatment;

- 378.1 (2) partial hospitalization;
- 378.2 (3) children's mental health day treatment services;
- 378.3 (4) physician services outside of care provided by a psychiatrist serving as a member of
- 378.4 the treatment team;
- 378.5 (5) room and board costs, as defined in section 256I.03, subdivision 6;
- 378.6 (6) home and community-based waiver services; and
- 378.7 (7) other mental health services identified in the child's individualized education program.

378.8 (b) The following services are not covered under this section and are not eligible for

378.9 medical assistance payment while youth are receiving intensive rehabilitative mental health

378.10 services:

- 378.11 (1) mental health residential treatment; and
- 378.12 (2) mental health behavioral aide services, as defined in section 256B.0943, subdivision
- 378.13 1, paragraph ~~(m)~~ (l).

378.14 Sec. 131. Minnesota Statutes 2018, section 256B.0949, subdivision 2, is amended to read:

378.15 Subd. 2. **Definitions.** (a) The terms used in this section have the meanings given in this

378.16 subdivision.

378.17 (b) "Agency" means the legal entity that is enrolled with Minnesota health care programs

378.18 as a medical assistance provider according to Minnesota Rules, part 9505.0195, to provide

378.19 EIDBI services and that has the legal responsibility to ensure that its employees or contractors

378.20 carry out the responsibilities defined in this section. Agency includes a licensed individual

378.21 professional who practices independently and acts as an agency.

378.22 (c) "Autism spectrum disorder or a related condition" or "ASD or a related condition"

378.23 means either autism spectrum disorder (ASD) as defined in the current version of the

378.24 Diagnostic and Statistical Manual of Mental Disorders (DSM) or a condition that is found

378.25 to be closely related to ASD, as identified under the current version of the DSM, and meets

378.26 all of the following criteria:

- 378.27 (1) is severe and chronic;
- 378.28 (2) results in impairment of adaptive behavior and function similar to that of a person
- 378.29 with ASD;
- 378.30 (3) requires treatment or services similar to those required for a person with ASD; and

379.1 (4) results in substantial functional limitations in three core developmental deficits of
379.2 ASD: social interaction; nonverbal or social communication; and restrictive, repetitive
379.3 behaviors or hyperreactivity or hyporeactivity to sensory input; and may include deficits or
379.4 a high level of support in one or more of the following domains:

379.5 (i) self-regulation;

379.6 (ii) self-care;

379.7 (iii) behavioral challenges;

379.8 (iv) expressive communication;

379.9 (v) receptive communication;

379.10 (vi) cognitive functioning; or

379.11 (vii) safety.

379.12 (d) "Person" means a person under 21 years of age.

379.13 (e) "Clinical supervision" means the overall responsibility for the control and direction
379.14 of EIDBI service delivery, including individual treatment planning, staff supervision,
379.15 individual treatment plan progress monitoring, and treatment review for each person. Clinical
379.16 supervision is provided by a qualified supervising professional (QSP) who takes full
379.17 professional responsibility for the service provided by each supervisee.

379.18 (f) "Commissioner" means the commissioner of human services, unless otherwise
379.19 specified.

379.20 (g) "Comprehensive multidisciplinary evaluation" or "CMDE" means a comprehensive
379.21 evaluation of a person to determine medical necessity for EIDBI services based on the
379.22 requirements in subdivision 5.

379.23 (h) "Department" means the Department of Human Services, unless otherwise specified.

379.24 (i) "Early intensive developmental and behavioral intervention benefit" or "EIDBI
379.25 benefit" means a variety of individualized, intensive treatment modalities approved by the
379.26 commissioner that are based in behavioral and developmental science consistent with best
379.27 practices on effectiveness.

379.28 (j) "Generalizable goals" means results or gains that are observed during a variety of
379.29 activities over time with different people, such as providers, family members, other adults,
379.30 and people, and in different environments including, but not limited to, clinics, homes,
379.31 schools, and the community.

380.1 (k) "Incident" means when any of the following occur:

380.2 (1) an illness, accident, or injury that requires first aid treatment;

380.3 (2) a bump or blow to the head; or

380.4 (3) an unusual or unexpected event that jeopardizes the safety of a person or staff,

380.5 including a person leaving the agency unattended.

380.6 (l) "Individual treatment plan" or "ITP" means the person-centered, individualized written
 380.7 plan of care that integrates and coordinates person and family information from the CMDE
 380.8 for a person who meets medical necessity for the EIDBI benefit. An individual treatment
 380.9 plan must meet the standards in subdivision 6.

380.10 (m) "Legal representative" means the parent of a child who is under 18 years of age, a
 380.11 court-appointed guardian, or other representative with legal authority to make decisions
 380.12 about service for a person. For the purpose of this subdivision, "other representative with
 380.13 legal authority to make decisions" includes a health care agent or an attorney-in-fact
 380.14 authorized through a health care directive or power of attorney.

380.15 (n) "Mental health professional" has the meaning given in section 245.4871, subdivision
 380.16 ~~27, clauses (1) to (6).~~

380.17 (o) "Person-centered" means a service that both responds to the identified needs, interests,
 380.18 values, preferences, and desired outcomes of the person or the person's legal representative
 380.19 and respects the person's history, dignity, and cultural background and allows inclusion and
 380.20 participation in the person's community.

380.21 (p) "Qualified EIDBI provider" means a person who is a QSP or a level I, level II, or
 380.22 level III treatment provider.

380.23 Sec. 132. Minnesota Statutes 2018, section 256B.0949, subdivision 4, is amended to read:

380.24 Subd. 4. **Diagnosis.** (a) A diagnosis of ASD or a related condition must:

380.25 (1) be based upon current DSM criteria including direct observations of the person and
 380.26 information from the person's legal representative or primary caregivers;

380.27 (2) be completed by either (i) a licensed physician or advanced practice registered nurse
 380.28 or (ii) a mental health professional; and

380.29 (3) meet the requirements of ~~Minnesota Rules, part 9505.0372, subpart 1, items B and~~
 380.30 € section 256B.071, subdivisions 2 and 3.

381.1 (b) Additional assessment information may be considered to complete a diagnostic
381.2 assessment including specialized tests administered through special education evaluations
381.3 and licensed school personnel, and from professionals licensed in the fields of medicine,
381.4 speech and language, psychology, occupational therapy, and physical therapy. A diagnostic
381.5 assessment may include treatment recommendations.

381.6 Sec. 133. Minnesota Statutes 2018, section 256B.0949, subdivision 5a, is amended to
381.7 read:

381.8 Subd. 5a. **Comprehensive multidisciplinary evaluation provider qualification.** A
381.9 CMDE provider must:

381.10 (1) be a licensed physician, advanced practice registered nurse, a mental health
381.11 professional, or a ~~mental health practitioner who meets the requirements of a clinical trainee~~
381.12 ~~as defined in Minnesota Rules, part 9505.0371, subpart 5, item C~~ described under section
381.13 245I.16, subdivision 6;

381.14 (2) have at least 2,000 hours of clinical experience in the evaluation and treatment of
381.15 people with ASD or a related condition or equivalent documented coursework at the graduate
381.16 level by an accredited university in the following content areas: ASD or a related condition
381.17 diagnosis, ASD or a related condition treatment strategies, and child development; and

381.18 (3) be able to diagnose, evaluate, or provide treatment within the provider's scope of
381.19 practice and professional license.

381.20 Sec. 134. **DIRECTION TO COMMISSIONER; SINGLE COMPREHENSIVE**
381.21 **LICENSE STRUCTURE.**

381.22 The commissioner of human services, in consultation with stakeholders including but
381.23 not limited to counties, tribes, managed care organizations, provider organizations, advocacy
381.24 groups, and individuals and families served, shall develop recommendations to provide a
381.25 single comprehensive license structure for mental health service programs, including
381.26 community mental health centers according to Minnesota Rules, part 9520.0750, intensive
381.27 residential treatment services, assertive community treatment, adult rehabilitative mental
381.28 health services, children's therapeutic services and supports, intensive rehabilitative mental
381.29 health services, intensive treatment in foster care, and children's residential treatment
381.30 programs currently approved under Minnesota Rules, chapter 2960. The recommendations
381.31 must prioritize program integrity, the welfare of individuals and families served, improved
381.32 integration of mental health and substance use disorder services, and the reduction of
381.33 administrative burden on providers.

382.1 Sec. 135. **REPEALER.**

382.2 (a) Minnesota Statutes 2018, sections 245.462, subdivision 4a; 256B.0615, subdivisions
 382.3 2, 4, and 5; 256B.0616, subdivisions 2, 4, and 5; 256B.0624, subdivision 10; 256B.0943,
 382.4 subdivision 10; 256B.0944, subdivision 10; 256B.0946, subdivision 5; and 256B.0947,
 382.5 subdivision 9, are repealed.

382.6 (b) Minnesota Rules, parts 9505.0370; 9505.0371; 9505.0372; 9520.0010; 9520.0020;
 382.7 9520.0030; 9520.0040; 9520.0050; 9520.0060; 9520.0070; 9520.0080; 9520.0090;
 382.8 9520.0100; 9520.0110; 9520.0120; 9520.0130; 9520.0140; 9520.0150; 9520.0160;
 382.9 9520.0170; 9520.0180; 9520.0190; 9520.0200; 9520.0210; and 9520.0230, are repealed.

382.10 **ARTICLE 8**

382.11 **HEALTH CARE**

382.12 Section 1. Minnesota Statutes 2018, section 13.69, subdivision 1, is amended to read:

382.13 Subdivision 1. **Classifications.** (a) The following government data of the Department
 382.14 of Public Safety are private data:

382.15 (1) medical data on driving instructors, licensed drivers, and applicants for parking
 382.16 certificates and special license plates issued to physically disabled persons;

382.17 (2) other data on holders of a disability certificate under section 169.345, except that (i)
 382.18 data that are not medical data may be released to law enforcement agencies, and (ii) data
 382.19 necessary for enforcement of sections 169.345 and 169.346 may be released to parking
 382.20 enforcement employees or parking enforcement agents of statutory or home rule charter
 382.21 cities and towns;

382.22 (3) Social Security numbers in driver's license and motor vehicle registration records,
 382.23 except that Social Security numbers must be provided to the Department of Revenue for
 382.24 purposes of tax administration, the Department of Labor and Industry for purposes of
 382.25 workers' compensation administration and enforcement, the judicial branch for purposes of
 382.26 debt collection, and the Department of Natural Resources for purposes of license application
 382.27 administration, and except that the last four digits of the Social Security number must be
 382.28 provided to the Department of Human Services for purposes of recovery of Minnesota health
 382.29 care program benefits paid; and

382.30 (4) data on persons listed as standby or temporary custodians under section 171.07,
 382.31 subdivision 11, except that the data must be released to:

383.1 (i) law enforcement agencies for the purpose of verifying that an individual is a designated
383.2 caregiver; or

383.3 (ii) law enforcement agencies who state that the license holder is unable to communicate
383.4 at that time and that the information is necessary for notifying the designated caregiver of
383.5 the need to care for a child of the license holder.

383.6 The department may release the Social Security number only as provided in clause (3)
383.7 and must not sell or otherwise provide individual Social Security numbers or lists of Social
383.8 Security numbers for any other purpose.

383.9 (b) The following government data of the Department of Public Safety are confidential
383.10 data: data concerning an individual's driving ability when that data is received from a member
383.11 of the individual's family.

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

383.13 Sec. 2. Minnesota Statutes 2018, section 16A.724, subdivision 2, is amended to read:

383.14 Subd. 2. **Transfers.** (a) Notwithstanding section 295.581, to the extent available resources
383.15 in the health care access fund exceed expenditures in that fund, effective for the biennium
383.16 beginning July 1, 2007, the commissioner of management and budget shall transfer the
383.17 excess funds from the health care access fund to the general fund on June 30 of each year,
383.18 provided that the amount transferred in fiscal year 2016 shall not exceed \$48,000,000, the
383.19 amount in fiscal year 2017 shall not exceed \$122,000,000, and the amount in any fiscal
383.20 biennium thereafter shall not exceed \$244,000,000. The purpose of this transfer is to meet
383.21 the rate increase required under ~~Laws 2003, First Special Session chapter 14, article 13C,~~
383.22 ~~section 2, subdivision 6~~ section 256B.688.

383.23 (b) For fiscal years 2006 to 2011, MinnesotaCare shall be a forecasted program, and, if
383.24 necessary, the commissioner shall reduce these transfers from the health care access fund
383.25 to the general fund to meet annual MinnesotaCare expenditures or, if necessary, transfer
383.26 sufficient funds from the general fund to the health care access fund to meet annual
383.27 MinnesotaCare expenditures.

383.28 Sec. 3. Minnesota Statutes 2018, section 245A.02, subdivision 5a, is amended to read:

383.29 Subd. 5a. **Controlling individual.** (a) "Controlling individual" means an owner of a
383.30 program or service provider licensed under this chapter and the following individuals, if
383.31 applicable:

384.1 (1) each officer of the organization, including the chief executive officer and chief
384.2 financial officer;

384.3 (2) the individual designated as the authorized agent under section 245A.04, subdivision
384.4 1, paragraph (b);

384.5 (3) the individual designated as the compliance officer under section 256B.04, subdivision
384.6 21, paragraph ~~(b)~~ (g); and

384.7 (4) each managerial official whose responsibilities include the direction of the
384.8 management or policies of a program.

384.9 (b) Controlling individual does not include:

384.10 (1) a bank, savings bank, trust company, savings association, credit union, industrial
384.11 loan and thrift company, investment banking firm, or insurance company unless the entity
384.12 operates a program directly or through a subsidiary;

384.13 (2) an individual who is a state or federal official, or state or federal employee, or a
384.14 member or employee of the governing body of a political subdivision of the state or federal
384.15 government that operates one or more programs, unless the individual is also an officer,
384.16 owner, or managerial official of the program, receives remuneration from the program, or
384.17 owns any of the beneficial interests not excluded in this subdivision;

384.18 (3) an individual who owns less than five percent of the outstanding common shares of
384.19 a corporation:

384.20 (i) whose securities are exempt under section 80A.45, clause (6); or

384.21 (ii) whose transactions are exempt under section 80A.46, clause (2);

384.22 (4) an individual who is a member of an organization exempt from taxation under section
384.23 290.05, unless the individual is also an officer, owner, or managerial official of the program
384.24 or owns any of the beneficial interests not excluded in this subdivision. This clause does
384.25 not exclude from the definition of controlling individual an organization that is exempt from
384.26 taxation; or

384.27 (5) an employee stock ownership plan trust, or a participant or board member of an
384.28 employee stock ownership plan, unless the participant or board member is a controlling
384.29 individual according to paragraph (a).

384.30 (c) For purposes of this subdivision, "managerial official" means an individual who has
384.31 the decision-making authority related to the operation of the program, and the responsibility
384.32 for the ongoing management of or direction of the policies, services, or employees of the

385.1 program. A site director who has no ownership interest in the program is not considered to
385.2 be a managerial official for purposes of this definition.

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

385.4 Sec. 4. Minnesota Statutes 2018, section 245D.081, subdivision 3, is amended to read:

385.5 Subd. 3. **Program management and oversight.** (a) The license holder must designate
385.6 a managerial staff person or persons to provide program management and oversight of the
385.7 services provided by the license holder. The designated manager is responsible for the
385.8 following:

385.9 (1) maintaining a current understanding of the licensing requirements sufficient to ensure
385.10 compliance throughout the program as identified in section 245A.04, subdivision 1, paragraph
385.11 (e), and when applicable, as identified in section 256B.04, subdivision 21, paragraph ~~(b)~~
385.12 (g);

385.13 (2) ensuring the duties of the designated coordinator are fulfilled according to the
385.14 requirements in subdivision 2;

385.15 (3) ensuring the program implements corrective action identified as necessary by the
385.16 program following review of incident and emergency reports according to the requirements
385.17 in section 245D.11, subdivision 2, clause (7). An internal review of incident reports of
385.18 alleged or suspected maltreatment must be conducted according to the requirements in
385.19 section 245A.65, subdivision 1, paragraph (b);

385.20 (4) evaluation of satisfaction of persons served by the program, the person's legal
385.21 representative, if any, and the case manager, with the service delivery and progress ~~towards~~
385.22 toward accomplishing outcomes identified in sections 245D.07 and 245D.071, and ensuring
385.23 and protecting each person's rights as identified in section 245D.04;

385.24 (5) ensuring staff competency requirements are met according to the requirements in
385.25 section 245D.09, subdivision 3, and ensuring staff orientation and training is provided
385.26 according to the requirements in section 245D.09, subdivisions 4, 4a, and 5;

385.27 (6) ensuring corrective action is taken when ordered by the commissioner and that the
385.28 terms and conditions of the license and any variances are met; and

385.29 (7) evaluating the information identified in clauses (1) to (6) to develop, document, and
385.30 implement ongoing program improvements.

385.31 (b) The designated manager must be competent to perform the duties as required and
385.32 must minimally meet the education and training requirements identified in subdivision 2,

386.1 paragraph (b), and have a minimum of three years of supervisory level experience in a
386.2 program providing direct support services to persons with disabilities or persons age 65 and
386.3 older.

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

386.5 Sec. 5. Minnesota Statutes 2018, section 256.962, subdivision 5, is amended to read:

386.6 Subd. 5. **Incentive program.** Beginning January 1, 2008, the commissioner shall establish
386.7 an incentive program for organizations and licensed insurance producers under chapter 60K
386.8 that directly identify and assist potential enrollees in filling out and submitting an application.
386.9 For each applicant who is successfully enrolled in MinnesotaCare or medical assistance,
386.10 the commissioner, within the available appropriation, shall pay the organization or licensed
386.11 insurance producer a ~~\$25~~ \$70 application assistance bonus. The organization or licensed
386.12 insurance producer may provide an applicant a gift certificate or other incentive upon
386.13 enrollment.

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

386.15 Sec. 6. Minnesota Statutes 2018, section 256.969, subdivision 2b, is amended to read:

386.16 Subd. 2b. **Hospital payment rates.** (a) For discharges occurring on or after November
386.17 1, 2014, hospital inpatient services for hospitals located in Minnesota shall be paid according
386.18 to the following:

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

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

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

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

386.27 (b) For the period beginning January 1, 2011, through October 31, 2014, rates shall not
386.28 be rebased, except that a Minnesota long-term hospital shall be rebased effective January
386.29 1, 2011, based on its most recent Medicare cost report ending on or before September 1,
386.30 2008, with the provisions under subdivisions 9 and 23, based on the rates in effect on
386.31 December 31, 2010. For rate setting periods after November 1, 2014, in which the base

387.1 years are updated, a Minnesota long-term hospital's base year shall remain within the same
387.2 period as other hospitals.

387.3 (c) Effective for discharges occurring on and after November 1, 2014, payment rates
387.4 for hospital inpatient services provided by hospitals located in Minnesota or the local trade
387.5 area, except for the hospitals paid under the methodologies described in paragraph (a),
387.6 clauses (2) and (3), shall be rebased, incorporating cost and payment methodologies in a
387.7 manner similar to Medicare. The base year for the rates effective November 1, 2014, shall
387.8 be calendar year 2012. The rebasing under this paragraph shall be budget neutral, ensuring
387.9 that the total aggregate payments under the rebased system are equal to the total aggregate
387.10 payments that were made for the same number and types of services in the base year. Separate
387.11 budget neutrality calculations shall be determined for payments made to critical access
387.12 hospitals and payments made to hospitals paid under the DRG system. Only the rate increases
387.13 or decreases under subdivision 3a or 3c that applied to the hospitals being rebased during
387.14 the entire base period shall be incorporated into the budget neutrality calculation.

387.15 (d) For discharges occurring on or after November 1, 2014, through the next rebasing
387.16 that occurs, the rebased rates under paragraph (c) that apply to hospitals under paragraph
387.17 (a), clause (4), shall include adjustments to the projected rates that result in no greater than
387.18 a five percent increase or decrease from the base year payments for any hospital. Any
387.19 adjustments to the rates made by the commissioner under this paragraph and paragraph (e)
387.20 shall maintain budget neutrality as described in paragraph (c).

387.21 (e) For discharges occurring on or after November 1, 2014, ~~through the next two rebasing~~
387.22 ~~periods~~ the commissioner may make additional adjustments to the rebased rates, and when
387.23 evaluating whether additional adjustments should be made, the commissioner shall consider
387.24 the impact of the rates on the following:

387.25 (1) pediatric services;

387.26 (2) behavioral health services;

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

387.28 (4) transplant services;

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

387.31 (6) outlier admissions;

387.32 (7) low-volume providers; and

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

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

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

388.6 (2) for critical access hospitals, payment rates for discharges between November 1, 2014,
388.7 and June 30, 2015, shall be set to the same rate of payment that applied for discharges on
388.8 October 31, 2014;

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

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

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

388.23 (h) Effective for discharges occurring on or after July 1, 2017, and every two years
388.24 thereafter, payment rates under this section shall be rebased to reflect only those changes
388.25 in hospital costs between the existing base year and the next base year. Changes in costs
388.26 between base years shall be measured using the lower of the hospital cost index defined in
388.27 subdivision 1, paragraph (a), or the percentage change in the case mix adjusted cost per
388.28 claim. The commissioner shall establish the base year for each rebasing period considering
388.29 the most recent year for which filed Medicare cost reports are available. The estimated
388.30 change in the average payment per hospital discharge resulting from a scheduled rebasing
388.31 must be calculated and made available to the legislature by January 15 of each year in which
388.32 rebasing is scheduled to occur, and must include by hospital the differential in payment
388.33 rates compared to the individual hospital's costs.

389.1 (i) Effective for discharges occurring on or after July 1, 2015, inpatient payment rates
389.2 for critical access hospitals located in Minnesota or the local trade area shall be determined
389.3 using a new cost-based methodology. The commissioner shall establish within the
389.4 methodology tiers of payment designed to promote efficiency and cost-effectiveness.
389.5 Payment rates for hospitals under this paragraph shall be set at a level that does not exceed
389.6 the total cost for critical access hospitals as reflected in base year cost reports. Until the
389.7 next rebasing that occurs, the new methodology shall result in no greater than a five percent
389.8 decrease from the base year payments for any hospital, except a hospital that had payments
389.9 that were greater than 100 percent of the hospital's costs in the base year shall have their
389.10 rate set equal to 100 percent of costs in the base year. The rates paid for discharges on and
389.11 after July 1, 2016, covered under this paragraph shall be increased by the inflation factor
389.12 in subdivision 1, paragraph (a). The new cost-based rate shall be the final rate and shall not
389.13 be settled to actual incurred costs. Hospitals shall be assigned a payment tier based on the
389.14 following criteria:

389.15 (1) hospitals that had payments at or below 80 percent of their costs in the base year
389.16 shall have a rate set that equals 85 percent of their base year costs;

389.17 (2) hospitals that had payments that were above 80 percent, up to and including 90
389.18 percent of their costs in the base year shall have a rate set that equals 95 percent of their
389.19 base year costs; and

389.20 (3) hospitals that had payments that were above 90 percent of their costs in the base year
389.21 shall have a rate set that equals 100 percent of their base year costs.

389.22 (j) The commissioner may refine the payment tiers and criteria for critical access hospitals
389.23 to coincide with the next rebasing under paragraph (h). The factors used to develop the new
389.24 methodology may include, but are not limited to:

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

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

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

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

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

390.3 (6) geographic location.

390.4 Sec. 7. Minnesota Statutes 2018, section 256.969, subdivision 3a, is amended to read:

390.5 Subd. 3a. **Payments.** (a) Acute care hospital billings under the medical assistance program
390.6 must not be submitted until the recipient is discharged. However, the commissioner shall
390.7 establish monthly interim payments for inpatient hospitals that have individual patient
390.8 lengths of stay over 30 days regardless of diagnostic category. Except as provided in section
390.9 256.9693, medical assistance reimbursement for treatment of mental illness shall be
390.10 reimbursed based on diagnostic classifications. Individual hospital payments established
390.11 under this section and sections 256.9685, 256.9686, and 256.9695, in addition to third-party
390.12 and recipient liability, for discharges occurring during the rate year shall not exceed, ~~in~~
390.13 ~~aggregate~~ on a per claim basis, the charges for the medical assistance covered inpatient
390.14 services paid for the same period of time to the hospital. Services that have rates established
390.15 under subdivision 12, must be limited separately from other services. After consulting with
390.16 the affected hospitals, the commissioner may consider related hospitals one entity and may
390.17 merge the payment rates while maintaining separate provider numbers. The operating and
390.18 property base rates per admission or per day shall be derived from the best Medicare and
390.19 claims data available when rates are established. The commissioner shall determine the best
390.20 Medicare and claims data, taking into consideration variables of recency of the data, audit
390.21 disposition, settlement status, and the ability to set rates in a timely manner. The
390.22 commissioner shall notify hospitals of payment rates 30 days prior to implementation. The
390.23 rate setting data must reflect the admissions data used to establish relative values. The
390.24 commissioner may adjust base year cost, relative value, and case mix index data to exclude
390.25 the costs of services that have been discontinued by October 1 of the year preceding the
390.26 rate year or that are paid separately from inpatient services. Inpatient stays that encompass
390.27 portions of two or more rate years shall have payments established based on payment rates
390.28 in effect at the time of admission unless the date of admission preceded the rate year in
390.29 effect by six months or more. In this case, operating payment rates for services rendered
390.30 during the rate year in effect and established based on the date of admission shall be adjusted
390.31 to the rate year in effect by the hospital cost index.

390.32 (b) For fee-for-service admissions occurring on or after July 1, 2002, the total payment,
390.33 before third-party liability and spenddown, made to hospitals for inpatient services is reduced
390.34 by .5 percent from the current statutory rates.

391.1 (c) In addition to the reduction in paragraph (b), the total payment for fee-for-service
391.2 admissions occurring on or after July 1, 2003, made to hospitals for inpatient services before
391.3 third-party liability and spenddown, is reduced five percent from the current statutory rates.
391.4 Mental health services within diagnosis related groups 424 to 432 or corresponding
391.5 APR-DRGs, and facilities defined under subdivision 16 are excluded from this paragraph.

391.6 (d) In addition to the reduction in paragraphs (b) and (c), the total payment for
391.7 fee-for-service admissions occurring on or after August 1, 2005, made to hospitals for
391.8 inpatient services before third-party liability and spenddown, is reduced 6.0 percent from
391.9 the current statutory rates. Mental health services within diagnosis related groups 424 to
391.10 432 or corresponding APR-DRGs, and facilities defined under subdivision 16 are excluded
391.11 from this paragraph. Payments made to managed care plans shall be reduced for services
391.12 provided on or after January 1, 2006, to reflect this reduction.

391.13 (e) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for
391.14 fee-for-service admissions occurring on or after July 1, 2008, through June 30, 2009, made
391.15 to hospitals for inpatient services before third-party liability and spenddown, is reduced
391.16 3.46 percent from the current statutory rates. Mental health services with diagnosis related
391.17 groups 424 to 432 or corresponding APR-DRGs, and facilities defined under subdivision
391.18 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced
391.19 for services provided on or after January 1, 2009, through June 30, 2009, to reflect this
391.20 reduction.

391.21 (f) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for
391.22 fee-for-service admissions occurring on or after July 1, 2009, through June 30, 2011, made
391.23 to hospitals for inpatient services before third-party liability and spenddown, is reduced 1.9
391.24 percent from the current statutory rates. Mental health services with diagnosis related groups
391.25 424 to 432 or corresponding APR-DRGs, and facilities defined under subdivision 16 are
391.26 excluded from this paragraph. Payments made to managed care plans shall be reduced for
391.27 services provided on or after July 1, 2009, through June 30, 2011, to reflect this reduction.

391.28 (g) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for
391.29 fee-for-service admissions occurring on or after July 1, 2011, made to hospitals for inpatient
391.30 services before third-party liability and spenddown, is reduced 1.79 percent from the current
391.31 statutory rates. Mental health services with diagnosis related groups 424 to 432 or
391.32 corresponding APR-DRGs, and facilities defined under subdivision 16 are excluded from
391.33 this paragraph. Payments made to managed care plans shall be reduced for services provided
391.34 on or after July 1, 2011, to reflect this reduction.

392.1 (h) In addition to the reductions in paragraphs (b), (c), (d), (f), and (g), the total payment
392.2 for fee-for-service admissions occurring on or after July 1, 2009, made to hospitals for
392.3 inpatient services before third-party liability and spenddown, is reduced one percent from
392.4 the current statutory rates. Facilities defined under subdivision 16 are excluded from this
392.5 paragraph. Payments made to managed care plans shall be reduced for services provided
392.6 on or after October 1, 2009, to reflect this reduction.

392.7 (i) In addition to the reductions in paragraphs (b), (c), (d), (g), and (h), the total payment
392.8 for fee-for-service admissions occurring on or after July 1, 2011, made to hospitals for
392.9 inpatient services before third-party liability and spenddown, is reduced 1.96 percent from
392.10 the current statutory rates. Facilities defined under subdivision 16 are excluded from this
392.11 paragraph. Payments made to managed care plans shall be reduced for services provided
392.12 on or after January 1, 2011, to reflect this reduction.

392.13 (j) Effective for discharges on and after November 1, 2014, from hospitals paid under
392.14 subdivision 2b, paragraph (a), clauses (1) and (4), the rate adjustments in this subdivision
392.15 must be incorporated into the rebased rates established under subdivision 2b, paragraph (c),
392.16 and must not be applied to each claim.

392.17 (k) Effective for discharges on and after July 1, 2015, from hospitals paid under
392.18 subdivision 2b, paragraph (a), clauses (2) and (3), the rate adjustments in this subdivision
392.19 must be incorporated into the rates and must not be applied to each claim.

392.20 (l) Effective for discharges on and after July 1, 2017, from hospitals paid under
392.21 subdivision 2b, paragraph (a), clause (2), the rate adjustments in this subdivision must be
392.22 incorporated into the rates and must not be applied to each claim.

392.23 Sec. 8. Minnesota Statutes 2018, section 256.969, subdivision 9, is amended to read:

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

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

393.1 payment rates by the difference between the hospital's actual medical assistance inpatient
393.2 utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers
393.3 and facilities of the federal Indian Health Service; and

393.4 (2) for a hospital with a medical assistance inpatient utilization rate above one standard
393.5 deviation above the mean, the adjustment must be determined by multiplying the adjustment
393.6 that would be determined under clause (1) for that hospital by 1.1. The commissioner shall
393.7 report annually on the number of hospitals likely to receive the adjustment authorized by
393.8 this paragraph. The commissioner shall specifically report on the adjustments received by
393.9 public hospitals and public hospital corporations located in cities of the first class.

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

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

393.19 (d) Effective July 1, 2015, disproportionate share hospital (DSH) payments shall be paid
393.20 in accordance with a new methodology using 2012 as the base year. Annual payments made
393.21 under this paragraph shall equal the total amount of payments made for 2012. A licensed
393.22 children's hospital shall receive only a single DSH factor for children's hospitals. Other
393.23 DSH factors may be combined to arrive at a single factor for each hospital that is eligible
393.24 for DSH payments. The new methodology shall make payments only to hospitals located
393.25 in Minnesota and include the following factors:

393.26 (1) a licensed children's hospital with at least 1,000 fee-for-service discharges in the
393.27 base year shall receive a factor of 0.868. A licensed children's hospital with less than 1,000
393.28 fee-for-service discharges in the base year shall receive a factor of 0.7880;

393.29 (2) a hospital that has in effect for the initial rate year a contract with the commissioner
393.30 to provide extended psychiatric inpatient services under section 256.9693 shall receive a
393.31 factor of 0.0160;

393.32 (3) a hospital that has received payment from the fee-for-service program for at least 20
393.33 transplant services in the base year shall receive a factor of 0.0435;

394.1 (4) a hospital that has a medical assistance utilization rate in the base year between 20
394.2 percent up to one standard deviation above the statewide mean utilization rate shall receive
394.3 a factor of 0.0468;

394.4 (5) a hospital that has a medical assistance utilization rate in the base year that is at least
394.5 one standard deviation above the statewide mean utilization rate but is less than three standard
394.6 deviations above the mean shall receive a factor of 0.2300; and

394.7 (6) a hospital that has a medical assistance utilization rate in the base year that is at least
394.8 ~~three~~ two and one-half standard deviations above the statewide mean utilization rate shall
394.9 receive a factor of 0.3711.

394.10 (e) Any payments or portion of payments made to a hospital under this subdivision that
394.11 are subsequently returned to the commissioner because the payments are found to exceed
394.12 the hospital-specific DSH limit for that hospital shall be redistributed, proportionate to the
394.13 number of fee-for-service discharges, to other DSH-eligible non-children's hospitals that
394.14 have a medical assistance utilization rate that is at least one standard deviation above the
394.15 mean.

394.16 (f) An additional payment adjustment shall be established by the commissioner under
394.17 this subdivision for a hospital that provides high levels of administering high-cost drugs to
394.18 enrollees in fee-for-service medical assistance. The commissioner shall consider factors
394.19 including fee-for-service medical assistance utilization rates and payments made for drugs
394.20 purchased through the 340B drug purchasing program and administered to fee-for-service
394.21 enrollees. If any part of this adjustment exceeds a hospital's hospital-specific disproportionate
394.22 share hospital limit, the commissioner shall make a payment to the hospital that equals the
394.23 nonfederal share of the amount that exceeds the limit. The total nonfederal share of the
394.24 amount of the payment adjustment under this paragraph shall not exceed \$1,500,000.

394.25 **EFFECTIVE DATE.** This section is effective July 1, 2019, except paragraph (f) is
394.26 effective for discharges on or after April 1, 2019.

394.27 Sec. 9. Minnesota Statutes 2018, section 256.969, subdivision 17, is amended to read:

394.28 Subd. 17. **Out-of-state hospitals in local trade areas.** Out-of-state hospitals that are
394.29 located within a Minnesota local trade area and that have ~~more than~~ 20 admissions in the
394.30 base year or years shall have rates established using the same procedures and methods that
394.31 apply to Minnesota hospitals. For this subdivision and subdivision 18, local trade area means
394.32 a county contiguous to Minnesota and located in a metropolitan statistical area as determined
394.33 by Medicare for October 1 prior to the most current rebased rate year. Hospitals that are

395.1 not required by law to file information in a format necessary to establish rates shall have
395.2 rates established based on the commissioner's estimates of the information. Relative values
395.3 of the diagnostic categories shall not be redetermined under this subdivision until required
395.4 by statute. Hospitals affected by this subdivision shall then be included in determining
395.5 relative values. However, hospitals that have rates established based upon the commissioner's
395.6 estimates of information shall not be included in determining relative values. This subdivision
395.7 is effective for hospital fiscal years beginning on or after July 1, 1988. A hospital shall
395.8 provide the information necessary to establish rates under this subdivision at least 90 days
395.9 before the start of the hospital's fiscal year.

395.10 Sec. 10. Minnesota Statutes 2018, section 256.969, subdivision 19, is amended to read:

395.11 Subd. 19. **Metabolic disorder testing of medical assistance recipients.** Medical
395.12 assistance inpatient payment rates must include the cost incurred by hospitals to pay the
395.13 Department of Health for metabolic disorder testing of newborns who are medical assistance
395.14 recipients, if the cost is not recognized by another payment source. This payment increase
395.15 remains in effect until the increase is fully recognized in the base year cost under subdivision
395.16 2b.

395.17 Sec. 11. Minnesota Statutes 2018, section 256B.04, subdivision 21, is amended to read:

395.18 Subd. 21. **Provider enrollment.** (a) The commissioner shall enroll providers and conduct
395.19 screening activities as required by Code of Federal Regulations, title 42, section 455, subpart
395.20 E. A provider providing services from multiple locations must enroll each location separately.
395.21 The commissioner may deny a provider's incomplete application if a provider fails to respond
395.22 to the commissioner's request for additional information within 60 days of the request. The
395.23 commissioner must conduct a background study under chapter 245C, including a review
395.24 of databases in section 245C.08, subdivision 1, paragraph (a), clauses (1) to (5), for a provider
395.25 described in this paragraph. The background study requirement may be satisfied if the
395.26 commissioner conducted a fingerprint-based background study on the provider that includes
395.27 a review of databases in section 245C.08, subdivision 1, paragraph (a), clauses (1) to (5).

395.28 (b) The commissioner shall revalidate each: (1) provider under this subdivision at least
395.29 once every five years; and (2) personal care assistance agency under this subdivision once
395.30 every three years.

395.31 (c) The commissioner shall conduct revalidation as follows:

395.32 (1) provide 30-day notice of the revalidation due date including instructions for
395.33 revalidation and a list of materials the provider must submit;

396.1 (2) if a provider fails to submit all required materials by the due date, notify the provider
396.2 of the deficiency within 30 days after the due date and allow the provider an additional 30
396.3 days from the notification date to comply; and

396.4 (3) if a provider fails to remedy a deficiency within the 30-day time period, give 60-day
396.5 notice of termination and immediately suspend the provider's ability to bill. The provider
396.6 does not have the right to appeal suspension of ability to bill.

396.7 (d) If a provider fails to comply with any individual provider requirement or condition
396.8 of participation, the commissioner may suspend the provider's ability to bill until the provider
396.9 comes into compliance. The commissioner's decision to suspend the provider is not subject
396.10 to an administrative appeal.

396.11 (e) All correspondence and notifications, including notifications of termination and other
396.12 actions, must be delivered electronically to a provider's MN-ITS mailbox. For a provider
396.13 that does not have a MN-ITS account and mailbox, notice must be sent by first-class mail.
396.14 This paragraph does not apply to correspondences and notifications related to background
396.15 studies.

396.16 (f) If the commissioner or the Centers for Medicare and Medicaid Services determines
396.17 that a provider is designated "high-risk," the commissioner may withhold payment from
396.18 providers within that category upon initial enrollment for a 90-day period. The withholding
396.19 for each provider must begin on the date of the first submission of a claim.

396.20 ~~(b)~~ (g) An enrolled provider that is also licensed by the commissioner under chapter
396.21 245A, or is licensed as a home care provider by the Department of Health under chapter
396.22 144A and has a home and community-based services designation on the home care license
396.23 under section 144A.484, must designate an individual as the entity's compliance officer.
396.24 The compliance officer must:

396.25 (1) develop policies and procedures to assure adherence to medical assistance laws and
396.26 regulations and to prevent inappropriate claims submissions;

396.27 (2) train the employees of the provider entity, and any agents or subcontractors of the
396.28 provider entity including billers, on the policies and procedures under clause (1);

396.29 (3) respond to allegations of improper conduct related to the provision or billing of
396.30 medical assistance services, and implement action to remediate any resulting problems;

396.31 (4) use evaluation techniques to monitor compliance with medical assistance laws and
396.32 regulations;

397.1 (5) promptly report to the commissioner any identified violations of medical assistance
397.2 laws or regulations; and

397.3 (6) within 60 days of discovery by the provider of a medical assistance reimbursement
397.4 overpayment, report the overpayment to the commissioner and make arrangements with
397.5 the commissioner for the commissioner's recovery of the overpayment.

397.6 The commissioner may require, as a condition of enrollment in medical assistance, that a
397.7 provider within a particular industry sector or category establish a compliance program that
397.8 contains the core elements established by the Centers for Medicare and Medicaid Services.

397.9 ~~(e)~~ (h) The commissioner may revoke the enrollment of an ordering or rendering provider
397.10 for a period of not more than one year, if the provider fails to maintain and, upon request
397.11 from the commissioner, provide access to documentation relating to written orders or requests
397.12 for payment for durable medical equipment, certifications for home health services, or
397.13 referrals for other items or services written or ordered by such provider, when the
397.14 commissioner has identified a pattern of a lack of documentation. A pattern means a failure
397.15 to maintain documentation or provide access to documentation on more than one occasion.
397.16 Nothing in this paragraph limits the authority of the commissioner to sanction a provider
397.17 under the provisions of section 256B.064.

397.18 ~~(d)~~ (i) The commissioner shall terminate or deny the enrollment of any individual or
397.19 entity if the individual or entity has been terminated from participation in Medicare or under
397.20 the Medicaid program or Children's Health Insurance Program of any other state.

397.21 ~~(e)~~ (j) As a condition of enrollment in medical assistance, the commissioner shall require
397.22 that a provider designated "moderate" or "high-risk" by the Centers for Medicare and
397.23 Medicaid Services or the commissioner permit the Centers for Medicare and Medicaid
397.24 Services, its agents, or its designated contractors and the state agency, its agents, or its
397.25 designated contractors to conduct unannounced on-site inspections of any provider location.
397.26 The commissioner shall publish in the Minnesota Health Care Program Provider Manual a
397.27 list of provider types designated "limited," "moderate," or "high-risk," based on the criteria
397.28 and standards used to designate Medicare providers in Code of Federal Regulations, title
397.29 42, section 424.518. The list and criteria are not subject to the requirements of chapter 14.
397.30 The commissioner's designations are not subject to administrative appeal.

397.31 ~~(f)~~ (k) As a condition of enrollment in medical assistance, the commissioner shall require
397.32 that a high-risk provider, or a person with a direct or indirect ownership interest in the
397.33 provider of five percent or higher, consent to criminal background checks, including
397.34 fingerprinting, when required to do so under state law or by a determination by the

398.1 commissioner or the Centers for Medicare and Medicaid Services that a provider is designated
398.2 high-risk for fraud, waste, or abuse.

398.3 ~~(g)~~ (l)(1) Upon initial enrollment, reenrollment, and notification of revalidation, all
398.4 durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) medical suppliers
398.5 meeting the durable medical equipment provider and supplier definition in clause (3),
398.6 operating in Minnesota and receiving Medicaid funds must purchase a surety bond that is
398.7 annually renewed and designates the Minnesota Department of Human Services as the
398.8 obligee, and must be submitted in a form approved by the commissioner. For purposes of
398.9 this clause, the following medical suppliers are not required to obtain a surety bond: a
398.10 federally qualified health center, a home health agency, the Indian Health Service, a
398.11 pharmacy, and a rural health clinic.

398.12 (2) At the time of initial enrollment or reenrollment, durable medical equipment providers
398.13 and suppliers defined in clause (3) must purchase a surety bond of \$50,000. If a revalidating
398.14 provider's Medicaid revenue in the previous calendar year is up to and including \$300,000,
398.15 the provider agency must purchase a surety bond of \$50,000. If a revalidating provider's
398.16 Medicaid revenue in the previous calendar year is over \$300,000, the provider agency must
398.17 purchase a surety bond of \$100,000. The surety bond must allow for recovery of costs and
398.18 fees in pursuing a claim on the bond.

398.19 (3) "Durable medical equipment provider or supplier" means a medical supplier that can
398.20 purchase medical equipment or supplies for sale or rental to the general public and is able
398.21 to perform or arrange for necessary repairs to and maintenance of equipment offered for
398.22 sale or rental.

398.23 ~~(h)~~ (m) The Department of Human Services may require a provider to purchase a surety
398.24 bond as a condition of initial enrollment, reenrollment, reinstatement, or continued enrollment
398.25 if: (1) the provider fails to demonstrate financial viability, (2) the department determines
398.26 there is significant evidence of or potential for fraud and abuse by the provider, or (3) the
398.27 provider or category of providers is designated high-risk pursuant to paragraph ~~(a)~~ (f) and
398.28 as per Code of Federal Regulations, title 42, section 455.450. The surety bond must be in
398.29 an amount of \$100,000 or ten percent of the provider's payments from Medicaid during the
398.30 immediately preceding 12 months, whichever is greater. The surety bond must name the
398.31 Department of Human Services as an obligee and must allow for recovery of costs and fees
398.32 in pursuing a claim on the bond. This paragraph does not apply if the provider currently
398.33 maintains a surety bond under the requirements in section 256B.0659 or 256B.85.

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

399.1 Sec. 12. Minnesota Statutes 2018, section 256B.04, subdivision 22, is amended to read:

399.2 Subd. 22. **Application fee.** (a) The commissioner must collect and retain federally
399.3 required nonrefundable application fees to pay for provider screening activities in accordance
399.4 with Code of Federal Regulations, title 42, section 455, subpart E. The enrollment application
399.5 must be made under the procedures specified by the commissioner, in the form specified
399.6 by the commissioner, and accompanied by an application fee described in paragraph (b),
399.7 or a request for a hardship exception as described in the specified procedures. Application
399.8 fees must be deposited in the provider screening account in the special revenue fund.
399.9 Amounts in the provider screening account are appropriated to the commissioner for costs
399.10 associated with the provider screening activities required in Code of Federal Regulations,
399.11 title 42, section 455, subpart E. ~~The commissioner shall conduct screening activities as~~
399.12 ~~required by Code of Federal Regulations, title 42, section 455, subpart E, and as otherwise~~
399.13 ~~provided by law, to include database checks, unannounced pre- and postenrollment site~~
399.14 ~~visits, fingerprinting, and criminal background studies. The commissioner must revalidate~~
399.15 ~~all providers under this subdivision at least once every five years.~~

399.16 (b) The application fee under this subdivision is \$532 for the calendar year 2013. For
399.17 calendar year 2014 and subsequent years, the fee:

399.18 (1) is adjusted by the percentage change to the Consumer Price Index for all urban
399.19 consumers, United States city average, for the 12-month period ending with June of the
399.20 previous year. The resulting fee must be announced in the Federal Register;

399.21 (2) is effective from January 1 to December 31 of a calendar year;

399.22 (3) is required on the submission of an initial application, an application to establish a
399.23 new practice location, an application for reenrollment when the provider is not enrolled at
399.24 the time of application of reenrollment, or at revalidation when required by federal regulation;
399.25 and

399.26 (4) must be in the amount in effect for the calendar year during which the application
399.27 for enrollment, new practice location, or reenrollment is being submitted.

399.28 (c) The application fee under this subdivision cannot be charged to:

399.29 (1) providers who are enrolled in Medicare or who provide documentation of payment
399.30 of the fee to, and enrollment with, another state, unless the commissioner is required to
399.31 rescreen the provider;

399.32 (2) providers who are enrolled but are required to submit new applications for purposes
399.33 of reenrollment;

400.1 (3) a provider who enrolls as an individual; and

400.2 (4) group practices and clinics that bill on behalf of individually enrolled providers
400.3 within the practice who have reassigned their billing privileges to the group practice or
400.4 clinic.

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

400.6 Sec. 13. Minnesota Statutes 2018, section 256B.055, subdivision 2, is amended to read:

400.7 Subd. 2. **Subsidized foster children.** Medical assistance may be paid for a child eligible
400.8 for or receiving foster care maintenance payments under Title IV-E of the Social Security
400.9 Act, United States Code, title 42, sections 670 to 676, and for a child who is not eligible for
400.10 Title IV-E of the Social Security Act but who is determined eligible for foster care or kinship
400.11 assistance under chapter 256N.

400.12 **EFFECTIVE DATE.** This section is effective January 1, 2020, or upon federal approval,
400.13 whichever is later. The commissioner of human services shall notify the revisor of statutes
400.14 when federal approval is obtained.

400.15 Sec. 14. Minnesota Statutes 2018, section 256B.056, subdivision 3, is amended to read:

400.16 Subd. 3. **Asset limitations for certain individuals.** (a) To be eligible for medical
400.17 assistance, a person must not individually own more than \$3,000 in assets, or if a member
400.18 of a household with two family members, husband and wife, or parent and child, the
400.19 household must not own more than \$6,000 in assets, plus \$200 for each additional legal
400.20 dependent. In addition to these maximum amounts, an eligible individual or family may
400.21 accrue interest on these amounts, but they must be reduced to the maximum at the time of
400.22 an eligibility redetermination. The accumulation of the clothing and personal needs allowance
400.23 according to section 256B.35 must also be reduced to the maximum at the time of the
400.24 eligibility redetermination. The value of assets that are not considered in determining
400.25 eligibility for medical assistance is the value of those assets excluded under the Supplemental
400.26 Security Income program for aged, blind, and disabled persons, with the following
400.27 exceptions:

400.28 (1) household goods and personal effects are not considered;

400.29 (2) capital and operating assets of a trade or business that the local agency determines
400.30 are necessary to the person's ability to earn an income are not considered;

400.31 (3) motor vehicles are excluded to the same extent excluded by the Supplemental Security
400.32 Income program;

401.1 (4) assets designated as burial expenses are excluded to the same extent excluded by the
401.2 Supplemental Security Income program. Burial expenses funded by annuity contracts or
401.3 life insurance policies must irrevocably designate the individual's estate as contingent
401.4 beneficiary to the extent proceeds are not used for payment of selected burial expenses;

401.5 (5) for a person who no longer qualifies as an employed person with a disability due to
401.6 loss of earnings, assets allowed while eligible for medical assistance under section 256B.057,
401.7 subdivision 9, are not considered for 12 months, beginning with the first month of ineligibility
401.8 as an employed person with a disability, to the extent that the person's total assets remain
401.9 within the allowed limits of section 256B.057, subdivision 9, paragraph (d);

401.10 ~~(6) when a person enrolled in medical assistance under section 256B.057, subdivision~~
401.11 ~~9, is age 65 or older and has been enrolled during each of the 24 consecutive months before~~
401.12 ~~the person's 65th birthday, the assets owned by the person and the person's spouse must be~~
401.13 ~~disregarded, up to the limits of section 256B.057, subdivision 9, paragraph (d), when~~
401.14 ~~determining eligibility for medical assistance under section 256B.055, subdivision 7. a~~
401.15 designated employment incentives asset account is disregarded when determining eligibility
401.16 for medical assistance for a person age 65 years or older under section 256B.055, subdivision
401.17 7. An employment incentives asset account must only be designated by a person who has
401.18 been enrolled in medical assistance under section 256B.057, subdivision 9, for a
401.19 24-consecutive-month period. A designated employment incentives asset account contains
401.20 qualified assets owned by the person and the person's spouse in the last month of enrollment
401.21 in medical assistance under section 256B.057, subdivision 9. Qualified assets include
401.22 retirement and pension accounts, medical expense accounts, and up to \$17,000 of the person's
401.23 other nonexcluded assets. An employment incentives asset account is no longer designated
401.24 when a person loses medical assistance eligibility for a calendar month or more before
401.25 turning age 65. A person who loses medical assistance eligibility before age 65 can establish
401.26 a new designated employment incentives asset account by establishing a new
401.27 24-consecutive-month period of enrollment under section 256B.057, subdivision 9. The
401.28 income of a spouse of a person enrolled in medical assistance under section 256B.057,
401.29 subdivision 9, during each of the 24 consecutive months before the person's 65th birthday
401.30 must be disregarded when determining eligibility for medical assistance under section
401.31 256B.055, subdivision 7. Persons eligible under this clause are not subject to the provisions
401.32 in section 256B.059; and

401.33 (7) effective July 1, 2009, certain assets owned by American Indians are excluded as
401.34 required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public

402.1 Law 111-5. For purposes of this clause, an American Indian is any person who meets the
402.2 definition of Indian according to Code of Federal Regulations, title 42, section 447.50.

402.3 (b) No asset limit shall apply to persons eligible under section 256B.055, subdivision
402.4 15.

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

402.6 Sec. 15. Minnesota Statutes 2018, section 256B.0625, subdivision 13, is amended to read:

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

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

402.15 (c) For the purpose of this subdivision and subdivision 13d, an "active pharmaceutical
402.16 ingredient" is defined as a substance that is represented for use in a drug and when used in
402.17 the manufacturing, processing, or packaging of a drug becomes an active ingredient of the
402.18 drug product. An "excipient" is defined as an inert substance used as a diluent or vehicle
402.19 for a drug. The commissioner shall establish a list of active pharmaceutical ingredients and
402.20 excipients which are included in the medical assistance formulary. Medical assistance covers
402.21 selected active pharmaceutical ingredients and excipients used in compounded prescriptions
402.22 when the compounded combination is specifically approved by the commissioner or when
402.23 a commercially available product:

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

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

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

402.29 (d) Medical assistance covers the following over-the-counter drugs when prescribed by
402.30 a licensed practitioner or by a licensed pharmacist who meets standards established by the
402.31 commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family
402.32 planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults

403.1 with documented vitamin deficiencies, vitamins for children under the age of seven and
403.2 pregnant or nursing women, and any other over-the-counter drug identified by the
403.3 commissioner, in consultation with the Formulary Committee, as necessary, appropriate,
403.4 and cost-effective for the treatment of certain specified chronic diseases, conditions, or
403.5 disorders, and this determination shall not be subject to the requirements of chapter 14. A
403.6 pharmacist may prescribe over-the-counter medications as provided under this paragraph
403.7 for purposes of receiving reimbursement under Medicaid. When prescribing over-the-counter
403.8 drugs under this paragraph, licensed pharmacists must consult with the recipient to determine
403.9 necessity, provide drug counseling, review drug therapy for potential adverse interactions,
403.10 and make referrals as needed to other health care professionals. ~~Over-the-counter medications
403.11 must be dispensed in a quantity that is the lowest of: (1) the number of dosage units contained
403.12 in the manufacturer's original package; (2) the number of dosage units required to complete
403.13 the patient's course of therapy; or (3) if applicable, the number of dosage units dispensed
403.14 from a system using retrospective billing, as provided under subdivision 13e, paragraph
403.15 (b).~~

403.16 (e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable
403.17 under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and
403.18 Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible
403.19 for drug coverage as defined in the Medicare Prescription Drug, Improvement, and
403.20 Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these
403.21 individuals, medical assistance may cover drugs from the drug classes listed in United States
403.22 Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to
403.23 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall
403.24 not be covered.

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

403.29 **EFFECTIVE DATE.** This section is effective April 1, 2019, or upon federal approval,
403.30 whichever is later. The commissioner of human services shall notify the revisor of statutes
403.31 when federal approval is obtained.

404.1 Sec. 16. Minnesota Statutes 2018, section 256B.0625, subdivision 13e, is amended to
404.2 read:

404.3 Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall
404.4 be the lower of the ~~actual acquisition~~ ingredient costs of the drugs ~~or the maximum allowable~~
404.5 ~~cost by the commissioner~~ plus the fixed professional dispensing fee; or the usual and
404.6 customary price charged to the public. The usual and customary price means the lowest
404.7 price charged by the provider to a patient who pays for the prescription by cash, check, or
404.8 charge account and includes prices the pharmacy charges to a patient enrolled in a
404.9 prescription savings club or prescription discount club administered by the pharmacy or
404.10 pharmacy chain. The amount of payment basis must be reduced to reflect all discount
404.11 amounts applied to the charge by any third-party provider/insurer agreement or contract for
404.12 submitted charges to medical assistance programs. The net submitted charge may not be
404.13 greater than the patient liability for the service. The ~~pharmacy~~ professional dispensing fee
404.14 shall be ~~\$3.65~~ \$10.48 for ~~legend prescription drugs, except that~~ prescriptions filled with
404.15 legend drugs meeting the definition of "covered outpatient drugs" according to United States
404.16 Code, title 42, section 1396r-8(k)(2). The dispensing fee for intravenous solutions ~~which~~
404.17 that must be compounded by the pharmacist shall be \$8 \$10.48 per bag; ~~\$14 per bag for~~
404.18 ~~cancer chemotherapy products, and \$30 per bag for total parenteral nutritional products~~
404.19 ~~dispensed in one-liter quantities, or \$44 per bag for total parenteral nutritional products~~
404.20 ~~dispensed in quantities greater than one-liter.~~ The professional dispensing fee for
404.21 prescriptions filled with over-the-counter drugs meeting the definition of covered outpatient
404.22 drugs shall be \$10.48 for dispensed quantities equal to or greater than the number of units
404.23 contained in the manufacturer's original package. The professional dispensing fee shall be
404.24 prorated based on the percentage of the package dispensed when the pharmacy dispenses
404.25 a quantity less than the number of units contained in the manufacturer's original package.
404.26 The pharmacy dispensing fee for prescribed over-the-counter drugs not meeting the definition
404.27 of covered outpatient drugs shall be \$3.65, except that the fee shall be \$1.31 for
404.28 ~~retrospectively billing pharmacies when billing for quantities less than the number of units~~
404.29 ~~contained in the manufacturer's original package. Actual acquisition cost includes quantity~~
404.30 ~~and other special discounts except time and cash discounts. The actual acquisition cost of~~
404.31 ~~a drug shall be estimated by the commissioner at wholesale acquisition cost plus four percent~~
404.32 ~~for independently owned pharmacies located in a designated rural area within Minnesota,~~
404.33 ~~and at wholesale acquisition cost plus two percent for all other pharmacies. A pharmacy is~~
404.34 ~~"independently owned" if it is one of four or fewer pharmacies under the same ownership~~
404.35 ~~nationally. A "designated rural area" means an area defined as a small rural area or isolated~~
404.36 ~~rural area according to the four-category classification of the Rural Urban Commuting Area~~

405.1 ~~system developed for the United States Health Resources and Services Administration.~~
405.2 ~~Effective January 1, 2014, the actual acquisition~~ for quantities equal to or greater than the
405.3 number of units contained in the manufacturer's original package and shall be prorated based
405.4 on the percentage of the package dispensed when the pharmacy dispenses a quantity less
405.5 than the number of units contained in the manufacturer's original package. The National
405.6 Average Drug Acquisition Cost (NADAC) shall be used to determine the ingredient cost
405.7 of a drug. For drugs for which a NADAC is not reported, the commissioner shall estimate
405.8 the ingredient cost at the wholesale acquisition cost minus two percent. The ingredient cost
405.9 of a drug acquired through for a provider participating in the federal 340B Drug Pricing
405.10 Program shall be estimated by the commissioner at wholesale acquisition cost minus 40
405.11 percent either the 340B Drug Pricing Program ceiling price established by the Health
405.12 Resources and Services Administration or NADAC, whichever is lower. Wholesale
405.13 acquisition cost is defined as the manufacturer's list price for a drug or biological to
405.14 wholesalers or direct purchasers in the United States, not including prompt pay or other
405.15 discounts, rebates, or reductions in price, for the most recent month for which information
405.16 is available, as reported in wholesale price guides or other publications of drug or biological
405.17 pricing data. The maximum allowable cost of a multisource drug may be set by the
405.18 commissioner and it shall be comparable to, ~~but~~ the actual acquisition cost of the drug
405.19 product and no higher than, the maximum amount paid by other third-party payors in this
405.20 ~~state who have maximum allowable cost programs~~ the NADAC of the generic product.
405.21 Establishment of the amount of payment for drugs shall not be subject to the requirements
405.22 of the Administrative Procedure Act.

405.23 (b) Pharmacies dispensing prescriptions to residents of long-term care facilities using
405.24 an automated drug distribution system meeting the requirements of section 151.58, or a
405.25 packaging system meeting the packaging standards set forth in Minnesota Rules, part
405.26 6800.2700, that govern the return of unused drugs to the pharmacy for reuse, may employ
405.27 retrospective billing for prescription drugs dispensed to long-term care facility residents. A
405.28 retrospectively billing pharmacy must submit a claim only for the quantity of medication
405.29 used by the enrolled recipient during the defined billing period. A retrospectively billing
405.30 pharmacy must use a billing period not less than one calendar month or 30 days.

405.31 (c) ~~An additional dispensing fee of \$.30 may be added to the dispensing fee paid to~~
405.32 ~~pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities~~
405.33 ~~when a unit dose blister card system, approved by the department, is used. Under this type~~
405.34 ~~of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National~~
405.35 ~~Drug Code (NDC) from the drug container used to fill the blister card must be identified~~

406.1 ~~on the claim to the department. The unit dose blister card containing the drug must meet~~
406.2 ~~the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return~~
406.3 ~~of unused drugs to the pharmacy for reuse.~~ A pharmacy provider using packaging that meets
406.4 the standards set forth in Minnesota Rules, part 6800.2700, is required to credit the
406.5 department for the actual acquisition cost of all unused drugs that are eligible for reuse,
406.6 unless the pharmacy is using retrospective billing. The commissioner may permit the drug
406.7 clozapine to be dispensed in a quantity that is less than a 30-day supply.

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

406.16 (e) The basis for determining the amount of payment for drugs administered in an
406.17 outpatient setting shall be the lower of the usual and customary cost submitted by the
406.18 provider, 106 percent of the average sales price as determined by the United States
406.19 Department of Health and Human Services pursuant to title XVIII, section 1847a of the
406.20 federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost
406.21 set by the commissioner. If average sales price is unavailable, the amount of payment must
406.22 be lower of the usual and customary cost submitted by the provider, the wholesale acquisition
406.23 cost, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner.
406.24 ~~Effective January 1, 2014,~~ The commissioner shall discount the payment rate for drugs
406.25 obtained through the federal 340B Drug Pricing Program by ~~20~~ 28.6 percent. The payment
406.26 for drugs administered in an outpatient setting shall be made to the administering facility
406.27 or practitioner. A retail or specialty pharmacy dispensing a drug for administration in an
406.28 outpatient setting is not eligible for direct reimbursement.

406.29 (f) The commissioner may ~~negotiate lower reimbursement~~ establish maximum allowable
406.30 cost rates for specialty pharmacy products than the rates that are lower than the ingredient
406.31 cost formulas specified in paragraph (a). The commissioner may require individuals enrolled
406.32 in the health care programs administered by the department to obtain specialty pharmacy
406.33 products from providers with whom the commissioner has negotiated lower reimbursement
406.34 rates. Specialty pharmacy products are defined as those used by a small number of recipients
406.35 or recipients with complex and chronic diseases that require expensive and challenging drug

407.1 regimens. Examples of these conditions include, but are not limited to: multiple sclerosis,
407.2 HIV/AIDS, transplantation, hepatitis C, growth hormone deficiency, Crohn's Disease,
407.3 rheumatoid arthritis, and certain forms of cancer. Specialty pharmaceutical products include
407.4 injectable and infusion therapies, biotechnology drugs, antihemophilic factor products,
407.5 high-cost therapies, and therapies that require complex care. The commissioner shall consult
407.6 with the Formulary Committee to develop a list of specialty pharmacy products subject to
407.7 ~~this paragraph~~ maximum allowable cost reimbursement. In consulting with the Formulary
407.8 Committee in developing this list, the commissioner shall take into consideration the
407.9 population served by specialty pharmacy products, the current delivery system and standard
407.10 of care in the state, and access to care issues. The commissioner shall have the discretion
407.11 to adjust the ~~reimbursement rate~~ maximum allowable cost to prevent access to care issues.

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

407.14 (h) The commissioner shall contract with a vendor to conduct a cost of dispensing survey
407.15 for all pharmacies that are physically located in the state of Minnesota that dispense outpatient
407.16 drugs under medical assistance. The commissioner shall ensure that the vendor has prior
407.17 experience in conducting cost of dispensing surveys. Each pharmacy enrolled with the
407.18 department to dispense outpatient prescription drugs to fee-for-service members must
407.19 respond to the cost of dispensing survey. The commissioner may sanction a pharmacy under
407.20 section 256B.064 for failure to respond. The commissioner shall require the vendor to
407.21 measure a single statewide cost of dispensing for all responding pharmacies to measure the
407.22 mean, mean weighted by total prescription volume, mean weighted by medical assistance
407.23 prescription volume, median, median weighted by total prescription volume, and median
407.24 weighted by total medical assistance prescription volume. The commissioner shall post a
407.25 copy of the final cost of dispensing survey report on the department's website. The initial
407.26 survey must be completed no later than January 1, 2021, and repeated every three years.
407.27 The commissioner shall provide a summary of the results of each cost of dispensing survey
407.28 and provide recommendations for any changes to the dispensing fee to the chairs and ranking
407.29 members of the legislative committees with jurisdiction over medical assistance pharmacy
407.30 reimbursement.

407.31 (i) The commissioner shall increase the ingredient cost reimbursement calculated in
407.32 paragraphs (a) and (f) by two percent for prescription and nonprescription drugs subject to
407.33 the wholesale drug distributor tax under section 295.52.

407.34 **EFFECTIVE DATE.** This section is effective April 1, 2019, or upon federal approval,
407.35 whichever is later. Paragraph (i) expires if federal approval is denied. The commissioner

408.1 of human services shall inform the revisor of statutes when federal approval is obtained or
408.2 denied.

408.3 Sec. 17. Minnesota Statutes 2018, section 256B.0625, subdivision 13f, is amended to read:

408.4 Subd. 13f. **Prior authorization.** (a) The Formulary Committee shall review and
408.5 recommend drugs which require prior authorization. The Formulary Committee shall
408.6 establish general criteria to be used for the prior authorization of brand-name drugs for
408.7 which generically equivalent drugs are available, but the committee is not required to review
408.8 each brand-name drug for which a generically equivalent drug is available.

408.9 (b) Prior authorization may be required by the commissioner before certain formulary
408.10 drugs are eligible for payment. The Formulary Committee may recommend drugs for prior
408.11 authorization directly to the commissioner. The commissioner may also request that the
408.12 Formulary Committee review a drug for prior authorization. Before the commissioner may
408.13 require prior authorization for a drug:

408.14 (1) the commissioner must provide information to the Formulary Committee on the
408.15 impact that placing the drug on prior authorization may have on the quality of patient care
408.16 and on program costs, information regarding whether the drug is subject to clinical abuse
408.17 or misuse, and relevant data from the state Medicaid program if such data is available;

408.18 (2) the Formulary Committee must review the drug, taking into account medical and
408.19 clinical data and the information provided by the commissioner; and

408.20 (3) the Formulary Committee must hold a public forum and receive public comment for
408.21 an additional 15 days.

408.22 The commissioner must provide a 15-day notice period before implementing the prior
408.23 authorization.

408.24 (c) Except as provided in subdivision 13j, prior authorization shall not be required or
408.25 utilized for any atypical antipsychotic drug prescribed for the treatment of mental illness
408.26 if:

408.27 (1) there is no generically equivalent drug available; and

408.28 (2) the drug was initially prescribed for the recipient prior to July 1, 2003; or

408.29 (3) the drug is part of the recipient's current course of treatment.

408.30 This paragraph applies to any multistate preferred drug list or supplemental drug rebate
408.31 program established or administered by the commissioner. Prior authorization shall
408.32 automatically be granted for 60 days for brand name drugs prescribed for treatment of mental

409.1 illness within 60 days of when a generically equivalent drug becomes available, provided
409.2 that the brand name drug was part of the recipient's course of treatment at the time the
409.3 generically equivalent drug became available.

409.4 ~~(d) Prior authorization shall not be required or utilized for any antihemophilic factor~~
409.5 ~~drug prescribed for the treatment of hemophilia and blood disorders where there is no~~
409.6 ~~generically equivalent drug available if the prior authorization is used in conjunction with~~
409.7 ~~any supplemental drug rebate program or multistate preferred drug list established or~~
409.8 ~~administered by the commissioner.~~

409.9 ~~(e)~~ (d) The commissioner may require prior authorization for brand name drugs whenever
409.10 a generically equivalent product is available, even if the prescriber specifically indicates
409.11 "dispense as written-brand necessary" on the prescription as required by section 151.21,
409.12 subdivision 2.

409.13 ~~(f)~~ (e) Notwithstanding this subdivision, the commissioner may automatically require
409.14 prior authorization, for a period not to exceed 180 days, for any drug that is approved by
409.15 the United States Food and Drug Administration on or after July 1, 2005. The 180-day
409.16 period begins no later than the first day that a drug is available for shipment to pharmacies
409.17 within the state. The Formulary Committee shall recommend to the commissioner general
409.18 criteria to be used for the prior authorization of the drugs, but the committee is not required
409.19 to review each individual drug. In order to continue prior authorizations for a drug after the
409.20 180-day period has expired, the commissioner must follow the provisions of this subdivision.

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

409.22 Sec. 18. Minnesota Statutes 2018, section 256B.0625, subdivision 17, is amended to read:

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

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

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

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

410.2 (3) taxicabs that meet the requirements of this subdivision;

410.3 (4) public transit, as defined in section 174.22, subdivision 7; or

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

410.5 (c) Medical assistance covers nonemergency medical transportation provided by
410.6 nonemergency medical transportation providers enrolled in the Minnesota health care
410.7 programs. All nonemergency medical transportation providers must comply with the
410.8 operating standards for special transportation service as defined in sections 174.29 to 174.30
410.9 and Minnesota Rules, chapter 8840, and ~~in consultation with the Minnesota Department of~~
410.10 ~~Transportation~~ all drivers must be individually enrolled with the commissioner and reported
410.11 on the claim as the individual who provided the service. All nonemergency medical
410.12 transportation providers shall bill for nonemergency medical transportation services in
410.13 accordance with Minnesota health care programs criteria. Publicly operated transit systems,
410.14 volunteers, and not-for-hire vehicles are exempt from the requirements outlined in this
410.15 paragraph.

410.16 (d) An organization may be terminated, denied, or suspended from enrollment if:

410.17 (1) the provider has not initiated background studies on the individuals specified in
410.18 section 174.30, subdivision 10, paragraph (a), clauses (1) to (3); or

410.19 (2) the provider has initiated background studies on the individuals specified in section
410.20 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:

410.21 (i) the commissioner has sent the provider a notice that the individual has been
410.22 disqualified under section 245C.14; and

410.23 (ii) the individual has not received a disqualification set-aside specific to the special
410.24 transportation services provider under sections 245C.22 and 245C.23.

410.25 (e) The administrative agency of nonemergency medical transportation must:

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

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

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

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

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

411.9 (g) The commissioner may use an order by the recipient's attending physician or a medical
411.10 or mental health professional to certify that the recipient requires nonemergency medical
411.11 transportation services. Nonemergency medical transportation providers shall perform
411.12 driver-assisted services for eligible individuals, when appropriate. Driver-assisted service
411.13 includes passenger pickup at and return to the individual's residence or place of business,
411.14 assistance with admittance of the individual to the medical facility, and assistance in
411.15 passenger securement or in securing of wheelchairs, child seats, or stretchers in the vehicle.

411.16 Nonemergency medical transportation providers must take clients to the health care
411.17 provider using the most direct route, and must not exceed 30 miles for a trip to a primary
411.18 care provider or 60 miles for a trip to a specialty care provider, unless the client receives
411.19 authorization from the local agency.

411.20 Nonemergency medical transportation providers may not bill for separate base rates for
411.21 the continuation of a trip beyond the original destination. Nonemergency medical
411.22 transportation providers must maintain trip logs, which include pickup and drop-off times,
411.23 signed by the medical provider or client, whichever is deemed most appropriate, attesting
411.24 to mileage traveled to obtain covered medical services. Clients requesting client mileage
411.25 reimbursement must sign the trip log attesting mileage traveled to obtain covered medical
411.26 services.

411.27 (h) The administrative agency shall use the level of service process established by the
411.28 commissioner in consultation with the Nonemergency Medical Transportation Advisory
411.29 Committee to determine the client's most appropriate mode of transportation. If public transit
411.30 or a certified transportation provider is not available to provide the appropriate service mode
411.31 for the client, the client may receive a onetime service upgrade.

411.32 (i) The covered modes of transportation are:

- 412.1 (1) client reimbursement, which includes client mileage reimbursement provided to
412.2 clients who have their own transportation, or to family or an acquaintance who provides
412.3 transportation to the client;
- 412.4 (2) volunteer transport, which includes transportation by volunteers using their own
412.5 vehicle;
- 412.6 (3) unassisted transport, which includes transportation provided to a client by a taxicab
412.7 or public transit. If a taxicab or public transit is not available, the client can receive
412.8 transportation from another nonemergency medical transportation provider;
- 412.9 (4) assisted transport, which includes transport provided to clients who require assistance
412.10 by a nonemergency medical transportation provider;
- 412.11 (5) lift-equipped/ramp transport, which includes transport provided to a client who is
412.12 dependent on a device and requires a nonemergency medical transportation provider with
412.13 a vehicle containing a lift or ramp;
- 412.14 (6) protected transport, which includes transport provided to a client who has received
412.15 a prescreening that has deemed other forms of transportation inappropriate and who requires
412.16 a provider: (i) with a protected vehicle that is not an ambulance or police car and has safety
412.17 locks, a video recorder, and a transparent thermoplastic partition between the passenger and
412.18 the vehicle driver; and (ii) who is certified as a protected transport provider; and
- 412.19 (7) stretcher transport, which includes transport for a client in a prone or supine position
412.20 and requires a nonemergency medical transportation provider with a vehicle that can transport
412.21 a client in a prone or supine position.
- 412.22 (j) The local agency shall be the single administrative agency and shall administer and
412.23 reimburse for modes defined in paragraph (i) according to paragraphs (m) and (n) when the
412.24 commissioner has developed, made available, and funded the web-based single administrative
412.25 structure, assessment tool, and level of need assessment under subdivision 18e. The local
412.26 agency's financial obligation is limited to funds provided by the state or federal government.
- 412.27 (k) The commissioner shall:
- 412.28 (1) in consultation with the Nonemergency Medical Transportation Advisory Committee,
412.29 verify that the mode and use of nonemergency medical transportation is appropriate;
- 412.30 (2) verify that the client is going to an approved medical appointment; and
- 412.31 (3) investigate all complaints and appeals.

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

413.5 (m) Payments for nonemergency medical transportation must be paid based on the client's
413.6 assessed mode under paragraph (h), not the type of vehicle used to provide the service. The
413.7 medical assistance reimbursement rates for nonemergency medical transportation services
413.8 that are payable by or on behalf of the commissioner for nonemergency medical
413.9 transportation services are:

413.10 (1) \$0.22 per mile for client reimbursement;

413.11 (2) up to 100 percent of the Internal Revenue Service business deduction rate for volunteer
413.12 transport;

413.13 (3) equivalent to the standard fare for unassisted transport when provided by public
413.14 transit, and \$11 for the base rate and \$1.30 per mile when provided by a nonemergency
413.15 medical transportation provider;

413.16 (4) \$13 for the base rate and \$1.30 per mile for assisted transport;

413.17 (5) \$18 for the base rate and \$1.55 per mile for lift-equipped/ramp transport;

413.18 (6) \$75 for the base rate and \$2.40 per mile for protected transport; and

413.19 (7) \$60 for the base rate and \$2.40 per mile for stretcher transport, and \$9 per trip for
413.20 an additional attendant if deemed medically necessary.

413.21 (n) The base rate for nonemergency medical transportation services in areas defined
413.22 under RUCA to be super rural is equal to 111.3 percent of the respective base rate in
413.23 paragraph (m), clauses (1) to (7). The mileage rate for nonemergency medical transportation
413.24 services in areas defined under RUCA to be rural or super rural areas is:

413.25 (1) for a trip equal to 17 miles or less, equal to 125 percent of the respective mileage
413.26 rate in paragraph (m), clauses (1) to (7); and

413.27 (2) for a trip between 18 and 50 miles, equal to 112.5 percent of the respective mileage
413.28 rate in paragraph (m), clauses (1) to (7).

413.29 (o) For purposes of reimbursement rates for nonemergency medical transportation
413.30 services under paragraphs (m) and (n), the zip code of the recipient's place of residence
413.31 shall determine whether the urban, rural, or super rural reimbursement rate applies.

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

414.4 (q) The commissioner, when determining reimbursement rates for nonemergency medical
414.5 transportation under paragraphs (m) and (n), shall exempt all modes of transportation listed
414.6 under paragraph (i) from Minnesota Rules, part 9505.0445, item R, subitem (2).

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

414.8 Sec. 19. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision
414.9 to read:

414.10 **Subd. 17d. Transportation services oversight.** The commissioner shall contract with
414.11 a vendor or dedicate staff to oversee providers of nonemergency medical transportation
414.12 services pursuant to the commissioner's authority in section 256B.04 and Minnesota Rules,
414.13 parts 9505.2160 to 9505.2245.

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

414.15 Sec. 20. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision
414.16 to read:

414.17 **Subd. 17e. Transportation provider termination.** (a) A terminated nonemergency
414.18 medical transportation provider, including all named individuals on the current enrollment
414.19 disclosure form and known or discovered affiliates of the nonemergency medical
414.20 transportation provider, is not eligible to enroll as a nonemergency medical transportation
414.21 provider for five years following the termination.

414.22 (b) After the five-year period in paragraph (a), if a provider seeks to reenroll as a
414.23 nonemergency medical transportation provider, the provider must be placed on a one-year
414.24 probation period. During a provider's probation period the commissioner shall complete
414.25 unannounced site visits and request documentation to review compliance with program
414.26 requirements.

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

414.28 Sec. 21. Minnesota Statutes 2018, section 256B.0625, subdivision 30, is amended to read:

414.29 **Subd. 30. Other clinic services.** (a) Medical assistance covers rural health clinic services,
414.30 federally qualified health center services, nonprofit community health clinic services, and
414.31 public health clinic services. Rural health clinic services and federally qualified health center

415.1 services mean services defined in United States Code, title 42, section 1396d(a)(2)(B) and
415.2 (C). Payment for rural health clinic and federally qualified health center services shall be
415.3 made according to applicable federal law and regulation.

415.4 (b) A federally qualified health center (FQHC) that is beginning initial operation shall
415.5 submit an estimate of budgeted costs and visits for the initial reporting period in the form
415.6 and detail required by the commissioner. ~~A federally qualified health center~~ An FQHC that
415.7 is already in operation shall submit an initial report using actual costs and visits for the
415.8 initial reporting period. Within 90 days of the end of its reporting period, ~~a federally qualified~~
415.9 ~~health center~~ an FQHC shall submit, in the form and detail required by the commissioner,
415.10 a report of its operations, including allowable costs actually incurred for the period and the
415.11 actual number of visits for services furnished during the period, and other information
415.12 required by the commissioner. ~~Federally qualified health centers~~ FQHCs that file Medicare
415.13 cost reports shall provide the commissioner with a copy of the most recent Medicare cost
415.14 report filed with the Medicare program intermediary for the reporting year which support
415.15 the costs claimed on their cost report to the state.

415.16 (c) In order to continue cost-based payment under the medical assistance program
415.17 according to paragraphs (a) and (b), ~~a federally qualified health center~~ an FQHC or rural
415.18 health clinic must apply for designation as an essential community provider within six
415.19 months of final adoption of rules by the Department of Health according to section 62Q.19,
415.20 subdivision 7. For those ~~federally qualified health centers~~ FQHCs and rural health clinics
415.21 that have applied for essential community provider status within the six-month time
415.22 prescribed, medical assistance payments will continue to be made according to paragraphs
415.23 (a) and (b) for the first three years after application. For ~~federally qualified health centers~~
415.24 FQHCs and rural health clinics that either do not apply within the time specified above or
415.25 who have had essential community provider status for three years, medical assistance
415.26 payments for health services provided by these entities shall be according to the same rates
415.27 and conditions applicable to the same service provided by health care providers that are not
415.28 ~~federally qualified health centers~~ FQHCs or rural health clinics.

415.29 (d) Effective July 1, 1999, the provisions of paragraph (c) requiring ~~a federally qualified~~
415.30 ~~health center~~ an FQHC or a rural health clinic to make application for an essential community
415.31 provider designation in order to have cost-based payments made according to paragraphs
415.32 (a) and (b) no longer apply.

415.33 (e) Effective January 1, 2000, payments made according to paragraphs (a) and (b) shall
415.34 be limited to the cost phase-out schedule of the Balanced Budget Act of 1997.

416.1 (f) Effective January 1, 2001, through December 31, 2020, each ~~federally qualified~~
416.2 ~~health center~~ FQHC and rural health clinic may elect to be paid either under the prospective
416.3 payment system established in United States Code, title 42, section 1396a(aa), or under an
416.4 alternative payment methodology consistent with the requirements of United States Code,
416.5 title 42, section 1396a(aa), and approved by the Centers for Medicare and Medicaid Services.
416.6 The alternative payment methodology shall be 100 percent of cost as determined according
416.7 to Medicare cost principles.

416.8 (g) Effective for services provided on or after January 1, 2021, all claims for payment
416.9 of clinic services provided by FQHCs and rural health clinics shall be paid by the
416.10 commissioner, according to an annual election by the FQHC or rural health clinic, under
416.11 the current prospective payment system described in paragraph (f) or the alternative payment
416.12 methodology described in paragraph (l).

416.13 (h) For purposes of this section, "nonprofit community clinic" is a clinic that:

416.14 (1) has nonprofit status as specified in chapter 317A;

416.15 (2) has tax exempt status as provided in Internal Revenue Code, section 501(c)(3);

416.16 (3) is established to provide health services to low-income population groups, uninsured,
416.17 high-risk and special needs populations, underserved and other special needs populations;

416.18 (4) employs professional staff at least one-half of which are familiar with the cultural
416.19 background of their clients;

416.20 (5) charges for services on a sliding fee scale designed to provide assistance to
416.21 low-income clients based on current poverty income guidelines and family size; and

416.22 (6) does not restrict access or services because of a client's financial limitations or public
416.23 assistance status and provides no-cost care as needed.

416.24 ~~(h)~~ (i) Effective for services provided on or after January 1, 2015, all claims for payment
416.25 of clinic services provided by ~~federally qualified health centers~~ FQHCs and rural health
416.26 clinics shall be paid by the commissioner. the commissioner shall determine the most feasible
416.27 method for paying claims from the following options:

416.28 (1) ~~federally qualified health centers~~ FQHCs and rural health clinics submit claims
416.29 directly to the commissioner for payment, and the commissioner provides claims information
416.30 for recipients enrolled in a managed care or county-based purchasing plan to the plan, on
416.31 a regular basis; or

417.1 (2) ~~federally qualified health centers~~ FQHCs and rural health clinics submit claims for
417.2 recipients enrolled in a managed care or county-based purchasing plan to the plan, and those
417.3 claims are submitted by the plan to the commissioner for payment to the clinic.

417.4 ~~(j)~~ (j) For clinic services provided prior to January 1, 2015, the commissioner shall
417.5 calculate and pay monthly the proposed managed care supplemental payments to clinics,
417.6 and clinics shall conduct a timely review of the payment calculation data in order to finalize
417.7 all supplemental payments in accordance with federal law. Any issues arising from a clinic's
417.8 review must be reported to the commissioner by January 1, 2017. Upon final agreement
417.9 between the commissioner and a clinic on issues identified under this subdivision, and in
417.10 accordance with United States Code, title 42, section 1396a(bb), no supplemental payments
417.11 for managed care plan or county-based purchasing plan claims for services provided prior
417.12 to January 1, 2015, shall be made after June 30, 2017. If the commissioner and clinics are
417.13 unable to resolve issues under this subdivision, the parties shall submit the dispute to the
417.14 arbitration process under section 14.57.

417.15 ~~(k)~~ (k) The commissioner shall seek a federal waiver, authorized under section 1115 of
417.16 the Social Security Act, to obtain federal financial participation at the 100 percent federal
417.17 matching percentage available to facilities of the Indian Health Service or tribal organization
417.18 in accordance with section 1905(b) of the Social Security Act for expenditures made to
417.19 organizations dually certified under Title V of the Indian Health Care Improvement Act,
417.20 Public Law 94-437, and as a federally qualified health center under paragraph (a) that
417.21 provides services to American Indian and Alaskan Native individuals eligible for services
417.22 under this subdivision.

417.23 (l) All claims for payment of clinic services provided by FQHCs and rural health clinics,
417.24 that have elected to be paid under this paragraph, shall be paid by the commissioner according
417.25 to the following requirements:

417.26 (1) the commissioner shall establish a single medical and single dental organization rate
417.27 for each FQHC and rural health clinic when applicable;

417.28 (2) each FQHC and rural health clinic is eligible for same day reimbursement of one
417.29 medical and one dental organization rate if eligible medical and dental visits are provided
417.30 on the same day;

417.31 (3) the commissioner shall reimburse FQHCs and rural health clinics, in accordance
417.32 with current applicable Medicare cost principles, their allowable costs, including direct
417.33 patient care costs and patient-related support services. Nonallowable costs include, but are
417.34 not limited to:

- 418.1 (i) general social service and administrative costs;
- 418.2 (ii) retail pharmacy;
- 418.3 (iii) patient incentives, food, housing assistance, and utility assistance;
- 418.4 (iv) external lab and x-ray;
- 418.5 (v) navigation services;
- 418.6 (vi) health care taxes;
- 418.7 (vii) advertising, public relations, and marketing;
- 418.8 (viii) office entertainment costs, food, alcohol, and gifts;
- 418.9 (ix) contributions and donations;
- 418.10 (x) bad debts or losses on awards or contracts;
- 418.11 (xi) fines, penalties, damages, or other settlements;
- 418.12 (xii) fund-raising, investment management, and associated administrative costs;
- 418.13 (xiii) research and associated administrative costs;
- 418.14 (xiv) nonpaid workers;
- 418.15 (xv) lobbying;
- 418.16 (xvi) scholarships and student aid; and
- 418.17 (xvii) nonmedical assistance covered services;
- 418.18 (4) the commissioner shall review the list of nonallowable costs in the years between
- 418.19 the rebasing process established in clause (5), in consultation with the Minnesota Association
- 418.20 of Community Health Centers, FQHCs, and rural health clinics. The commissioner shall
- 418.21 publish the list and any updates in the Minnesota health care programs provider manual;
- 418.22 (5) the initial applicable base year organization rates for FQHCs and rural health clinics
- 418.23 shall be computed for services delivered on or after January 1, 2021, and:
- 418.24 (i) must be determined using each FQHC's and rural health clinic's Medicare cost reports
- 418.25 from both 2017 and 2018;
- 418.26 (ii) must be according to current applicable Medicare cost principles as applicable to
- 418.27 FQHCs and rural health clinics without the application of productivity screens and upper
- 418.28 payment limits or the Medicare prospective payment system FQHC aggregate mean upper
- 418.29 payment limit;

419.1 (iii) must be subsequently rebased every two years thereafter using the Medicare cost
419.2 reports that are three and four years prior to the rebasing year;

419.3 (iv) must be inflated to the base year using the inflation factor described in clause (6);
419.4 and

419.5 (v) the commissioner must provide for a 60-day appeals process under section 14.57;

419.6 (6) the commissioner shall annually inflate the applicable organization rates for FQHCs
419.7 and rural health clinics from the base year payment rate to the effective date by using the
419.8 CMS FQHC Market Basket inflator established under United States Code, title 42, section
419.9 1395m(o), less productivity;

419.10 (7) FQHCs and rural health clinics that have elected the alternative payment methodology
419.11 under this paragraph shall submit all necessary documentation required by the commissioner
419.12 to compute the rebased organization rates no later than six months following the date the
419.13 applicable Medicare cost reports are due to the Centers for Medicare and Medicaid Services;

419.14 (8) the commissioner shall reimburse FQHCs and rural health clinics an additional
419.15 amount relative to their medical and dental organization rates that is attributable to the tax
419.16 required to be paid according to section 295.52, if applicable;

419.17 (9) FQHCs and rural health clinics may submit change of scope requests to the
419.18 commissioner if the change of scope would result in an increase or decrease of 2.5 percent
419.19 or higher in the medical or dental organization rate currently received by the FQHC or rural
419.20 health clinic;

419.21 (10) for FQHCs and rural health clinics seeking a change in scope with the commissioner
419.22 under clause (9) that requires the approval of the scope change by the federal Health
419.23 Resources Services Administration:

419.24 (i) FQHCs and rural health clinics shall submit the change of scope request, including
419.25 the start date of services, to the commissioner within seven business days of submission of
419.26 the scope change to the federal Health Resources Services Administration;

419.27 (ii) the commissioner shall establish the effective date of the payment change as the
419.28 federal Health Resources Services Administration date of approval of the FQHC's or rural
419.29 health clinic's scope change request, or the effective start date of services, whichever is
419.30 later; and

419.31 (iii) within 45 days of one year after the effective date established in item (ii), the
419.32 commissioner shall conduct a retroactive review to determine if the actual costs established
419.33 under clause (3) or encounters result in an increase or decrease of 2.5 percent or higher in

420.1 the medical or dental organization rate, and if this is the case, the commissioner shall revise
420.2 the rate accordingly and shall adjust payments retrospectively to the effective date established
420.3 in item (ii);

420.4 (11) for change of scope requests that do not require federal Health Resources Services
420.5 Administration approval, the FQHC and rural health clinic shall submit the request to the
420.6 commissioner before implementing the change, and the effective date of the change is the
420.7 date the commissioner received the FQHC's or rural health clinic's request, or the effective
420.8 start date of the service, whichever is later. The commissioner shall provide a response to
420.9 the FQHC's or rural health clinic's request within 45 days of submission and provide a final
420.10 approval within 120 days of submission. This timeline may be waived at the mutual
420.11 agreement of the commissioner and the FQHC or rural health clinic if more information is
420.12 needed to evaluate the request;

420.13 (12) the commissioner, when establishing organization rates for new FQHCs and rural
420.14 health clinics, shall consider the patient caseload of existing FQHCs and rural health clinics
420.15 in a 60-mile radius for organizations established outside of the seven-county metropolitan
420.16 area, and in a 30-mile radius for organizations in the seven-county metropolitan area. If this
420.17 information is not available, the commissioner may use Medicare cost reports or audited
420.18 financial statements to establish base rate;

420.19 (13) the commissioner shall establish a quality measures workgroup that includes
420.20 representatives from the Minnesota Association of Community Health Centers, FQHCs,
420.21 and rural health clinics, to evaluate clinical and nonclinical measures; and

420.22 (14) the commissioner shall not disallow or reduce costs that are related to an FQHC's
420.23 or rural health clinic's participation in health care educational programs to the extent that
420.24 the costs are not accounted for in the alternative payment methodology encounter rate
420.25 established in this paragraph.

420.26 Sec. 22. Minnesota Statutes 2018, section 256B.0625, subdivision 57, is amended to read:

420.27 **Subd. 57. Payment for Part B Medicare crossover claims.** (a) Effective for services
420.28 provided on or after January 1, 2012, medical assistance payment for an enrollee's
420.29 cost-sharing associated with Medicare Part B is limited to an amount up to the medical
420.30 assistance total allowed, when the medical assistance rate exceeds the amount paid by
420.31 Medicare.

420.32 (b) Excluded from this limitation are payments for mental health services and payments
420.33 for dialysis services provided to end-stage renal disease patients. The exclusion for mental

421.1 health services does not apply to payments for physician services provided by psychiatrists
421.2 and advanced practice nurses with a specialty in mental health.

421.3 (c) Excluded from this limitation are payments to federally qualified health centers,
421.4 Indian Health Services, and rural health clinics.

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

421.6 Sec. 23. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision
421.7 to read:

421.8 **Subd. 66. Provider tax rate increase.** (a) The commissioner shall increase the total
421.9 payments to managed care plans under section 256B.69 by an amount equal to the cost
421.10 increases to the managed care plans from the elimination of:

421.11 (1) the exemption from the taxes imposed under section 297I.05, subdivision 5, for
421.12 premiums paid by the state for medical assistance and the MinnesotaCare program; and

421.13 (2) the exemption of gross revenues subject to the taxes imposed under sections 295.50
421.14 to 295.57, for payments paid by the state for services provided under medical assistance
421.15 and the MinnesotaCare program. Any increase based on this clause must be reflected in
421.16 provider rates paid by the managed care plan unless the managed care plan is a staff model
421.17 health plan company.

421.18 (b) The commissioner shall increase by two percent the fee-for-service payments under
421.19 medical assistance and the MinnesotaCare program for services subject to the hospital,
421.20 surgical center, or health care provider taxes under sections 295.50 to 295.57.

421.21 Sec. 24. Minnesota Statutes 2018, section 256B.064, subdivision 1a, is amended to read:

421.22 **Subd. 1a. Grounds for sanctions against vendors.** (a) The commissioner may impose
421.23 sanctions against a vendor of medical care for any of the following: (1) fraud, theft, or abuse
421.24 in connection with the provision of medical care to recipients of public assistance; (2) a
421.25 pattern of presentment of false or duplicate claims or claims for services not medically
421.26 necessary; (3) a pattern of making false statements of material facts for the purpose of
421.27 obtaining greater compensation than that to which the vendor is legally entitled; (4)
421.28 suspension or termination as a Medicare vendor; (5) refusal to grant the state agency access
421.29 during regular business hours to examine all records necessary to disclose the extent of
421.30 services provided to program recipients and appropriateness of claims for payment; (6)
421.31 failure to repay an overpayment or a fine finally established under this section; (7) failure
421.32 to correct errors in the maintenance of health service or financial records for which a fine

422.1 was imposed or after issuance of a warning by the commissioner; and (8) any reason for
 422.2 which a vendor could be excluded from participation in the Medicare program under section
 422.3 1128, 1128A, or 1866(b)(2) of the Social Security Act.

422.4 (b) The commissioner may impose sanctions against a pharmacy provider for failure to
 422.5 respond to a cost of dispensing survey under section 256B.0625, subdivision 13e, paragraph
 422.6 (h).

422.7 **EFFECTIVE DATE.** This section is effective April 1, 2019.

422.8 Sec. 25. Minnesota Statutes 2018, section 256B.0659, subdivision 21, is amended to read:

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

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

422.16 (2) proof of surety bond coverage for each business location providing services. Upon
 422.17 new enrollment, or if the provider's Medicaid revenue in the previous calendar year is up
 422.18 to and including \$300,000, the provider agency must purchase a surety bond of \$50,000. If
 422.19 the Medicaid revenue in the previous year is over \$300,000, the provider agency must
 422.20 purchase a surety bond of \$100,000. The surety bond must be in a form approved by the
 422.21 commissioner, must be renewed annually, and must allow for recovery of costs and fees in
 422.22 pursuing a claim on the bond;

422.23 (3) proof of fidelity bond coverage in the amount of \$20,000 for each business location
 422.24 providing service;

422.25 (4) proof of workers' compensation insurance coverage identifying the business location
 422.26 where personal care assistance services are provided;

422.27 (5) proof of liability insurance coverage identifying the business location where personal
 422.28 care assistance services are provided and naming the department as a certificate holder;

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

423.1 ~~(7)~~ (6) a copy of the personal care assistance provider agency's written policies and
423.2 procedures including: hiring of employees; training requirements; service delivery; and
423.3 employee and consumer safety including process for notification and resolution of consumer
423.4 grievances, identification and prevention of communicable diseases, and employee
423.5 misconduct;

423.6 ~~(8)~~ (7) copies of all other forms the personal care assistance provider agency uses in the
423.7 course of daily business including, but not limited to:

423.8 (i) a copy of the personal care assistance provider agency's time sheet if the time sheet
423.9 varies from the standard time sheet for personal care assistance services approved by the
423.10 commissioner, and a letter requesting approval of the personal care assistance provider
423.11 agency's nonstandard time sheet;

423.12 (ii) the personal care assistance provider agency's template for the personal care assistance
423.13 care plan; and

423.14 (iii) the personal care assistance provider agency's template for the written agreement
423.15 in subdivision 20 for recipients using the personal care assistance choice option, if applicable;

423.16 ~~(9)~~ (8) a list of all training and classes that the personal care assistance provider agency
423.17 requires of its staff providing personal care assistance services;

423.18 ~~(10)~~ (9) documentation that the personal care assistance provider agency and staff have
423.19 successfully completed all the training required by this section;

423.20 ~~(11)~~ (10) documentation of the agency's marketing practices;

423.21 ~~(12)~~ (11) disclosure of ownership, leasing, or management of all residential properties
423.22 that is used or could be used for providing home care services;

423.23 ~~(13)~~ (12) documentation that the agency will use the following percentages of revenue
423.24 generated from the medical assistance rate paid for personal care assistance services for
423.25 employee personal care assistant wages and benefits: 72.5 percent of revenue in the personal
423.26 care assistance choice option and 72.5 percent of revenue from other personal care assistance
423.27 providers. The revenue generated by the qualified professional and the reasonable costs
423.28 associated with the qualified professional shall not be used in making this calculation; and

423.29 ~~(14)~~ (13) effective May 15, 2010, documentation that the agency does not burden
423.30 recipients' free exercise of their right to choose service providers by requiring personal care
423.31 assistants to sign an agreement not to work with any particular personal care assistance
423.32 recipient or for another personal care assistance provider agency after leaving the agency

424.1 and that the agency is not taking action on any such agreements or requirements regardless
424.2 of the date signed.

424.3 (b) Personal care assistance provider agencies shall provide the information specified
424.4 in paragraph (a) to the commissioner at the time the personal care assistance provider agency
424.5 enrolls as a vendor or upon request from the commissioner. The commissioner shall collect
424.6 the information specified in paragraph (a) from all personal care assistance providers
424.7 beginning July 1, 2009.

424.8 (c) All personal care assistance provider agencies shall require all employees in
424.9 management and supervisory positions and owners of the agency who are active in the
424.10 day-to-day management and operations of the agency to complete mandatory training as
424.11 determined by the commissioner before submitting an application for enrollment of the
424.12 agency as a provider. All personal care assistance provider agencies shall also require
424.13 qualified professionals to complete the training required by subdivision 13 before submitting
424.14 an application for enrollment of the agency as a provider. Employees in management and
424.15 supervisory positions and owners who are active in the day-to-day operations of an agency
424.16 who have completed the required training as an employee with a personal care assistance
424.17 provider agency do not need to repeat the required training if they are hired by another
424.18 agency, if they have completed the training within the past three years. By September 1,
424.19 2010, the required training must be available with meaningful access according to title VI
424.20 of the Civil Rights Act and federal regulations adopted under that law or any guidance from
424.21 the United States Health and Human Services Department. The required training must be
424.22 available online or by electronic remote connection. The required training must provide for
424.23 competency testing. Personal care assistance provider agency billing staff shall complete
424.24 training about personal care assistance program financial management. This training is
424.25 effective July 1, 2009. Any personal care assistance provider agency enrolled before that
424.26 date shall, if it has not already, complete the provider training within 18 months of July 1,
424.27 2009. Any new owners or employees in management and supervisory positions involved
424.28 in the day-to-day operations are required to complete mandatory training as a requisite of
424.29 working for the agency. Personal care assistance provider agencies certified for participation
424.30 in Medicare as home health agencies are exempt from the training required in this
424.31 subdivision. When available, Medicare-certified home health agency owners, supervisors,
424.32 or managers must successfully complete the competency test.

424.33 (d) All surety bonds, fidelity bonds, workers compensation insurance, and liability
424.34 insurance required by this subdivision must be maintained continuously. After initial
424.35 enrollment, a provider must submit proof of bonds and required coverages at any time at

425.1 the request of the commissioner. Services provided while there are lapses in coverage are
425.2 not eligible for payment. Lapses in coverage may result in sanctions, including termination.
425.3 The commissioner shall send instructions and a due date to submit the requested information
425.4 to the personal care assistance provider agency.

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

425.6 Sec. 26. Minnesota Statutes 2018, section 256B.766, is amended to read:

425.7 **256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.**

425.8 Subdivision 1. Generally. (a) Effective for services provided on or after July 1, 2009,
425.9 total payments for basic care services, shall be reduced by three percent, except that for the
425.10 period July 1, 2009, through June 30, 2011, total payments shall be reduced by 4.5 percent
425.11 for the medical assistance and general assistance medical care programs, prior to third-party
425.12 liability and spenddown calculation. Effective July 1, 2010, the commissioner shall classify
425.13 physical therapy services, occupational therapy services, and speech-language pathology
425.14 and related services as basic care services. The reduction in this paragraph shall apply to
425.15 physical therapy services, occupational therapy services, and speech-language pathology
425.16 and related services provided on or after July 1, 2010.

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

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

425.24 (d) Effective for services provided on or after September 1, 2011, through June 30, 2013,
425.25 total payments for ambulatory surgery centers facility fees, medical supplies and durable
425.26 medical equipment not subject to a volume purchase contract, prosthetics and orthotics,
425.27 renal dialysis services, laboratory services, public health nursing services, physical therapy
425.28 services, occupational therapy services, speech therapy services, eyeglasses not subject to
425.29 a volume purchase contract, hearing aids not subject to a volume purchase contract, and
425.30 anesthesia services shall be reduced by three percent from the rates in effect on August 31,
425.31 2011.

425.32 (e) Effective for services provided on or after September 1, 2014, payments for
425.33 ambulatory surgery centers facility fees, hospice services, renal dialysis services, laboratory

426.1 services, public health nursing services, eyeglasses not subject to a volume purchase contract,
426.2 and hearing aids not subject to a volume purchase contract shall be increased by three percent
426.3 and payments for outpatient hospital facility fees shall be increased by three percent.
426.4 Payments made to managed care plans and county-based purchasing plans shall not be
426.5 adjusted to reflect payments under this paragraph.

426.6 (f) Payments for medical supplies and durable medical equipment not subject to a volume
426.7 purchase contract, and prosthetics and orthotics, provided on or after July 1, 2014, through
426.8 June 30, 2015, shall be decreased by .33 percent. Payments for medical supplies and durable
426.9 medical equipment not subject to a volume purchase contract, and prosthetics and orthotics,
426.10 provided on or after July 1, 2015, shall be increased by three percent from the rates as
426.11 determined under paragraphs (i) and (j).

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

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

426.22 ~~(i) Effective for services provided on or after July 1, 2015, the following categories of~~
426.23 ~~medical supplies and durable medical equipment shall be individually priced items: enteral~~
426.24 ~~nutrition and supplies, customized and other specialized tracheostomy tubes and supplies,~~
426.25 ~~electric patient lifts, and durable medical equipment repair and service. This paragraph does~~
426.26 ~~not apply to medical supplies and durable medical equipment subject to a volume purchase~~
426.27 ~~contract, products subject to the preferred diabetic testing supply program, and items provided~~
426.28 ~~to dually eligible recipients when Medicare is the primary payer for the item. The~~
426.29 ~~commissioner shall not apply any medical assistance rate reductions to durable medical~~
426.30 ~~equipment as a result of Medicare competitive bidding.~~

426.31 ~~(j) Effective for services provided on or after July 1, 2015, medical assistance payment~~
426.32 ~~rates for durable medical equipment, prosthetics, orthotics, or supplies shall be increased~~
426.33 ~~as follows:~~

427.1 ~~(1) payment rates for durable medical equipment, prosthetics, orthotics, or supplies that~~
427.2 ~~were subject to the Medicare competitive bid that took effect in January of 2009 shall be~~
427.3 ~~increased by 9.5 percent; and~~

427.4 ~~(2) payment rates for durable medical equipment, prosthetics, orthotics, or supplies on~~
427.5 ~~the medical assistance fee schedule, whether or not subject to the Medicare competitive bid~~
427.6 ~~that took effect in January of 2009, shall be increased by 2.94 percent, with this increase~~
427.7 ~~being applied after calculation of any increased payment rate under clause (1).~~

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

427.14 ~~(k)~~ (i) Effective for nonpressure support ventilators provided on or after January 1, 2016,
427.15 the rate shall be the lower of the submitted charge or the Medicare fee schedule rate. Effective
427.16 for pressure support ventilators provided on or after January 1, 2016, the rate shall be the
427.17 lower of the submitted charge or 47 percent above the Medicare fee schedule rate. For
427.18 payments made in accordance with this paragraph, if, and to the extent that, the commissioner
427.19 identifies that the state has received federal financial participation for ventilators in excess
427.20 of the amount allowed effective January 1, 2018, under United States Code, title 42, section
427.21 1396b(i)(27), the state shall repay the excess amount to the Centers for Medicare and
427.22 Medicaid Services with state funds and maintain the full payment rate under this paragraph.

427.23 Subd. 2. Durable medical equipment. (a) Notwithstanding Minnesota Rules, part
427.24 9505.0445, item S, this subdivision governs medical assistance rates for medical supplies
427.25 and equipment described under this subdivision. Payment rates for all durable medical
427.26 equipment, prosthetics, orthotics, or supplies that are not subject to a volume purchase
427.27 contract, preferred product program, or competitively bid contract, and not reimbursed under
427.28 paragraph (b), shall be the lesser of the provider's submitted charges or the Medicare non-rural
427.29 fee schedule amount applicable on the date of service, with no increase or decrease described
427.30 in subdivision 1.

427.31 (b) Payment rates for durable medical equipment, prosthetics, orthotics, or supplies that
427.32 are not subject to a volume purchase contract, preferred product program, or competitively
427.33 bid contract for which Medicare has not established a payment amount shall be the lesser

428.1 of the provider's submitted charges, or the alternative payment methodology rate described
428.2 in paragraphs (c) to (h), with no increase or decrease described in subdivision 1.

428.3 (c) The alternate payment methodology rate is calculated from either:

428.4 (1) at least 100 paid claim lines, as priced under paragraph (f), provided by at least ten
428.5 different providers within one calendar month for services that are provided at least 100
428.6 times in a calendar month; or

428.7 (2) at least 20 paid claim lines, as priced under paragraph (f), submitted by at least five
428.8 different providers within two consecutive quarters for services that are not provided 100
428.9 times in a calendar month.

428.10 (d) The alternate payment methodology rate is the mean of the payment per unit of the
428.11 claim lines, with the top and bottom ten percent of claim lines, by amount of payment per
428.12 unit, excluded from the calculation of the mean.

428.13 (e) The alternate payment methodology rate is added to the commissioner's fee schedule
428.14 on the first day of a calendar month, or the first day of a calendar quarter if claims from
428.15 more than one month are used to determine the rate. The alternate payment methodology
428.16 rate is subject to Medicare's inflation or deflation factor on January 1 of each year unless
428.17 the rate was calculated and posted to the fee schedule after July 1 of the previous year.

428.18 (f) Not more than once every three years, the commissioner must evaluate the alternate
428.19 payment methodology rate for reasonableness by reviewing invoices from at least 20 paid
428.20 claim lines and five different providers for services provided during one calendar month,
428.21 or one quarter if necessary to obtain the required sample. If the evaluation demonstrates
428.22 that the alternate payment methodology rate is more than five percent higher or lower than
428.23 the provider's actual acquisition cost plus 20 percent, the commissioner shall recalculate
428.24 and update the alternate payment methodology fee schedule according to paragraphs (c) to
428.25 (e). If the evaluation demonstrates that the alternate payment methodology fee schedule
428.26 rate is not five percent higher or lower than the provider's actual acquisition cost plus 20
428.27 percent, or a sufficient sample of claims according to paragraph (a) cannot be collected due
428.28 to low utilization, the commissioner shall maintain the previously calculated alternate
428.29 payment methodology fee schedule.

428.30 (g) Until sufficient data is available to calculate the alternative payment methodology
428.31 rate, the payment is based on the provider's actual acquisition cost plus 20 percent as
428.32 documented on an invoice submitted by the provider. The payment may be based on a quote
428.33 the provider received from a vendor showing the provider's actual acquisition cost only if

429.1 the durable medical equipment, prosthetic, orthotic, or supply requires authorization and
429.2 the rate is required to complete the authorization.

429.3 (h) When procuring goods or services under competitive bidding authority in section
429.4 256B.04, the commissioner may establish a payment rate for the procured services, or
429.5 establish a fee schedule, based on the following:

429.6 (1) the contracted rate established through a competitive procurement process;

429.7 (2) actual acquisition cost plus 20 percent consistent with paragraph (f); or

429.8 (3) a rate or rate methodology established by an administrative rule.

429.9 Sec. 27. Minnesota Statutes 2018, section 256B.767, is amended to read:

429.10 **256B.767 MEDICARE PAYMENT LIMIT.**

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

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

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

429.26 (d) ~~Effective July 1, 2015,~~ This section shall not apply to durable medical equipment,
429.27 prosthetics, orthotics, or supplies specified in section 256B.766, subdivision 1, paragraph
429.28 (i).

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

430.1 Sec. 28. Minnesota Statutes 2018, section 256L.11, subdivision 2, is amended to read:

430.2 Subd. 2. **Payment of certain providers.** Services provided by federally qualified health
 430.3 centers, rural health clinics, and facilities of the Indian health service shall be paid for
 430.4 according to the same rates and conditions applicable to the same service provided by
 430.5 providers that are not federally qualified health centers, rural health clinics, or facilities of
 430.6 the Indian health service. The alternative payment methodology described under section
 430.7 256B.0625, subdivision 30, paragraph (l), shall not apply to services delivered under this
 430.8 chapter by federally qualified health centers, rural health clinics, and facilities of the Indian
 430.9 Health Services.

430.10 Sec. 29. Laws 2003, First Special Session chapter 14, article 13C, section 2, subdivision
 430.11 6, as amended by Laws 2004, chapter 272, article 2, section 4; Laws 2005, First Special
 430.12 Session chapter 4, article 5, section 18; and Laws 2005, First Special Session chapter 4,
 430.13 article 9, section 11, is amended to read:

430.14 Subd. 6. **Basic Health Care Grants**

430.15	Summary by Fund	
430.16	General	1,290,454,000 1,475,996,000
430.17	Health Care Access	254,121,000 282,689,000

430.18 **UPDATING FEDERAL POVERTY**

430.19 **GUIDELINES.** Annual updates to the federal
 430.20 poverty guidelines are effective each July 1,
 430.21 following publication by the United States
 430.22 Department of Health and Human Services
 430.23 for health care programs under Minnesota
 430.24 Statutes, chapters 256, 256B, 256D, and 256L.

430.25 The amounts that may be spent from this
 430.26 appropriation for each purpose are as follows:

430.27 (a) MinnesotaCare Grants

430.28	Health Care Access	253,371,000 281,939,000
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430.29 **MINNESOTACARE FEDERAL**

430.30 **RECEIPTS.** Receipts received as a result of
 430.31 federal participation pertaining to
 430.32 administrative costs of the Minnesota health
 430.33 care reform waiver shall be deposited as

431.1 nondedicated revenue in the health care access
 431.2 fund. Receipts received as a result of federal
 431.3 participation pertaining to grants shall be
 431.4 deposited in the federal fund and shall offset
 431.5 health care access funds for payments to
 431.6 providers.

431.7 **MINNESOTACARE FUNDING.** The
 431.8 commissioner may expend money
 431.9 appropriated from the health care access fund
 431.10 for MinnesotaCare in either fiscal year of the
 431.11 biennium.

431.12 (b) MA Basic Health Care Grants - Families
 431.13 and Children

431.14 General	427,769,000	489,545,000
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431.15 **SERVICES TO PREGNANT WOMEN.**
 431.16 The commissioner shall use available federal
 431.17 money for the State-Children's Health
 431.18 Insurance Program for medical assistance
 431.19 services provided to pregnant women who are
 431.20 not otherwise eligible for federal financial
 431.21 participation beginning in fiscal year 2003.
 431.22 This federal money shall be deposited in the
 431.23 federal fund and shall offset general funds for
 431.24 payments to providers. Notwithstanding
 431.25 section 14, this paragraph shall not expire.

431.26 **MANAGED CARE RATE INCREASE.** ~~(a)~~
 431.27 ~~Effective January 1, 2004, the commissioner~~
 431.28 ~~of human services shall increase the total~~
 431.29 ~~payments to managed care plans under~~
 431.30 ~~Minnesota Statutes, section 256B.69, by an~~
 431.31 ~~amount equal to the cost increases to the~~
 431.32 ~~managed care plans from by the elimination~~
 431.33 ~~of: (1) the exemption from the taxes imposed~~
 431.34 ~~under Minnesota Statutes, section 297I.05,~~

432.1 ~~subdivision 5, for premiums paid by the state~~
432.2 ~~for medical assistance, general assistance~~
432.3 ~~medical care, and the MinnesotaCare program;~~
432.4 ~~and (2) the exemption of gross revenues~~
432.5 ~~subject to the taxes imposed under Minnesota~~
432.6 ~~Statutes, sections 295.50 to 295.57, for~~
432.7 ~~payments paid by the state for services~~
432.8 ~~provided under medical assistance, general~~
432.9 ~~assistance medical care, and the~~
432.10 ~~MinnesotaCare program. Any increase based~~
432.11 ~~on clause (2) must be reflected in provider~~
432.12 ~~rates paid by the managed care plan unless the~~
432.13 ~~managed care plan is a staff model health plan~~
432.14 ~~company.~~

432.15 ~~(b) The commissioner of human services shall~~
432.16 ~~increase by the applicable tax rate in effect~~
432.17 ~~under Minnesota Statutes, section 295.52, the~~
432.18 ~~fee for service payments under medical~~
432.19 ~~assistance, general assistance medical care,~~
432.20 ~~and the MinnesotaCare program for services~~
432.21 ~~subject to the hospital, surgical center, or~~
432.22 ~~health care provider taxes under Minnesota~~
432.23 ~~Statutes, sections 295.50 to 295.57, effective~~
432.24 ~~for services rendered on or after January 1,~~
432.25 ~~2004.~~

432.26 (c) The commissioner of finance shall transfer
432.27 from the health care access fund to the general
432.28 fund the following amounts in the fiscal years
432.29 indicated: 2004, \$16,587,000; 2005,
432.30 \$46,322,000; 2006, \$49,413,000; and 2007,
432.31 \$58,695,000.

432.32 (d) Notwithstanding section 14, these
432.33 provisions shall not expire.

432.34 (c) MA Basic Health Care Grants - Elderly
432.35 and Disabled

433.1 General 610,518,000 743,858,000

433.2 **DELAY MEDICAL ASSISTANCE**

433.3 **FEE-FOR-SERVICE - ACUTE CARE.** The
 433.4 following payments in fiscal year 2005 from
 433.5 the Medicaid Management Information
 433.6 System that would otherwise have been made
 433.7 to providers for medical assistance and general
 433.8 assistance medical care services shall be
 433.9 delayed and included in the first payment in
 433.10 fiscal year 2006:

433.11 (1) for hospitals, the last two payments; and
 433.12 (2) for nonhospital providers, the last payment.

433.13 This payment delay shall not include payments
 433.14 to skilled nursing facilities, intermediate care
 433.15 facilities for mental retardation, prepaid health
 433.16 plans, home health agencies, personal care
 433.17 nursing providers, and providers of only
 433.18 waiver services. The provisions of Minnesota
 433.19 Statutes, section 16A.124, shall not apply to
 433.20 these delayed payments. Notwithstanding
 433.21 section 14, this provision shall not expire.

433.22 **DEAF AND HARD-OF-HEARING**

433.23 **SERVICES.** If, after making reasonable
 433.24 efforts, the service provider for mental health
 433.25 services to persons who are deaf or hearing
 433.26 impaired is not able to earn \$227,000 through
 433.27 participation in medical assistance intensive
 433.28 rehabilitation services in fiscal year 2005, the
 433.29 commissioner shall transfer \$227,000 minus
 433.30 medical assistance earnings achieved by the
 433.31 grantee to deaf and hard-of-hearing grants to
 433.32 enable the provider to continue providing
 433.33 services to eligible persons.

433.34 (d) General Assistance Medical Care Grants

434.1 General 239,861,000 229,960,000

434.2 (e) Health Care Grants - Other Assistance

434.3 General 3,067,000 3,407,000

434.4 Health Care Access 750,000 750,000

434.5 **MINNESOTA PRESCRIPTION DRUG**

434.6 **DEDICATED FUND.** Of the general fund

434.7 appropriation, \$284,000 in fiscal year 2005 is

434.8 appropriated to the commissioner for the

434.9 prescription drug dedicated fund established

434.10 under the prescription drug discount program.

434.11 **DENTAL ACCESS GRANTS**

434.12 **CARRYOVER AUTHORITY.** Any unspent

434.13 portion of the appropriation from the health

434.14 care access fund in fiscal years 2002 and 2003

434.15 for dental access grants under Minnesota

434.16 Statutes, section 256B.53, shall not cancel but

434.17 shall be allowed to carry forward to be spent

434.18 in the biennium beginning July 1, 2003, for

434.19 these purposes.

434.20 **STOP-LOSS FUND ACCOUNT.** The

434.21 appropriation to the purchasing alliance

434.22 stop-loss fund account established under

434.23 Minnesota Statutes, section 256.956,

434.24 subdivision 2, for fiscal years 2004 and 2005

434.25 shall only be available for claim

434.26 reimbursements for qualifying enrollees who

434.27 are members of purchasing alliances that meet

434.28 the requirements described under Minnesota

434.29 Statutes, section 256.956, subdivision 1,

434.30 paragraph (f), clauses (1), (2), and (3).

434.31 (f) Prescription Drug Program

434.32 General 9,239,000 9,226,000

434.33 **PRESCRIPTION DRUG ASSISTANCE**

434.34 **PROGRAM.** Of the general fund

435.1 appropriation, \$702,000 in fiscal year 2004
435.2 and \$887,000 in fiscal year 2005 are for the
435.3 commissioner to establish and administer the
435.4 prescription drug assistance program through
435.5 the Minnesota board on aging.

435.6 **REBATE REVENUE RECAPTURE.** Any
435.7 funds received by the state from a drug
435.8 manufacturer due to errors in the
435.9 pharmaceutical pricing used by the
435.10 manufacturer in determining the prescription
435.11 drug rebate are appropriated to the
435.12 commissioner to augment funding of the
435.13 prescription drug program established in
435.14 Minnesota Statutes, section 256.955.

435.15 Sec. 30. **STUDY OF CLINIC COSTS.**

435.16 The commissioner of human services shall conduct a five-year comparative analysis of
435.17 the actual change in aggregate federally qualified health center (FQHC) and rural health
435.18 clinic costs versus the CMS FQHC Market Basket inflator using 2017 through 2022 finalized
435.19 Medicare Cost Reports, CMS 2224-14, and report the findings to the chairs and ranking
435.20 minority members of the legislative committees with jurisdiction over health and human
435.21 services policy and finance, by July 1, 2025.

435.22 Sec. 31. **REPEALER.**

435.23 Minnesota Statutes 2018, sections 256B.0625, subdivision 63; 256B.0659, subdivision
435.24 22; and 256L.11, subdivision 2a, are repealed.

435.25

ARTICLE 9

435.26

ONECARE BUY-IN

435.27 Section 1. Minnesota Statutes 2018, section 62J.497, subdivision 1, is amended to read:

435.28 Subdivision 1. **Definitions.** (a) For the purposes of this section, the following terms have
435.29 the meanings given.

435.30 (b) "Backward compatible" means that the newer version of a data transmission standard
435.31 would retain, at a minimum, the full functionality of the versions previously adopted, and

436.1 would permit the successful completion of the applicable transactions with entities that
436.2 continue to use the older versions.

436.3 (c) "Dispense" or "dispensing" has the meaning given in section 151.01, subdivision 30.
436.4 Dispensing does not include the direct administering of a controlled substance to a patient
436.5 by a licensed health care professional.

436.6 (d) "Dispenser" means a person authorized by law to dispense a controlled substance,
436.7 pursuant to a valid prescription.

436.8 (e) "Electronic media" has the meaning given under Code of Federal Regulations, title
436.9 45, part 160.103.

436.10 (f) "E-prescribing" means the transmission using electronic media of prescription or
436.11 prescription-related information between a prescriber, dispenser, pharmacy benefit manager,
436.12 or group purchaser, either directly or through an intermediary, including an e-prescribing
436.13 network. E-prescribing includes, but is not limited to, two-way transmissions between the
436.14 point of care and the dispenser and two-way transmissions related to eligibility, formulary,
436.15 and medication history information.

436.16 (g) "Electronic prescription drug program" means a program that provides for
436.17 e-prescribing.

436.18 (h) "Group purchaser" has the meaning given in section 62J.03, subdivision 6, excluding
436.19 state and federal health care programs under chapters 256B, 256L, and 256T.

436.20 (i) "HL7 messages" means a standard approved by the standards development
436.21 organization known as Health Level Seven.

436.22 (j) "National Provider Identifier" or "NPI" means the identifier described under Code
436.23 of Federal Regulations, title 45, part 162.406.

436.24 (k) "NCPDP" means the National Council for Prescription Drug Programs, Inc.

436.25 (l) "NCPDP Formulary and Benefits Standard" means the National Council for
436.26 Prescription Drug Programs Formulary and Benefits Standard, Implementation Guide,
436.27 Version 1, Release 0, October 2005.

436.28 (m) "NCPDP SCRIPT Standard" means the National Council for Prescription Drug
436.29 Programs Prescriber/Pharmacist Interface SCRIPT Standard, Implementation Guide Version
436.30 8, Release 1 (Version 8.1), October 2005, or the most recent standard adopted by the Centers
436.31 for Medicare and Medicaid Services for e-prescribing under Medicare Part D as required
436.32 by section 1860D-4(e)(4)(D) of the Social Security Act, and regulations adopted under it.

437.1 The standards shall be implemented according to the Centers for Medicare and Medicaid
437.2 Services schedule for compliance. Subsequently released versions of the NCPDP SCRIPT
437.3 Standard may be used, provided that the new version of the standard is backward compatible
437.4 to the current version adopted by the Centers for Medicare and Medicaid Services.

437.5 (n) "Pharmacy" has the meaning given in section 151.01, subdivision 2.

437.6 (o) "Prescriber" means a licensed health care practitioner, other than a veterinarian, as
437.7 defined in section 151.01, subdivision 23.

437.8 (p) "Prescription-related information" means information regarding eligibility for drug
437.9 benefits, medication history, or related health or drug information.

437.10 (q) "Provider" or "health care provider" has the meaning given in section 62J.03,
437.11 subdivision 8.

437.12 **EFFECTIVE DATE.** This section is effective January 1, 2022.

437.13 Sec. 2. **[256B.0371] ADMINISTRATION OF DENTAL SERVICES.**

437.14 **Subdivision 1. Contract for dental administration services.** (a) Effective January 1,
437.15 2022, the commissioner shall contract with up to two dental administrators to administer
437.16 dental services for all recipients of medical assistance and MinnesotaCare.

437.17 **(b) The dental administrator must provide administrative services including but not**
437.18 **limited to:**

437.19 **(1) provider recruitment, contracting, and assistance;**

437.20 **(2) recipient outreach and assistance;**

437.21 **(3) utilization management and review for medical necessity of dental services;**

437.22 **(4) dental claims processing;**

437.23 **(5) coordination with other services;**

437.24 **(6) management of fraud and abuse;**

437.25 **(7) monitoring of access to dental services;**

437.26 **(8) performance measurement;**

437.27 **(9) quality improvement and evaluation requirements; and**

437.28 **(10) management of third-party liability requirements.**

438.1 (c) Payments to contracted dental providers must be at the rates established under section
438.2 256B.76.

438.3 **EFFECTIVE DATE.** This section is effective January 1, 2022.

438.4 Sec. 3. Minnesota Statutes 2018, section 256B.0644, is amended to read:

438.5 **256B.0644 REIMBURSEMENT UNDER OTHER STATE HEALTH CARE**
438.6 **PROGRAMS.**

438.7 (a) A vendor of medical care, as defined in section 256B.02, subdivision 7, and a health
438.8 maintenance organization, as defined in chapter 62D, must participate as a provider or
438.9 contractor in the medical assistance program and MinnesotaCare as a condition of
438.10 participating as a provider in health insurance plans and programs or contractor for state
438.11 employees established under section 43A.18, the public employees insurance program under
438.12 section 43A.316, for health insurance plans offered to local statutory or home rule charter
438.13 city, county, and school district employees, the workers' compensation system under section
438.14 176.135, and insurance plans provided through the Minnesota Comprehensive Health
438.15 Association under sections 62E.01 to 62E.19. The limitations on insurance plans offered to
438.16 local government employees shall not be applicable in geographic areas where provider
438.17 participation is limited by managed care contracts with the Department of Human Services.
438.18 This section does not apply to dental service providers providing dental services outside
438.19 the seven-county metropolitan area.

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

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

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

438.26 (3) for dental service providers providing dental services in the seven-county metropolitan
438.27 area, at least ten percent of the provider's patients are covered by medical assistance and
438.28 MinnesotaCare as their primary source of coverage, or the provider accepts new medical
438.29 assistance and MinnesotaCare patients who are children with special health care needs. For
438.30 purposes of this section, "children with special health care needs" means children up to age
438.31 18 who: (i) require health and related services beyond that required by children generally;
438.32 and (ii) have or are at risk for a chronic physical, developmental, behavioral, or emotional
438.33 condition, including: bleeding and coagulation disorders; immunodeficiency disorders;

439.1 cancer; endocrinopathy; developmental disabilities; epilepsy, cerebral palsy, and other
 439.2 neurological diseases; visual impairment or deafness; Down syndrome and other genetic
 439.3 disorders; autism; fetal alcohol syndrome; and other conditions designated by the
 439.4 commissioner after consultation with representatives of pediatric dental providers and
 439.5 consumers.

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

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

439.19 (e) A vendor of medical care, as defined in section 256B.02, subdivision 7, that dispenses
 439.20 outpatient prescription drugs in accordance with chapter 151 must participate as a provider
 439.21 or contractor in the MinnesotaCare program as a condition of participating as a provider in
 439.22 the medical assistance program.

439.23 **EFFECTIVE DATE.** This section is effective January 1, 2022.

439.24 Sec. 4. Minnesota Statutes 2018, section 256B.69, subdivision 6d, is amended to read:

439.25 Subd. 6d. **Prescription drugs.** The commissioner ~~may~~ shall exclude or ~~modify~~ coverage
 439.26 for prescription drugs from the prepaid managed care contracts entered into under this
 439.27 section ~~in order to increase savings to the state by collecting additional prescription drug~~
 439.28 ~~rebates. The contracts must maintain incentives for the managed care plan to manage drug~~
 439.29 ~~costs and utilization and may require that the managed care plans maintain an open drug~~
 439.30 ~~formulary. In order to manage drug costs and utilization, the contracts may authorize the~~
 439.31 ~~managed care plans to use preferred drug lists and prior authorization. This subdivision is~~
 439.32 ~~contingent on federal approval of the managed care contract changes and the collection of~~
 439.33 ~~additional prescription drug rebates.~~

440.1 **EFFECTIVE DATE.** This section is effective January 1, 2022.

440.2 Sec. 5. Minnesota Statutes 2018, section 256B.76, subdivision 2, is amended to read:

440.3 Subd. 2. **Dental reimbursement.** (a) Effective for services rendered on or after October
440.4 1, 1992, the commissioner shall make payments for dental services as follows:

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

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

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

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

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

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

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

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

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

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

441.4 (j) Effective for services rendered on or after January 1, 2014, payment rates for dental
441.5 services shall be increased by five percent from the rates in effect on December 31, 2013.
441.6 This increase does not apply to state-operated dental clinics in paragraph (f), federally
441.7 qualified health centers, rural health centers, and Indian health services. Effective January
441.8 1, 2014, payments made to managed care plans and county-based purchasing plans under
441.9 sections 256B.69, 256B.692, and 256L.12 shall reflect the payment increase described in
441.10 this paragraph.

441.11 (k) Effective for services rendered on or after July 1, 2015, through December 31, 2016,
441.12 the commissioner shall increase payment rates for services furnished by dental providers
441.13 located outside of the seven-county metropolitan area by the maximum percentage possible
441.14 above the rates in effect on June 30, 2015, while remaining within the limits of funding
441.15 appropriated for this purpose. This increase does not apply to state-operated dental clinics
441.16 in paragraph (f), federally qualified health centers, rural health centers, and Indian health
441.17 services. Effective January 1, 2016, through December 31, 2016, payments to managed care
441.18 plans and county-based purchasing plans under sections 256B.69 and 256B.692 shall reflect
441.19 the payment increase described in this paragraph. The commissioner shall require managed
441.20 care and county-based purchasing plans to pass on the full amount of the increase, in the
441.21 form of higher payment rates to dental providers located outside of the seven-county
441.22 metropolitan area.

441.23 (l) Effective for services provided on or after January 1, 2017, through December 31,
441.24 2021, the commissioner shall increase payment rates by 9.65 percent for dental services
441.25 provided outside of the seven-county metropolitan area. This increase does not apply to
441.26 state-operated dental clinics in paragraph (f), federally qualified health centers, rural health
441.27 centers, or Indian health services. Effective January 1, 2017, payments to managed care
441.28 plans and county-based purchasing plans under sections 256B.69 and 256B.692 shall reflect
441.29 the payment increase described in this paragraph.

441.30 (m) Effective for services provided on or after July 1, 2017, through December 31, 2021,
441.31 the commissioner shall increase payment rates by 23.8 percent for dental services provided
441.32 to enrollees under the age of 21. This rate increase does not apply to state-operated dental
441.33 clinics in paragraph (f), federally qualified health centers, rural health centers, or Indian
441.34 health centers. This rate increase does not apply to managed care plans and county-based
441.35 purchasing plans.

442.1 (n) Effective for dental services provided on or after January 1, 2022, the commissioner
442.2 shall increase payment rates by 54 percent. This rate increase does not apply to state-operated
442.3 dental clinics in paragraph (f), federally qualified health centers, rural health centers, or
442.4 Indian health centers.

442.5 Sec. 6. Minnesota Statutes 2018, section 256B.76, subdivision 4, is amended to read:

442.6 Subd. 4. **Critical access dental providers.** (a) The commissioner shall increase
442.7 reimbursements to dentists and dental clinics deemed by the commissioner to be critical
442.8 access dental providers. For dental services rendered on or after July 1, 2016, through
442.9 December 31, 2021, the commissioner shall increase reimbursement by 37.5 percent above
442.10 the reimbursement rate that would otherwise be paid to the critical access dental provider,
442.11 except as specified under paragraph (b). The commissioner shall pay the managed care
442.12 plans and county-based purchasing plans in amounts sufficient to reflect increased
442.13 reimbursements to critical access dental providers as approved by the commissioner.

442.14 (b) For dental services rendered on or after July 1, 2016, by a dental clinic or dental
442.15 group that meets the critical access dental provider designation under paragraph (d), clause
442.16 (4), and is owned and operated by a health maintenance organization licensed under chapter
442.17 62D, the commissioner shall increase reimbursement by 35 percent above the reimbursement
442.18 rate that would otherwise be paid to the critical access provider.

442.19 (c) Critical access dental payments made under paragraph (a) or (b) for dental services
442.20 provided by a critical access dental provider to an enrollee of a managed care plan or
442.21 county-based purchasing plan must not reflect any capitated payments or cost-based payments
442.22 from the managed care plan or county-based purchasing plan. The managed care plan or
442.23 county-based purchasing plan must base the additional critical access dental payment on
442.24 the amount that would have been paid for that service had the dental provider been paid
442.25 according to the managed care plan or county-based purchasing plan's fee schedule that
442.26 applies to dental providers that are not paid under a capitated payment or cost-based payment.

442.27 (d) The commissioner shall designate the following dentists and dental clinics as critical
442.28 access dental providers:

442.29 (1) nonprofit community clinics that:

442.30 (i) have nonprofit status in accordance with chapter 317A;

442.31 (ii) have tax exempt status in accordance with the Internal Revenue Code, section
442.32 501(c)(3);

443.1 (iii) are established to provide oral health services to patients who are low income,
443.2 uninsured, have special needs, and are underserved;

443.3 (iv) have professional staff familiar with the cultural background of the clinic's patients;

443.4 (v) charge for services on a sliding fee scale designed to provide assistance to low-income
443.5 patients based on current poverty income guidelines and family size;

443.6 (vi) do not restrict access or services because of a patient's financial limitations or public
443.7 assistance status; and

443.8 (vii) have free care available as needed;

443.9 (2) federally qualified health centers, rural health clinics, and public health clinics;

443.10 (3) hospital-based dental clinics owned and operated by a city, county, or former state
443.11 hospital as defined in section 62Q.19, subdivision 1, paragraph (a), clause (4);

443.12 (4) a dental clinic or dental group owned and operated by a nonprofit corporation in
443.13 accordance with chapter 317A with more than 10,000 patient encounters per year with
443.14 patients who are uninsured or covered by medical assistance or MinnesotaCare;

443.15 (5) a dental clinic owned and operated by the University of Minnesota or the Minnesota
443.16 State Colleges and Universities system; and

443.17 (6) private practicing dentists if:

443.18 (i) the dentist's office is located within the seven-county metropolitan area and more
443.19 than 50 percent of the dentist's patient encounters per year are with patients who are uninsured
443.20 or covered by medical assistance or MinnesotaCare; or

443.21 (ii) the dentist's office is located outside the seven-county metropolitan area and more
443.22 than 25 percent of the dentist's patient encounters per year are with patients who are uninsured
443.23 or covered by medical assistance or MinnesotaCare.

443.24 Sec. 7. Minnesota Statutes 2018, section 256L.03, is amended by adding a subdivision to
443.25 read:

443.26 Subd. 7. **Outpatient prescription drugs.** Outpatient prescription drugs are covered
443.27 according to section 256L.30. This subdivision applies to all individuals enrolled in the
443.28 MinnesotaCare program.

443.29 **EFFECTIVE DATE.** This section is effective January 1, 2022.

444.1 Sec. 8. Minnesota Statutes 2018, section 256L.07, subdivision 2, is amended to read:

444.2 Subd. 2. **Must not have access to employer-subsidized minimum essential**
444.3 **coverage.** (a) To be eligible, a family or individual must not have access to subsidized health
444.4 coverage that is affordable and provides minimum value as defined in Code of Federal
444.5 Regulations, title 26, section 1.36B-2.

444.6 (b) Notwithstanding paragraph (a), an individual who has access to subsidized health
444.7 coverage through a spouse's employer that is deemed minimum essential coverage under
444.8 Code of Federal Regulations, title 26, section 1.36B-2, is eligible for MinnesotaCare if the
444.9 portion of the annual premium the employee pays for employee and dependent coverage
444.10 exceeds the required contribution percentage under Code of Federal Regulations, title 26,
444.11 section 1.36B-2, and the individual meets all other eligibility requirements of this chapter.

444.12 ~~(b)~~ (c) This subdivision does not apply to a family or individual who no longer has
444.13 employer-subsidized coverage due to the employer terminating health care coverage as an
444.14 employee benefit.

444.15 **EFFECTIVE DATE.** This section is effective January 1, 2020, or upon federal approval,
444.16 whichever is later. The commissioner of human services shall notify the revisor of statutes
444.17 when federal approval is obtained.

444.18 Sec. 9. Minnesota Statutes 2018, section 256L.07, is amended by adding a subdivision to
444.19 read:

444.20 Subd. 2b. **Federal waiver.** The commissioner of human services, in consultation with
444.21 the executive director of MNsure, shall apply for a federal waiver to allow an individual:
444.22 who has access to employer-sponsored health insurance through a spouse or parent that is
444.23 deemed minimum essential coverage under Code of Federal Regulations, title 26, section
444.24 1.36B-2; and who pays a portion of the annual premium for employee and dependent
444.25 coverage that exceeds the required contribution percentage in Code of Federal Regulations,
444.26 title 26, section 1.36B-2, to:

444.27 (1) enroll in MinnesotaCare, if the individual meets all eligibility requirements, except
444.28 for section 256L.07, subdivision 2, paragraph (a);

444.29 (2) qualify for advanced premium tax credits under Code of Federal Regulations, title
444.30 26, section 1.36B-2 and cost-sharing reductions under Code of Federal Regulations, title
444.31 45, section 155.305(g), if the individual meets all eligibility requirements, except for the
444.32 affordability for related individual requirement under Code of Federal Regulations, title 26,
444.33 section 1.36B-2(c)(3)(v)(A)(2); and

445.1 (3) qualify to purchase OneCare Buy-In coverage under section 256T.03, if the individual
445.2 meets all eligibility requirements.

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

445.4 Sec. 10. Minnesota Statutes 2018, section 256L.11, subdivision 7, is amended to read:

445.5 Subd. 7. **Critical access dental providers.** Effective for dental services provided to
445.6 MinnesotaCare enrollees on or after July 1, 2017, through December 31, 2021, the
445.7 commissioner shall increase payment rates to dentists and dental clinics deemed by the
445.8 commissioner to be critical access providers under section 256B.76, subdivision 4, by 20
445.9 percent above the payment rate that would otherwise be paid to the provider. The
445.10 commissioner shall pay the prepaid health plans under contract with the commissioner
445.11 amounts sufficient to reflect this rate increase. The prepaid health plan must pass this rate
445.12 increase to providers who have been identified by the commissioner as critical access dental
445.13 providers under section 256B.76, subdivision 4.

445.14 Sec. 11. **[256L.30] OUTPATIENT PRESCRIPTION DRUGS.**

445.15 Subdivision 1. **Establishment of program.** The commissioner shall administer and
445.16 oversee the outpatient prescription drug program for MinnesotaCare. The commissioner
445.17 shall not include the outpatient pharmacy benefit in a contract with a public or private entity.

445.18 Subd. 2. **Covered outpatient prescription drugs.** (a) In consultation with the Drug
445.19 Formulary Committee under section 256B.0625, subdivision 13d, the commissioner shall
445.20 establish an outpatient prescription drug formulary for MinnesotaCare that satisfies the
445.21 requirements for an essential health benefit under Code of Federal Regulations, title 45,
445.22 section 156.122. The commissioner may modify the formulary after consulting with the
445.23 Drug Formulary Committee and providing public notice and the opportunity for public
445.24 comment. The commissioner is exempt from the rulemaking requirements of chapter 14 to
445.25 establish the drug formulary, and section 14.386 does not apply. The commissioner shall
445.26 make the drug formulary available to the public on the agency website.

445.27 (b) The MinnesotaCare formulary must contain at least one drug in every United States
445.28 Pharmacopeia category and class or the same number of prescription drugs in each category
445.29 and class as the essential health benefit benchmark plan, whichever is greater.

445.30 (c) The commissioner may negotiate drug rebates or discounts directly with a drug
445.31 manufacturer to place a drug on the formulary. The commissioner may also negotiate drug
445.32 rebates, or discounts, with a drug manufacturer through a contract with a vendor.

446.1 (d) Prior authorization may be required by the commissioner before certain formulary
446.2 drugs are eligible for payment. The Drug Formulary Committee may recommend drugs for
446.3 prior authorization directly to the commissioner. The commissioner may also request that
446.4 the Drug Formulary Committee review a drug for prior authorization.

446.5 (e) Before the commissioner requires prior authorization for a drug:

446.6 (1) the commissioner must provide the Drug Formulary Committee with information
446.7 on the impact that placing the drug on prior authorization may have on the quality of patient
446.8 care and on program costs and information regarding whether the drug is subject to clinical
446.9 abuse or misuse if such data is available; and

446.10 (2) the Drug Formulary Committee must hold a public forum and receive public comment
446.11 for an additional 15 days from the date of the public forum.

446.12 (f) Notwithstanding paragraph (e), the commissioner may automatically require prior
446.13 authorization for a period not to exceed 180 days for any drug that is approved by the United
446.14 States Food and Drug Administration after July 1, 2019. The 180-day period begins no later
446.15 than the first day that a drug is available for shipment to pharmacies within the state. The
446.16 Drug Formulary Committee shall recommend to the commissioner general criteria to use
446.17 for determining prior authorization of the drugs, but the Drug Formulary Committee is not
446.18 required to review each individual drug.

446.19 (g) The commissioner may also require prior authorization before nonformulary drugs
446.20 are eligible for payment.

446.21 (h) Prior authorization requests must be processed in accordance with Code of Federal
446.22 Regulations, title 45, section 156.122.

446.23 Subd. 3. **Pharmacy provider participation.** (a) A pharmacy enrolled to dispense
446.24 prescription drugs to medical assistance enrollees under section 256B.0625 must participate
446.25 as a provider in the MinnesotaCare outpatient prescription drug program.

446.26 (b) A pharmacy that is enrolled to dispense prescription drugs to MinnesotaCare enrollees
446.27 is not permitted to refuse service to an enrollee unless:

446.28 (1) the pharmacy does not have a prescription drug in stock and cannot obtain the drug
446.29 in time to treat the enrollee's medical condition;

446.30 (2) the enrollee is unable or unwilling to pay the enrollee's co-payment at the time the
446.31 drug is dispensed;

447.1 (3) after performing drug utilization review, the pharmacist identifies the prescription
447.2 drug as being a therapeutic duplication, having a drug-disease contraindication, having a
447.3 drug-drug interaction, having been prescribed for the incorrect dosage or duration of
447.4 treatment, having a drug-allergy interaction, or having issues related to clinical abuse or
447.5 misuse by the enrollee;

447.6 (4) the prescription drug is not covered by MinnesotaCare; or

447.7 (5) dispensing the drug would violate a provision of chapter 151.

447.8 Subd. 4. Covered outpatient prescription drug reimbursement rate. (a) The basis
447.9 for determining the amount of payment shall be the lowest of the National Average Drug
447.10 Acquisition Cost; the maximum allowable cost established under section 256B.0625,
447.11 subdivision 13e, plus a fixed dispensing fee; or the usual and customary price. The fixed
447.12 dispensing fee shall be \$1.50 for covered outpatient prescription drugs.

447.13 (b) The basis for determining the amount of payment for a pharmacy that acquires drugs
447.14 through the federal 340B Drug Pricing Program shall be the lowest of (1) the National
447.15 Average Drug Acquisition Cost minus 30 percent; (2) the maximum allowable cost
447.16 established under section 256B.0625, subdivision 13e, minus 30 percent, plus a fixed
447.17 dispensing fee; or (3) the usual and customary price. The fixed dispensing fee shall be \$1.50
447.18 for covered outpatient prescription drugs.

447.19 (c) For purposes of this subdivision, the usual and customary price is the lowest price
447.20 charged by the provider to a patient who pays for the prescription by cash, check, or charge
447.21 account and includes the prices the pharmacy charges to customers enrolled in a prescription
447.22 savings club or prescription discount club administered by the pharmacy, pharmacy chain,
447.23 or contractor to the provider.

447.24 **EFFECTIVE DATE.** This section is effective January 1, 2022.

447.25 Sec. 12. **[256T.01] PURPOSE.**

447.26 (a) The legislature finds that the staggering growth in health care costs is having a
447.27 devastating effect on the health and cost of living of Minnesota residents. The legislature
447.28 further finds that the number of uninsured and underinsured residents is growing each year
447.29 and that the cost of health care coverage for our insured residents often far exceeds their
447.30 ability to pay.

447.31 (b) The legislature further finds that it must enact immediate and intensive cost
447.32 containment measures to limit the growth of health care expenditures, reform insurance

448.1 practices, and finance a plan that offers access to affordable health care for Minnesota
448.2 residents by capturing dollars now lost to inefficiencies in Minnesota's health care system.

448.3 (c) The legislature further finds that providing affordable access to health care is essential
448.4 to quality of life in Minnesota.

448.5 (d) It is, therefore, the intent of the legislature to establish the OneCare Buy-In to address
448.6 the immediate challenges of affordability and access related to prescription drugs and dental
448.7 care and to offer comprehensive coverage options that establish contingencies for failures
448.8 in the individual market.

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

448.10 Sec. 13. **[256T.02] DEFINITIONS.**

448.11 Subdivision 1. **Application.** For purposes of this chapter, the terms in this section have
448.12 the meanings given.

448.13 Subd. 2. **Commissioner.** "Commissioner" means the commissioner of human services.

448.14 Subd. 3. **Department.** "Department" means the Department of Human Services.

448.15 Subd. 4. **Essential health benefits.** "Essential health benefits" has the meaning given
448.16 in section 62Q.81, subdivision 4.

448.17 Subd. 5. **Health plan.** "Health plan" has the meaning given in section 62A.011,
448.18 subdivision 3.

448.19 Subd. 6. **Individual market.** "Individual market" has the meaning given in section
448.20 62A.011, subdivision 5.

448.21 Subd. 7. **MNsure website.** "MNsure website" has the meaning given in section 62V.02,
448.22 subdivision 13.

448.23 Subd. 8. **Qualified health plan.** "Qualified health plan" has the meaning given in section
448.24 62A.011, subdivision 7.

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

448.26 Sec. 14. **[256T.03] ONECARE BUY-IN.**

448.27 Subdivision 1. **Establishment.** (a) The commissioner shall establish a program consistent
448.28 with this section to offer products developed for the OneCare Buy-In through the MNsure
448.29 website.

449.1 (b) The commissioner, in collaboration with the commissioner of commerce and the
449.2 MNsure Board, shall:

449.3 (1) establish a cost allocation methodology to reimburse MNsure operations in lieu of
449.4 the premium withhold for qualified health plans under section 62V.05;

449.5 (2) implement mechanisms to ensure the long-term financial sustainability of Minnesota's
449.6 public health care programs and mitigate any adverse financial impacts to the state and
449.7 MNsure. These mechanisms must minimize adverse selection, state financial risk and
449.8 contribution, and negative impacts to premiums in the individual and group health insurance
449.9 markets; and

449.10 (3) coordinate eligibility and coverage to ensure that persons, to the extent possible,
449.11 transitioning between medical assistance, MinnesotaCare, and the OneCare Buy-In have
449.12 continuity of care.

449.13 (c) The OneCare Buy-In shall be considered: (1) a public health care program for purposes
449.14 of chapter 62V; and (2) the MinnesotaCare program for purposes of requirements for health
449.15 maintenance organizations under section 62D.04, subdivision 5, and providers under section
449.16 256B.0644.

449.17 (d) The Department of Human Services is deemed to meet and receive certification and
449.18 authority under section 62D.03 and be in compliance with sections 62D.01 to 62D.30. The
449.19 commissioner has the authority to accept and expend all federal funds made available under
449.20 this chapter upon federal approval.

449.21 (e) Unless otherwise specified under this chapter, health plans offered under the OneCare
449.22 Buy-In program must meet all requirements of chapters 62A, 62D, 62K, 62M, 62Q, and
449.23 62V determined to be applicable by the regulating authority.

449.24 Subd. 2. **Premium administration and payment.** (a) The commissioner shall establish
449.25 annually a per-enrollee monthly premium rate.

449.26 (b) OneCare Buy-In premium administration shall be consistent with requirements under
449.27 the federal Affordable Care Act for qualified health plan premium administration. Premium
449.28 rates shall be established in accordance with section 62A.65, subdivision 3.

449.29 Subd. 3. **Rates to providers.** The commissioner shall establish rates for provider
449.30 payments that are targeted to the current rates established under chapter 256L, plus the
449.31 aggregate difference between those rates and Medicare rates. The aggregate must not consider
449.32 services that receive a Medicare encounter payment.

450.1 Subd. 4. Reserve requirements. A OneCare Buy-In reserve account is established in
450.2 the state treasury. Enrollee premiums collected under subdivision 2 shall be deposited into
450.3 the reserve account. The reserve account shall be used to cover expenditures related to
450.4 operation of the OneCare Buy-In, including the payment of claims and all other accrued
450.5 liabilities. No other account within the state treasury shall be used to finance the reserve
450.6 account except as otherwise specified in state law.

450.7 Subd. 5. Covered benefits. Each health plan established under this chapter must include
450.8 the essential health benefits package required under section 1302(a) of the Affordable Care
450.9 Act and as described in section 62Q.81; dental services described in section 256B.0625,
450.10 subdivision 9, paragraphs (b) and (c); and vision services described in Minnesota Rules,
450.11 part 9505.0277, and may include other services under section 256L.03, subdivision 1.

450.12 Subd. 6. Third-party administrator. (a) The commissioner may enter into a contract
450.13 with a third-party administrator to perform the operational management of the OneCare
450.14 Buy-In. Duties of the third-party administrator include but are not limited to the following:

450.15 (1) development and distribution of plan materials for potential enrollees;

450.16 (2) receipt and processing of electronic enrollment files sent from the state;

450.17 (3) creation and distribution of plan enrollee materials including identification cards,
450.18 certificates of coverage, plan formulary, provider directory, and premium billing statements;

450.19 (4) processing premium payments and sending termination notices for nonpayment to
450.20 enrollees and the state;

450.21 (5) payment and adjudication of claims;

450.22 (6) utilization management;

450.23 (7) coordination of benefits;

450.24 (8) grievance and appeals activities; and

450.25 (9) fraud, waste, and abuse prevention activities.

450.26 (b) Any solicitation of vendors to serve as the third-party administrator is subject to the
450.27 requirements under section 16C.06.

450.28 Subd. 7. Eligibility. (a) To be eligible for the OneCare Buy-In, a person must:

450.29 (1) be a resident of Minnesota; and

450.30 (2) not be enrolled in government-sponsored programs as defined in United States Code,
450.31 title 26, section 5000A(f)(1)(A). For purposes of this subdivision, an applicant who is

451.1 enrolled in Medicare Part A or enrolled in Medicare Part B coverage under title XVIII of
 451.2 the Social Security Act, United States Code, title 42, sections 1395c to 1395w-152, is
 451.3 considered enrolled in government-sponsored programs. An applicant shall not refuse to
 451.4 apply for or enroll in Medicare coverage to establish eligibility for the OneCare Buy-In.

451.5 (b) A person who is determined eligible for enrollment in a qualified health plan with
 451.6 or without advance payments of the premium tax credit and with or without cost-sharing
 451.7 reductions according to Code of Federal Regulations, title 45, section 155.305, paragraphs
 451.8 (a), (f), and (g), is eligible to purchase and enroll in the OneCare Buy-In instead of purchasing
 451.9 a qualified health plan as defined under section 62V.02.

451.10 Subd. 8. **Enrollment.** (a) A person may apply for the OneCare Buy-In during the annual
 451.11 open and special enrollment periods established for MNsure as defined in Code of Federal
 451.12 Regulations, title 45, sections 155.410 and 155.420 through the MNsure website.

451.13 (b) A person must annually reenroll for the OneCare Buy-In during open and special
 451.14 enrollment periods.

451.15 Subd. 9. **Premium tax credits, cost-sharing reductions, and subsidies.** A person who
 451.16 is eligible under this chapter, and whose income is less than or equal to 400 percent of the
 451.17 federal poverty guidelines, may qualify for advance premium tax credits and cost-sharing
 451.18 reductions under Code of Federal Regulations, title 45, section 155.305, paragraphs (a), (f),
 451.19 and (g), to purchase a health plan established under this chapter.

451.20 Subd. 10. **Covered benefits and payment rate modifications.** The commissioner, after
 451.21 providing public notice and an opportunity for public comment, may modify the covered
 451.22 benefits and payment rates to carry out this chapter.

451.23 Subd. 11. **Provider tax.** Section 295.582, subdivision 1, applies to health plans offered
 451.24 under the OneCare Buy-In program.

451.25 Subd. 12. **Request for federal authority.** The commissioner shall seek all necessary
 451.26 federal waivers to establish the OneCare Buy-In under this chapter.

451.27 **EFFECTIVE DATE.** (a) Subdivisions 1 to 10 are effective January 1, 2023.

451.28 (b) Subdivision 11 is effective the day following final enactment.

451.29 Sec. 15. **[256T.04] ONECARE BUY-IN PRODUCTS.**

451.30 Subdivision 1. **Platinum product.** The commissioner of human services shall establish
 451.31 a OneCare Buy-In coverage option that provides platinum level of coverage in accordance
 451.32 with the Affordable Care Act and benefits that are actuarially equivalent to 90 percent of

452.1 the full actuarial value of the benefits provided under the OneCare Buy-In coverage option.
452.2 This product must be made available in all rating areas in the state.

452.3 Subd. 2. **Silver and gold products.** (a) If any rating area lacks an affordable or
452.4 comprehensive health care coverage option according to standards developed by the
452.5 commissioner of health, the following year the commissioner of human services shall offer
452.6 silver and gold products established under paragraph (b) in the rating area for a five-year
452.7 period. Notwithstanding section 62U.04, subdivision 11, the commissioner of health may
452.8 use data collected under section 62U.04, subdivisions 4 and 5, to monitor triggers in the
452.9 individual market under this chapter. Effective January 1, 2020, the commissioner of health
452.10 may require submission of additional data elements under section 62U.04, subdivisions 4
452.11 and 5, in a manner specified by the commissioner, to conduct the analysis necessary to
452.12 monitor the individual market under this chapter.

452.13 (b) The commissioner shall establish the following OneCare Buy-In coverage options:
452.14 one coverage option shall provide silver level of coverage in accordance with the Affordable
452.15 Care Act and benefits that are actuarially equivalent to 70 percent of the full actuarial value
452.16 of the benefits provided under the OneCare Buy-In coverage option, and one coverage
452.17 option shall provide gold level of coverage in accordance with the Affordable Care Act and
452.18 benefits that are actuarially equivalent to 80 percent of the full actuarial value of the benefits
452.19 provided under the OneCare Buy-In coverage option.

452.20 Subd. 3. **Qualified health plan rules.** (a) The coverage options developed under this
452.21 section are subject to the process under section 62K.06. The coverage options developed
452.22 under this section shall meet requirements of chapters 62A, 62K, and 62V that apply to
452.23 qualified health plans.

452.24 (b) The Department of Human Services is not an insurance company for purposes of
452.25 this chapter.

452.26 Subd. 4. **Actuarial value.** Determination of the actuarial value of coverage options under
452.27 this section must be calculated in accordance with Code of Federal Regulations, title 45,
452.28 section 156.135.

452.29 **EFFECTIVE DATE.** This section is effective January 1, 2023.

452.30 Sec. 16. **[256T.30] OUTPATIENT PRESCRIPTION DRUGS.**

452.31 Subdivision 1. **Establishment of program.** The commissioner shall administer and
452.32 oversee the outpatient prescription drug program. The commissioner shall not include the
452.33 outpatient pharmacy benefit in a contract with a public or private entity.

453.1 Subd. 2. Covered outpatient prescription drugs. Outpatient prescription drugs are
453.2 covered in accordance with chapter 256L.

453.3 Subd. 3. Pharmacy provider participation. Pharmacy provider participation is governed
453.4 by section 256L.30, subdivision 3.

453.5 Subd. 4. Reimbursement rate. The commissioner shall establish outpatient prescription
453.6 drug reimbursement rates according to chapter 256L.

453.7 EFFECTIVE DATE. This section is effective January 1, 2023.

453.8 Sec. 17. Minnesota Statutes 2018, section 295.582, subdivision 1, is amended to read:

453.9 Subdivision 1. **Tax expense transfer.** (a) A hospital, surgical center, or health care
453.10 provider that is subject to a tax under section 295.52, or a pharmacy that has paid additional
453.11 expense transferred under this section by a wholesale drug distributor, may transfer additional
453.12 expense generated by section 295.52 obligations on to all third-party contracts for the
453.13 purchase of health care services on behalf of a patient or consumer. Nothing shall prohibit
453.14 a pharmacy from transferring the additional expense generated under section 295.52 to a
453.15 pharmacy benefits manager. The additional expense transferred to the third-party purchaser
453.16 or a pharmacy benefits manager must not exceed the tax percentage specified in section
453.17 295.52 multiplied against the gross revenues received under the third-party contract, and
453.18 the tax percentage specified in section 295.52 multiplied against co-payments and deductibles
453.19 paid by the individual patient or consumer. The expense must not be generated on revenues
453.20 derived from payments that are excluded from the tax under section 295.53. All third-party
453.21 purchasers of health care services including, but not limited to, third-party purchasers
453.22 regulated under chapter 60A, 62A, 62C, 62D, 62H, 62N, 64B, 65A, 65B, 79, ~~or 79A~~, or
453.23 256T, or under section 471.61 or 471.617, and pharmacy benefits managers must pay the
453.24 transferred expense in addition to any payments due under existing contracts with the
453.25 hospital, surgical center, pharmacy, or health care provider, to the extent allowed under
453.26 federal law. A third-party purchaser of health care services includes, but is not limited to,
453.27 a health carrier or community integrated service network that pays for health care services
453.28 on behalf of patients or that reimburses, indemnifies, compensates, or otherwise insures
453.29 patients for health care services. For purposes of this section, a pharmacy benefits manager
453.30 means an entity that performs pharmacy benefits management. A third-party purchaser or
453.31 pharmacy benefits manager shall comply with this section regardless of whether the
453.32 third-party purchaser or pharmacy benefits manager is a for-profit, not-for-profit, or nonprofit
453.33 entity. A wholesale drug distributor may transfer additional expense generated by section
453.34 295.52 obligations to entities that purchase from the wholesaler, and the entities must pay

454.1 the additional expense. Nothing in this section limits the ability of a hospital, surgical center,
454.2 pharmacy, wholesale drug distributor, or health care provider to recover all or part of the
454.3 section 295.52 obligation by other methods, including increasing fees or charges.

454.4 (b) Any hospital, surgical center, or health care provider subject to a tax under section
454.5 295.52 or a pharmacy that has paid additional expense transferred under this section by a
454.6 wholesale drug distributor may file a complaint with the commissioner responsible for
454.7 regulating the third-party purchaser if at any time the third-party purchaser fails to comply
454.8 with paragraph (a).

454.9 (c) If the commissioner responsible for regulating the third-party purchaser finds at any
454.10 time that the third-party purchaser has not complied with paragraph (a), the commissioner
454.11 may take enforcement action against a third-party purchaser which is subject to the
454.12 commissioner's regulatory jurisdiction and which does not allow a hospital, surgical center,
454.13 pharmacy, or provider to pass-through the tax. The commissioner may by order fine or
454.14 censure the third-party purchaser or revoke or suspend the certificate of authority or license
454.15 of the third-party purchaser to do business in this state if the commissioner finds that the
454.16 third-party purchaser has not complied with this section. The third-party purchaser may
454.17 appeal the commissioner's order through a contested case hearing in accordance with chapter
454.18 14.

454.19 Sec. 18. **DIRECTION TO COMMISSIONER; STATE-BASED RISK ADJUSTMENT**
454.20 **ANALYSIS.**

454.21 The commissioner of commerce, in consultation with the commissioner of health, shall
454.22 conduct a study on the design and implementation of a state-based risk adjustment program.
454.23 The commissioner shall report on the findings of the study and any recommendations to
454.24 the legislative committees with jurisdiction over the individual health insurance market by
454.25 February 15, 2021.

454.26 Sec. 19. **REPEALER.**

454.27 Minnesota Statutes 2018, section 256L.11, subdivision 6a, is repealed.

454.28 **EFFECTIVE DATE.** This section is effective January 1, 2022.

ARTICLE 10

OPIOIDS

455.1

455.2

455.3 Section 1. Minnesota Statutes 2018, section 151.01, is amended by adding a subdivision
455.4 to read:

455.5 Subd. 2b. **Chain pharmacy.** "Chain pharmacy" means any pharmacy that is part of a
455.6 group of ten or more establishments that (1) conduct business under the same business
455.7 name, or (2) operate under common ownership or management or pursuant to a franchise
455.8 agreement with the same franchisor.

455.9 Sec. 2. Minnesota Statutes 2018, section 151.01, is amended by adding a subdivision to
455.10 read:

455.11 Subd. 42. **Unit.** "Unit" means, with respect to a particular drug product, the individual
455.12 dosage form of the drug product that is most commonly prescribed to a patient, including
455.13 but not limited to tablet, capsule, patch, syringe, milliliter, or gram.

455.14 Sec. 3. Minnesota Statutes 2018, section 151.065, is amended by adding a subdivision to
455.15 read:

455.16 Subd. 3a. **Controlled substance registration fees.** (a) Initial and annual renewal
455.17 controlled substance registration fees are as follows:

455.18 (1) controlled substance drug manufacturer, large, \$75,000;

455.19 (2) controlled substance drug manufacturer, medium, \$5,000;

455.20 (3) controlled substance drug manufacturer, small, \$500;

455.21 (4) drug wholesaler distributing controlled substances, large, \$75,000;

455.22 (5) drug wholesaler distributing controlled substances, small, \$2,500;

455.23 (6) pharmacy dispensing controlled substances other than a hospital, chain pharmacy,
455.24 \$2,500;

455.25 (7) pharmacy dispensing controlled substances other than a hospital, independent, \$500;

455.26 (8) pharmacy dispensing controlled substances, hospital (50 or more beds), \$2,500;

455.27 (9) pharmacy dispensing controlled substances, hospital (fewer than 50 beds), \$500;

455.28 (10) practitioner prescribing, administering, or dispensing controlled substances, \$125;

455.29 and

456.1 (1) controlled substances researcher, \$125.

456.2 (b) For the purposes of this subdivision:

456.3 (1) a controlled substance drug manufacturer shall be subject to the fee established under
456.4 paragraph (a), clause (1), if the data collected through the prescription monitoring program
456.5 established under section 152.126 indicates that 5,000,000 or more units of the manufacturer's
456.6 controlled substance products have been dispensed to residents of this state during the
456.7 previous calendar year;

456.8 (2) a controlled substance drug manufacturer shall be subject to the fee established under
456.9 paragraph (a), clause (2), if the data collected through the prescription monitoring program
456.10 established under section 152.126 indicates that more than 1,000,000 but less than 5,000,000
456.11 units of the manufacturer's controlled substance products have been dispensed to residents
456.12 of this state during the previous calendar year;

456.13 (3) a controlled substance drug manufacturer shall be subject to the fee established under
456.14 paragraph (a), clause (3), if the data collected through the prescription monitoring program
456.15 established under section 152.126 indicates that 1,000,000 or fewer units of the
456.16 manufacturer's controlled substance products have been dispensed to residents of this state
456.17 during the previous calendar year;

456.18 (4) a wholesaler of controlled substances shall be subject to the fee established under
456.19 paragraph (a), clause (4), if the data collected pursuant to section 152.10, subdivision 4,
456.20 indicates that the wholesaler has distributed 5,000,000 or more units of controlled substances
456.21 within or into this state; and

456.22 (5) a wholesaler of controlled substances shall be subject to the fee established under
456.23 paragraph (a), clause (5), if the data collected pursuant to section 152.10, subdivision 4,
456.24 indicates that the wholesaler has distributed less than 5,000,000 units of controlled substances
456.25 within or into this state.

456.26 Sec. 4. Minnesota Statutes 2018, section 151.252, subdivision 1, is amended to read:

456.27 Subdivision 1. **Requirements.** (a) No person shall act as a drug manufacturer without
456.28 first obtaining a license from the board and paying any applicable fee specified in section
456.29 151.065.

456.30 (b) In addition to the license required under paragraph (a), a manufacturer of a Schedule
456.31 II through IV opiate controlled substance must pay the applicable registration fee specified
456.32 in section 151.77, subdivision 3, by June 1 of each year, beginning June 1, 2020. In the
456.33 event of a change of ownership of the manufacturer, the new owner must pay the registration

457.1 fee specified under section 151.77, subdivision 3, that the original owner would have been
457.2 assessed had it retained ownership. The board may assess a late fee of ten percent per month
457.3 for every portion of a month that the registration fee is paid after the due date.

457.4 ~~(b)~~ (c) Application for a drug manufacturer license under this section shall be made in
457.5 a manner specified by the board.

457.6 ~~(e)~~ (d) No license shall be issued or renewed for a drug manufacturer unless the applicant
457.7 agrees to operate in a manner prescribed by federal and state law and according to Minnesota
457.8 Rules.

457.9 ~~(d)~~ (e) No license shall be issued or renewed for a drug manufacturer that is required to
457.10 be registered pursuant to United States Code, title 21, section 360, unless the applicant
457.11 supplies the board with proof of registration. The board may establish by rule the standards
457.12 for licensure of drug manufacturers that are not required to be registered under United States
457.13 Code, title 21, section 360.

457.14 ~~(e)~~ (f) No license shall be issued or renewed for a drug manufacturer that is required to
457.15 be licensed or registered by the state in which it is physically located unless the applicant
457.16 supplies the board with proof of licensure or registration. The board may establish, by rule,
457.17 standards for the licensure of a drug manufacturer that is not required to be licensed or
457.18 registered by the state in which it is physically located.

457.19 ~~(f)~~ (g) The board shall require a separate license for each facility located within the state
457.20 at which drug manufacturing occurs and for each facility located outside of the state at
457.21 which drugs that are shipped into the state are manufactured.

457.22 ~~(g)~~ (h) The board shall not issue an initial or renewed license for a drug manufacturing
457.23 facility unless the facility passes an inspection conducted by an authorized representative
457.24 of the board. In the case of a drug manufacturing facility located outside of the state, the
457.25 board may require the applicant to pay the cost of the inspection, in addition to the license
457.26 fee in section 151.065, unless the applicant furnishes the board with a report, issued by the
457.27 appropriate regulatory agency of the state in which the facility is located or by the United
457.28 States Food and Drug Administration, of an inspection that has occurred within the 24
457.29 months immediately preceding receipt of the license application by the board. The board
457.30 may deny licensure unless the applicant submits documentation satisfactory to the board
457.31 that any deficiencies noted in an inspection report have been corrected.

458.1 Sec. 5. Minnesota Statutes 2018, section 151.47, is amended by adding a subdivision to
458.2 read:

458.3 Subd. 1a. **Controlled substance wholesale drug distributor requirements.** In addition
458.4 to the license required under subdivision 1, a wholesale drug distributor distributing a
458.5 Schedule II through IV opiate controlled substance must pay the applicable registration fee
458.6 specified in section 151.77, subdivision 4, by June 1 of each year beginning June 1, 2020.
458.7 In the event of a change in ownership of the wholesale drug distributor, the new owner must
458.8 pay the registration fee specified in section 151.77, subdivision 4, that the original owner
458.9 would have been assessed had it retained ownership. The board may assess a late fee of ten
458.10 percent per month for every portion of a month that the registration fee is paid after the due
458.11 date.

458.12 Sec. 6. **[151.77] OPIATE PRODUCT REGISTRATION FEE.**

458.13 Subdivision 1. **Definitions.** For purposes of this section, the following terms have the
458.14 meanings given them:

458.15 (1) "manufacturer" means a manufacturer licensed under section 151.252 that is engaged
458.16 in the manufacturing of an opiate;

458.17 (2) "opiate" means any opiate-containing controlled substance listed in section 152.02,
458.18 subdivisions 3 to 5, that is distributed, delivered, sold, or dispensed into or within this state;
458.19 and

458.20 (3) "wholesaler" means a wholesale drug distributor who is licensed under section 151.47,
458.21 and is engaged in the wholesale drug distribution of an opiate.

458.22 Subd. 2. **Reporting requirements.** (a) By March 1 of each year, beginning March 1,
458.23 2020, each manufacturer and each wholesale drug distributor must report to the board every
458.24 sale, delivery, or other distribution within or into this state of any opiate that is made to any
458.25 practitioner, pharmacy, hospital, veterinary hospital, or other person who is permitted by
458.26 section 151.37 to possess controlled substances for administration or dispensing to patients
458.27 that occurred during the previous calendar year. Reporting must be in the automation of
458.28 reports and consolidated orders system format unless otherwise specified by the board. If
458.29 a manufacturer or wholesaler fails to provide information required under this paragraph on
458.30 a timely basis, the board may assess an administrative penalty of \$500 per day. This penalty
458.31 shall not be considered a form of disciplinary action.

458.32 (b) By March 1 of each year, beginning March 1, 2020, each owner of a pharmacy with
458.33 at least one location within this state must report to the board the intracompany delivery or

459.1 distribution into this state of any opiate, to the extent that those deliveries and distributions
459.2 are not reported to the board by a licensed wholesale drug distributor owned by, under
459.3 contract to, or otherwise operating on behalf of the owner of the pharmacy. Reporting must
459.4 be in the manner and format specified by the board for deliveries and distributions that
459.5 occurred during the previous calendar year. The report must include the name of the
459.6 manufacturer or wholesaler from which the owner of the pharmacy ultimately purchased
459.7 the opiate, and the amount and date that the purchases occurred.

459.8 Subd. 3. **Determination of each manufacturer's registration fee.** (a) The board shall
459.9 annually assess manufacturer registration fees that in an aggregate amount total \$12,000,000.
459.10 The board shall determine each manufacturer's annual registration fee that is prorated and
459.11 based on the manufacturer's percentage of the total number of units reported to the board
459.12 under subdivision 2.

459.13 (b) By April 1 of each year, beginning April 1, 2020, the board shall notify each
459.14 manufacturer of the annual amount of the manufacturer's registration fee to be paid by June
459.15 1, in accordance with section 151.252, subdivision 1, paragraph (b).

459.16 (c) In conjunction with the data reported under this section, and notwithstanding section
459.17 152.126, subdivision 6, the board may use the data reported under section 152.126,
459.18 subdivision 4, to determine the manufacturer registration fees required under this subdivision.

459.19 (d) A manufacturer may dispute the registration fee as determined by the board no later
459.20 than 30 days after the date of notification; however, the manufacturer must still remit the
459.21 fee as required by section 151.252, subdivision 1, paragraph (b). The dispute must be filed
459.22 with the board in the manner and using the forms specified by the board. A manufacturer
459.23 must submit, with the required forms, data satisfactory to the board that demonstrates that
459.24 the registration fee was incorrect. The board must make a decision concerning a dispute no
459.25 later than 60 days after receiving the required dispute forms. If the board determines that
459.26 the manufacturer has satisfactorily demonstrated that the original fee was incorrect, the
459.27 board must adjust the manufacturer's registration fee due the next year by the amount that
459.28 is in excess of the correct fee that should have been paid.

459.29 Subd. 4. **Determination of each wholesaler's registration fee.** (a) The board shall
459.30 annually assess wholesaler registration fees that in an aggregate amount total \$8,000,000.
459.31 The board shall determine each wholesaler's annual registration fee that is prorated and
459.32 based on the wholesaler's percentage of the total number of units reported to the board under
459.33 subdivision 2. This paragraph does not apply to a wholesaler if the wholesaler is also licensed
459.34 as a drug manufacturer under section 151.252.

460.1 (b) By April 1 of each year, beginning April 1, 2020, the board shall notify each
460.2 wholesaler of the annual amount of the wholesaler's registration fee to be paid by June 1,
460.3 in accordance with section 151.47, subdivision 1a.

460.4 (c) A wholesaler may dispute the registration fee as determined by the board no later
460.5 than 30 days after the date of notification. However, the wholesaler must still remit the fee
460.6 as required by section 151.47, subdivision 1a. The dispute must be filed with the board in
460.7 the manner and using the forms specified by the board. A wholesaler must submit, with the
460.8 required forms, data satisfactory to the board that demonstrates that the registration fee was
460.9 incorrect. The board must make a decision concerning a dispute no later than 60 days after
460.10 receiving the required dispute forms. If the board determines that the wholesaler has
460.11 satisfactorily demonstrated that the original fee was incorrect, the board must adjust the
460.12 wholesaler's registration fee due the next year by the amount that is in excess of the correct
460.13 fee that should have been paid.

460.14 Subd. 5. **Report.** (a) The Board of Pharmacy shall evaluate the registration fee on drug
460.15 manufacturers and wholesalers established under this section, and whether the fee has
460.16 impacted the prescribing practices for opiates by reducing the number of opiate prescriptions
460.17 issued during calendar years 2020, 2021, and 2022, to the extent the board has the ability
460.18 to effectively identify a correlation. Notwithstanding section 152.126, subdivision 6, the
460.19 board may access the data reported under section 152.126, subdivision 4, to conduct this
460.20 evaluation.

460.21 (b) The board shall submit the results of its evaluation to the chairs and ranking minority
460.22 members of the legislative committees with jurisdiction over health and human services
460.23 policy and finance by March 1, 2023.

460.24 Subd. 6. **Legislative review.** The legislature shall review the reports from the Opioid
460.25 Addiction Advisory Council under section 151.255, subdivision 1, paragraph (c), the report
460.26 from the Board of Pharmacy under subdivision 5, and any other relevant report or information
460.27 related to the opioid crisis in Minnesota, to make a determination about whether the opiate
460.28 product registration fee assessed under this section should continue beyond July 1, 2023.

460.29 Sec. 7. Minnesota Statutes 2018, section 152.01, is amended by adding a subdivision to
460.30 read:

460.31 Subd. 25. **Practitioner.** "Practitioner" has the meaning given in section 151.01,
460.32 subdivision 23.

461.1 Sec. 8. Minnesota Statutes 2018, section 152.10, is amended to read:

461.2 **152.10 SALES, PERSONS ELIGIBLE CONTROLLED SUBSTANCE**
461.3 **REGISTRATION.**

461.4 Subdivision 1. Generally. No person ~~other than a licensed pharmacist, assistant~~
461.5 ~~pharmacist or pharmacist intern under the supervision of a pharmacist shall sell a stimulant~~
461.6 ~~or depressant drug and then only as provided in sections 152.021 to 152.12 and 152.0262.~~
461.7 controlled substance except (1) as provided in this chapter, and (2) when any registration
461.8 required under this section has been obtained and is active.

461.9 Subd. 2. Registration requirement. (a) A person must obtain a registration issued by
461.10 the Board of Pharmacy in order to:

461.11 (1) manufacture, distribute, prescribe, or dispense any controlled substance within the
461.12 state;

461.13 (2) propose to engage in the manufacture, distribution, prescription, or dispensing of
461.14 any controlled substance within the state;

461.15 (3) dispense, distribute, or propose to dispense or distribute any controlled substance
461.16 for use in the state by shipping, mailing, or otherwise delivering the controlled substance
461.17 from a location outside this state; or

461.18 (4) use or propose to use controlled substances in the course of a bona fide research
461.19 project.

461.20 (b) Persons registered by the Board of Pharmacy under this section to manufacture,
461.21 distribute, prescribe, dispense, store, or conduct research with controlled substances may
461.22 possess, manufacture, distribute, prescribe, dispense, store, or conduct research with the
461.23 controlled substances to the extent authorized by the registration and in conformity with
461.24 this section. Registered persons must also comply with any other statutes or rules applicable
461.25 to the manufacture, distribution, prescribing, dispensing, or storage of, or research with,
461.26 prescription drugs.

461.27 (c) Except as otherwise provided by law, the following persons and entities are not
461.28 required to register and may lawfully possess controlled substances under this chapter:

461.29 (1) an agent or employee of any registered manufacturer, registered drug wholesaler, or
461.30 registered pharmacy while acting in the course of employment only;

461.31 (2) a common carrier, or an employee of a common carrier, whose possession of a
461.32 controlled substance is in the usual course of the person's business or employment;

462.1 (3) a licensed hospital or other licensed institution where sick and injured persons are
462.2 cared for or treated, bona fide hospitals where animals are treated, or employees of a licensed
462.3 hospital or institution acting in the course of employment, except that (i) employees who
462.4 are licensed practitioners must be registered to the extent that they engage in the prescribing
462.5 of controlled substances, and (ii) hospital pharmacies licensed by the board must be
462.6 registered;

462.7 (4) a licensed or registered health care professional who acts as the authorized agent of
462.8 a practitioner and who administers controlled substances at the direction of the practitioner,
462.9 provided that the practitioner is authorized to prescribe controlled substances pursuant to
462.10 section 152.12;

462.11 (5) an analytical laboratory, or employee of an analytical laboratory when acting in the
462.12 course of employment, when conducting an anonymous analysis service and when the
462.13 analytical laboratory is registered by the federal Drug Enforcement Administration;

462.14 (6) a medical cannabis manufacturer registered under section 152.25;

462.15 (7) a person in possession of any controlled substance prescribed for that person pursuant
462.16 to section 152.12, subdivision 1, or obtained pursuant to the requirements of the medical
462.17 cannabis program established under this chapter; or

462.18 (8) the owner of an animal for which a controlled substance has been prescribed pursuant
462.19 to section 152.12, subdivision 2.

462.20 (d) Nothing in this section prohibits a person for whom a controlled substance has been
462.21 dispensed in accordance with a prescription issued pursuant to section 152.12 from
462.22 designating a family member, caregiver, or other individual to assist the person in obtaining
462.23 or administering the controlled substance, or disposing of the controlled substance pursuant
462.24 to section 152.105.

462.25 (e) A separate registration is required at each principal place of business or professional
462.26 practice where the applicant manufactures, distributes, prescribes, dispenses, or conducts
462.27 research with controlled substances. This paragraph does not apply to an office used by a
462.28 practitioner who is registered at another location, where controlled substances are prescribed
462.29 but neither administered nor otherwise dispensed as a regular part of the professional practice
462.30 of the practitioner at the office, and where no supplies of controlled substances are
462.31 maintained.

462.32 (f) The Board of Pharmacy, through its authorized representative, has the authority to
462.33 inspect the establishment of a registrant or applicant for registration. This authority is granted

463.1 for routine inspections and for the purpose of conducting investigations of complaints made
463.2 against registrants.

463.3 (g) The board may require a registrant to submit documents or written statements of fact
463.4 relevant to a registration that the board deems necessary to determine whether the registration
463.5 should be granted or denied. If the registrant fails to provide the documents or statements
463.6 within a reasonable time after being requested to do so, the registrant shall be deemed to
463.7 have waived the opportunity to present the documents or statements for consideration by
463.8 the board in granting or denying the registration.

463.9 (h) Failure to renew the controlled substance registration on a timely basis shall cause
463.10 the registration to be automatically forfeited. A forfeited registration may be reinstated
463.11 pursuant to section 151.065, subdivision 7.

463.12 Subd. 3. **Registration.** (a) The Board of Pharmacy shall register an applicant to
463.13 manufacture, dispense, prescribe, distribute, or conduct research with controlled substances
463.14 included in section 152.02, subdivisions 3 to 6, unless it determines that the issuance of that
463.15 registration would be inconsistent with the public interest. In determining the public interest,
463.16 the board shall consider the following factors:

463.17 (1) maintaining effective controls against diversion of controlled substances into other
463.18 than legitimate medical, scientific, or industrial channels;

463.19 (2) complying with applicable federal, state, and local law;

463.20 (3) whether the applicant has been convicted under any federal or state laws relating to
463.21 any controlled substance;

463.22 (4) past experience in the manufacture, distribution, or dispensing of controlled substances
463.23 or in research involving controlled substances, and the existence in the applicant's
463.24 establishment of effective controls against diversion;

463.25 (5) whether the applicant has furnished false or fraudulent material in any application
463.26 filed under this chapter;

463.27 (6) suspension or revocation of the applicant's federal registration to manufacture,
463.28 distribute, prescribe, dispense, or conduct research with controlled substances as authorized
463.29 by federal law; and

463.30 (7) any other factor relevant to and consistent with public health and safety.

463.31 (b) Registration under paragraph (a) does not entitle a registrant to manufacture, dispense,
463.32 prescribe, and distribute controlled substances included in section 152.02, subdivision 2.

464.1 Manufacturing, dispensing, prescribing, and distribution of controlled substances included
464.2 in section 152.02, subdivision 2, may only occur as part of a bona fide research project
464.3 pursuant to section 152.12, subdivision 3, or 152.21 and as allowed under federal law and
464.4 regulations. However, medical cannabis, as defined in section 152.22, subdivision 6, may
464.5 be produced and distributed as allowed under section 152.29.

464.6 (c) A practitioner must be registered under this section in order to dispense or prescribe
464.7 any controlled substances included in section 152.02, subdivisions 3 to 6.

464.8 Subd. 4. **Revocation and suspension of registration.** (a) A registration under this
464.9 section to manufacture, dispense, prescribe, distribute, or conduct research with a controlled
464.10 substance may be suspended or revoked by the Board of Pharmacy upon finding probable
464.11 cause that the registrant has:

464.12 (1) furnished false or fraudulent material information in any application filed under this
464.13 chapter;

464.14 (2) been convicted of a felony pursuant to any state or federal law relating to any
464.15 controlled substance;

464.16 (3) had the registrant's federal controlled substance registration to manufacture, distribute,
464.17 prescribe, dispense, or conduct research with controlled substances suspended or revoked;

464.18 (4) had the registrant's state license to practice the registrant's profession suspended or
464.19 revoked by the applicable health-related licensing board;

464.20 (5) had the registrant's state license to practice the registrant's profession placed on
464.21 conditional status by the applicable health-related licensing board when the conditions
464.22 prohibit the registrant from prescribing, administering, dispensing, or otherwise handling
464.23 controlled substances; or

464.24 (6) violated federal or state statutes or regulations related to the manufacture, distribution,
464.25 prescribing, dispensing, or research of a controlled substance in a manner that places the
464.26 public at imminent risk of serious harm.

464.27 (b) The Board of Pharmacy may limit revocation or suspension of a registration to the
464.28 particular controlled substance with respect to which grounds for revocation or suspension
464.29 exist.

464.30 Subd. 5. **Reporting.** On at least a quarterly basis, drug wholesalers must report to the
464.31 board all distributions, within or into the state, of all Schedule II controlled substance
464.32 products, and of all Schedule III controlled substance products that contain narcotics or
464.33 gamma hydroxybutyric acid. Reporting must be in the automation of reports and consolidated

465.1 orders system format unless otherwise specified by the board. This reporting shall also meet
465.2 any other requirement for reporting distribution data to the board found in this chapter or
465.3 in chapter 151.

465.4 Sec. 9. Minnesota Statutes 2018, section 152.11, subdivision 1, is amended to read:

465.5 Subdivision 1. **General prescription requirements for controlled substances.** (a) A
465.6 written prescription or an oral prescription reduced to writing, when issued for a controlled
465.7 substance in Schedule II, III, IV, or V, is void unless: (1) it is written in ink and contains
465.8 the name and address of the person for whose use it is intended; (2) it states the amount of
465.9 the controlled substance to be ~~compounded or~~ dispensed, with directions for its use; (3) if
465.10 a written prescription, it contains the handwritten signature of the prescriber, the prescriber's
465.11 address, and federal registry number of the prescriber and a designation of the branch of
465.12 the healing art pursued by the prescriber; and if an oral prescription, the name and address
465.13 of the prescriber and a designation of the prescriber's branch of the healing art; ~~and~~ (4) it
465.14 shows the date when signed by the prescriber, or the date of acceptance in the pharmacy if
465.15 an oral prescription; and (5) it includes the prescriber's current state and federal controlled
465.16 substance registration numbers.

465.17 (b) An electronic prescription for a controlled substance in Schedule II, III, IV, or V is
465.18 void unless: (1) it complies with the standards established pursuant to section 62J.497 and
465.19 with those portions of Code of Federal Regulations, title 21, parts 1300, 1304, 1306, and
465.20 1311, that pertain to electronic prescriptions; and (2) it includes the prescriber's current
465.21 state controlled substance registration number.

465.22 (c) A prescription for a controlled substance in Schedule II, III, IV, or V that is transmitted
465.23 by facsimile, either computer to facsimile machine or facsimile machine to facsimile machine,
465.24 is void unless: (1) it complies with the applicable requirements of Code of Federal
465.25 Regulations, title 21, part 1306; and (2) it includes the prescriber's current state controlled
465.26 substance registration number.

465.27 (d) Every licensed pharmacy that dispenses a controlled substance prescription shall
465.28 retain the original prescription in a file for a period of not less than two years, open to
465.29 inspection by any officer of the state, county, or municipal government whose duty it is to
465.30 aid and assist with the enforcement of this chapter. An original electronic or facsimile
465.31 prescription may be stored in an electronic database, provided that the database provides a
465.32 means by which original prescriptions can be retrieved, as transmitted to the pharmacy, for
465.33 a period of not less than two years.

466.1 (e) Every licensed pharmacy shall distinctly label the container in which a controlled
466.2 substance is dispensed with the directions contained in the prescription for the use of that
466.3 controlled substance.

466.4 Sec. 10. Minnesota Statutes 2018, section 152.11, subdivision 1a, is amended to read:

466.5 Subd. 1a. **Prescription requirements for Schedule II controlled substances.** (a) No
466.6 person may dispense a controlled substance included in Schedule II of section 152.02 without
466.7 a prescription issued by (1) a doctor of medicine, a doctor of osteopathic medicine licensed
466.8 to practice medicine, a doctor of dental surgery, a doctor of dental medicine, a doctor of
466.9 podiatry, or a doctor of veterinary medicine, practitioner lawfully licensed to prescribe in
466.10 this state, acting within the practitioner's scope of practice, and having a current federal
466.11 controlled substance registration number and a state controlled substance registration number
466.12 issued pursuant to section 152.10, or by (2) a practitioner licensed to prescribe controlled
466.13 substances by the state in which the prescription is issued, and having a current federal ~~Drug~~
466.14 ~~Enforcement Administration~~ controlled substance registration number and, if required, a
466.15 controlled substance registration number issued by the other state.

466.16 (b) The prescription must either be printed or written in ink and contain the handwritten
466.17 signature of the prescriber or be transmitted electronically or by facsimile as permitted under
466.18 subdivision 1. Provided that in emergency situations, as authorized by federal law, such
466.19 drug may be dispensed upon oral prescription reduced promptly to writing and filed by the
466.20 pharmacist. Such prescriptions shall be retained in conformity with section 152.101. No
466.21 prescription for a Schedule II substance may be refilled.

466.22 Sec. 11. Minnesota Statutes 2018, section 152.11, subdivision 2, is amended to read:

466.23 Subd. 2. **Prescription requirements for Schedule III or IV controlled substances.** (a)
466.24 No person may dispense a controlled substance included in Schedule III or IV of section
466.25 152.02 without a prescription issued, as permitted under subdivision 1, by (1) a doctor of
466.26 medicine, a doctor of osteopathic medicine licensed to practice medicine, a doctor of dental
466.27 surgery, a doctor of dental medicine, a doctor of podiatry, a doctor of optometry limited to
466.28 Schedule IV, or a doctor of veterinary medicine, practitioner lawfully licensed to prescribe
466.29 in this state, acting within the practitioner's scope of practice, and having a current federal
466.30 controlled substance registration number and a state controlled substance registration number
466.31 issued pursuant to section 152.10, or from (2) a practitioner licensed to prescribe controlled
466.32 substances by the state in which the prescription is issued, and having a current federal ~~drug~~

467.1 ~~enforcement administration~~ controlled substance registration number and, if required, a
467.2 controlled substance registration number issued by the other state.

467.3 (b) Such prescription may not be dispensed or refilled except with the documented
467.4 consent of the prescriber, and in no event more than six months after the date on which such
467.5 prescription was issued and no such prescription may be refilled more than five times.

467.6 Sec. 12. Minnesota Statutes 2018, section 152.11, subdivision 2a, is amended to read:

467.7 Subd. 2a. **Federal and state registration number exemption.** A prescription need not
467.8 bear a federal drug enforcement administration registration number ~~that authorizes the~~
467.9 ~~prescriber to prescribe controlled substances~~ or a state controlled substance registration
467.10 number if the drug prescribed is not a controlled substance in Schedule II, III, IV, or V. No
467.11 person shall impose a requirement inconsistent with this subdivision.

467.12 Sec. 13. Minnesota Statutes 2018, section 152.11, subdivision 2b, is amended to read:

467.13 Subd. 2b. **Restriction on release of federal and state registration number.** No person
467.14 or entity may offer for sale, sell, lease, or otherwise release a federal drug enforcement
467.15 administration registration number or a state controlled substance registration number for
467.16 any reason, except for drug enforcement purposes authorized by this chapter and the federal
467.17 controlled substances registration system. For purposes of this section, an entity includes a
467.18 state governmental agency or regulatory board, a health plan company as defined under
467.19 section 62Q.01, subdivision 4, a managed care organization as defined under section 62Q.01,
467.20 subdivision 5, or any other entity that maintains prescription data.

467.21 Sec. 14. Minnesota Statutes 2018, section 152.11, subdivision 2c, is amended to read:

467.22 Subd. 2c. **Restriction on use of federal and state registration number.** No entity may
467.23 use a federal drug enforcement administration registration number or a state controlled
467.24 substance registration number to identify or monitor the prescribing practices of a prescriber
467.25 to whom that number has been assigned, except for drug enforcement purposes authorized
467.26 by this chapter and the federal controlled substances registration system. For purposes of
467.27 this section, an entity includes a health plan company as defined under section 62Q.01,
467.28 subdivision 4, a managed care organization as defined under section 62Q.01, subdivision
467.29 5, or any other entity that maintains prescription data.

468.1 Sec. 15. Minnesota Statutes 2018, section 152.12, subdivision 1, is amended to read:

468.2 Subdivision 1. **Prescribing, dispensing, administering controlled substances in**
468.3 **Schedules II through V.** A ~~licensed doctor of medicine, a doctor of osteopathic medicine,~~
468.4 ~~duly licensed to practice medicine, a doctor of dental surgery, a doctor of dental medicine,~~
468.5 ~~a licensed doctor of podiatry, a licensed advanced practice registered nurse, or a licensed~~
468.6 ~~doctor of optometry limited to Schedules IV and V, and~~ practitioner in the course of
468.7 professional practice ~~only~~ and within the practitioner's scope of practice, may prescribe,
468.8 administer, and dispense a controlled substance included in Schedules II through V of section
468.9 152.02, may cause the same to be administered by a nurse, an intern or an assistant under
468.10 the direction and supervision of the ~~doctor~~ practitioner, and may cause a person who is an
468.11 appropriately certified and licensed health care professional to prescribe and administer the
468.12 same within the expressed legal scope of the person's practice as defined in Minnesota
468.13 Statutes. An individual who prescribes under this subdivision must be registered pursuant
468.14 to section 152.10 and must have a current federal controlled substance registration number.

468.15 Sec. 16. Minnesota Statutes 2018, section 152.12, subdivision 2, is amended to read:

468.16 Subd. 2. **Doctor of veterinary medicine.** A licensed doctor of veterinary medicine who
468.17 is registered pursuant to section 152.10 and who has a current federal controlled substance
468.18 registration number, in good faith, and in the course of professional practice only, and not
468.19 for use by a human being, may prescribe, administer, and dispense a controlled substance
468.20 included in Schedules II through V of section 152.02, and may cause the same to be
468.21 administered by an assistant under the direction and supervision of the doctor.

468.22 Sec. 17. Minnesota Statutes 2018, section 152.12, subdivision 3, is amended to read:

468.23 Subd. 3. **Research project use of controlled substances.** Any qualified person may
468.24 use controlled substances in the course of a bona fide research project but cannot administer
468.25 or dispense such drugs to human beings unless such drugs are prescribed, dispensed and
468.26 administered by a person lawfully authorized to do so. Every person who engages in research
468.27 involving the use of such substances ~~shall apply annually for registration by~~ must register
468.28 with the state Board of Pharmacy and shall pay any applicable fee specified in section
468.29 ~~151.065, provided that such registration shall not be required if the person is covered by~~
468.30 ~~and has complied with federal laws covering such research projects~~ pursuant to section
468.31 152.10.

469.1 Sec. 18. Minnesota Statutes 2018, section 152.12, subdivision 4, is amended to read:

469.2 Subd. 4. **Sale of controlled substances not prohibited for certain persons and**
469.3 **entities.** (a) Provided that the registration requirements in section 152.10 are met, nothing
469.4 in this chapter shall prohibit the sale to, or the possession of, a controlled substance in
469.5 Schedule II, III, IV or V by: ~~Registered~~ licensed drug wholesalers, ~~registered~~ licensed
469.6 manufacturers, ~~registered~~ licensed pharmacies, or any licensed hospital or other licensed
469.7 institutions wherein sick and injured persons are cared for or treated, or bona fide hospitals
469.8 wherein animals are treated; or by licensed pharmacists, or licensed ~~doctors of medicine,~~
469.9 ~~doctors of osteopathic medicine duly licensed to practice medicine, licensed doctors of~~
469.10 ~~dental surgery, licensed doctors of dental medicine, licensed doctors of podiatry, licensed~~
469.11 ~~doctors of optometry limited to Schedules IV and V, or licensed doctors of veterinary~~
469.12 ~~medicine when such practitioners use controlled substances~~ acting within the course and
469.13 scope of their professional practice only.

469.14 (b) Provided that the registration requirements in section 152.10 are met, nothing in this
469.15 chapter shall prohibit the possession of a controlled substance in Schedule II, III, IV or V
469.16 by an employee or agent of a ~~registered~~ licensed drug wholesaler, ~~registered~~ licensed
469.17 manufacturer, or ~~registered~~ licensed pharmacy, while acting in the course of employment;
469.18 by a patient of a licensed ~~doctor of medicine, a doctor of osteopathic medicine duly licensed~~
469.19 ~~to practice medicine, a licensed doctor of dental surgery, a licensed doctor of dental medicine,~~
469.20 ~~or a licensed doctor of optometry limited to Schedules IV and V~~ practitioner; or by the
469.21 owner of an animal for which a controlled substance has been prescribed by a licensed
469.22 doctor of veterinary medicine, when such controlled substances are prescribed and dispensed
469.23 according to law.

469.24 Sec. 19. Minnesota Statutes 2018, section 152.125, subdivision 2, is amended to read:

469.25 Subd. 2. **Prescription and administration of controlled substances for intractable**
469.26 **pain.** Notwithstanding any other provision of this chapter, a physician practitioner lawfully
469.27 licensed to prescribe controlled substances in this state and registered pursuant to section
469.28 152.10 may prescribe or administer a controlled substance in Schedules II to V of section
469.29 152.02 to an individual in the course of the physician's practitioner's treatment of the
469.30 individual for a diagnosed condition causing intractable pain. No physician practitioner
469.31 shall be subject to disciplinary action by ~~the Board of Medical Practice~~ a health-related
469.32 licensing board for appropriately prescribing or administering a controlled substance in
469.33 Schedules II to V of section 152.02 in the course of treatment of an individual for intractable
469.34 pain, provided the physician practitioner keeps accurate records of the purpose, use,

470.1 prescription, and disposal of controlled substances, writes accurate prescriptions, and
470.2 prescribes medications in conformance with the chapter 147 of law under which the
470.3 practitioner is licensed.

470.4 Sec. 20. Minnesota Statutes 2018, section 152.125, subdivision 3, is amended to read:

470.5 Subd. 3. **Limits on applicability.** This section does not apply to:

470.6 (1) a ~~physician's~~ practitioner's treatment of an individual for chemical dependency
470.7 resulting from the use of controlled substances in Schedules II to V of section 152.02;

470.8 (2) the prescription or administration of controlled substances in Schedules II to V of
470.9 section 152.02 to an individual whom the ~~physician~~ practitioner knows to be using the
470.10 controlled substances for nontherapeutic purposes;

470.11 (3) the prescription or administration of controlled substances in Schedules II to V of
470.12 section 152.02 for the purpose of terminating the life of an individual having intractable
470.13 pain; or

470.14 (4) the prescription or administration of a controlled substance in Schedules II to V of
470.15 section 152.02 that is not a controlled substance approved by the United States Food and
470.16 Drug Administration for pain relief.

470.17 Sec. 21. Minnesota Statutes 2018, section 152.125, subdivision 4, is amended to read:

470.18 Subd. 4. **Notice of risks.** Prior to treating an individual for intractable pain in accordance
470.19 with subdivision 2, a ~~physician~~ practitioner shall discuss with the individual the risks
470.20 associated with the controlled substances in Schedules II to V of section 152.02 to be
470.21 prescribed or administered in the course of the ~~physician's~~ practitioner's treatment of an
470.22 individual, and document the discussion in the individual's record.

470.23 Sec. 22. Minnesota Statutes 2018, section 245.4661, is amended by adding a subdivision
470.24 to read:

470.25 Subd. 9a. **Traditional healing grants.** The commissioner shall establish a grant program
470.26 to improve access, coordination, and referral processes for traditional healing in American
470.27 Indian communities across Minnesota. Grants shall be distributed equally to each tribal
470.28 nation and urban American Indian community located in Minnesota.

471.1 Sec. 23. Minnesota Statutes 2018, section 254A.03, subdivision 3, is amended to read:

471.2 Subd. 3. **Rules for substance use disorder care.** (a) The commissioner of human
471.3 services shall establish by rule criteria to be used in determining the appropriate level of
471.4 chemical dependency care for each recipient of public assistance seeking treatment for
471.5 substance misuse or substance use disorder. Upon federal approval of a comprehensive
471.6 assessment as a Medicaid benefit, or on July 1, 2018, whichever is later, and notwithstanding
471.7 the criteria in Minnesota Rules, parts 9530.6600 to 9530.6655, an eligible vendor of
471.8 comprehensive assessments under section 254B.05 may determine and approve the
471.9 appropriate level of substance use disorder treatment for a recipient of public assistance.
471.10 The process for determining an individual's financial eligibility for the consolidated chemical
471.11 dependency treatment fund or determining an individual's enrollment in or eligibility for a
471.12 publicly subsidized health plan is not affected by the individual's choice to access a
471.13 comprehensive assessment for placement.

471.14 (b) The commissioner shall develop and implement a utilization review process for
471.15 publicly funded treatment placements to monitor and review the clinical appropriateness
471.16 and timeliness of all publicly funded placements in treatment.

471.17 (c) If a screen result is positive for alcohol or substance misuse, a brief screening for
471.18 alcohol or substance use disorder that is provided to a recipient of public assistance within
471.19 a primary care clinic, hospital, or other medical setting or school setting establishes medical
471.20 necessity and approval for an initial set of substance use disorder services identified in
471.21 section 254B.05, subdivision 5. The initial set of services approved for a recipient whose
471.22 screen result is positive may include any combination of up to four hours of individual or
471.23 group substance use disorder treatment, two hours of substance use disorder treatment
471.24 coordination, or two hours of substance use disorder peer support services provided by a
471.25 qualified individual according to chapter 245G. A recipient must obtain an assessment
471.26 pursuant to paragraph (a) to be approved for additional treatment services.

471.27 **EFFECTIVE DATE.** Contingent upon federal approval, this section is effective July
471.28 1, 2019. The commissioner of human services shall notify the revisor of statutes when
471.29 federal approval is obtained or denied.

471.30 Sec. 24. **[256.042] OPIOID STEWARDSHIP ADVISORY COUNCIL.**

471.31 Subdivision 1. **Establishment of the advisory council.** (a) The Opioid Stewardship
471.32 Advisory Council is established to develop and implement a comprehensive and effective
471.33 statewide effort to address the opioid addiction and overdose epidemic in Minnesota. The
471.34 council shall focus on:

472.1 (1) prevention and education, including public education and awareness for adults and
472.2 youth, prescriber education, the development and sustainability of opioid overdose prevention
472.3 and education programs, and providing financial support to local law enforcement agencies
472.4 for opiate antagonist programs;

472.5 (2) treatment, including statewide access to effective treatment and recovery services
472.6 that is aligned with Minnesota's model of care approach to promoting access to treatment
472.7 and recovery services. This includes ensuring that individuals throughout the state have
472.8 access to treatment and recovery services, including care coordination services; peer recovery
472.9 services; medication-assisted treatment and office-based opioid treatment; integrative and
472.10 multidisciplinary therapies; and culturally specific services; and

472.11 (3) innovation and capacity building, including development of evidence-based practices
472.12 and using research and evaluation to understand which policies and programs promote
472.13 efficient and effective prevention, treatment, and recovery results. This also includes ensuring
472.14 that there are qualified providers and a comprehensive set of treatment and recovery services
472.15 throughout the state.

472.16 (b) The council shall:

472.17 (1) review local, state, and federal initiatives and funding related to prevention and
472.18 education, treatment, and services for individuals and families experiencing and affected
472.19 by opioid abuse, and promoting innovation and capacity building to address the opioid
472.20 addiction and overdose epidemic;

472.21 (2) establish priorities to address the state's opioid addiction and overdose epidemic for
472.22 the purpose of allocating funds and consult with the commissioner of management and
472.23 budget and the commissioner of human services to determine whether proposals are for
472.24 evidence-based practices, promising practices, or theory-based practices and whether
472.25 proposals align with evidence-based practices for opioid use disorder and co-occurring
472.26 conditions according to the Substance Abuse and Mental Health Services Administration
472.27 and the American Society for Addiction Medicine;

472.28 (3) ensure that available funding under this section is allocated to align with existing
472.29 state and federal funding to achieve the greatest impact and ensure a coordinated state effort
472.30 to address the opioid addiction and overdose epidemic;

472.31 (4) develop criteria and procedures to be used in awarding grants and allocating available
472.32 funds from the opioid stewardship fund and select proposals to receive grant funding. The
472.33 council is encouraged to select proposals that are promising practices or theory-based

473.1 practices, in addition to evidence-based practices, to help identify new approaches to effective
473.2 prevention, treatment, and recovery; and

473.3 (5) in consultation with the commissioner of management and budget, and within
473.4 available appropriations, select from the awarded grants projects that include promising
473.5 practices or theory-based activities for which the commissioner of management and budget
473.6 shall conduct evaluations using experimental or quasi-experimental design with de-identified
473.7 data. Grants awarded to proposals that include promising practices or theory-based activities
473.8 and that are selected for an evaluation shall be administered to support the experimental or
473.9 quasi-experimental evaluation and require grantees to collect and report de-identified data
473.10 that is needed to complete the evaluation. The commissioner of management and budget,
473.11 under section 15.08, may obtain additional relevant de-identified data to support the
473.12 experimental or quasi-experimental evaluation studies that comply with state and federal
473.13 laws and regulations relating to the confidentiality of substance use disorder treatment
473.14 records.

473.15 Subd. 2. **Membership.** (a) The council shall consist of 19 members appointed by the
473.16 commissioner of human services, except as otherwise specified:

473.17 (1) two members of the house of representatives, one from the majority party appointed
473.18 by the speaker of the house and one from the minority party appointed by the minority
473.19 leader;

473.20 (2) two members of the senate, one from the majority party appointed by the senate
473.21 majority leader and one from the minority party appointed by the senate minority leader;

473.22 (3) one member appointed by the Board of Pharmacy;

473.23 (4) one member who is a physician appointed by the Minnesota chapter of the American
473.24 College of Emergency Physicians;

473.25 (5) one member representing opioid treatment programs or other medication-assisted
473.26 treatment programs;

473.27 (6) one member who is a physician appointed by the Minnesota Hospital Association;

473.28 (7) one member who is a physician appointed by the Minnesota Society of Addiction
473.29 Medicine;

473.30 (8) one member who is a pain psychologist;

473.31 (9) one member appointed by a nonprofit organization or by the Steve Rummeler Hope
473.32 Network;

474.1 (10) one member appointed by the Minnesota Ambulance Association;

474.2 (11) one member representing the Minnesota courts who is a judge or law enforcement
474.3 officer;

474.4 (12) two public members who are Minnesota residents and who have been impacted by
474.5 the opioid epidemic;

474.6 (13) two members representing an Indian tribe;

474.7 (14) the commissioner of human services or designee; and

474.8 (15) the commissioner of health or designee.

474.9 (b) The commissioner of human services shall coordinate appointments to provide
474.10 geographic diversity and shall ensure that at least one-half of the council members appointed
474.11 by the commissioner reside outside of the seven-county metropolitan area.

474.12 (c) The council is governed by section 15.059, except that members of the council who
474.13 are receiving compensation for the member's appointed role shall receive no compensation
474.14 other than reimbursement for expenses. Notwithstanding section 15.059, subdivision 6, the
474.15 council shall not expire.

474.16 (d) The chair shall convene the council at least quarterly, and may convene other meetings
474.17 as necessary. The chair shall convene meetings at different locations in the state to provide
474.18 geographic access, and shall ensure that at least one-half of the meetings are held at locations
474.19 outside of the seven-county metropolitan area.

474.20 (e) The commissioner of human services shall provide staff and administrative services
474.21 for the advisory council.

474.22 (f) The council is subject to chapter 13D.

474.23 Subd. 3. **Conflict of interest.** Advisory council members must disclose to the council
474.24 and recuse themselves from voting on any matter before the council if the member has a
474.25 conflict of interest. A conflict of interest means a financial association that has the potential
474.26 to bias or have the appearance of biasing a council member's decision related to the opiate
474.27 epidemic response grant decision process or other council activities under this section.

474.28 Subd. 4. **Council recommendations.** The council shall make recommendations on the
474.29 funds annually appropriated to the commissioner of human services from the opioid
474.30 stewardship fund to be awarded for the upcoming fiscal year.

474.31 Subd. 5. **Grants.** The commissioner of human services shall award grants within
474.32 appropriations from the opioid stewardship fund under section 256.043. The grants shall

475.1 be awarded based on recommendations from the advisory council that address the priorities
475.2 in subdivision 1, paragraph (a), clauses (1) to (3).

475.3 Subd. 6. **Reports.** (a) The commissioner, in consultation with the advisory council, shall
475.4 report annually to the chairs and ranking minority members of the legislative committees
475.5 with jurisdiction over health and human services policy and finance by March 1 of each
475.6 year beginning March 1, 2022, information about the individual projects that receive grants
475.7 and the overall role of the project in addressing the opioid addiction and overdose epidemic
475.8 in Minnesota. The report must describe the grantees and the activities implemented, along
475.9 with measurable outcomes as determined by the council in consultation with the
475.10 commissioner of human services and the commissioner of management and budget. At a
475.11 minimum, the report must include information about the number of individuals who received
475.12 information or treatment, the outcomes the individuals achieved, and demographic
475.13 information about the individuals participating in the project; an assessment of the progress
475.14 toward achieving statewide access to qualified providers and comprehensive treatment and
475.15 recovery services; and an update on the evaluation implemented by the commissioner of
475.16 management and budget for the promising practices and theory-based projects that receive
475.17 funding. Each report must also identify instances in which the commissioner did not follow
475.18 recommendations of the advisory council and the commissioner's rationale for not doing
475.19 so.

475.20 (b) The commissioner of management and budget, in consultation with the Opioid
475.21 Stewardship Advisory Council and the commissioner of human services, shall report to the
475.22 chairs and ranking minority members of the legislative committees with jurisdiction over
475.23 health and human services policy and finance when an evaluation study described in
475.24 subdivision 1, paragraph (b), clause (5), is complete on the promising practices or
475.25 theory-based projects that are selected for evaluation activities. The report shall include
475.26 demographic information; outcome information for the individuals in the program; the
475.27 results for the program in promoting recovery, employment, family reunification, and
475.28 reducing involvement with the criminal justice system; and other relevant outcomes
475.29 determined by the commissioner of management and budget that are specific to the projects
475.30 that are evaluated and must comply with state and federal laws and regulations relating to
475.31 the confidentiality of substance use disorder treatment records. The report shall include
475.32 information about the ability of grant programs to be scaled to achieve the statewide results
475.33 that the grant project demonstrated.

476.1 Sec. 25. [256.043] OPIOID STEWARDSHIP FUND.

476.2 The opioid stewardship fund is established in the state treasury. The registration fees
476.3 assessed by the Board of Pharmacy under section 151.77 and the license fees identified in
476.4 section 151.065, subdivision 3a, shall be deposited into the fund. All interest earnings shall
476.5 be credited to the fund.

476.6 Sec. 26. OPIOID STEWARDSHIP ADVISORY COUNCIL FIRST MEETING.

476.7 The commissioner of human services shall convene the first meeting of the Opioid
476.8 Stewardship Advisory Council established under Minnesota Statutes, section 256.042, no
476.9 later than October 1, 2019. The members shall elect a chair at the first meeting.

476.10 **ARTICLE 11**

476.11 **HEALTH-RELATED LICENSING BOARDS**

476.12 Section 1. [144A.39] FEES.

476.13 Subdivision 1. Nonrefundable fees. All fees are nonrefundable.

476.14 Subd. 2. Amounts. (a) Fees may not exceed the following amounts but may be adjusted
476.15 lower by board direction and are for the exclusive use of the board as required to sustain
476.16 board operations. The maximum amounts of fees are:

476.17 (1) application for licensure, \$200;

476.18 (2) for a prospective applicant for a review of education and experience advisory to the
476.19 license application, \$100, to be applied to the fee for application for licensure if the latter
476.20 is submitted within one year of the request for review of education and experience;

476.21 (3) state examination, \$125;

476.22 (4) initial license, \$250 if issued between July 1 and December 31, \$100 if issued between
476.23 January 1 and June 30;

476.24 (5) acting administrator permit, \$400;

476.25 (6) renewal license, \$250;

476.26 (7) duplicate license, \$50;

476.27 (8) reinstatement fee, \$250;

476.28 (9) health services executive initial license, \$200;

476.29 (10) health services executive renewal license, \$200;

- 477.1 (11) reciprocity verification fee, \$50;
- 477.2 (12) second shared administrator assignment, \$250;
- 477.3 (13) continuing education fees:
- 477.4 (i) greater than 6 hours, \$50; and
- 477.5 (ii) 7 hours or more, \$75;
- 477.6 (14) education review, \$100;
- 477.7 (15) fee to a sponsor for review of individual continuing education seminars, institutes,
477.8 workshops, or home study courses:
- 477.9 (i) for less than seven clock hours, \$30; and
- 477.10 (ii) for seven or more clock hours, \$50;
- 477.11 (16) fee to a licensee for review of continuing education seminars, institutes, workshops,
477.12 or home study courses not previously approved for a sponsor and submitted with an
477.13 application for license renewal:
- 477.14 (i) for less than seven clock hours total, \$30; and
- 477.15 (ii) for seven or more clock hours total, \$50;
- 477.16 (17) late renewal fee, \$75;
- 477.17 (18) fee to a licensee for verification of licensure status and examination scores, \$30;
- 477.18 (19) registration as a registered continuing education sponsor, \$1,000; and
- 477.19 (20) mail labels, \$75.
- 477.20 (b) The revenue generated from the fees must be deposited in an account in the state
477.21 government special revenue fund.
- 477.22 Sec. 2. Minnesota Statutes 2018, section 147D.27, is amended by adding a subdivision to
477.23 read:
- 477.24 Subd. 5. **Additional fees.** (a) The following fees also apply:
- 477.25 (1) traditional midwifery annual registration fee, \$100;
- 477.26 (2) traditional midwifery application fee, \$100;
- 477.27 (3) traditional midwifery late fee, \$75;
- 477.28 (4) traditional midwifery inactive status, \$50;

- 478.1 (5) traditional midwifery temporary permit, \$75;
478.2 (6) traditional midwifery certification fee, \$25;
478.3 (7) duplicate license or registration fee, \$20;
478.4 (8) certification letter, \$25;
478.5 (9) education or training program approval fee, \$100; and
478.6 (10) report creation and generation, \$60 per hour billed in quarter-hour increments with
478.7 a quarter-hour minimum.

478.8 (b) The revenue generated from the fees must be deposited in an account in the state
478.9 government special revenue fund.

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

478.11 Sec. 3. Minnesota Statutes 2018, section 147E.40, subdivision 1, is amended to read:

478.12 Subdivision 1. **Fees.** (a) Fees are as follows:

- 478.13 (1) registration application fee, \$200;
478.14 (2) renewal fee, \$150;
478.15 (3) late fee, \$75;
478.16 (4) inactive status fee, \$50; ~~and~~
478.17 (5) temporary permit fee, \$25;
478.18 (6) naturopathic doctor certification fee, \$25;
478.19 (7) naturopathic doctor duplicate license fee, \$20;
478.20 (8) naturopathic doctor emeritus registration fee, \$50;
478.21 (9) naturopathic doctor certification fee, \$25;
478.22 (10) duplicate license or registration fee, \$20;
478.23 (11) education or training program approval fee, \$100; and
478.24 (12) report creation and generation, \$60 per hour billed in quarter-hour increments with
478.25 a quarter-hour minimum.

478.26 (b) The revenue generated from the fees must be deposited in an account in the state
478.27 government special revenue fund.

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

479.1 Sec. 4. Minnesota Statutes 2018, section 147F.17, subdivision 1, is amended to read:

479.2 Subdivision 1. **Fees.** (a) Fees are as follows:

479.3 (1) license application fee, \$200;

479.4 (2) initial licensure and annual renewal, \$150; ~~and~~

479.5 (3) late fee, \$75₂;

479.6 (4) genetic counselor certification fee, \$25;

479.7 (5) duplicate license fee, \$20;

479.8 (6) education or training program approval fee, \$100; and

479.9 (7) report creation and generation, \$60 per hour billed in quarter-hour increments with

479.10 a quarter-hour minimum.

479.11 (b) The revenue generated from the fees must be deposited in an account in the state

479.12 government special revenue fund.

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

479.14 Sec. 5. Minnesota Statutes 2018, section 148.59, is amended to read:

479.15 **148.59 LICENSE RENEWAL; LICENSE AND REGISTRATION FEES.**

479.16 A licensed optometrist shall pay to the state Board of Optometry a fee as set by the board
479.17 in order to renew a license as provided by board rule. No fees shall be refunded. Fees may
479.18 not exceed the following amounts but may be adjusted lower by board direction and are for
479.19 the exclusive use of the board:

479.20 (1) optometry licensure application, \$160;

479.21 (2) optometry annual licensure renewal, ~~\$135~~ \$200;

479.22 (3) optometry late penalty fee, \$75;

479.23 (4) annual license renewal card, \$10;

479.24 (5) continuing education provider application, \$45;

479.25 (6) emeritus registration, \$10;

479.26 (7) endorsement/reciprocity application, \$160;

479.27 (8) replacement of initial license, \$12; ~~and~~

479.28 (9) license verification, \$50₂;

480.1 (10) state juris prudence examination, \$75; and

480.2 (11) miscellaneous labels and data retrieval, \$50.

480.3 Sec. 6. Minnesota Statutes 2018, section 148.6445, subdivision 1, is amended to read:

480.4 Subdivision 1. **Initial licensure fee.** The initial licensure fee for occupational therapists
480.5 is ~~\$145~~ \$185. The initial licensure fee for occupational therapy assistants is ~~\$80~~ \$105. ~~The~~
480.6 ~~board shall prorate fees based on the number of quarters remaining in the biennial licensure~~
480.7 ~~period.~~

480.8 Sec. 7. Minnesota Statutes 2018, section 148.6445, subdivision 2, is amended to read:

480.9 Subd. 2. **Licensure renewal fee.** The biennial licensure renewal fee for occupational
480.10 therapists is ~~\$145~~ \$185. The biennial licensure renewal fee for occupational therapy assistants
480.11 is ~~\$80~~ \$105.

480.12 Sec. 8. Minnesota Statutes 2018, section 148.6445, subdivision 2a, is amended to read:

480.13 Subd. 2a. **Duplicate license fee.** The fee for a duplicate license is ~~\$25~~ \$30.

480.14 Sec. 9. Minnesota Statutes 2018, section 148.6445, subdivision 3, is amended to read:

480.15 Subd. 3. **Late fee.** The fee for late submission of a renewal application is ~~\$25~~ \$50.

480.16 Sec. 10. Minnesota Statutes 2018, section 148.6445, subdivision 4, is amended to read:

480.17 Subd. 4. **Temporary licensure fee.** The fee for temporary licensure is ~~\$50~~ \$75.

480.18 Sec. 11. Minnesota Statutes 2018, section 148.6445, subdivision 5, is amended to read:

480.19 Subd. 5. **Limited licensure fee.** The fee for limited licensure is ~~\$96~~ \$100.

480.20 Sec. 12. Minnesota Statutes 2018, section 148.6445, subdivision 6, is amended to read:

480.21 Subd. 6. **Fee for course approval after lapse of licensure.** The fee for course approval
480.22 after lapse of licensure is ~~\$96~~ \$100.

480.23 Sec. 13. Minnesota Statutes 2018, section 148.6445, subdivision 10, is amended to read:

480.24 Subd. 10. **Use of fees.** (a) All fees are nonrefundable. The board shall only use fees
480.25 collected under this section for the purposes of administering this chapter. The legislature

481.1 must not transfer money generated by these fees from the state government special revenue
481.2 fund to the general fund.

481.3 (b) Licensure fees are for the exclusive use of the board and shall be established by the
481.4 board not to exceed the nonrefundable amounts in this section.

481.5 Sec. 14. Minnesota Statutes 2018, section 148.7815, subdivision 1, is amended to read:

481.6 Subdivision 1. **Fees.** (a) The board shall establish fees as follows:

481.7 (1) application fee, \$50; ~~and~~

481.8 (2) annual license fee, \$100~~;~~

481.9 (3) athletic trainer certification fee, \$25;

481.10 (4) athletic trainer duplicate license fee, \$20;

481.11 (5) duplicate license or registration fee, \$20;

481.12 (6) education or training program approval fee, \$100;

481.13 (7) report creation and generation, \$60 per hour billed in quarter-hour increments with

481.14 a quarter-hour minimum; and

481.15 (8) examination administrative fee:

481.16 (i) half day, \$50; and

481.17 (ii) full day, \$80.

481.18 (b) The revenue generated from the fees must be deposited in an account in the state

481.19 government special revenue fund.

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

481.21 Sec. 15. **[148.981] FEES.**

481.22 Subdivision 1. **Licensing fees.** The nonrefundable fees for licensure shall be established

481.23 by the board, not to exceed the following amounts:

481.24 (1) application for admission to national standardized examination, \$150;

481.25 (2) application for professional responsibility examination, \$150;

481.26 (3) application for licensure as a licensed psychologist, \$500;

481.27 (4) renewal of license for a licensed psychologist, \$500;

481.28 (5) late renewal of license for a licensed psychologist, \$250;

482.1 (6) application for converting from master's to doctoral level licensure, \$150;

482.2 (7) application for guest licensure, \$150;

482.3 (8) certificate replacement fee, \$25;

482.4 (9) mailing and duplication fee, \$5;

482.5 (10) statute and rule book fee, \$10;

482.6 (11) verification fee, \$20; and

482.7 (12) fee for optional preapproval of postdoctoral supervision, \$50.

482.8 Subd. 2. **Continuing education sponsor fee.** A sponsor applying for approval of a
 482.9 continuing education activity pursuant to Minnesota Rules, part 7200.3830, subpart 2, shall
 482.10 submit with the application a fee to be established by the board, not to exceed \$80 for each
 482.11 activity.

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

482.13 Sec. 16. Minnesota Statutes 2018, section 148E.180, is amended to read:

482.14 **148E.180 FEE AMOUNTS.**

482.15 Subdivision 1. **Application fees.** Nonrefundable application fees for licensure are as
 482.16 follows may not exceed the following amounts but may be adjusted lower by board action:

482.17 (1) for a licensed social worker, ~~\$45~~ \$75;

482.18 (2) for a licensed graduate social worker, ~~\$45~~ \$75;

482.19 (3) for a licensed independent social worker, ~~\$45~~ \$75;

482.20 (4) for a licensed independent clinical social worker, ~~\$45~~ \$75;

482.21 (5) for a temporary license, \$50; and

482.22 (6) for a ~~licensure~~ license by endorsement, ~~\$85~~ \$115.

482.23 The fee for criminal background checks is the fee charged by the Bureau of Criminal
 482.24 Apprehension. The criminal background check fee must be included with the application
 482.25 fee as required according to section 148E.055.

482.26 Subd. 2. **License fees.** Nonrefundable license fees are as follows may not exceed the
 482.27 following amounts but may be adjusted lower by board action:

482.28 (1) for a licensed social worker, ~~\$81~~ \$115;

482.29 (2) for a licensed graduate social worker, ~~\$144~~ \$210;

483.1 (3) for a licensed independent social worker, ~~\$216~~ \$305;

483.2 (4) for a licensed independent clinical social worker, ~~\$238.50~~ \$335;

483.3 (5) for an emeritus inactive license, ~~\$43.20~~ \$65;

483.4 (6) for an emeritus active license, one-half of the renewal fee specified in subdivision

483.5 3; and

483.6 (7) for a temporary leave fee, the same as the renewal fee specified in subdivision 3.

483.7 If the licensee's initial license term is less or more than 24 months, the required license
483.8 fees must be prorated proportionately.

483.9 Subd. 3. **Renewal fees.** Nonrefundable renewal fees for licensure ~~are as follows~~ may
483.10 not exceed the following amounts but may be adjusted lower by board action:

483.11 (1) for a licensed social worker, ~~\$81~~ \$115;

483.12 (2) for a licensed graduate social worker, ~~\$144~~ \$210;

483.13 (3) for a licensed independent social worker, ~~\$216~~ \$305; and

483.14 (4) for a licensed independent clinical social worker, ~~\$238.50~~ \$335.

483.15 Subd. 4. **Continuing education provider fees.** Continuing education provider fees are
483.16 ~~as follows~~ the following nonrefundable amounts:

483.17 (1) for a provider who offers programs totaling one to eight clock hours in a one-year
483.18 period according to section 148E.145, \$50;

483.19 (2) for a provider who offers programs totaling nine to 16 clock hours in a one-year
483.20 period according to section 148E.145, \$100;

483.21 (3) for a provider who offers programs totaling 17 to 32 clock hours in a one-year period
483.22 according to section 148E.145, \$200;

483.23 (4) for a provider who offers programs totaling 33 to 48 clock hours in a one-year period
483.24 according to section 148E.145, \$400; and

483.25 (5) for a provider who offers programs totaling 49 or more clock hours in a one-year
483.26 period according to section 148E.145, \$600.

483.27 Subd. 5. **Late fees.** Late fees are ~~as follows~~ the following nonrefundable amounts:

483.28 (1) renewal late fee, one-fourth of the renewal fee specified in subdivision 3;

483.29 (2) supervision plan late fee, \$40; and

484.1 (3) license late fee, \$100 plus the prorated share of the license fee specified in subdivision
484.2 2 for the number of months during which the individual practiced social work without a
484.3 license.

484.4 Subd. 6. **License cards and wall certificates.** (a) The nonrefundable fee for a license
484.5 card as specified in section 148E.095 is \$10.

484.6 (b) The nonrefundable fee for a license wall certificate as specified in section 148E.095
484.7 is \$30.

484.8 Subd. 7. **Reactivation fees.** Reactivation fees are as follows the following nonrefundable
484.9 amounts:

484.10 (1) reactivation from a temporary leave or emeritus status, the prorated share of the
484.11 renewal fee specified in subdivision 3; and

484.12 (2) reactivation of an expired license, 1-1/2 times the renewal fees specified in subdivision
484.13 3.

484.14 Sec. 17. Minnesota Statutes 2018, section 150A.06, is amended by adding a subdivision
484.15 to read:

484.16 Subd. 10. **Emeritus inactive license.** A person licensed to practice dentistry, dental
484.17 therapy, dental hygiene, or dental assisting pursuant to section 150A.05 or Minnesota Rules,
484.18 part 3100.8500, who retires from active practice in the state may apply to the board for
484.19 emeritus inactive licensure. An application for emeritus inactive licensure may be made on
484.20 the biennial licensing form or by petitioning the board, and the applicant must pay a onetime
484.21 application fee pursuant to section 150A.091, subdivision 19. In order to receive emeritus
484.22 inactive licensure, the applicant must be in compliance with board requirements and cannot
484.23 be the subject of current disciplinary action resulting in suspension, revocation,
484.24 disqualification, condition, or restriction of the licensee to practice dentistry, dental therapy,
484.25 dental hygiene, or dental assisting. An emeritus inactive license is not a license to practice,
484.26 but is a formal recognition of completion of a person's dental career in good standing.

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

484.28 Sec. 18. Minnesota Statutes 2018, section 150A.06, is amended by adding a subdivision
484.29 to read:

484.30 Subd. 11. **Emeritus active licensure.** (a) A person licensed to practice dentistry, dental
484.31 therapy, dental hygiene, or dental assisting may apply for an emeritus active license if the
484.32 person is retired from active practice, is in compliance with board requirements, and is not

485.1 the subject of current disciplinary action resulting in suspension, revocation, disqualification,
485.2 condition, or restriction of the license to practice dentistry, dental therapy, dental hygiene,
485.3 or dental assisting.

485.4 (b) An emeritus active licensee may engage only in the following types of practice:

485.5 (1) pro bono or volunteer dental practice;

485.6 (2) paid practice not to exceed 500 hours per calendar year for the exclusive purpose of
485.7 providing licensing supervision to meet the board's requirements; or

485.8 (3) paid consulting services not to exceed 500 hours per calendar year.

485.9 (c) An emeritus active licensee shall not hold out as a full licensee and may only hold
485.10 out as authorized to practice as described in this subdivision. The board may take disciplinary
485.11 or corrective action against an emeritus active licensee based on violations of applicable
485.12 law or board requirements.

485.13 (d) A person may apply for an emeritus active license by completing an application form
485.14 specified by the board and must pay the application fee pursuant to section 150A.091,
485.15 subdivision 20.

485.16 (e) If an emeritus active license is not renewed every two years, the license expires. The
485.17 renewal date is the same as the licensee's renewal date when the licensee was in active
485.18 practice. In order to renew an emeritus active license, the licensee must:

485.19 (1) complete an application form as specified by the board;

485.20 (2) pay the required renewal fee pursuant to section 150A.091, subdivision 20; and

485.21 (3) report at least 25 continuing education hours completed since the last renewal, which
485.22 must include:

485.23 (i) at least one hour in two different required CORE areas;

485.24 (ii) at least one hour of mandatory infection control;

485.25 (iii) for dentists and dental therapists, at least 15 hours of fundamental credits for dentists
485.26 and dental therapists, and for dental hygienists and dental assistants, at least seven hours of
485.27 fundamental credits; and

485.28 (iv) for dentists and dental therapists, no more than ten elective credits, and for dental
485.29 hygienists and dental assistants, no more than six elective credits.

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

486.1 Sec. 19. Minnesota Statutes 2018, section 150A.091, is amended by adding a subdivision
486.2 to read:

486.3 Subd. 19. **Emeritus inactive license.** An individual applying for emeritus inactive
486.4 licensure under section 150A.06, subdivision 10, must pay a onetime fee of \$50. There is
486.5 no renewal fee for an emeritus inactive license.

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

486.7 Sec. 20. Minnesota Statutes 2018, section 150A.091, is amended by adding a subdivision
486.8 to read:

486.9 Subd. 20. **Emeritus active license.** An individual applying for emeritus active licensure
486.10 under section 150A.06, subdivision 11, must pay a fee upon application and upon renewal
486.11 every two years. The fees for emeritus active license application and renewal are as follows:
486.12 dentist, \$212; dental therapist, \$100; dental hygienist, \$75; and dental assistant, \$55.

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

486.14 Sec. 21. Minnesota Statutes 2018, section 151.065, subdivision 1, is amended to read:

486.15 Subdivision 1. **Application fees.** Application fees for licensure and registration are as
486.16 follows:

486.17 (1) pharmacist licensed by examination, ~~\$145~~ \$175;

486.18 (2) pharmacist licensed by reciprocity, ~~\$240~~ \$275;

486.19 (3) pharmacy intern, ~~\$37.50~~ \$50;

486.20 (4) pharmacy technician, ~~\$37.50~~ \$50;

486.21 (5) pharmacy, ~~\$225~~ \$260;

486.22 (6) drug wholesaler, legend drugs only, ~~\$235~~ \$260;

486.23 (7) drug wholesaler, legend and nonlegend drugs, ~~\$235~~ \$260;

486.24 (8) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, ~~\$210~~ \$260;

486.25 (9) drug wholesaler, medical gases, ~~\$175~~ \$260;

486.26 (10) drug wholesaler, also licensed as a pharmacy in Minnesota, ~~\$150~~ \$260;

486.27 (11) drug manufacturer, legend drugs only, ~~\$235~~ \$260;

486.28 (12) drug manufacturer, legend and nonlegend drugs, ~~\$235~~ \$260;

- 487.1 (13) drug manufacturer, nonlegend or veterinary legend drugs, ~~\$210~~ \$260;
- 487.2 (14) drug manufacturer, medical gases, ~~\$185~~ \$260;
- 487.3 (15) drug manufacturer, also licensed as a pharmacy in Minnesota, ~~\$150~~ \$260;
- 487.4 (16) medical gas distributor, ~~\$110~~ \$260; and
- 487.5 ~~(17) controlled substance researcher, \$75; and~~
- 487.6 ~~(18)~~ (17) pharmacy professional corporation, ~~\$125~~ \$150.

487.7 Sec. 22. Minnesota Statutes 2018, section 151.065, subdivision 2, is amended to read:

487.8 Subd. 2. **Original license fee.** The pharmacist original licensure fee, ~~\$145~~ \$175.

487.9 Sec. 23. Minnesota Statutes 2018, section 151.065, subdivision 3, is amended to read:

487.10 Subd. 3. **Annual renewal fees.** Annual licensure and registration renewal fees are as
487.11 follows:

- 487.12 (1) pharmacist, ~~\$145~~ \$175;
- 487.13 (2) pharmacy technician, ~~\$37.50~~ \$50;
- 487.14 (3) pharmacy, ~~\$225~~ \$260;
- 487.15 (4) drug wholesaler, legend drugs only, ~~\$235~~ \$260;
- 487.16 (5) drug wholesaler, legend and nonlegend drugs, ~~\$235~~ \$260;
- 487.17 (6) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, ~~\$210~~ \$260;
- 487.18 (7) drug wholesaler, medical gases, ~~\$185~~ \$260;
- 487.19 (8) drug wholesaler, also licensed as a pharmacy in Minnesota, ~~\$150~~ \$260;
- 487.20 (9) drug manufacturer, legend drugs only, ~~\$235~~ \$260;
- 487.21 (10) drug manufacturer, legend and nonlegend drugs, ~~\$235~~ \$260;
- 487.22 (11) drug manufacturer, nonlegend, veterinary legend drugs, or both, ~~\$210~~ \$260;
- 487.23 (12) drug manufacturer, medical gases, ~~\$185~~ \$260;
- 487.24 (13) drug manufacturer, also licensed as a pharmacy in Minnesota, ~~\$150~~ \$260;
- 487.25 (14) medical gas distributor, ~~\$110~~ \$260; and
- 487.26 ~~(15) controlled substance researcher, \$75; and~~
- 487.27 ~~(16)~~ (15) pharmacy professional corporation, ~~\$75~~ \$100.

488.1 Sec. 24. Minnesota Statutes 2018, section 151.065, subdivision 6, is amended to read:

488.2 Subd. 6. **Reinstatement fees.** (a) A pharmacist who has allowed the pharmacist's license
488.3 to lapse may reinstate the license with board approval and upon payment of any fees and
488.4 late fees in arrears, up to a maximum of \$1,000.

488.5 (b) A pharmacy technician who has allowed the technician's registration to lapse may
488.6 reinstate the registration with board approval and upon payment of any fees and late fees
488.7 in arrears, up to a maximum of \$90.

488.8 (c) An owner of a pharmacy, a drug wholesaler, a drug manufacturer, or a medical gas
488.9 distributor who has allowed the license of the establishment to lapse may reinstate the license
488.10 with board approval and upon payment of any fees and late fees in arrears.

488.11 (d) A controlled substance ~~researcher~~ registrant who has allowed ~~the researcher's a~~
488.12 registration issued pursuant to subdivision 4 to lapse may reinstate the registration with
488.13 board approval and upon payment of any fees and late fees in arrears.

488.14 (e) A pharmacist owner of a professional corporation who has allowed the corporation's
488.15 registration to lapse may reinstate the registration with board approval and upon payment
488.16 of any fees and late fees in arrears.

488.17 Sec. 25. **REPEALER.**

488.18 Minnesota Rules, parts 6400.6970; 7200.6100; and 7200.6105, are repealed.

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

488.20

ARTICLE 12

488.21

HEALTH DEPARTMENT

488.22 Section 1. Minnesota Statutes 2018, section 144.3831, subdivision 1, is amended to read:

488.23 Subdivision 1. **Fee setting.** The commissioner of health may assess an annual fee of
488.24 ~~\$6.36~~ \$9.72 for every service connection to a public water supply that is owned or operated
488.25 by a home rule charter city, a statutory city, a city of the first class, or a town. The
488.26 commissioner of health may also assess an annual fee for every service connection served
488.27 by a water user district defined in section 110A.02.

488.28 **EFFECTIVE DATE.** This section is effective January 1, 2020.

489.1 **Sec. 2. [144.397] STATEWIDE TOBACCO CESSATION SERVICES.**

489.2 (a) The commissioner of health shall administer, or contract for the administration of,
489.3 statewide tobacco cessation services to assist Minnesotans who are seeking advice or services
489.4 to help them quit using tobacco products. The commissioner shall establish statewide public
489.5 awareness activities to inform the public of the availability of the services and encourage
489.6 the public to utilize the services because of the dangers and harm of tobacco use and
489.7 dependence.

489.8 (b) Services to be provided may include but are not limited to:

489.9 (1) telephone-based coaching and counseling;

489.10 (2) referrals;

489.11 (3) written materials mailed upon request;

489.12 (4) web-based texting or e-mail services; and

489.13 (5) free Food and Drug Administration-approved tobacco cessation medications.

489.14 (c) Services provided must be consistent with evidence-based best practices in tobacco
489.15 cessation services. Services provided must be coordinated with health plan company tobacco
489.16 prevention and cessation services that may be available to individuals depending on their
489.17 health coverage.

489.18 **Sec. 3. [145.9275] COMMUNITY-BASED OPIOID AND OTHER DRUG ABUSE**
489.19 **PREVENTION; PILOT GRANT PROGRAM.**

489.20 Subdivision 1. **Community pilot prevention projects.** To the extent funds are
489.21 appropriated for the purposes of this subdivision, the commissioner shall establish a grant
489.22 program to fund community opioid abuse prevention pilot grants to reduce emergency room
489.23 and other health care provider visits resulting from opioid use or abuse and to reduce rates
489.24 of opioid addiction in the community using the following six activities:

489.25 (1) establishing multidisciplinary controlled substance care teams that may consist of
489.26 physicians, pharmacists, social workers, nurse care coordinators, and mental health
489.27 professionals;

489.28 (2) delivering health care services and care coordination, through controlled substance
489.29 care teams, to reduce the inappropriate use of opioids by patients and rates of opioid
489.30 addiction;

490.1 (3) addressing any unmet social services needs that create barriers to managing pain
 490.2 effectively and obtaining optimal health outcomes;

490.3 (4) providing prescriber and dispenser education and assistance to reduce the inappropriate
 490.4 prescribing and dispensing of opioids;

490.5 (5) promoting the adoption of best practices related to opioid disposal and reducing
 490.6 opportunities for illegal access to opioids; and

490.7 (6) engaging partners outside of the health care system, including schools, law
 490.8 enforcement, and social services, to address root causes of opioid abuse and addiction at
 490.9 the community level.

490.10 Subd. 2. **Culture as health; preventing disparities.** To the extent funds are appropriated
 490.11 for the purposes of this subdivision, the commissioner shall establish a grant program to
 490.12 fund organizations working directly with African Americans, urban American Indians, and
 490.13 Minnesota's 11 Tribal Nations. For grants to Tribal Nations, the tribal governments shall
 490.14 determine how to best use allocated funds to address and prevent substance use disorder
 490.15 and overdoses within their communities.

490.16 Sec. 4. **[145.9285] COMMUNITY SOLUTIONS FOR HEALTHY CHILD**
 490.17 **DEVELOPMENT GRANT PROGRAM.**

490.18 Subdivision 1. **Establishment.** The commissioner shall establish the community solutions
 490.19 for healthy child development grant program. The purpose of the program is to:

490.20 (1) improve child development outcomes as related to the well-being of children of color
 490.21 and American Indian children from prenatal to grade 3 and their families, including but not
 490.22 limited to the goals outlined by the Department of Human Service's early childhood systems
 490.23 reform effort: early learning; health and well-being; economic security; and safe, stable,
 490.24 nurturing relationships and environments by funding community-based solutions for
 490.25 challenges that are identified by the affected community;

490.26 (2) reduce racial disparities in children's health and development, from prenatal to grade
 490.27 3; and

490.28 (3) promote racial and geographic equity.

490.29 Subd. 2. **Commissioner's duties.** The commissioner of health shall:

490.30 (1) develop a request for proposals for the healthy child development grant program in
 490.31 consultation with the Community Solutions Advisory Council;

491.1 (2) provide outreach, technical assistance, and program development support to increase
491.2 capacity for new and existing service providers in order to better meet statewide needs,
491.3 particularly in greater Minnesota and areas where services to reduce health disparities have
491.4 not been established;

491.5 (3) review responses to requests for proposals, in consultation with the Community
491.6 Solutions Advisory Council, and award grants under this section;

491.7 (4) ensure communication with the ethnic councils, Minnesota Indian Affairs Council,
491.8 and the governor's early learning council on the request for proposal process;

491.9 (5) establish a transparent and objective accountability process, in consultation with the
491.10 Community Solutions Advisory Council, focused on outcomes that grantees agree to achieve;

491.11 (6) provide grantees with access to data to assist grantees in establishing and
491.12 implementing effective community-led solutions;

491.13 (7) maintain data on outcomes reported by grantees; and

491.14 (8) contract with an independent third-party entity to evaluate the success of the grant
491.15 program and to build the evidence base for effective community solutions in reducing health
491.16 disparities of children of color and American Indian children from prenatal to grade 3.

491.17 **Subd. 3. Community Solutions Advisory Council; establishment; duties;**
491.18 **compensation.** (a) No later than October 1, 2019, the commissioner shall convene a
491.19 12-member Community Solutions Advisory Council as follows:

491.20 (1) two members representing the African Heritage community;

491.21 (2) two members representing the Latino community;

491.22 (3) two members representing the Asian-Pacific Islander community;

491.23 (4) two members representing the American Indian community;

491.24 (5) two parents of children of color or that are American Indian with children under nine
491.25 years of age;

491.26 (6) one member with research or academic expertise in racial equity and healthy child
491.27 development; and

491.28 (7) one member representing an organization that advocates on behalf of communities
491.29 of color or American Indians.

491.30 (b) At least three of the 12 members of the advisory council must come from outside
491.31 the seven-county metropolitan area.

492.1 (c) The Community Solutions Advisory Council shall:

492.2 (1) advise the commissioner on the development of the request for proposals for
 492.3 community solutions healthy child development grants. In advising the commissioner, the
 492.4 council must consider how to build on the capacity of communities to promote child and
 492.5 family well-being and address social determinants of healthy child development;

492.6 (2) review responses to requests for proposals and advise the commissioner on the
 492.7 selection of grantees and grant awards;

492.8 (3) advise the commissioner on the establishment of a transparent and objective
 492.9 accountability process focused on outcomes the grantees agree to achieve;

492.10 (4) advise the commissioner on ongoing oversight and necessary support in the
 492.11 implementation of the program; and

492.12 (5) support the commissioner on other racial equity and early childhood grant efforts.

492.13 (d) Each advisory council member shall be compensated in accordance with section
 492.14 15.059, subdivision 3.

492.15 Subd. 4. **Eligible grantees.** Organizations eligible to receive grant funding under this
 492.16 section include:

492.17 (1) organizations or entities that work with communities of color and American Indian
 492.18 communities;

492.19 (2) tribal nations and tribal organizations as defined in section 658P of the Child Care
 492.20 and Development Block Grant Act of 1990; and

492.21 (3) organizations or entities focused on supporting healthy child development.

492.22 Subd. 5. **Strategic consideration and priority of proposals; eligible populations;**

492.23 **grant awards.** (a) The commissioner, in consultation with the Community Solutions
 492.24 Advisory Council, shall develop a request for proposals for healthy child development
 492.25 grants. In developing the proposals and awarding the grants, the commissioner shall consider
 492.26 building on the capacity of communities to promote child and family well-being and address
 492.27 social determinants of healthy child development. Proposals must focus on increasing racial
 492.28 equity and healthy child development and reducing health disparities experienced by children
 492.29 of color and American Indian children from prenatal to grade 3 and their families.

492.30 (b) In awarding the grants, the commissioner shall provide strategic consideration and
 492.31 give priority to proposals from:

492.32 (1) organizations or entities led by people of color and serving communities of color;

493.1 (2) organizations or entities led by American Indians and serving American Indians,
 493.2 including tribal nations and tribal organizations;

493.3 (3) organizations or entities with proposals focused on healthy development from prenatal
 493.4 to age three;

493.5 (4) organizations or entities with proposals focusing on multigenerational solutions;

493.6 (5) organizations or entities located in or with proposals to serve communities located
 493.7 in counties that are moderate to high risk according to the Wilder Research Risk and Reach
 493.8 Report; and

493.9 (6) community-based organizations that have historically served communities of color
 493.10 and American Indians and have not traditionally had access to state grant funding.

493.11 The advisory council may recommend additional strategic considerations and priorities to
 493.12 the commissioner.

493.13 (c) The first round of grants must be awarded no later than April 15, 2020.

493.14 Subd. 6. **Geographic distribution of grants.** The commissioner and the advisory council
 493.15 shall ensure that grant funds are prioritized and awarded to organizations and entities that
 493.16 are within counties that have a higher proportion of people of color and American Indians
 493.17 than the state average, to the extent possible.

493.18 Subd. 7. **Report.** Grantees must report grant program outcomes to the commissioner on
 493.19 the forms and according to the timelines established by the commissioner.

493.20 Sec. 5. Minnesota Statutes 2018, section 152.22, subdivision 13, is amended to read:

493.21 Subd. 13. **Registry verification.** "Registry verification" means the verification provided
 493.22 by the commissioner that a patient is enrolled in the registry program and that includes the
 493.23 patient's name, registry number, and qualifying medical condition and, if applicable, the
 493.24 name of the patient's registered designated caregiver or parent or, legal guardian, or spouse.

493.25 Sec. 6. Minnesota Statutes 2018, section 152.25, subdivision 1c, is amended to read:

493.26 Subd. 1c. **Notice to patients.** Upon the revocation or nonrenewal of a manufacturer's
 493.27 registration under subdivision 1a or implementation of an enforcement action under
 493.28 subdivision 1b that may affect the ability of a registered patient, registered designated
 493.29 caregiver, or a registered patient's parent or, legal guardian, or spouse to obtain medical
 493.30 cannabis from the manufacturer subject to the enforcement action, the commissioner shall
 493.31 notify in writing each registered patient and the patient's registered designated caregiver or

494.1 registered patient's parent ~~or~~, legal guardian, or spouse about the outcome of the proceeding
494.2 and information regarding alternative registered manufacturers. This notice must be provided
494.3 two or more business days prior to the effective date of the revocation, nonrenewal, or other
494.4 enforcement action.

494.5 Sec. 7. Minnesota Statutes 2018, section 152.27, subdivision 3, is amended to read:

494.6 Subd. 3. **Patient application.** (a) The commissioner shall develop a patient application
494.7 for enrollment into the registry program. The application shall be available to the patient
494.8 and given to health care practitioners in the state who are eligible to serve as health care
494.9 practitioners. The application must include:

494.10 (1) the name, mailing address, and date of birth of the patient;

494.11 (2) the name, mailing address, and telephone number of the patient's health care
494.12 practitioner;

494.13 (3) the name, mailing address, and date of birth of the patient's designated caregiver, if
494.14 any, or the patient's parent ~~or~~, legal guardian, or spouse if the parent ~~or~~, legal guardian, or
494.15 spouse will be acting as a caregiver;

494.16 (4) a copy of the certification from the patient's health care practitioner that is dated
494.17 within 90 days prior to submitting the application which certifies that the patient has been
494.18 diagnosed with a qualifying medical condition and, if applicable, that, in the health care
494.19 practitioner's medical opinion, the patient is developmentally or physically disabled and,
494.20 as a result of that disability, the patient is unable to self-administer medication or acquire
494.21 medical cannabis from a distribution facility; and

494.22 (5) all other signed affidavits and enrollment forms required by the commissioner under
494.23 sections 152.22 to 152.37, including, but not limited to, the disclosure form required under
494.24 paragraph (c).

494.25 (b) The commissioner shall require a patient to resubmit a copy of the certification from
494.26 the patient's health care practitioner on a yearly basis and shall require that the recertification
494.27 be dated within 90 days of submission.

494.28 (c) The commissioner shall develop a disclosure form and require, as a condition of
494.29 enrollment, all patients to sign a copy of the disclosure. The disclosure must include:

494.30 (1) a statement that, notwithstanding any law to the contrary, the commissioner, or an
494.31 employee of any state agency, may not be held civilly or criminally liable for any injury,

495.1 loss of property, personal injury, or death caused by any act or omission while acting within
495.2 the scope of office or employment under sections 152.22 to 152.37; and

495.3 (2) the patient's ~~acknowledgement~~ acknowledgment that enrollment in the patient registry
495.4 program is conditional on the patient's agreement to meet all of the requirements of sections
495.5 152.22 to 152.37.

495.6 Sec. 8. Minnesota Statutes 2018, section 152.27, subdivision 4, is amended to read:

495.7 Subd. 4. **Registered designated caregiver.** (a) The commissioner shall register a
495.8 designated caregiver for a patient if the patient's health care practitioner has certified that
495.9 the patient, in the health care practitioner's medical opinion, is developmentally or physically
495.10 disabled and, as a result of that disability, the patient is unable to self-administer medication
495.11 or acquire medical cannabis from a distribution facility and the caregiver has agreed, in
495.12 writing, to be the patient's designated caregiver. As a condition of registration as a designated
495.13 caregiver, the commissioner shall require the person to:

495.14 (1) be at least 21 years of age;

495.15 (2) agree to only possess any medical cannabis for purposes of assisting the patient; and

495.16 (3) agree that if the application is approved, the person will not be a registered designated
495.17 caregiver for more than one patient, unless the patients reside in the same residence.

495.18 (b) The commissioner shall conduct a criminal background check on the designated
495.19 caregiver prior to registration to ensure that the person does not have a conviction for a
495.20 disqualifying felony offense. Any cost of the background check shall be paid by the person
495.21 seeking registration as a designated caregiver. A designated caregiver must have the criminal
495.22 background check renewed every two years.

495.23 Sec. 9. Minnesota Statutes 2018, section 152.27, subdivision 5, is amended to read:

495.24 Subd. 5. **Parents ~~or~~, legal guardians, and spouses.** A parent ~~or~~, legal guardian, or
495.25 spouse of a patient may act as the caregiver to the patient without having to register as a
495.26 designated caregiver. The parent ~~or~~, legal guardian, or spouse shall follow all of the
495.27 requirements of parents ~~and~~, legal guardians, and spouses listed in sections 152.22 to 152.37.
495.28 Nothing in sections 152.22 to 152.37 limits any legal authority a parent ~~or~~, legal guardian,
495.29 or spouse may have for the patient under any other law.

496.1 Sec. 10. Minnesota Statutes 2018, section 152.27, subdivision 6, is amended to read:

496.2 Subd. 6. **Patient enrollment.** (a) After receipt of a patient's application, application fees,
496.3 and signed disclosure, the commissioner shall enroll the patient in the registry program and
496.4 issue the patient and patient's registered designated caregiver or parent ~~or~~ legal guardian,
496.5 or spouse, if applicable, a registry verification. The commissioner shall approve or deny a
496.6 patient's application for participation in the registry program within 30 days after the
496.7 commissioner receives the patient's application and application fee. The commissioner may
496.8 approve applications up to 60 days after the receipt of a patient's application and application
496.9 fees until January 1, 2016. A patient's enrollment in the registry program shall only be
496.10 denied if the patient:

496.11 (1) does not have certification from a health care practitioner that the patient has been
496.12 diagnosed with a qualifying medical condition;

496.13 (2) has not signed and returned the disclosure form required under subdivision 3,
496.14 paragraph (c), to the commissioner;

496.15 (3) does not provide the information required;

496.16 (4) has previously been removed from the registry program for violations of section
496.17 152.30 or 152.33; or

496.18 (5) provides false information.

496.19 (b) The commissioner shall give written notice to a patient of the reason for denying
496.20 enrollment in the registry program.

496.21 (c) Denial of enrollment into the registry program is considered a final decision of the
496.22 commissioner and is subject to judicial review under the Administrative Procedure Act
496.23 pursuant to chapter 14.

496.24 (d) A patient's enrollment in the registry program may only be revoked upon the death
496.25 of the patient or if a patient violates a requirement under section 152.30 or 152.33.

496.26 (e) The commissioner shall develop a registry verification to provide to the patient, the
496.27 health care practitioner identified in the patient's application, and to the manufacturer. The
496.28 registry verification shall include:

496.29 (1) the patient's name and date of birth;

496.30 (2) the patient registry number assigned to the patient;

496.31 (3) the patient's qualifying medical condition as provided by the patient's health care
496.32 practitioner in the certification; and

497.1 (4) the name and date of birth of the patient's registered designated caregiver, if any, or
497.2 the name of the patient's parent ~~or~~₂ legal guardian, or spouse if the parent ~~or~~₂ legal guardian,
497.3 or spouse will be acting as a caregiver.

497.4 Sec. 11. Minnesota Statutes 2018, section 152.28, subdivision 1, is amended to read:

497.5 Subdivision 1. **Health care practitioner duties.** (a) Prior to a patient's enrollment in
497.6 the registry program, a health care practitioner shall:

497.7 (1) determine, in the health care practitioner's medical judgment, whether a patient suffers
497.8 from a qualifying medical condition, and, if so determined, provide the patient with a
497.9 certification of that diagnosis;

497.10 (2) determine whether a patient is developmentally or physically disabled and, as a result
497.11 of that disability, the patient is unable to self-administer medication or acquire medical
497.12 cannabis from a distribution facility, and, if so determined, include that determination on
497.13 the patient's certification of diagnosis;

497.14 (3) advise patients, registered designated caregivers, and parents ~~or~~₂ legal guardians, or
497.15 spouses who are acting as caregivers of the existence of any nonprofit patient support groups
497.16 or organizations;

497.17 (4) provide explanatory information from the commissioner to patients with qualifying
497.18 medical conditions, including disclosure to all patients about the experimental nature of
497.19 therapeutic use of medical cannabis; the possible risks, benefits, and side effects of the
497.20 proposed treatment; the application and other materials from the commissioner; and provide
497.21 patients with the Tennessen warning as required by section 13.04, subdivision 2; and

497.22 (5) agree to continue treatment of the patient's qualifying medical condition and report
497.23 medical findings to the commissioner.

497.24 (b) Upon notification from the commissioner of the patient's enrollment in the registry
497.25 program, the health care practitioner shall:

497.26 (1) participate in the patient registry reporting system under the guidance and supervision
497.27 of the commissioner;

497.28 (2) report health records of the patient throughout the ongoing treatment of the patient
497.29 to the commissioner in a manner determined by the commissioner and in accordance with
497.30 subdivision 2;

497.31 (3) determine, on a yearly basis, if the patient continues to suffer from a qualifying
497.32 medical condition and, if so, issue the patient a new certification of that diagnosis; and

498.1 (4) otherwise comply with all requirements developed by the commissioner.

498.2 (c) Nothing in this section requires a health care practitioner to participate in the registry
498.3 program.

498.4 Sec. 12. Minnesota Statutes 2018, section 152.29, subdivision 3, is amended to read:

498.5 Subd. 3. **Manufacturer; distribution.** (a) A manufacturer shall require that employees
498.6 licensed as pharmacists pursuant to chapter 151 be the only employees to give final approval
498.7 for the distribution of medical cannabis to a patient.

498.8 (b) A manufacturer may dispense medical cannabis products, whether or not the products
498.9 have been manufactured by the manufacturer, but is not required to dispense medical cannabis
498.10 products.

498.11 (c) Prior to distribution of any medical cannabis, the manufacturer shall:

498.12 (1) verify that the manufacturer has received the registry verification from the
498.13 commissioner for that individual patient;

498.14 (2) verify that the person requesting the distribution of medical cannabis is the patient,
498.15 the patient's registered designated caregiver, or the patient's parent ~~or~~ legal guardian, or
498.16 spouse listed in the registry verification using the procedures described in section 152.11,
498.17 subdivision 2d;

498.18 (3) assign a tracking number to any medical cannabis distributed from the manufacturer;

498.19 (4) ensure that any employee of the manufacturer licensed as a pharmacist pursuant to
498.20 chapter 151 has consulted with the patient to determine the proper dosage for the individual
498.21 patient after reviewing the ranges of chemical compositions of the medical cannabis and
498.22 the ranges of proper dosages reported by the commissioner. For purposes of this clause, a
498.23 consultation may be conducted remotely using a videoconference, so long as the employee
498.24 providing the consultation is able to confirm the identity of the patient, the consultation
498.25 occurs while the patient is at a distribution facility, and the consultation adheres to patient
498.26 privacy requirements that apply to health care services delivered through telemedicine;

498.27 (5) properly package medical cannabis in compliance with the United States Poison
498.28 Prevention Packing Act regarding child-resistant packaging and exemptions for packaging
498.29 for elderly patients, and label distributed medical cannabis with a list of all active ingredients
498.30 and individually identifying information, including:

498.31 (i) the patient's name and date of birth;

499.1 (ii) the name and date of birth of the patient's registered designated caregiver or, if listed
499.2 on the registry verification, the name of the patient's parent ~~or~~, legal guardian, or spouse, if
499.3 applicable;

499.4 (iii) the patient's registry identification number;

499.5 (iv) the chemical composition of the medical cannabis; and

499.6 (v) the dosage; and

499.7 (6) ensure that the medical cannabis distributed contains a maximum of a 30-day supply
499.8 of the dosage determined for that patient.

499.9 (d) A manufacturer shall require any employee of the manufacturer who is transporting
499.10 medical cannabis or medical cannabis products to a distribution facility to carry identification
499.11 showing that the person is an employee of the manufacturer.

499.12 Sec. 13. Minnesota Statutes 2018, section 152.32, subdivision 2, is amended to read:

499.13 Subd. 2. **Criminal and civil protections.** (a) Subject to section 152.23, the following
499.14 are not violations under this chapter:

499.15 (1) use or possession of medical cannabis or medical cannabis products by a patient
499.16 enrolled in the registry program, or possession by a registered designated caregiver or the
499.17 parent ~~or~~, legal guardian, or spouse of a patient if the parent ~~or~~, legal guardian, or spouse
499.18 is listed on the registry verification;

499.19 (2) possession, dosage determination, or sale of medical cannabis or medical cannabis
499.20 products by a medical cannabis manufacturer, employees of a manufacturer, a laboratory
499.21 conducting testing on medical cannabis, or employees of the laboratory; and

499.22 (3) possession of medical cannabis or medical cannabis products by any person while
499.23 carrying out the duties required under sections 152.22 to 152.37.

499.24 (b) Medical cannabis obtained and distributed pursuant to sections 152.22 to 152.37 and
499.25 associated property is not subject to forfeiture under sections 609.531 to 609.5316.

499.26 (c) The commissioner, the commissioner's staff, the commissioner's agents or contractors,
499.27 and any health care practitioner are not subject to any civil or disciplinary penalties by the
499.28 Board of Medical Practice, the Board of Nursing, or by any business, occupational, or
499.29 professional licensing board or entity, solely for the participation in the registry program
499.30 under sections 152.22 to 152.37. A pharmacist licensed under chapter 151 is not subject to
499.31 any civil or disciplinary penalties by the Board of Pharmacy when acting in accordance

500.1 with the provisions of sections 152.22 to 152.37. Nothing in this section affects a professional
500.2 licensing board from taking action in response to violations of any other section of law.

500.3 (d) Notwithstanding any law to the contrary, the commissioner, the governor of
500.4 Minnesota, or an employee of any state agency may not be held civilly or criminally liable
500.5 for any injury, loss of property, personal injury, or death caused by any act or omission
500.6 while acting within the scope of office or employment under sections 152.22 to 152.37.

500.7 (e) Federal, state, and local law enforcement authorities are prohibited from accessing
500.8 the patient registry under sections 152.22 to 152.37 except when acting pursuant to a valid
500.9 search warrant.

500.10 (f) Notwithstanding any law to the contrary, neither the commissioner nor a public
500.11 employee may release data or information about an individual contained in any report,
500.12 document, or registry created under sections 152.22 to 152.37 or any information obtained
500.13 about a patient participating in the program, except as provided in sections 152.22 to 152.37.

500.14 (g) No information contained in a report, document, or registry or obtained from a patient
500.15 under sections 152.22 to 152.37 may be admitted as evidence in a criminal proceeding
500.16 unless independently obtained or in connection with a proceeding involving a violation of
500.17 sections 152.22 to 152.37.

500.18 (h) Notwithstanding section 13.09, any person who violates paragraph (e) or (f) is guilty
500.19 of a gross misdemeanor.

500.20 (i) An attorney may not be subject to disciplinary action by the Minnesota Supreme
500.21 Court or professional responsibility board for providing legal assistance to prospective or
500.22 registered manufacturers or others related to activity that is no longer subject to criminal
500.23 penalties under state law pursuant to sections 152.22 to 152.37.

500.24 (j) Possession of a registry verification or application for enrollment in the program by
500.25 a person entitled to possess or apply for enrollment in the registry program does not constitute
500.26 probable cause or reasonable suspicion, nor shall it be used to support a search of the person
500.27 or property of the person possessing or applying for the registry verification, or otherwise
500.28 subject the person or property of the person to inspection by any governmental agency.

500.29 Sec. 14. Minnesota Statutes 2018, section 152.33, subdivision 1, is amended to read:

500.30 Subdivision 1. **Intentional diversion; criminal penalty.** In addition to any other
500.31 applicable penalty in law, a manufacturer or an agent of a manufacturer who intentionally
500.32 transfers medical cannabis to a person other than a patient, a registered designated caregiver
500.33 or, if listed on the registry verification, a parent ~~or~~ legal guardian, or spouse of a patient is

501.1 guilty of a felony punishable by imprisonment for not more than two years or by payment
501.2 of a fine of not more than \$3,000, or both. A person convicted under this subdivision may
501.3 not continue to be affiliated with the manufacturer and is disqualified from further
501.4 participation under sections 152.22 to 152.37.

501.5 Sec. 15. Minnesota Statutes 2018, section 152.33, subdivision 2, is amended to read:

501.6 Subd. 2. **Diversion by patient, registered designated caregiver, ~~or parent, legal~~**
501.7 **guardian, or patient's spouse; criminal penalty.** In addition to any other applicable penalty
501.8 in law, a patient, registered designated caregiver or, if listed on the registry verification, a
501.9 parent ~~or~~, legal guardian, or spouse of a patient who intentionally sells or otherwise transfers
501.10 medical cannabis to a person other than a patient, designated registered caregiver or, if listed
501.11 on the registry verification, a parent ~~or~~, legal guardian, or spouse of a patient is guilty of a
501.12 felony punishable by imprisonment for not more than two years or by payment of a fine of
501.13 not more than \$3,000, or both.

501.14 Sec. 16. Minnesota Statutes 2018, section 214.25, subdivision 2, is amended to read:

501.15 Subd. 2. **Commissioner of health data.** ~~(a)~~ All data collected or maintained as part of
501.16 the commissioner of health's duties under Minnesota Statutes 2018, sections 214.19, 214.23,
501.17 and 214.24, shall be classified as investigative data under section 13.39, except that inactive
501.18 investigative data shall be classified as private data under section 13.02, subdivision 12, or
501.19 nonpublic data under section 13.02, subdivision 9, in the case of data not on individuals.

501.20 ~~(b) Notwithstanding section 13.05, subdivision 9, data addressed in this subdivision~~
501.21 ~~shall not be disclosed except as provided in this subdivision or section 13.04; except that~~
501.22 ~~the commissioner may disclose to the boards under section 214.23.~~

501.23 ~~(c) The commissioner may disclose data addressed under this subdivision as necessary:~~
501.24 ~~to identify, establish, implement, and enforce a monitoring plan; to investigate a regulated~~
501.25 ~~person; to alert persons who may be threatened by illness as evidenced by epidemiologic~~
501.26 ~~data; to control or prevent the spread of HIV, HBV, or HCV disease; or to diminish an~~
501.27 ~~imminent threat to the public health.~~

501.28 **EFFECTIVE DATE.** This section is effective on January 1, 2020, and no new cases
501.29 shall be investigated under this subdivision after June 1, 2019.

502.1 Sec. 17. **REVISOR INSTRUCTION.**

502.2 The revisor of statutes shall correct any internal cross-references to sections 214.17 to
502.3 214.25 that occur as a result of the repealed language and may make changes necessary to
502.4 correct punctuation, grammar, or structure of the remaining text and preserve its meaning.

502.5 Sec. 18. **REPEALER.**

502.6 Minnesota Statutes 2018, sections 214.17; 214.18; 214.19; 214.20; 214.21; 214.22;
502.7 214.23; and 214.24, are repealed on January 1, 2020, and no new cases shall be investigated
502.8 under these sections after June 1, 2019.

502.9 **ARTICLE 13**

502.10 **ADULT PROTECTION**

502.11 Section 1. **[256M.42] ADULT PROTECTION GRANT ALLOCATION.**

502.12 Subdivision 1. **Formula.** (a) The commissioner shall allocate state money appropriated
502.13 under this section to each county board and tribal government approved by the commissioner
502.14 to assume county agency duties for adult protective services or as a lead investigative agency
502.15 under section 626.557 on an annual basis in an amount determined according to the following
502.16 formula:

502.17 (1) 25 percent must be allocated on the basis of the number of reports of suspected
502.18 vulnerable adult maltreatment under sections 626.557 and 626.5572, when the county or
502.19 tribe is responsible as determined by the most recent data of the commissioner; and

502.20 (2) 75 percent must be allocated on the basis of the number of screened-in reports for
502.21 adult protective services or vulnerable adult maltreatment investigations under sections
502.22 626.557 and 626.5572, when the county or tribe is responsible as determined by the most
502.23 recent data of the commissioner.

502.24 (b) The commissioner is precluded from changing the formula under this subdivision
502.25 or recommending a change to the legislature without public review and input.

502.26 Subd. 2. **Payment.** The commissioner shall make allocations under subdivision 1 to
502.27 each county board or tribal government each year on or before July 10.

502.28 Subd. 3. **Prohibition on supplanting existing money.** Money received under this section
502.29 must be used for staffing for protection of vulnerable adults or to expand adult protective
502.30 services. Money must not be used to supplant current county or tribe expenditures for these
502.31 purposes.

503.1 **EFFECTIVE DATE.** This section is effective July 1, 2020.

503.2 **ARTICLE 14**

503.3 **ASSISTED LIVING LICENSURE**

503.4 Section 1. **[144I.01] DEFINITIONS.**

503.5 Subdivision 1. **Applicability.** For the purposes of this chapter, the definitions in this
503.6 section have the meanings given.

503.7 Subd. 2. **Adult.** "Adult" means a natural person who has attained the age of 18 years.

503.8 Subd. 3. **Agent.** "Agent" means the person upon whom all notices and orders shall be
503.9 served and who is authorized to accept service of notices and orders on behalf of the facility.

503.10 Subd. 4. **Applicant.** "Applicant" means an individual, legal entity, controlling individual,
503.11 or other organization that has applied for licensure under this chapter.

503.12 Subd. 5. **Assisted living administrator.** "Assisted living administrator" means a person
503.13 who administers, manages, supervises, or is in general administrative charge of an assisted
503.14 living facility, whether or not the individual has an ownership interest in the facility, and
503.15 whether or not the person's functions or duties are shared with one or more individuals and
503.16 who is licensed by the Board of Executives for Long Term Services and Supports pursuant
503.17 to section 144I.31.

503.18 Subd. 6. **Assisted living facility.** "Assisted living facility" means a licensed facility that:
503.19 (1) provides sleeping accommodations to one or more adults; and (2) provides assisted
503.20 living services. For purposes of this chapter, assisted living facility does not include:

503.21 (i) emergency shelter, transitional housing, or any other residential units serving
503.22 exclusively or primarily homeless individuals, as defined under section 116L.361;

503.23 (ii) a nursing home licensed under chapter 144A;

503.24 (iii) a hospital, certified boarding care, or supervised living facility licensed under sections
503.25 144.50 to 144.56;

503.26 (iv) a lodging establishment licensed under chapter 157 and Minnesota Rules, parts
503.27 9520.0500 to 9520.0670, or under chapter 245D or 245G;

503.28 (v) a lodging establishment serving as a shelter for individuals fleeing domestic violence;

503.29 (vi) services and residential settings licensed under chapter 245A, including adult foster
503.30 care and services and settings governed under the standards in chapter 245D;

504.1 (vii) private homes where the residents own or offer for rent the home and control all
504.2 aspects of the property and building;

504.3 (viii) a duly organized condominium, cooperative, and common interest community, or
504.4 owners' association of the condominium, cooperative, and common interest community
504.5 where at least 80 percent of the units that comprise the condominium, cooperative, or
504.6 common interest community are occupied by individuals who are the owners, members, or
504.7 shareholders of the units;

504.8 (ix) temporary family health care dwellings as defined in sections 394.307 and 462.3593;

504.9 (x) settings offering services conducted by and for the adherents of any recognized
504.10 church or religious denomination for its members exclusively through spiritual means or
504.11 by prayer for healing;

504.12 (xi) housing financed pursuant to sections 462A.37 and 462A.375, units financed with
504.13 low-income housing tax credits pursuant to United States Code, title 26, section 42, and
504.14 units financed by the Minnesota Housing Finance Agency that are intended to serve
504.15 individuals with disabilities or individuals who are homeless;

504.16 (xii) rental housing developed under United States Code, title 42, section 1437, or United
504.17 States Code, title 12, section 1701q;

504.18 (xiii) rental housing designated for occupancy by only elderly or elderly and disabled
504.19 residents under United States Code, title 42, section 1437e, or rental housing for qualifying
504.20 families under Code of Federal Regulations, title 24, section 983.56; or

504.21 (xiv) rental housing funded under United States Code, title 42, chapter 89, or United
504.22 States Code, title 42, section 8011.

504.23 Subd. 7. **Assisted living services.** "Assisted living services" include any of the basic
504.24 care services and one or more of the following:

504.25 (1) services of an advanced practice nurse, registered nurse, licensed practical nurse,
504.26 physical therapist, respiratory therapist, occupational therapist, speech-language pathologist,
504.27 dietitian or nutritionist, or social worker;

504.28 (2) tasks delegated to unlicensed personnel by a registered nurse or assigned by a licensed
504.29 health professional within the person's scope of practice;

504.30 (3) medication management services;

504.31 (4) hands-on assistance with transfers and mobility;

504.32 (5) treatment and therapies;

505.1 (6) assisting residents with eating when the clients have complicated eating problems
505.2 as identified in the resident record or through an assessment such as difficulty swallowing,
505.3 recurrent lung aspirations, or requiring the use of a tube or parenteral or intravenous
505.4 instruments to be fed; or

505.5 (7) providing other complex or specialty health care services.

505.6 **Subd. 8. Assisted living with dementia care.** "Assisted living with dementia care"
505.7 means a licensed assisted living facility defined in subdivision 6 that also provides dementia
505.8 care services. An assisted living facility with dementia care may also have a secured dementia
505.9 care unit.

505.10 **Subd. 9. Assisted living facility contract.** "Assisted living facility contract" means the
505.11 legal agreement between an assisted living facility and a resident for the provision of housing
505.12 and services.

505.13 **Subd. 10. Basic care services.** "Basic care services" means assistive tasks provided by
505.14 licensed or unlicensed personnel that include:

505.15 (1) assisting with dressing, self-feeding, oral hygiene, hair care, grooming, toileting, and
505.16 bathing;

505.17 (2) providing standby assistance;

505.18 (3) providing verbal or visual reminders to the resident to take regularly scheduled
505.19 medication, which includes bringing the client previously set-up medication, medication in
505.20 original containers, or liquid or food to accompany the medication;

505.21 (4) providing verbal or visual reminders to the client to perform regularly scheduled
505.22 treatments and exercises;

505.23 (5) preparing modified diets ordered by a licensed health professional;

505.24 (6) having, maintaining, and documenting a system to visually check on each resident
505.25 a minimum of once daily or more than once daily depending on the person-centered care
505.26 plan; and

505.27 (7) supportive services in addition to the provision of at least one of the activities in
505.28 clauses (1) to (5).

505.29 **Subd. 11. Change of ownership.** "Change of ownership" means a change in the individual
505.30 or legal entity that is responsible for the operation of a facility.

505.31 **Subd. 12. Commissioner.** "Commissioner" means the commissioner of health.

506.1 Subd. 13. **Compliance officer.** "Compliance officer" means a designated individual
506.2 who is qualified by knowledge, training, and experience in health care or risk management
506.3 to promote, implement, and oversee the facility's compliance program.

506.4 Subd. 14. **Controlled substance.** "Controlled substance" has the meaning given in
506.5 section 152.01, subdivision 4.

506.6 Subd. 15. **Controlling individual.** (a) "Controlling individual" means an owner of a
506.7 facility licensed under this chapter and the following individuals, if applicable:

506.8 (1) each officer of the organization, including the chief executive officer and chief
506.9 financial officer;

506.10 (2) the individual designated as the authorized agent under subdivision 3;

506.11 (3) the individual designated as the compliance officer under subdivision 13; and

506.12 (4) each managerial official whose responsibilities include the direction of the
506.13 management or policies of the facility.

506.14 (b) Controlling individual also means any owner who directly or indirectly owns five
506.15 percent or more interest in:

506.16 (1) the land on which the facility is located, including a real estate investment trust
506.17 (REIT);

506.18 (2) the structure in which a facility is located;

506.19 (3) any mortgage, contract for deed, or other obligation secured in whole or part by the
506.20 land or structure comprising the facility; or

506.21 (4) any lease or sublease of the land, structure, or facilities comprising the facility.

506.22 (c) Controlling individual does not include:

506.23 (1) a bank, savings bank, trust company, savings association, credit union, industrial
506.24 loan and thrift company, investment banking firm, or insurance company unless the entity
506.25 operates a program directly or through a subsidiary;

506.26 (2) government and government-sponsored entities such as the U.S. Department of
506.27 Housing and Urban Development, Ginnie Mae, Fannie Mae, Freddie Mac, and the Minnesota
506.28 Housing Finance Agency which provide loans, financing, and insurance products for housing
506.29 sites;

506.30 (3) an individual who is a state or federal official, or a state or federal employee, or a
506.31 member or employee of the governing body of a political subdivision of the state or federal

507.1 government that operates one or more facilities, unless the individual is also an officer,
507.2 owner, or managerial official of the facility, receives remuneration from the facility, or
507.3 owns any of the beneficial interests not excluded in this subdivision;

507.4 (4) an individual who owns less than five percent of the outstanding common shares of
507.5 a corporation:

507.6 (i) whose securities are exempt under section 80A.45, clause (6); or

507.7 (ii) whose transactions are exempt under section 80A.46, clause (2);

507.8 (5) an individual who is a member of an organization exempt from taxation under section
507.9 290.05, unless the individual is also an officer, owner, or managerial official of the license
507.10 or owns any of the beneficial interests not excluded in this subdivision. This clause does
507.11 not exclude from the definition of controlling individual an organization that is exempt from
507.12 taxation; or

507.13 (6) an employee stock ownership plan trust, or a participant or board member of an
507.14 employee stock ownership plan, unless the participant or board member is a controlling
507.15 individual.

507.16 Subd. 16. **Dementia.** "Dementia" means the loss of intellectual function of sufficient
507.17 severity that interferes with an individual's daily functioning. Dementia affects an individual's
507.18 memory and ability to think, reason, speak, and move. Symptoms may also include changes
507.19 in personality, mood, and behavior. Irreversible dementias include but are not limited to:

507.20 (1) Alzheimer's disease;

507.21 (2) vascular dementia;

507.22 (3) Lewy body dementia;

507.23 (4) frontal-temporal lobe dementia;

507.24 (5) alcohol dementia;

507.25 (6) Huntington's disease; and

507.26 (7) Creutzfeldt-Jakob disease.

507.27 Subd. 17. **Dementia care services.** "Dementia care services" means a distinct form of
507.28 long-term care designed to meet the specific needs of an individual with dementia.

507.29 Subd. 18. **Dementia care unit.** "Dementia care unit" means a special care unit in a
507.30 designated, separate area for individuals with dementia that is locked, segregated, or secured
507.31 to prevent or limit access by a resident outside the designated or separated area.

508.1 Subd. 19. **Dementia-trained staff.** "Dementia-trained staff" means any employee that
508.2 has completed the minimum training requirements and has demonstrated knowledge and
508.3 understanding in supporting individuals with dementia.

508.4 Subd. 20. **Designated representative.** "Designated representative" means one of the
508.5 following in the order of priority listed, to the extent the person may reasonably be identified
508.6 and located:

508.7 (1) a court-appointed guardian acting in accordance with the powers granted to the
508.8 guardian under chapter 524;

508.9 (2) a conservator acting in accordance with the powers granted to the conservator under
508.10 chapter 524;

508.11 (3) a health care agent acting in accordance with the powers granted to the health care
508.12 agent under chapter 145C;

508.13 (4) a power of attorney acting in accordance with the powers granted to the
508.14 attorney-in-fact under chapter 523; or

508.15 (5) the resident representative.

508.16 Subd. 21. **Dietary supplement.** "Dietary supplement" means a product taken by mouth
508.17 that contains a dietary ingredient intended to supplement the diet. Dietary ingredients may
508.18 include vitamins, minerals, herbs or other botanicals, amino acids, and substances such as
508.19 enzymes, organ tissue, glandulars, or metabolites.

508.20 Subd. 22. **Direct contact.** "Direct contact" means providing face-to-face care, training,
508.21 supervision, counseling, consultation, or medication assistance to residents of a facility.

508.22 Subd. 23. **Direct ownership interest.** "Direct ownership interest" means an individual
508.23 or organization with the possession of at least five percent equity in capital, stock, or profits
508.24 of an organization, or who is a member of a limited liability company. An individual with
508.25 a five percent or more direct ownership is presumed to have an effect on the operation of
508.26 the facility with respect to factors affecting the care or training provided.

508.27 Subd. 24. **Facility.** "Facility" means an assisted living facility and an assisted living
508.28 facility with dementia care.

508.29 Subd. 25. **Hands-on assistance.** "Hands-on assistance" means physical help by another
508.30 person without which the resident is not able to perform the activity.

508.31 Subd. 26. **Indirect ownership interest.** "Indirect ownership interest" means an individual
508.32 or organization with a direct ownership interest in an entity that has a direct or indirect

509.1 ownership interest in a facility of at least five percent or more. An individual with a five
509.2 percent or more indirect ownership is presumed to have an effect on the operation of the
509.3 facility with respect to factors affecting the care or training provided.

509.4 Subd. 27. **Licensed health professional.** "Licensed health professional" means a person
509.5 licensed in Minnesota to practice the professions described in section 214.01, subdivision
509.6 2.

509.7 Subd. 28. **Licensed resident bed capacity.** "Licensed resident bed capacity" means the
509.8 resident occupancy level requested by a licensee and approved by the commissioner.

509.9 Subd. 29. **Licensee.** "Licensee" means a person or legal entity to whom the commissioner
509.10 issues a license for a facility and who is responsible for the management, control, and
509.11 operation of a facility. A facility must be managed, controlled, and operated in a manner
509.12 that enables it to use its resources effectively and efficiently to attain or maintain the highest
509.13 practicable physical, mental, and psychosocial well-being of each resident.

509.14 Subd. 30. **Maltreatment.** "Maltreatment" means conduct described in section 626.5572,
509.15 subdivision 15.

509.16 Subd. 31. **Management agreement.** "Management agreement" means a written, executed
509.17 agreement between a licensee and manager regarding the provision of certain services on
509.18 behalf of the licensee.

509.19 Subd. 32. **Managerial official.** "Managerial official" means an individual who has the
509.20 decision-making authority related to the operation of the facility and the responsibility for
509.21 the ongoing management or direction of the policies, services, or employees of the facility.

509.22 Subd. 33. **Medication.** "Medication" means a prescription or over-the-counter drug. For
509.23 purposes of this chapter only, medication includes dietary supplements.

509.24 Subd. 34. **Medication administration.** "Medication administration" means performing
509.25 a set of tasks that includes the following:

509.26 (1) checking the client's medication record;

509.27 (2) preparing the medication as necessary;

509.28 (3) administering the medication to the client;

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

509.30 (5) reporting to a registered nurse or appropriate licensed health professional any concerns
509.31 about the medication, the resident, or the resident's refusal to take the medication.

510.1 Subd. 35. **Medication management.** "Medication management" means the provision
510.2 of any of the following medication-related services to a resident:

510.3 (1) performing medication setup;

510.4 (2) administering medications;

510.5 (3) storing and securing medications;

510.6 (4) documenting medication activities;

510.7 (5) verifying and monitoring the effectiveness of systems to ensure safe handling and
510.8 administration;

510.9 (6) coordinating refills;

510.10 (7) handling and implementing changes to prescriptions;

510.11 (8) communicating with the pharmacy about the resident's medications; and

510.12 (9) coordinating and communicating with the prescriber.

510.13 Subd. 36. **Medication reconciliation.** "Medication reconciliation" means the process
510.14 of identifying the most accurate list of all medications the resident is taking, including the
510.15 name, dosage, frequency, and route by comparing the resident record to an external list of
510.16 medications obtained from the resident, hospital, prescriber or other provider.

510.17 Subd. 37. **Medication setup.** "Medication setup" means arranging medications by a
510.18 nurse, pharmacy, or authorized prescriber for later administration by the resident or by
510.19 facility staff.

510.20 Subd. 38. **New construction.** "New construction" means a new building, renovation,
510.21 modification, reconstruction, physical changes altering the use of occupancy, or an addition
510.22 to a building.

510.23 Subd. 39. **Nurse.** "Nurse" means a person who is licensed under sections 148.171 to
510.24 148.285.

510.25 Subd. 40. **Occupational therapist.** "Occupational therapist" means a person who is
510.26 licensed under sections 148.6401 to 148.6449.

510.27 Subd. 41. **Ombudsman.** "Ombudsman" means the ombudsman for long-term care.

510.28 Subd. 42. **Owner.** "Owner" means an individual or organization that has a direct or
510.29 indirect ownership interest of five percent or more in a facility. For purposes of this chapter,
510.30 "owner of a nonprofit corporation" means the president and treasurer of the board of directors
510.31 or, for an entity owned by an employee stock ownership plan, means the president and

511.1 treasurer of the entity. A government entity that is issued a license under this chapter shall
511.2 be designated the owner. An individual with a five percent or more direct or indirect
511.3 ownership is presumed to have an effect on the operation of the facility with respect to
511.4 factors affecting the care or training provided.

511.5 Subd. 43. **Over-the-counter drug.** "Over-the-counter drug" means a drug that is not
511.6 required by federal law to bear the symbol "Rx only."

511.7 Subd. 44. **Person-centered planning and service delivery.** "Person-centered planning
511.8 and service delivery" means services as defined in section 245D.07, subdivision 1a, paragraph
511.9 (b).

511.10 Subd. 45. **Pharmacist.** "Pharmacist" has the meaning given in section 151.01, subdivision
511.11 3.

511.12 Subd. 46. **Physical therapist.** "Physical therapist" means a person who is licensed under
511.13 sections 148.65 to 148.78.

511.14 Subd. 47. **Physician.** "Physician" means a person who is licensed under chapter 147.

511.15 Subd. 48. **Prescriber.** "Prescriber" means a person who is authorized by sections 148.235;
511.16 151.01, subdivision 23; and 151.37 to prescribe prescription drugs.

511.17 Subd. 49. **Prescription.** "Prescription" has the meaning given in section 151.01,
511.18 subdivision 16a.

511.19 Subd. 50. **Provisional license.** "Provisional license" means the initial license the
511.20 department issues after approval of a complete written application and before the department
511.21 completes the provisional license survey and determines that the provisional licensee is in
511.22 substantial compliance.

511.23 Subd. 51. **Regularly scheduled.** "Regularly scheduled" means ordered or planned to be
511.24 completed at predetermined times or according to a predetermined routine.

511.25 Subd. 52. **Reminder.** "Reminder" means providing a verbal or visual reminder to a
511.26 resident.

511.27 Subd. 53. **Resident.** "Resident" means a person living in an assisted living facility.

511.28 Subd. 54. **Resident record.** "Resident record" means all records that document
511.29 information about the services provided to the resident.

511.30 Subd. 55. **Resident representative.** "Resident representative" means a person designated
511.31 in writing by the resident and identified in the resident's records on file with the facility.

512.1 Subd. 56. **Respiratory therapist.** "Respiratory therapist" means a person who is licensed
512.2 under chapter 147C.

512.3 Subd. 57. **Revenues.** "Revenues" means all money received by a licensee derived from
512.4 the provision of home care services, including fees for services and appropriations of public
512.5 money for home care services.

512.6 Subd. 58. **Service plan.** "Service plan" means the written agreement between the resident
512.7 or the resident's representative and the provisional licensee or licensee about the services
512.8 that will be provided to the resident.

512.9 Subd. 59. **Social worker.** "Social worker" means a person who is licensed under chapter
512.10 148D or 148E.

512.11 Subd. 60. **Speech-language pathologist.** "Speech-language pathologist" has the meaning
512.12 given in section 148.512.

512.13 Subd. 61. **Standby assistance.** "Standby assistance" means the presence of another
512.14 person within arm's reach to minimize the risk of injury while performing daily activities
512.15 through physical intervention or cueing to assist a resident with an assistive task by providing
512.16 cues, oversight, and minimal physical assistance.

512.17 Subd. 62. **Substantial compliance.** "Substantial compliance" means complying with
512.18 the requirements in this chapter sufficiently to prevent unacceptable health or safety risks
512.19 to residents.

512.20 Subd. 63. **Supportive services.** "Supportive services" means:

512.21 (1) assistance with laundry, shopping, and household chores;

512.22 (2) housekeeping services;

512.23 (3) provision or assistance with meals or food preparation;

512.24 (4) help with arranging for, or arranging transportation to medical, social, recreational,
512.25 personal, or social services appointments; or

512.26 (5) provision of social or recreational services.

512.27 Arranging for services does not include making referrals, or contacting a service provider
512.28 in an emergency.

512.29 Subd. 64. **Survey.** "Survey" means an inspection of a licensee or applicant for licensure
512.30 for compliance with this chapter.

513.1 Subd. 65. **Surveyor.** "Surveyor" means a staff person of the department who is authorized
 513.2 to conduct surveys of assisted living facilities and applicants.

513.3 Subd. 66. **Treatment or therapy.** "Treatment" or "therapy" means the provision of care,
 513.4 other than medications, ordered or prescribed by a licensed health professional and provided
 513.5 to a resident to cure, rehabilitate, or ease symptoms.

513.6 Subd. 67. **Unit of government.** "Unit of government" means a city, county, town, school
 513.7 district, other political subdivision of the state, or an agency of the state or federal
 513.8 government, that includes any instrumentality of a unit of government.

513.9 Subd. 68. **Unlicensed personnel.** "Unlicensed personnel" means individuals not otherwise
 513.10 licensed or certified by a governmental health board or agency who provide services to a
 513.11 resident.

513.12 Subd. 69. **Verbal.** "Verbal" means oral and not in writing.

513.13 Sec. 2. **[144I.02] ASSISTED LIVING FACILITY LICENSE; APPLICABLE LAWS;**
 513.14 **APPLICATION AND RENEWAL.**

513.15 Subdivision 1. **License required.** Beginning August 1, 2021, an entity may not operate
 513.16 an assisted living facility in Minnesota unless it is licensed under this chapter. No assisted
 513.17 living facility licensed under this section shall be required to be licensed as a boarding
 513.18 establishment, food and beverage service establishment, hotel or motel, lodging
 513.19 establishment, resort, or restaurant as defined in section 157.15.

513.20 Subd. 2. **Licensure categories.** (a) The categories in this subdivision are established for
 513.21 assisted living facility licensure.

513.22 (b) An assisted living category is an assisted living facility that provides assisted living
 513.23 services.

513.24 (c) An assisted living with dementia care category is an assisted living facility that
 513.25 provides assisted living services and dementia care services. An assisted living facility with
 513.26 dementia care may also provide dementia care services in a secure dementia care unit.

513.27 Subd. 3. **Provisional license.** (a) Beginning August 1, 2021, for new applicants, the
 513.28 commissioner shall issue a provisional license to each of the licensure categories specified
 513.29 in subdivision 2 which is effective for up to one year from the license effective date, except
 513.30 that a provisional license may be extended according to paragraph (e).

513.31 (b) Assisted living facilities are subject to evaluation and approval by the commissioner
 513.32 of the facility's physical environment and its operational aspects before a change in ownership

514.1 or capacity, or an addition of services which necessitates a change in the facility's physical
514.2 environment.

514.3 (c) During the provisional license period, the commissioner shall survey the provisional
514.4 licensee after the commissioner is notified or has evidence that the provisional licensee has
514.5 residents and is providing services.

514.6 (d) Within two days of beginning to provide services, the provisional licensee must
514.7 provide notice to the commissioner that it is serving residents by sending an e-mail to the
514.8 e-mail address provided by the commissioner. If the provisional licensee does not provide
514.9 services during the provisional license year period, then the provisional license expires at
514.10 the end of the period and the applicant must reapply for the provisional facility license.

514.11 (e) If the provisional licensee notifies the commissioner that the licensee has residents
514.12 within 45 days prior to the provisional license expiration, the commissioner may extend the
514.13 provisional license for up to 60 days in order to allow the commissioner to complete the
514.14 on-site survey required under this section and follow-up survey visits.

514.15 (f) If the provisional licensee is in substantial compliance with the survey, the
514.16 commissioner shall issue a facility license. If the provisional licensee is not in substantial
514.17 compliance with the initial survey, the commissioner shall either: (1) not issue the facility
514.18 license and terminate the provisional license; or (2) extend the provisional license for a
514.19 period not to exceed 90 days and apply conditions necessary to bring the facility into
514.20 substantial compliance. If the provisional licensee is not in substantial compliance with the
514.21 survey within the time period of the extension or if the provisional licensee does not satisfy
514.22 the license conditions, the commissioner may deny the license.

514.23 (g) If a provisional licensee whose facility license has been denied or extended with
514.24 conditions disagrees with the conclusions of the commissioner, then the provisional licensee
514.25 may request a reconsideration by the commissioner or commissioner's designee. The
514.26 reconsideration request process must be conducted internally by the commissioner or
514.27 designee, and chapter 14 does not apply.

514.28 (h) The provisional licensee requesting the reconsideration must make the request in
514.29 writing and must list and describe the reasons why the provisional licensee disagrees with
514.30 the decision to deny the facility license or the decision to extend the provisional license
514.31 with conditions.

514.32 (i) The reconsideration request and supporting documentation must be received by the
514.33 commissioner within 15 calendar days after the date the provisional license receives the
514.34 denial or provisional license with conditions.

515.1 (j) A provisional licensee whose license is denied is permitted to continue operating
515.2 during the period of time when:

515.3 (1) a reconsideration is in process;

515.4 (2) an extension of the provisional license and terms associated with it is in active
515.5 negotiation between the commissioner and the licensee and the commissioner confirms the
515.6 negotiation is active; or

515.7 (3) a transfer of residents to a new facility is underway and not all the residents have
515.8 relocated.

515.9 (k) A provisional licensee whose license is denied must comply with the requirements
515.10 for notification and transfer of residents in section 144I.07.

515.11 (l) The fee for failure to comply with the notification requirements in section 144I.07,
515.12 subdivision 6, paragraph (b), is \$1,000.

515.13 Subd. 4. **License applications.** (a) Each application for a facility license, including a
515.14 provisional license, must include information sufficient to show that the applicant meets
515.15 the requirements of licensure, including:

515.16 (1) the business name and legal entity name of the operating entity; street address and
515.17 mailing address of the facility; and the names, e-mail addresses, telephone numbers, and
515.18 mailing addresses of all owners, controlling individuals, managerial officials, and the assisted
515.19 living administrator;

515.20 (2) the name and e-mail address of the managing agent, if applicable;

515.21 (3) the licensed bed capacity and the license category;

515.22 (4) the license fee in the amount specified in section 144.122;

515.23 (5) any judgments, private or public litigation, tax liens, written complaints, administrative
515.24 actions, or investigations by any government agency against the applicant, owner, controlling
515.25 individual, managerial official, or assisted living administrator that are unresolved or
515.26 otherwise filed or commenced within the preceding ten years;

515.27 (6) documentation of compliance with the background study requirements in subdivision
515.28 7 for the owner, controlling individuals, and managerial officials. Each application for a
515.29 new license must include documentation for the applicant and for each individual with five
515.30 percent or more direct or indirect ownership in the applicant;

515.31 (7) evidence of workers' compensation coverage as required by sections 176.181 and
515.32 176.182;

- 516.1 (8) disclosure that the provider has no liability coverage or, if the provider has coverage,
516.2 documentation of coverage;
- 516.3 (9) a copy of the executed lease agreement if applicable;
- 516.4 (10) a copy of the management agreement if applicable;
- 516.5 (11) a copy of the operations transfer agreement or similar agreement if applicable;
- 516.6 (12) a copy of the executed agreement if the facility has contracted services with another
516.7 organization or individual for services such as managerial, billing, consultative, or medical
516.8 personnel staffing;
- 516.9 (13) a copy of the organizational chart that identifies all organizations and individuals
516.10 with any ownership interests in the facility;
- 516.11 (14) whether any applicant, owner, controlling individual, managerial official, or assisted
516.12 living administrator of the facility has ever been convicted of a crime or found civilly liable
516.13 for an offense involving moral turpitude, including forgery, embezzlement, obtaining money
516.14 under false pretenses, larceny, extortion, conspiracy to defraud, or any other similar offense
516.15 or violation, or any violation of section 626.557 or any other similar law in any other state,
516.16 or any violation of a federal or state law or regulation in connection with activities involving
516.17 any consumer fraud, false advertising, deceptive trade practices, or similar consumer
516.18 protection law;
- 516.19 (15) whether the applicant or any owner, controlling individual, managerial official, or
516.20 assisted living administrator of the facility has a record of defaulting in the payment of
516.21 money collected for others, including the discharge of debts through bankruptcy proceedings;
- 516.22 (16) documentation that the applicant has designated one or more owners, controlling
516.23 individuals, or employees as an agent or agents, which shall not affect the legal responsibility
516.24 of any other owner or controlling individual under this chapter;
- 516.25 (17) the signature of the owner or owners, or an authorized agent of the owner or owners
516.26 of the facility applicant. An application submitted on behalf of a business entity must be
516.27 signed by at least two owners or controlling individuals;
- 516.28 (18) identification of all states where the applicant, or individual having a five percent
516.29 or more ownership, currently or previously has been licensed as owner or operator of a
516.30 long-term care, community-based, or health care facility or agency where its license or
516.31 federal certification has been denied, suspended, restricted, conditioned, or revoked under
516.32 a private or state-controlled receivership, or where these same actions are pending under
516.33 the laws of any state or federal authority; and

517.1 (19) any other information required by the commissioner.

517.2 Subd. 5. **Agents.** (a) An application for a facility or for renewal of a facility must specify
517.3 one or more owners, controlling individuals, or employees as agents:

517.4 (1) who shall be responsible for dealing with the commissioner on all requirements of
517.5 this chapter; and

517.6 (2) on whom personal service of all notices and orders shall be made, and who shall be
517.7 authorized to accept service on behalf of all of the controlling individuals of the facility, in
517.8 proceedings under this chapter.

517.9 (b) Notwithstanding any law to the contrary, personal service on the designated person
517.10 or persons named in the application is deemed to be service on all of the controlling
517.11 individuals or managerial employees of the facility, and it is not a defense to any action
517.12 arising under this chapter that personal service was not made on each controlling individual
517.13 or managerial official of the facility. The designation of one or more controlling individuals
517.14 or managerial officials under this subdivision shall not affect the legal responsibility of any
517.15 other controlling individual or managerial official under this chapter.

517.16 Subd. 6. **Transfers prohibited; changes in ownership.** (a) Any facility license issued
517.17 by the commissioner may not be transferred to another party. Before acquiring ownership
517.18 of a facility, a prospective applicant must apply for a new license. The licensee of a basic
517.19 care facility or an assisted living facility must change whenever the following events occur,
517.20 including but not limited to:

517.21 (1) the licensee's form of legal organization is changed;

517.22 (2) the licensee transfers ownership of the facility business enterprise to another party
517.23 regardless of whether ownership of some or all of the real property or personal property
517.24 assets of the assisted living facility is also transferred;

517.25 (3) the licensee dissolves, consolidates, or merges with another legal organization and
517.26 the licensee's legal organization does not survive;

517.27 (4) during any continuous 24-month period, 50 percent or more of the licensed entity is
517.28 transferred, whether by a single transaction or multiple transactions, to:

517.29 (i) a different person; or

517.30 (ii) a person who had less than a five percent ownership interest in the facility at the
517.31 time of the first transaction; or

518.1 (5) any other event or combination of events that results in a substitution, elimination,
518.2 or withdrawal of the licensee's control of the facility.

518.3 (b) As used in this section, "control" means the possession, directly or indirectly, of the
518.4 power to direct the management, operation, and policies of the licensee or facility, whether
518.5 through ownership, voting control, by agreement, by contract, or otherwise.

518.6 (c) The current facility licensee must provide written notice to the department and
518.7 residents, or designated representatives, at least 60 calendar days prior to the anticipated
518.8 date of the change of licensee.

518.9 (d) For all new licensees after a change in ownership, the commissioner shall complete
518.10 a survey within six months after the new license is issued.

518.11 Subd. 7. **Background studies.** (a) Before the commissioner issues a provisional license,
518.12 issues a license as a result of an approved change of ownership, or renews a license, a
518.13 controlling individual or managerial official is required to complete a background study
518.14 under section 144.057. No person may be involved in the management, operation, or control
518.15 of a facility if the person has been disqualified under chapter 245C. If an individual is
518.16 disqualified under section 144.057 or chapter 245C, the individual may request
518.17 reconsideration of the disqualification. If the individual requests reconsideration and the
518.18 commissioner sets aside or rescinds the disqualification, the individual is eligible to be
518.19 involved in the management, operation, or control of the facility. If an individual has a
518.20 disqualification under section 245C.15, subdivision 1, and the disqualification is affirmed,
518.21 the individual's disqualification is barred from a set aside, and the individual must not be
518.22 involved in the management, operation, or control of the facility.

518.23 (b) For the purposes of this section, managerial officials subject to the background check
518.24 requirement are individuals who provide direct contact as defined in section 144I.01,
518.25 subdivision 22.

518.26 (c) The commissioner shall not issue a license if the controlling individual or managerial
518.27 official has been unsuccessful in having a background study disqualification set aside under
518.28 section 144.057 and chapter 245C.

518.29 (d) Data collected under this subdivision shall be classified as private data on individuals
518.30 under section 13.02, subdivision 12.

518.31 (e) Employees, contractors, and volunteers of the facility are subject to the background
518.32 study required by section 144.057, and may be disqualified under chapter 245C. Nothing

519.1 in this section shall be construed to prohibit the facility from requiring self-disclosure of
519.2 criminal conviction information.

519.3 (f) Termination of an employee in good faith reliance on information or records obtained
519.4 under this section regarding a confirmed conviction does not subject the assisted living
519.5 facility to civil liability or liability for unemployment benefits.

519.6 Subd. 8. **License renewal.** Except as provided in section 144I.15, a license that is not
519.7 a provisional license may be renewed for a period of up to one year if the licensee satisfies
519.8 the following:

519.9 (1) submits an application for renewal in the format provided by the commissioner at
519.10 least 60 days before expiration of the license;

519.11 (2) submits the renewal fee under section 144I.12;

519.12 (3) submits the late fee pursuant to subdivision 11 if the renewal application is received
519.13 less than 30 days before the expiration date of the license;

519.14 (4) provides information sufficient to show that the applicant meets the requirements of
519.15 licensure, including items required under subdivision 4; and

519.16 (5) provides any other information deemed necessary by the commissioner.

519.17 Subd. 9. **Notification of changes of information.** The provisional licensee or licensee
519.18 shall notify the commissioner in writing prior to any financial or contractual change and
519.19 within 60 calendar days after any change in the information required in subdivision 4.

519.20 Subd. 10. **Actions on licenses.** (a) The commissioner shall consider an applicant's
519.21 performance history, in Minnesota and in other states, including repeat violations or rule
519.22 violations, before issuing a provisional license, license, or renewal license.

519.23 (b) An applicant must not have a history within the last five years in Minnesota or in
519.24 any other state of a license or certification involuntarily suspended or voluntarily terminated
519.25 during any enforcement process in a facility that provides care to children, the elderly or ill
519.26 individuals, or individuals with disabilities.

519.27 (c) Failure to provide accurate information or demonstrate required performance history
519.28 may result in the denial of a license.

519.29 (d) The commissioner may deny, revoke, suspend, restrict, or refuse to renew the license
519.30 or impose conditions if:

520.1 (1) the applicant fails to provide complete and accurate information on the application
520.2 and the commissioner concludes that the missing or corrected information is needed to
520.3 determine if a license shall be granted;

520.4 (2) the applicant, knowingly or with reason to know, made a false statement of a material
520.5 fact in an application for the license or any data attached to the application, or in any matter
520.6 under investigation by the department;

520.7 (3) the applicant refused to allow representatives or agents of the department to inspect
520.8 its books, records, and files, or any portion of the premises;

520.9 (4) the applicant willfully prevented, interfered with, or attempted to impede in any way:
520.10 (i) the work of any authorized representative of the department, the ombudsman for long-term
520.11 care or the ombudsman for mental health and developmental disabilities; or (ii) the duties
520.12 of the commissioner, local law enforcement, city or county attorneys, adult protection,
520.13 county case managers, or other local government personnel;

520.14 (5) the applicant has a history of noncompliance with federal or state regulations that
520.15 was detrimental to the health, welfare, or safety of a resident or a client; and

520.16 (6) the applicant violates any requirement in this chapter.

520.17 (e) For all new licensees after a change in ownership, the commissioner shall complete
520.18 a survey within six months after the new license is issued.

520.19 Subd. 11. Fees. (a) An initial applicant or applicant filing a change of ownership for an
520.20 assisted living facility license must submit the application fee required in section 144I.122
520.21 to the commissioner, along with a completed application.

520.22 (b) The penalty for late submission of the renewal application after expiration of the
520.23 license is \$200. The penalty for practicing after expiration of the license and before a renewal
520.24 license is issued is \$250 per each day after expiration of the license until the renewal license
520.25 issuance date. The facility is still subject to the criminal gross misdemeanor penalties for
520.26 operating after license expiration.

520.27 (c) Fees collected under this section shall be deposited in the state treasury and credited
520.28 to the state government special revenue fund. All fees are nonrefundable.

520.29 (d) Fines collected under this subdivision shall be deposited in a dedicated special revenue
520.30 account. On an annual basis, the balance in the special revenue account shall be appropriated
520.31 to the commissioner to implement the recommendations of the advisory council established
520.32 in section 144A.4799.

521.1 Subd. 12. **Violations; penalty.** (a) Operating a facility without a license is a misdemeanor
521.2 punishable by a fine imposed by the commissioner.

521.3 (b) A controlling individual of the facility in violation of this section is guilty of a
521.4 misdemeanor. The provisions of this subdivision shall not apply to any controlling individual
521.5 who had no legal authority to affect or change decisions related to the operation of the
521.6 facility.

521.7 (c) The sanctions in this section do not restrict other available sanctions in law.

521.8 **Sec. 3. [144I.03] MINIMUM ASSISTED LIVING FACILITY REQUIREMENTS.**

521.9 Subdivision 1. **Minimum requirements.** All licensed facilities shall:

521.10 (1) distribute to residents, families, and resident representatives the assisted living bill
521.11 of rights in section 144I.21;

521.12 (2) provide health-related services in a manner that complies with the Nurse Practice
521.13 Act in sections 148.171 to 148.285;

521.14 (3) utilize person-centered planning and service delivery process as defined in section
521.15 245D.07;

521.16 (4) have and maintain a system for delegation of health care activities to unlicensed
521.17 personnel by a registered nurse, including supervision and evaluation of the delegated
521.18 activities as required by the Nurse Practice Act in sections 148.171 to 148.285;

521.19 (5) provide a means for residents to request assistance for health and safety needs 24
521.20 hours per day, seven days per week;

521.21 (6) allow residents the ability to furnish and decorate the resident's unit within the terms
521.22 of the lease;

521.23 (7) permit residents access to food at any time;

521.24 (8) allow residents to choose the resident's visitors and times of visits;

521.25 (9) allow the resident the right to choose a roommate if sharing a unit;

521.26 (10) notify the resident of the resident's right to have and use a lockable door to the
521.27 resident's unit. The licensee shall provide the locks on the unit. Only a staff member with
521.28 a specific need to enter the unit shall have keys, and advance notice must be given to the
521.29 resident before entrance, when possible;

521.30 (11) develop and implement a staffing plan for determining its staffing level that:

- 522.1 (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness
522.2 of staffing levels in the facility;
- 522.3 (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably
522.4 foreseeable unscheduled needs of each resident as required by the residents' assessments
522.5 and service plans on a 24-hour per day basis; and
- 522.6 (iii) ensures that the facility can respond promptly and effectively to individual resident
522.7 emergencies and to emergency, life safety, and disaster situations affecting staff or residents
522.8 in the facility;
- 522.9 (12) ensures that a person or persons are available 24 hours per day, seven days per
522.10 week, who are responsible for responding to the requests of residents for assistance with
522.11 health or safety needs, who shall be:
- 522.12 (i) awake;
- 522.13 (ii) located in the same building, in an attached building, or on a contiguous campus
522.14 with the facility in order to respond within a reasonable amount of time;
- 522.15 (iii) capable of communicating with residents;
- 522.16 (iv) capable of providing or summoning the appropriate assistance;
- 522.17 (v) capable of following directions; and
- 522.18 (vi) for an assisted living facility providing dementia care in a dementia care unit, the
522.19 awake person must be physically present in the locked or secure unit; and
- 522.20 (13) offer to provide or make available at least the following services to residents:
- 522.21 (i) at least three daily nutritious meals with snacks available seven days per week,
522.22 according to the recommended dietary allowances in the United States Department of
522.23 Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The
522.24 following apply:
- 522.25 (A) modified special diets that are appropriate to residents' needs and choices;
- 522.26 (B) menus prepared at least one week in advance, and made available to all residents.
522.27 The facility must encourage residents' involvement in menu planning. Meal substitutions
522.28 must be of similar nutritional value if a resident refuses a food that is served. Residents
522.29 must be informed in advance of menu changes;
- 522.30 (C) food must be prepared and served according to the Minnesota Food Code, Minnesota
522.31 Rules, chapter 4626; and

- 523.1 (D) the facility cannot require a resident to include and pay for meals in their contract;
- 523.2 (ii) weekly housekeeping;
- 523.3 (iii) weekly laundry service;
- 523.4 (iv) upon the request of the resident, provide direct or reasonable assistance with arranging
- 523.5 for transportation to medical and social services appointments, shopping, and other recreation,
- 523.6 and provide the name of or other identifying information about the person or persons
- 523.7 responsible for providing this assistance;
- 523.8 (v) upon the request of the resident, provide reasonable assistance with accessing
- 523.9 community resources and social services available in the community, and provide the name
- 523.10 of or other identifying information about the person or persons responsible for providing
- 523.11 this assistance; and
- 523.12 (vi) have a daily program of social and recreational activities that are based upon
- 523.13 individual and group interests, physical, mental, and psychosocial needs, and that creates
- 523.14 opportunities for active participation in the community at large.
- 523.15 Subd. 2. **Policies and procedures.** (a) Each facility must have policies and procedures
- 523.16 in place to address the following and keep them current:
- 523.17 (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults;
- 523.18 (2) conducting and handling background studies on employees;
- 523.19 (3) orientation, training, and competency evaluations of staff, and a process for evaluating
- 523.20 staff performance;
- 523.21 (4) handling complaints from residents, family members, or designated representatives
- 523.22 regarding staff or services provided by staff;
- 523.23 (5) conducting initial evaluation of residents' needs and the providers' ability to provide
- 523.24 those services;
- 523.25 (6) conducting initial and ongoing resident evaluations and assessments and how changes
- 523.26 in a resident's condition are identified, managed, and communicated to staff and other health
- 523.27 care providers as appropriate;
- 523.28 (7) orientation to and implementation of the assisted living bill of rights;
- 523.29 (8) infection control practices;
- 523.30 (9) reminders for medications, treatments, or exercises, if provided; and

524.1 (10) conducting appropriate screenings, or documentation of prior screenings, to show
524.2 that staff are free of tuberculosis, consistent with current United States Centers for Disease
524.3 Control and Prevention standards.

524.4 (b) For assisted living facilities and assisted living facilities with dementia care, the
524.5 following are also required:

524.6 (1) conducting initial and ongoing assessments of the resident's needs by a registered
524.7 nurse or appropriate licensed health professional, including how changes in the resident's
524.8 conditions are identified, managed, and communicated to staff and other health care
524.9 providers, as appropriate;

524.10 (2) ensuring that nurses and licensed health professionals have current and valid licenses
524.11 to practice;

524.12 (3) medication and treatment management;

524.13 (4) delegation of tasks by registered nurses or licensed health professionals;

524.14 (5) supervision of registered nurses and licensed health professionals; and

524.15 (6) supervision of unlicensed personnel performing delegated tasks.

524.16 Subd. 3. **Infection control program.** The facility shall establish and maintain an infection
524.17 control program.

524.18 Subd. 4. **Clinical nurse supervision.** All assisted living facilities must have a clinical
524.19 nurse supervisor who is a registered nurse licensed in Minnesota.

524.20 Subd. 5. **Resident and family or resident representative councils.** (a) If a resident,
524.21 family, or designated representative chooses to establish a council, the licensee shall support
524.22 the council's establishment. The facility must provide assistance and space for meetings and
524.23 afford privacy. Staff or visitors may attend meetings only upon the council's invitation. A
524.24 staff person must be designated the responsibility of providing this assistance and responding
524.25 to written requests that result from council meetings. Resident council minutes are public
524.26 data and shall be available to all residents in the facility. Family or resident representatives
524.27 may attend resident councils upon invitation by a resident on the council.

524.28 (b) All assisted living facilities shall engage their residents and families or designated
524.29 representatives in the operation of their community and document the methods and results
524.30 of this engagement.

524.31 Subd. 6. **Resident grievances.** All facilities must post in a conspicuous place information
524.32 about the facilities' grievance procedure, and the name, telephone number, and e-mail contact

525.1 information for the individuals who are responsible for handling resident grievances. The
525.2 notice must also have the contact information for the Minnesota Adult Abuse Reporting
525.3 Center and the state and applicable regional Office of Ombudsman for Long-Term Care.

525.4 Subd. 7. **Protecting resident rights.** A facility shall ensure that every resident has access
525.5 to consumer advocacy or legal services by:

525.6 (1) providing names and contact information, including telephone numbers and e-mail
525.7 addresses of at least three organizations that provide advocacy or legal services to residents;

525.8 (2) providing the name and contact information for the Minnesota Office of Ombudsman
525.9 for Long-Term Care and the Office of the Ombudsman for Mental Health and Developmental
525.10 Disabilities, including both the state and regional contact information;

525.11 (3) assisting residents in obtaining information on whether Medicare or medical assistance
525.12 under chapter 256B will pay for services;

525.13 (4) making reasonable accommodations for people who have communication disabilities
525.14 and those who speak a language other than English; and

525.15 (5) providing all information and notices in plain language and in terms the residents
525.16 can understand.

525.17 Subd. 8. **Protection-related rights.** (a) In addition to the rights required in the basic
525.18 care and assisted living bill of rights under section 144I.21, the following rights must be
525.19 provided to all residents. The facility must promote and protect these rights for each resident
525.20 by making residents aware of these rights and ensuring staff are trained to support these
525.21 rights:

525.22 (1) the right to furnish and decorate the resident's unit within the terms of the lease;

525.23 (2) the right to access food at any time;

525.24 (3) the right to choose visitors and the times of visits;

525.25 (4) the right to choose a roommate if sharing a unit;

525.26 (5) the right to personal privacy including the right to have and use a lockable door on
525.27 the resident's unit. The facility shall provide the locks on the resident's unit. Only a staff
525.28 member with a specific need to enter the unit shall have keys, and advance notice must be
525.29 given to the resident before entrance, when possible;

525.30 (6) the right to engage in chosen activities;

525.31 (7) the right to engage in community life;

526.1 (8) the right to control personal resources; and

526.2 (9) the right to individual autonomy, initiative, and independence in making life choices
526.3 including a daily schedule and with whom to interact.

526.4 (b) The resident's rights in paragraph (a), clauses (2), (3), and (5), may be restricted for
526.5 an individual resident only if determined necessary for health and safety reasons identified
526.6 by the facility through an initial assessment or reassessment, as defined under section
526.7 144I.035, subdivision 10, and documented in the written service plan under section 144I.035,
526.8 subdivision 11. Any restrictions of those rights for people served under sections 256B.0915
526.9 and 256B.49 must be documented by the case manager in the resident's coordinated service
526.10 and support plan (CSSP), as defined in sections 256B.0915, subdivision 6, and 256B.49,
526.11 subdivision 15.

526.12 Subd. 9. **Payment for services under disability waivers.** For new facilities, home and
526.13 community-based services under section 256B.49 are not available when the new facility
526.14 setting is adjoined to, or on the same property as, an institution as defined in Code of Federal
526.15 Regulations, title 42, section 441.301(c).

526.16 Subd. 10. **No discrimination based on source of payment.** All facilities must, regardless
526.17 of the source of payment and for all persons seeking to reside or residing in the facility:

526.18 (1) provide equal access to quality care; and

526.19 (2) establish, maintain, and implement identical policies and practices regarding residency,
526.20 transfer, and provision and termination of services.

526.21 **EFFECTIVE DATE.** This section is effective August 1, 2021.

526.22 Sec. 4. **[144I.031] FACILITY RESPONSIBILITIES; HOUSING AND**
526.23 **SERVICE-RELATED MATTERS.**

526.24 Subdivision 1. **Responsibility for housing and services.** The facility is directly
526.25 responsible to the resident for all housing and service-related matters provided, irrespective
526.26 of a management contract. Housing and service-related matters include but are not limited
526.27 to the handling of complaints, the provision of notices, and the initiation of any adverse
526.28 action against the resident involving housing or services provided by the facility.

526.29 Subd. 2. **Uniform checklist disclosure of services.** (a) On and after August 1, 2021, a
526.30 facility must provide to prospective residents, the prospective resident's designated
526.31 representative, and any other person or persons the resident chooses:

527.1 (1) a written checklist listing all services permitted under the facility's license, identifying
527.2 all services the facility offers to provide under the assisted living facility contract, and
527.3 identifying all services allowed under the license that the facility does not provide; and

527.4 (2) an oral explanation of the services offered under the contract.

527.5 (b) The requirements of paragraph (a) must be completed prior to the execution of the
527.6 resident contract.

527.7 (c) The commissioner must, in consultation with all interested stakeholders, design the
527.8 uniform checklist disclosure form for use as provided under paragraph (a).

527.9 Subd. 3. **Reservation of rights.** Nothing in this chapter:

527.10 (1) requires a resident to utilize any service provided by or through, or made available
527.11 in, a facility;

527.12 (2) prevents a facility from requiring, as a condition of the contract, that the resident pay
527.13 for a package of services even if the resident does not choose to use all or some of the
527.14 services in the package. For residents who are eligible for home and community-based
527.15 waiver services under sections 256B.0915 and 256B.49, payment for services will follow
527.16 the policies of those programs;

527.17 (3) requires a facility to fundamentally alter the nature of the operations of the facility
527.18 in order to accommodate a resident's request; or

527.19 (4) affects the duty of a facility to grant a resident's request for reasonable
527.20 accommodations.

527.21 Sec. 5. **[144L.032] TRANSFER OF RESIDENTS WITHIN FACILITY.**

527.22 (a) A facility must provide for the safe, orderly, and appropriate transfer of residents
527.23 within the facility.

527.24 (b) If an assisted living contract permits resident transfers within the facility, the facility
527.25 must provide at least 30 days' advance notice of the transfer to the resident and the resident's
527.26 designated representative.

527.27 (c) In situations where there is a curtailment, reduction, capital improvement, or change
527.28 in operations within a facility, the facility must minimize the number of transfers needed
527.29 to complete the project or change in operations, consider individual resident needs and
527.30 preferences, and provide reasonable accommodation for individual resident requests regarding
527.31 the room transfer. The facility must provide notice to the Office of Ombudsman for
527.32 Long-Term Care and, when appropriate, the Office of Ombudsman for Mental Health and

528.1 Developmental Disabilities in advance of any notice to residents, residents' designated
 528.2 representatives, and families when all of the following circumstances apply:

528.3 (1) the transfers of residents within the facility are being proposed due to curtailment,
 528.4 reduction, capital improvements, or change in operations;

528.5 (2) the transfers of residents within the facility are not temporary moves to accommodate
 528.6 physical plan upgrades or renovation; and

528.7 (3) the transfers involve multiple residents being moved simultaneously.

528.8 **EFFECTIVE DATE.** This section is effective August 1, 2021.

528.9 Sec. 6. **[144I.033] FACILITY RESPONSIBILITIES; BUSINESS OPERATION.**

528.10 Subdivision 1. **Display of license.** The original current license must be displayed at the
 528.11 main entrance of the facility. The facility must provide a copy of the license to any person
 528.12 who requests it.

528.13 Subd. 2. **Quality management.** The facility shall engage in quality management
 528.14 appropriate to the size of the facility and relevant to the type of services provided. The
 528.15 quality management activity means evaluating the quality of care by periodically reviewing
 528.16 resident services, complaints made, and other issues that have occurred and determining
 528.17 whether changes in services, staffing, or other procedures need to be made in order to ensure
 528.18 safe and competent services to residents. Documentation about quality management activity
 528.19 must be available for two years. Information about quality management must be available
 528.20 to the commissioner at the time of the survey, investigation, or renewal.

528.21 Subd. 3. **Facility restrictions.** (a) This subdivision does not apply to licensees that are
 528.22 Minnesota counties or other units of government.

528.23 (b) A facility or staff person cannot accept a power-of-attorney from residents for any
 528.24 purpose, and may not accept appointments as guardians or conservators of residents.

528.25 (c) A facility cannot serve as a resident's representative.

528.26 Subd. 4. **Handling resident's finances and property.** (a) A facility may assist residents
 528.27 with household budgeting, including paying bills and purchasing household goods, but may
 528.28 not otherwise manage a resident's property. A facility must provide a resident with receipts
 528.29 for all transactions and purchases paid with the resident's funds. When receipts are not
 528.30 available, the transaction or purchase must be documented. A facility must maintain records
 528.31 of all such transactions.

529.1 (b) A facility or staff person may not borrow a resident's funds or personal or real
529.2 property, nor in any way convert a resident's property to the facility's or staff person's
529.3 possession.

529.4 (c) Nothing in this section precludes a facility or staff from accepting gifts of minimal
529.5 value or precludes the acceptance of donations or bequests made to a facility that are exempt
529.6 from income tax under section 501(c) of the Internal Revenue Code of 1986.

529.7 **Subd. 5. Reporting maltreatment of vulnerable adults; abuse prevention plan.** (a)
529.8 All facilities must comply with the requirements for the reporting of maltreatment of
529.9 vulnerable adults in section 626.557. Each facility must establish and implement a written
529.10 procedure to ensure that all cases of suspected maltreatment are reported.

529.11 (b) Each facility must develop and implement an individual abuse prevention plan for
529.12 each vulnerable adult. The plan shall contain an individualized review or assessment of the
529.13 person's susceptibility to abuse by another individual, including other vulnerable adults; the
529.14 person's risk of abusing other vulnerable adults; and statements of the specific measures to
529.15 be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes
529.16 of the abuse prevention plan, abuse includes self-abuse.

529.17 **Subd. 6. Reporting suspected crime and maltreatment.** (a) A facility shall support
529.18 protection and safety through access to the state's systems for reporting suspected criminal
529.19 activity and suspected vulnerable adult maltreatment by:

529.20 (1) posting the 911 emergency number in common areas and near telephones provided
529.21 by the assisted living facility;

529.22 (2) posting information and the reporting number for the Minnesota Adult Abuse
529.23 Reporting Center under section 626.557 to report suspected maltreatment of a vulnerable
529.24 adult; and

529.25 (3) providing reasonable accommodations with information and notices in plain language.

529.26 **Subd. 7. Employee records.** (a) The facility must maintain current records of each paid
529.27 employee, regularly scheduled volunteers providing services, and each individual contractor
529.28 providing services. The records must include the following information:

529.29 (1) evidence of current professional licensure, registration, or certification if licensure,
529.30 registration, or certification is required by this statute or other rules;

529.31 (2) records of orientation, required annual training and infection control training, and
529.32 competency evaluations;

530.1 (3) current job description, including qualifications, responsibilities, and identification
 530.2 of staff persons providing supervision;

530.3 (4) documentation of annual performance reviews that identify areas of improvement
 530.4 needed and training needs;

530.5 (5) for individuals providing facility services, verification that required health screenings
 530.6 under section 144I.034, subdivision 7, have taken place and the dates of those screenings;
 530.7 and

530.8 (6) documentation of the background study as required under section 144.057.

530.9 (b) Each employee record must be retained for at least three years after a paid employee,
 530.10 volunteer, or contractor ceases to be employed by or under contract with the facility. If a
 530.11 facility ceases operation, employee records must be maintained for three years.

530.12 Subd. 8. **Compliance officer.** Every assisted living facility shall have a compliance
 530.13 officer who is a licensed assisted living administrator under section 144I.31. An individual
 530.14 licensed as a nursing home administrator, an assisted living administrator, or a health services
 530.15 executive shall automatically meet the qualifications of a compliance officer. The compliance
 530.16 officer must exhibit knowledge of relevant regulations, provide expertise in compliance
 530.17 processes, and address fraud, abuse, and waste under this chapter and state and federal law.

530.18 Sec. 7. **[144I.034] FACILITY RESPONSIBILITIES; STAFF.**

530.19 Subdivision 1. **Qualifications, training, and competency.** All staff persons providing
 530.20 services must be trained and competent in the provision of services consistent with current
 530.21 practice standards appropriate to the resident's needs and be informed of the assisted living
 530.22 bill of rights under section 144I.21.

530.23 Subd. 2. **Licensed health professionals and nurses.** (a) Licensed health professionals
 530.24 and nurses providing services as employees of a licensed facility must possess a current
 530.25 Minnesota license or registration to practice.

530.26 (b) Licensed health professionals and registered nurses must be competent in assessing
 530.27 resident needs, planning appropriate services to meet resident needs, implementing services,
 530.28 and supervising staff if assigned.

530.29 (c) Nothing in this section limits or expands the rights of nurses or licensed health
 530.30 professionals to provide services within the scope of their licenses or registrations, as
 530.31 provided by law.

530.32 Subd. 3. **Unlicensed personnel.** (a) Unlicensed personnel providing services must have:

531.1 (1) successfully completed a training and competency evaluation appropriate to the
531.2 services provided by the facility and the topics listed in subdivision 6, paragraph (b); or

531.3 (2) demonstrated competency by satisfactorily completing a written or oral test on the
531.4 tasks the unlicensed personnel will perform and on the topics listed in subdivision 6,
531.5 paragraph (b); and successfully demonstrated competency of topics in subdivision 6,
531.6 paragraph (b), clauses (5), (7), and (8), by a practical skills test.

531.7 Unlicensed personnel providing basic care services shall not perform delegated nursing or
531.8 therapy tasks.

531.9 (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility
531.10 must:

531.11 (1) have successfully completed training and demonstrated competency by successfully
531.12 completing a written or oral test of the topics in subdivision 6, paragraphs (b) and (c), and
531.13 a practical skills test on tasks listed in subdivision 6, paragraphs (b), clauses (5) and (7),
531.14 and (c), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform;

531.15 (2) satisfy the current requirements of Medicare for training or competency of home
531.16 health aides or nursing assistants, as provided by Code of Federal Regulations, title 42,
531.17 section 483 or 484.36; or

531.18 (3) have, before April 19, 1993, completed a training course for nursing assistants that
531.19 was approved by the commissioner.

531.20 (c) Unlicensed personnel performing therapy or treatment tasks delegated or assigned
531.21 by a licensed health professional must meet the requirements for delegated tasks in
531.22 subdivision 4 and any other training or competency requirements within the licensed health
531.23 professional's scope of practice relating to delegation or assignment of tasks to unlicensed
531.24 personnel.

531.25 Subd. 4. **Delegation of assisted living services.** A registered nurse or licensed health
531.26 professional may delegate tasks only to staff who are competent and possess the knowledge
531.27 and skills consistent with the complexity of the tasks and according to the appropriate
531.28 Minnesota practice act. The assisted living facility must establish and implement a system
531.29 to communicate up-to-date information to the registered nurse or licensed health professional
531.30 regarding the current available staff and their competency so the registered nurse or licensed
531.31 health professional has sufficient information to determine the appropriateness of delegating
531.32 tasks to meet individual resident needs and preferences.

532.1 Subd. 5. **Temporary staff.** When a facility contracts with a temporary staffing agency,
532.2 those individuals must meet the same requirements required by this section for personnel
532.3 employed by the facility and shall be treated as if they are staff of the facility.

532.4 Subd. 6. **Requirements for instructors, training content, and competency evaluations**
532.5 **for unlicensed personnel.** (a) Instructors and competency evaluators must meet the following
532.6 requirements:

532.7 (1) training and competency evaluations of unlicensed personnel providing basic care
532.8 services must be conducted by individuals with work experience and training in providing
532.9 basic care services; and

532.10 (2) training and competency evaluations of unlicensed personnel providing assisted
532.11 living services must be conducted by a registered nurse, or another instructor may provide
532.12 training in conjunction with the registered nurse.

532.13 (b) Training and competency evaluations for all unlicensed personnel must include the
532.14 following:

532.15 (1) documentation requirements for all services provided;

532.16 (2) reports of changes in the resident's condition to the supervisor designated by the
532.17 facility;

532.18 (3) basic infection control, including blood-borne pathogens;

532.19 (4) maintenance of a clean and safe environment;

532.20 (5) appropriate and safe techniques in personal hygiene and grooming, including:

532.21 (i) hair care and bathing;

532.22 (ii) care of teeth, gums, and oral prosthetic devices;

532.23 (iii) care and use of hearing aids; and

532.24 (iv) dressing and assisting with toileting;

532.25 (6) training on the prevention of falls;

532.26 (7) standby assistance techniques and how to perform them;

532.27 (8) medication, exercise, and treatment reminders;

532.28 (9) basic nutrition, meal preparation, food safety, and assistance with eating;

532.29 (10) preparation of modified diets as ordered by a licensed health professional;

- 533.1 (11) communication skills that include preserving the dignity of the resident and showing
533.2 respect for the resident and the resident's preferences, cultural background, and family;
- 533.3 (12) awareness of confidentiality and privacy;
- 533.4 (13) understanding appropriate boundaries between staff and residents and the resident's
533.5 family;
- 533.6 (14) procedures to use in handling various emergency situations; and
- 533.7 (15) awareness of commonly used health technology equipment and assistive devices.
- 533.8 (c) In addition to paragraph (b), training and competency evaluation for unlicensed
533.9 personnel providing assisted living services must include:
- 533.10 (1) observing, reporting, and documenting resident status;
- 533.11 (2) basic knowledge of body functioning and changes in body functioning, injuries, or
533.12 other observed changes that must be reported to appropriate personnel;
- 533.13 (3) reading and recording temperature, pulse, and respirations of the resident;
- 533.14 (4) recognizing physical, emotional, cognitive, and developmental needs of the resident;
- 533.15 (5) safe transfer techniques and ambulation;
- 533.16 (6) range of motioning and positioning; and
- 533.17 (7) administering medications or treatments as required.
- 533.18 (d) When the registered nurse or licensed health professional delegates tasks, that person
533.19 must ensure that prior to the delegation the unlicensed personnel is trained in the proper
533.20 methods to perform the tasks or procedures for each resident and are able to demonstrate
533.21 the ability to competently follow the procedures and perform the tasks. If an unlicensed
533.22 personnel has not regularly performed the delegated assisted living task for a period of 24
533.23 consecutive months, the unlicensed personnel must demonstrate competency in the task to
533.24 the registered nurse or appropriate licensed health professional. The registered nurse or
533.25 licensed health professional must document instructions for the delegated tasks in the
533.26 resident's record.
- 533.27 Subd. 7. **Tuberculosis prevention and control.** A facility must establish and maintain
533.28 a comprehensive tuberculosis infection control program according to the most current
533.29 tuberculosis infection control guidelines issued by the United States Centers for Disease
533.30 Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the
533.31 CDC's Morbidity and Mortality Weekly Report (MMWR). The program must include a

534.1 tuberculosis infection control plan that covers all paid and unpaid employees, contractors,
534.2 students, and volunteers. The Department of Health shall provide technical assistance
534.3 regarding implementation of the guidelines.

534.4 Subd. 8. **Disaster planning and emergency preparedness plan.** (a) Each facility must
534.5 meet the following requirements:

534.6 (1) have a written emergency disaster plan that contains a plan for evacuation, addresses
534.7 elements of sheltering in place, identifies temporary relocation sites, and details staff
534.8 assignments in the event of a disaster or an emergency;

534.9 (2) post an emergency disaster plan prominently;

534.10 (3) provide building emergency exit diagrams to all residents;

534.11 (4) post emergency exit diagrams on each floor; and

534.12 (5) have a written policy and procedure regarding missing tenant residents.

534.13 (b) Each facility must provide emergency and disaster training to all staff during the
534.14 initial staff orientation and annually thereafter and must make emergency and disaster
534.15 training annually available to all residents. Staff who have not received emergency and
534.16 disaster training are allowed to work only when trained staff are also working on site.

534.17 (c) Each facility must meet any additional requirements adopted in rule.

534.18 Sec. 8. **[144I.035] FACILITY RESPONSIBILITIES WITH RESPECT TO**
534.19 **RESIDENTS.**

534.20 Subdivision 1. **Assisted living bill of rights; notification to resident.** (a) The facility
534.21 shall provide the resident and the designated representative a written notice of the rights
534.22 under section 144I.21 before the initiation of services to that resident. The facility shall
534.23 make all reasonable efforts to provide notice of the rights to the resident and the designated
534.24 representative in a language the resident and designated representative can understand.

534.25 (b) In addition to the text of the bill of rights in section 144I.21, the notice shall also
534.26 contain the following statement describing how to file a complaint.

534.27 "If you have a complaint about the facility or the person providing your services, you may
534.28 call the Minnesota Adult Abuse Reporting Center at 1-844-880-1574, or you may contact
534.29 the Office of Health Facility Complaints, Minnesota Department of Health. You may also
534.30 contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for
534.31 Mental Health and Developmental Disabilities."

535.1 (c) The statement must include the telephone number, website address, e-mail address,
535.2 mailing address, and street address of the Office of Health Facility Complaints at the
535.3 Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the
535.4 Office of Ombudsman for Mental Health and Developmental Disabilities. The statement
535.5 must include the facility's name, address, e-mail, telephone number, and name or title of
535.6 the person at the facility to whom problems or complaints may be directed. It must also
535.7 include a statement that the facility will not retaliate because of a complaint.

535.8 (d) The facility must obtain written acknowledgment of the resident's receipt of the bill
535.9 of rights or shall document why an acknowledgment cannot be obtained. The
535.10 acknowledgment may be obtained from the resident and the designated representative.
535.11 Acknowledgment of receipt shall be retained in the resident's record.

535.12 Subd. 2. **Notices in plain language; language accommodations.** The facility must
535.13 provide all notices in plain language that residents can understand and make reasonable
535.14 accommodations for residents who have communication disabilities and those whose primary
535.15 language is a language other than English.

535.16 Subd. 3. **Notice of services for dementia or related disorders.** The facility that provides
535.17 services to residents with dementia shall provide in written or electronic form, to residents
535.18 and families or other persons who request it, a description of the training program and related
535.19 training it provides, including the categories of employees trained, the frequency of training,
535.20 and the basic topics covered.

535.21 Subd. 4. **Services oversight and information.** The facility shall provide each resident
535.22 with identifying and contact information about the persons who can assist with health care
535.23 or supportive services being provided. The facility shall keep each resident informed of
535.24 changes in the personnel referenced in this subdivision.

535.25 Subd. 5. **Notice to residents; change in ownership or management.** A facility must
535.26 provide prompt written notice to the resident or designated representative of any change of
535.27 legal name, telephone number, and physical mailing address, which may not be a public or
535.28 private post office box, of:

535.29 (1) the licensee of the facility;

535.30 (2) the manager of the facility, if applicable; and

535.31 (3) the agent authorized to accept legal process on behalf of the facility.

535.32 Subd. 6. **Acceptance of residents.** A facility may not accept a person as a resident unless
535.33 the facility has staff, sufficient in qualifications, competency, and numbers, to adequately

536.1 provide the services agreed to in the assisted living contract and the service plan and that
536.2 are within the facility's ability to provide services.

536.3 Subd. 7. **Referrals.** If a facility reasonably believes that a resident is in need of another
536.4 medical or health service, including a licensed health professional, or social service provider,
536.5 the facility shall:

536.6 (1) determine the resident's preferences with respect to obtaining the service; and

536.7 (2) inform the resident of the resources available, if known, to assist the resident in
536.8 obtaining services.

536.9 Subd. 8. **Initiation of services.** When a facility initiates services and the individualized
536.10 review or assessment required in subdivision 10 has not been completed, the facility must
536.11 complete a temporary plan and agreement with the resident for services.

536.12 Subd. 9. **Initial reviews, assessments, and monitoring.** (a) For residents who do not
536.13 contract for health-related services, the facility shall complete an individualized initial
536.14 review of the resident's needs and preferences. The initial review must be completed within
536.15 30 days of the start of services. Resident monitoring and review must be conducted as needed
536.16 based on changes in the needs of the resident and cannot exceed 90 days from the date of
536.17 the last review.

536.18 (b) For residents receiving assisted living services, an assisted living facility shall conduct
536.19 a nursing assessment by a registered nurse of the physical and cognitive needs of the
536.20 prospective resident and propose a temporary service plan prior to the date on which a
536.21 prospective resident executes a contract with a facility or the date on which a prospective
536.22 resident moves in, whichever is earlier. If necessitated by either the geographic distance
536.23 between the prospective resident and the facility, or urgent or unexpected circumstances,
536.24 the assessment may be conducted using telecommunication methods based on practice
536.25 standards that meet the resident's needs and reflect person-centered planning and care
536.26 delivery.

536.27 (c) Resident reassessment and monitoring must be conducted no more than 14 days after
536.28 initiation of services. Ongoing resident reassessment and monitoring must be conducted as
536.29 needed based on changes in the needs of the resident and cannot exceed 90 days from the
536.30 last date of the assessment.

536.31 (d) Residents who are not receiving any services shall not be required to undergo an
536.32 initial review or nursing assessment.

537.1 (e) A facility must inform the prospective resident of the availability of and contact
537.2 information for long-term care consultation services under section 256B.0911, prior to the
537.3 date on which a prospective resident executes a contract with a facility or the date on which
537.4 a prospective resident moves in, whichever is earlier.

537.5 Subd. 10. **Service plan, implementation, and revisions to service plan.** (a) No later
537.6 than 14 days after the date that services are first provided, a facility shall finalize a current
537.7 written service plan.

537.8 (b) The service plan and any revisions must include a signature or other authentication
537.9 by the facility and by the resident or the designated representative documenting agreement
537.10 on the services to be provided. The service plan must be revised, if needed, based on resident
537.11 review or reassessment under subdivision 10. The facility must provide information to the
537.12 resident about changes to the facility's fee for services and how to contact the Office of
537.13 Ombudsman for Long-Term Care.

537.14 (c) The facility must implement and provide all services required by the current service
537.15 agreement.

537.16 (d) The service plan and the revised service plan must be entered into the resident's
537.17 record, including notice of a change in a resident's fees when applicable.

537.18 (e) Staff providing services must be informed of the current written service plan.

537.19 (f) The service plan must include:

537.20 (1) a description of the services to be provided, the fees for services, and the frequency
537.21 of each service, according to the resident's current review or assessment and resident
537.22 preferences;

537.23 (2) the identification of staff or categories of staff who will provide the services;

537.24 (3) the schedule and methods of monitoring reviews or assessments of the resident;

537.25 (4) the schedule and methods of monitoring staff providing services; and

537.26 (5) a contingency plan that includes:

537.27 (i) the action to be taken by the facility and by the resident and the designated
537.28 representative if the scheduled service cannot be provided;

537.29 (ii) information and a method for a resident and the designated representative to contact
537.30 the facility;

538.1 (iii) the names and contact information of persons the resident wishes to have notified
538.2 in an emergency or if there is a significant adverse change in the resident's condition,
538.3 including identification of and information as to who has authority to sign for the resident
538.4 in an emergency; and

538.5 (iv) the circumstances in which emergency medical services are not to be summoned
538.6 consistent with chapters 145B and 145C, and declarations made by the resident under those
538.7 chapters.

538.8 **Subd. 11. Request for discontinuation of life-sustaining treatment.** (a) If a resident,
538.9 family member, or other caregiver of the resident requests that an employee or other agent
538.10 of the facility discontinue a life-sustaining treatment, the employee or agent receiving the
538.11 request:

538.12 (1) shall take no action to discontinue the treatment; and

538.13 (2) shall promptly inform the supervisor or other agent of the facility of the resident's
538.14 request.

538.15 (b) Upon being informed of a request for termination of treatment, the facility shall
538.16 promptly:

538.17 (1) inform the resident that the request will be made known to the physician or advanced
538.18 practice registered nurse who ordered the resident's treatment;

538.19 (2) inform the physician or advanced practice registered nurse of the resident's request;
538.20 and

538.21 (3) work with the resident and the resident's physician or advanced practice registered
538.22 nurse to comply with the provisions of the Health Care Directive Act in chapter 145C.

538.23 (c) This section does not require the facility to discontinue treatment, except as may be
538.24 required by law or court order.

538.25 (d) This section does not diminish the rights of residents to control their treatments,
538.26 refuse services, or terminate their relationships with the facility.

538.27 (e) This section shall be construed in a manner consistent with chapter 145B or 145C,
538.28 whichever applies, and declarations made by residents under those chapters.

538.29 **Subd. 12. Medical cannabis.** Facilities may exercise the authority and are subject to
538.30 the protections in section 152.34.

538.31 **Subd. 13. Landlord and tenant.** Facilities are subject to and must comply with chapter
538.32 504B.

539.1 **Sec. 9. [144I.036] PROVISION OF SERVICES.**

539.2 **Subdivision 1. Availability of contact person to staff.** (a) Assisted living facilities and
539.3 assisted living facilities that provide dementia care must have a registered nurse available
539.4 for consultation to staff performing delegated nursing tasks and must have an appropriate
539.5 licensed health professional available if performing other delegated services such as therapies.

539.6 (b) The appropriate contact person must be readily available either in person, by
539.7 telephone, or by other means to the staff at times when the staff is providing services.

539.8 **Subd. 2. Supervision of staff; basic care services.** (a) Staff who perform basic care
539.9 services must be supervised periodically where the services are being provided to verify
539.10 that the work is being performed competently and to identify problems and solutions to
539.11 address issues relating to the staff's ability to provide the services. The supervision of the
539.12 unlicensed personnel must be done by staff of the facility having the authority, skills, and
539.13 ability to provide the supervision of unlicensed personnel and who can implement changes
539.14 as needed, and train staff.

539.15 (b) Supervision includes direct observation of unlicensed personnel while the unlicensed
539.16 personnel are providing the services and may also include indirect methods of gaining input
539.17 such as gathering feedback from the resident. Supervisory review of staff must be provided
539.18 at a frequency based on the staff person's competency and performance.

539.19 **Subd. 3. Supervision of staff providing delegated nursing or therapy tasks.** (a) Staff
539.20 who perform delegated nursing or therapy tasks must be supervised by an appropriate
539.21 licensed health professional or a registered nurse per the assisted living facility's policy
539.22 where the services are being provided to verify that the work is being performed competently
539.23 and to identify problems and solutions related to the staff person's ability to perform the
539.24 tasks. Supervision of staff performing medication or treatment administration shall be
539.25 provided by a registered nurse or appropriate licensed health professional and must include
539.26 observation of the staff administering the medication or treatment and the interaction with
539.27 the resident.

539.28 (b) The direct supervision of staff performing delegated tasks must be provided within
539.29 30 days after the date on which the individual begins working for the facility and first
539.30 performs the delegated tasks for residents and thereafter as needed based on performance.
539.31 This requirement also applies to staff who have not performed delegated tasks for one year
539.32 or longer.

539.33 **Subd. 4. Documentation.** A facility must retain documentation of supervision activities
539.34 in the personnel records.

540.1 Sec. 10. [144I.037] MEDICATION MANAGEMENT.

540.2 Subdivision 1. Medication management services. (a) This section applies only to
540.3 assisted living facilities that provide medication management services.

540.4 (b) An assisted living facility that provides medication management services must
540.5 develop, implement, and maintain current written medication management policies and
540.6 procedures. The policies and procedures must be developed under the supervision and
540.7 direction of a registered nurse, licensed health professional, or pharmacist consistent with
540.8 current practice standards and guidelines.

540.9 (c) The written policies and procedures must address requesting and receiving
540.10 prescriptions for medications; preparing and giving medications; verifying that prescription
540.11 drugs are administered as prescribed; documenting medication management activities;
540.12 controlling and storing medications; monitoring and evaluating medication use; resolving
540.13 medication errors; communicating with the prescriber, pharmacist, and resident and
540.14 designated representative, if any; disposing of unused medications; and educating residents
540.15 and designated representatives about medications. When controlled substances are being
540.16 managed, the policies and procedures must also identify how the provider will ensure security
540.17 and accountability for the overall management, control, and disposition of those substances
540.18 in compliance with state and federal regulations and with subdivision 23.

540.19 Subd. 2. Provision of medication management services. (a) For each resident who
540.20 requests medication management services, the assisted living facility shall, prior to providing
540.21 medication management services, have a registered nurse, licensed health professional, or
540.22 authorized prescriber under section 151.37 conduct an assessment to determine what
540.23 medication management services will be provided and how the services will be provided.
540.24 This assessment must be conducted face-to-face with the resident. The assessment must
540.25 include an identification and review of all medications the resident is known to be taking.
540.26 The review and identification must include indications for medications, side effects,
540.27 contraindications, allergic or adverse reactions, and actions to address these issues.

540.28 (b) The assessment must identify interventions needed in management of medications
540.29 to prevent diversion of medication by the resident or others who may have access to the
540.30 medications. "Diversion of medications" means the misuse, theft, or illegal or improper
540.31 disposition of medications and to provide instructions to the resident and designated
540.32 representative on interventions to manage the resident's medications and prevent diversion
540.33 of medications.

541.1 Subd. 3. **Individualized medication monitoring and reassessment.** The assisted living
541.2 facility must monitor and reassess the resident's medication management services as needed
541.3 under subdivision 2 when the resident presents with symptoms or other issues that may be
541.4 medication-related and, at a minimum, annually.

541.5 Subd. 4. **Resident refusal.** The assisted living facility must document in the resident's
541.6 record any refusal for an assessment for medication management by the resident. The assisted
541.7 living facility must discuss with the resident the possible consequences of the resident's
541.8 refusal and document the discussion in the resident's record.

541.9 Subd. 5. **Individualized medication management plan.** (a) For each resident receiving
541.10 medication management services, the assisted living facility must prepare and include in
541.11 the service plan a written statement of the medication management services that will be
541.12 provided to the resident. The assisted living facility must develop and maintain a current
541.13 individualized medication management record for each resident based on the resident's
541.14 assessment that must contain the following:

541.15 (1) a statement describing the medication management services that will be provided;

541.16 (2) a description of storage of medications based on the resident's needs and preferences,
541.17 risk of diversion, and consistent with the manufacturer's directions;

541.18 (3) documentation of specific resident instructions relating to the administration of
541.19 medications;

541.20 (4) identification of persons responsible for monitoring medication supplies and ensuring
541.21 that medication refills are ordered on a timely basis;

541.22 (5) identification of medication management tasks that may be delegated to unlicensed
541.23 personnel;

541.24 (6) procedures for staff notifying a registered nurse or appropriate licensed health
541.25 professional when a problem arises with medication management services; and

541.26 (7) any resident-specific requirements relating to documenting medication administration,
541.27 verifications that all medications are administered as prescribed, and monitoring of
541.28 medication use to prevent possible complications or adverse reactions.

541.29 (b) The medication management record must be current and updated when there are any
541.30 changes.

541.31 (c) Medication reconciliation must be completed when a licensed nurse, licensed health
541.32 professional, or authorized prescriber is providing medication management.

542.1 Subd. 6. **Administration of medication.** Medications may be administered by a nurse,
542.2 physician, or other licensed health practitioner authorized to administer medications or by
542.3 unlicensed personnel who have been delegated medication administration tasks by a
542.4 registered nurse.

542.5 Subd. 7. **Delegation of medication administration.** When administration of medications
542.6 is delegated to unlicensed personnel, the assisted living facility must ensure that the registered
542.7 nurse has:

542.8 (1) instructed the unlicensed personnel in the proper methods to administer the
542.9 medications, and the unlicensed personnel has demonstrated the ability to competently
542.10 follow the procedures;

542.11 (2) specified, in writing, specific instructions for each resident and documented those
542.12 instructions in the resident's records; and

542.13 (3) communicated with the unlicensed personnel about the individual needs of the
542.14 resident.

542.15 Subd. 8. **Documentation of administration of medications.** Each medication
542.16 administered by the assisted living facility staff must be documented in the resident's record.
542.17 The documentation must include the signature and title of the person who administered the
542.18 medication. The documentation must include the medication name, dosage, date and time
542.19 administered, and method and route of administration. The staff must document the reason
542.20 why medication administration was not completed as prescribed and document any follow-up
542.21 procedures that were provided to meet the resident's needs when medication was not
542.22 administered as prescribed and in compliance with the resident's medication management
542.23 plan.

542.24 Subd. 9. **Documentation of medication setup.** Documentation of dates of medication
542.25 setup, name of medication, quantity of dose, times to be administered, route of administration,
542.26 and name of person completing medication setup must be done at the time of setup.

542.27 Subd. 10. **Medication management for residents who will be away from home.** (a)
542.28 An assisted living facility that is providing medication management services to the resident
542.29 must develop and implement policies and procedures for giving accurate and current
542.30 medications to residents for planned or unplanned times away from home according to the
542.31 resident's individualized medication management plan. The policies and procedures must
542.32 state that:

543.1 (1) for planned time away, the medications must be obtained from the pharmacy or set
543.2 up by the licensed nurse according to appropriate state and federal laws and nursing standards
543.3 of practice;

543.4 (2) for unplanned time away, when the pharmacy is not able to provide the medications,
543.5 a licensed nurse or unlicensed personnel shall give the resident and designated representative
543.6 medications in amounts and dosages needed for the length of the anticipated absence, not
543.7 to exceed seven calendar days;

543.8 (3) the resident or designated representative must be provided written information on
543.9 medications, including any special instructions for administering or handling the medications,
543.10 including controlled substances;

543.11 (4) the medications must be placed in a medication container or containers appropriate
543.12 to the provider's medication system and must be labeled with the resident's name and the
543.13 dates and times that the medications are scheduled; and

543.14 (5) the resident and designated representative must be provided in writing the facility's
543.15 name and information on how to contact the facility.

543.16 (b) For unplanned time away when the licensed nurse is not available, the registered
543.17 nurse may delegate this task to unlicensed personnel if:

543.18 (1) the registered nurse has trained the unlicensed staff and determined the unlicensed
543.19 staff is competent to follow the procedures for giving medications to residents; and

543.20 (2) the registered nurse has developed written procedures for the unlicensed personnel,
543.21 including any special instructions or procedures regarding controlled substances that are
543.22 prescribed for the resident. The procedures must address:

543.23 (i) the type of container or containers to be used for the medications appropriate to the
543.24 provider's medication system;

543.25 (ii) how the container or containers must be labeled;

543.26 (iii) written information about the medications to be given to the resident or designated
543.27 representative;

543.28 (iv) how the unlicensed staff must document in the resident's record that medications
543.29 have been given to the resident and the designated representative, including documenting
543.30 the date the medications were given to the resident or the designated representative and who
543.31 received the medications, the person who gave the medications to the resident, the number
543.32 of medications that were given to the resident, and other required information;

544.1 (v) how the registered nurse shall be notified that medications have been given to the
544.2 resident or designated representative and whether the registered nurse needs to be contacted
544.3 before the medications are given to the resident or the designated representative;

544.4 (vi) a review by the registered nurse of the completion of this task to verify that this task
544.5 was completed accurately by the unlicensed personnel; and

544.6 (vii) how the unlicensed personnel must document in the resident's record any unused
544.7 medications that are returned to the facility, including the name of each medication and the
544.8 doses of each returned medication.

544.9 Subd. 11. **Prescribed and nonprescribed medication.** The assisted living facility must
544.10 determine whether the facility shall require a prescription for all medications the provider
544.11 manages. The assisted living facility must inform the resident or the designated representative
544.12 whether the facility requires a prescription for all over-the-counter and dietary supplements
544.13 before the facility agrees to manage those medications.

544.14 Subd. 12. **Medications; over-the-counter; dietary supplements not prescribed.** An
544.15 assisted living facility providing medication management services for over-the-counter
544.16 drugs or dietary supplements must retain those items in the original labeled container with
544.17 directions for use prior to setting up for immediate or later administration. The facility must
544.18 verify that the medications are up to date and stored as appropriate.

544.19 Subd. 13. **Prescriptions.** There must be a current written or electronically recorded
544.20 prescription as defined in section 151.01, subdivision 16a, for all prescribed medications
544.21 that the assisted living facility is managing for the resident.

544.22 Subd. 14. **Renewal of prescriptions.** Prescriptions must be renewed at least every 12
544.23 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions
544.24 for controlled substances must comply with chapter 152.

544.25 Subd. 15. **Verbal prescription orders.** Verbal prescription orders from an authorized
544.26 prescriber must be received by a nurse or pharmacist. The order must be handled according
544.27 to Minnesota Rules, part 6800.6200.

544.28 Subd. 16. **Written or electronic prescription.** When a written or electronic prescription
544.29 is received, it must be communicated to the registered nurse in charge and recorded or placed
544.30 in the resident's record.

544.31 Subd. 17. **Records confidential.** A prescription or order received verbally, in writing,
544.32 or electronically must be kept confidential according to sections 144.291 to 144.298 and
544.33 144A.44.

545.1 Subd. 18. **Medications provided by resident or family members.** When the assisted
545.2 living facility is aware of any medications or dietary supplements that are being used by
545.3 the resident and are not included in the assessment for medication management services,
545.4 the staff must advise the registered nurse and document that in the resident's record.

545.5 Subd. 19. **Storage of medications.** An assisted living facility must store all prescription
545.6 medications in securely locked and substantially constructed compartments according to
545.7 the manufacturer's directions and permit only authorized personnel to have access.

545.8 Subd. 20. **Prescription drugs.** A prescription drug, prior to being set up for immediate
545.9 or later administration, must be kept in the original container in which it was dispensed by
545.10 the pharmacy bearing the original prescription label with legible information including the
545.11 expiration or beyond-use date of a time-dated drug.

545.12 Subd. 21. **Prohibitions.** No prescription drug supply for one resident may be used or
545.13 saved for use by anyone other than the resident.

545.14 Subd. 22. **Disposition of medications.** (a) Any current medications being managed by
545.15 the assisted living facility must be given to the resident or the designated representative
545.16 when the resident's service plan ends or medication management services are no longer part
545.17 of the service plan. Medications for a resident who is deceased or that have been discontinued
545.18 or have expired may be given to the resident or the designated representative for disposal.

545.19 (b) The assisted living facility shall dispose of any medications remaining with the
545.20 facility that are discontinued or expired or upon the termination of the service contract or
545.21 the resident's death according to state and federal regulations for disposition of medications
545.22 and controlled substances.

545.23 (c) Upon disposition, the facility must document in the resident's record the disposition
545.24 of the medication including the medication's name, strength, prescription number as
545.25 applicable, quantity, to whom the medications were given, date of disposition, and names
545.26 of staff and other individuals involved in the disposition.

545.27 Subd. 23. **Loss or spillage.** (a) Assisted living facilities providing medication
545.28 management must develop and implement procedures for loss or spillage of all controlled
545.29 substances defined in Minnesota Rules, part 6800.4220. These procedures must require that
545.30 when a spillage of a controlled substance occurs, a notation must be made in the resident's
545.31 record explaining the spillage and the actions taken. The notation must be signed by the
545.32 person responsible for the spillage and include verification that any contaminated substance
545.33 was disposed of according to state or federal regulations.

546.1 (b) The procedures must require that the facility providing medication management
546.2 investigate any known loss or unaccounted for prescription drugs and take appropriate action
546.3 required under state or federal regulations and document the investigation in required records.

546.4 Sec. 11. **[144I.038] TREATMENT AND THERAPY MANAGEMENT SERVICES.**

546.5 Subdivision 1. **Treatment and therapy management services.** This section applies
546.6 only to assisted living facilities that provide assisted living services.

546.7 Subd. 2. **Policies and procedures.** (a) An assisted living facility that provides treatment
546.8 and therapy management services must develop, implement, and maintain up-to-date written
546.9 treatment or therapy management policies and procedures. The policies and procedures
546.10 must be developed under the supervision and direction of a registered nurse or appropriate
546.11 licensed health professional consistent with current practice standards and guidelines.

546.12 (b) The written policies and procedures must address requesting and receiving orders
546.13 or prescriptions for treatments or therapies, providing the treatment or therapy, documenting
546.14 treatment or therapy activities, educating and communicating with residents about treatments
546.15 or therapies they are receiving, monitoring and evaluating the treatment or therapy, and
546.16 communicating with the prescriber.

546.17 Subd. 3. **Individualized treatment or therapy management plan.** For each resident
546.18 receiving management of ordered or prescribed treatments or therapy services, the assisted
546.19 living facility must prepare and include in the service plan a written statement of the treatment
546.20 or therapy services that will be provided to the resident. The facility must also develop and
546.21 maintain a current individualized treatment and therapy management record for each resident
546.22 which must contain at least the following:

546.23 (1) a statement of the type of services that will be provided;

546.24 (2) documentation of specific resident instructions relating to the treatments or therapy
546.25 administration;

546.26 (3) identification of treatment or therapy tasks that will be delegated to unlicensed
546.27 personnel;

546.28 (4) procedures for notifying a registered nurse or appropriate licensed health professional
546.29 when a problem arises with treatments or therapy services; and

546.30 (5) any resident-specific requirements relating to documentation of treatment and therapy
546.31 received, verification that all treatment and therapy was administered as prescribed, and
546.32 monitoring of treatment or therapy to prevent possible complications or adverse reactions.

547.1 The treatment or therapy management record must be current and updated when there are
547.2 any changes.

547.3 Subd. 4. **Administration of treatments and therapy.** Ordered or prescribed treatments
547.4 or therapies must be administered by a nurse, physician, or other licensed health professional
547.5 authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed
547.6 personnel by the licensed health professional according to the appropriate practice standards
547.7 for delegation or assignment. When administration of a treatment or therapy is delegated
547.8 or assigned to unlicensed personnel, the facility must ensure that the registered nurse or
547.9 authorized licensed health professional has:

547.10 (1) instructed the unlicensed personnel in the proper methods with respect to each resident
547.11 and the unlicensed personnel has demonstrated the ability to competently follow the
547.12 procedures;

547.13 (2) specified, in writing, specific instructions for each resident and documented those
547.14 instructions in the resident's record; and

547.15 (3) communicated with the unlicensed personnel about the individual needs of the
547.16 resident.

547.17 Subd. 5. **Documentation of administration of treatments and therapies.** Each treatment
547.18 or therapy administered by an assisted living facility must be in the resident's record. The
547.19 documentation must include the signature and title of the person who administered the
547.20 treatment or therapy and must include the date and time of administration. When treatment
547.21 or therapies are not administered as ordered or prescribed, the provider must document the
547.22 reason why it was not administered and any follow-up procedures that were provided to
547.23 meet the resident's needs.

547.24 Subd. 6. **Treatment and therapy orders.** There must be an up-to-date written or
547.25 electronically recorded order from an authorized prescriber for all treatments and therapies.
547.26 The order must contain the name of the resident, a description of the treatment or therapy
547.27 to be provided, and the frequency, duration, and other information needed to administer the
547.28 treatment or therapy. Treatment and therapy orders must be renewed at least every 12
547.29 months.

547.30 Subd. 7. **Right to outside service provider; other payors.** Under section 144I.21, a
547.31 resident is free to retain therapy and treatment services from an off-site service provider.
547.32 Assisted living facilities must make every effort to assist residents in obtaining information
547.33 regarding whether the Medicare, medical assistance under chapter 256B, or another public
547.34 program will pay for any or all of the services.

548.1 Sec. 12. [144I.039] RESIDENT RECORD REQUIREMENTS.

548.2 Subdivision 1. Resident record. (a) The facility must maintain records for each resident
548.3 for whom it is providing services. Entries in the resident records must be current, legible,
548.4 permanently recorded, dated, and authenticated with the name and title of the person making
548.5 the entry.

548.6 (b) Resident records, whether written or electronic, must be protected against loss,
548.7 tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable
548.8 relevant federal and state laws. The facility shall establish and implement written procedures
548.9 to control use, storage, and security of resident's records and establish criteria for release
548.10 of resident information.

548.11 (c) The facility may not disclose to any other person any personal, financial, or medical
548.12 information about the resident, except:

548.13 (1) as may be required by law;

548.14 (2) to employees or contractors of the facility, another facility, other health care
548.15 practitioner or provider, or inpatient facility needing information in order to provide services
548.16 to the resident, but only the information that is necessary for the provision of services;

548.17 (3) to persons authorized in writing by the resident or the resident's representative to
548.18 receive the information, including third-party payers; and

548.19 (4) to representatives of the commissioner authorized to survey or investigate facilities
548.20 under this chapter or federal laws.

548.21 Subd. 2. Access to records. The facility must ensure that the appropriate records are
548.22 readily available to employees and contractors authorized to access the records. Resident
548.23 records must be maintained in a manner that allows for timely access, printing, or
548.24 transmission of the records. The records must be made readily available to the commissioner
548.25 upon request.

548.26 Subd. 3. Contents of resident record. Contents of a resident record include the following
548.27 for each resident:

548.28 (1) identifying information, including the resident's name, date of birth, address, and
548.29 telephone number;

548.30 (2) the name, address, and telephone number of an emergency contact, family members,
548.31 designated representative, if any, or others as identified;

549.1 (3) names, addresses, and telephone numbers of the resident's health and medical service
549.2 providers, if known;

549.3 (4) health information, including medical history, allergies, and when the provider is
549.4 managing medications, treatments or therapies that require documentation, and other relevant
549.5 health records;

549.6 (5) the resident's advance directives, if any;

549.7 (6) copies of any health care directives, guardianships, powers of attorney, or
549.8 conservatorships;

549.9 (7) the facility's current and previous assessments and service plans;

549.10 (8) all records of communications pertinent to the resident's services;

549.11 (9) documentation of significant changes in the resident's status and actions taken in
549.12 response to the needs of the resident, including reporting to the appropriate supervisor or
549.13 health care professional;

549.14 (10) documentation of incidents involving the resident and actions taken in response to
549.15 the needs of the resident, including reporting to the appropriate supervisor or health care
549.16 professional;

549.17 (11) documentation that services have been provided as identified in the service
549.18 agreement;

549.19 (12) documentation that the resident has received and reviewed the assisted living bill
549.20 of rights;

549.21 (13) documentation of complaints received and any resolution;

549.22 (14) a discharge summary, including service termination notice and related
549.23 documentation, when applicable; and

549.24 (15) other documentation required under this chapter and relevant to the resident's
549.25 services or status.

549.26 Subd. 4. **Transfer of resident records.** If a resident transfers to another facility or
549.27 another health care practitioner or provider, or is admitted to an inpatient facility, the facility,
549.28 upon request of the resident or the resident's representative, shall take steps to ensure a
549.29 coordinated transfer including sending a copy or summary of the resident's record to the
549.30 new facility or the resident, as appropriate.

550.1 Subd. 5. **Record retention.** Following the resident's discharge or termination of services,
 550.2 a facility must retain a resident's record for at least five years or as otherwise required by
 550.3 state or federal regulations. Arrangements must be made for secure storage and retrieval of
 550.4 resident records if the facility ceases business.

550.5 Sec. 13. **[144I.0391] ORIENTATION AND ANNUAL TRAINING REQUIREMENTS.**

550.6 Subdivision 1. **Orientation of staff and supervisors.** All staff providing and supervising
 550.7 direct services must complete an orientation to facility licensing requirements and regulations
 550.8 before providing services to residents. The orientation may be incorporated into the training
 550.9 required under subdivision 6. The orientation need only be completed once for each staff
 550.10 person and is not transferable to another facility.

550.11 Subd. 2. **Content.** (a) The orientation must contain the following topics:

550.12 (1) an overview of this chapter;

550.13 (2) an introduction and review of the facility's policies and procedures related to the
 550.14 provision of assisted living services by the individual staff person;

550.15 (3) handling of emergencies and use of emergency services;

550.16 (4) compliance with and reporting of the maltreatment of vulnerable adults under section
 550.17 626.557;

550.18 (5) assisted living bill of rights under section 144I.21;

550.19 (6) protection-related rights under section 144I.03, subdivision 7, and staff responsibilities
 550.20 related to ensuring the exercise and protection of those rights;

550.21 (7) the principles of person-centered service planning and delivery and how they apply
 550.22 to direct support services provided by the staff person;

550.23 (8) handling of residents' complaints, reporting of complaints, and where to report
 550.24 complaints, including information on the Minnesota Adult Abuse Reporting Center and the
 550.25 Office of Health Facility Complaints;

550.26 (9) consumer advocacy services of the Office of Ombudsman for Long-Term Care,
 550.27 Office of Ombudsman for Mental Health and Developmental Disabilities, Minnesota Adult
 550.28 Abuse Reporting Center (MAARC), Managed Care Ombudsman at the Department of
 550.29 Human Services, county-managed care advocates, or other relevant advocacy services; and

550.30 (10) a review of the types of assisted living services the employee will be providing and
 550.31 the facility's category of licensure.

551.1 (b) In addition to the topics in paragraph (a), orientation may also contain training on
551.2 providing services to residents with hearing loss. Any training on hearing loss provided
551.3 under this subdivision must be high quality and research based, may include online training,
551.4 and must include training on one or more of the following topics:

551.5 (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence,
551.6 and the challenges it poses to communication;

551.7 (2) health impacts related to untreated age-related hearing loss, such as increased
551.8 incidence of dementia, falls, hospitalizations, isolation, and depression; or

551.9 (3) information about strategies and technology that may enhance communication and
551.10 involvement, including communication strategies, assistive listening devices, hearing aids,
551.11 visual and tactile alerting devices, communication access in real time, and closed captions.

551.12 Subd. 3. **Verification and documentation of orientation.** Each facility shall retain
551.13 evidence in the employee record of each staff person having completed the orientation
551.14 required by this section.

551.15 Subd. 4. **Orientation to resident.** Staff providing services must be oriented specifically
551.16 to each individual resident and the services to be provided. This orientation may be provided
551.17 in person, orally, in writing, or electronically.

551.18 Subd. 5. **Training required relating to dementia.** All direct care staff and supervisors
551.19 providing direct services must receive training that includes a current explanation of dementia
551.20 and related disorders, effective approaches to use to problem solve when working with a
551.21 resident's challenging behaviors, and how to communicate with residents who have dementia
551.22 or related memory disorders.

551.23 Subd. 6. **Required annual training.** (a) All staff that perform direct services must
551.24 complete at least eight hours of annual training for each 12 months of employment. The
551.25 training may be obtained from the facility or another source and must include topics relevant
551.26 to the provision of assisted living services. The annual training must include:

551.27 (1) training on reporting of maltreatment of vulnerable adults under section 626.557;

551.28 (2) review of the assisted living bill of rights in section 144I.21;

551.29 (3) review of infection control techniques used in the home and implementation of
551.30 infection control standards including a review of hand washing techniques; the need for and
551.31 use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials
551.32 and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable
551.33 equipment; disinfecting environmental surfaces; and reporting communicable diseases;

552.1 (4) effective approaches to use to problem solve when working with a resident's
552.2 challenging behaviors, and how to communicate with residents who have dementia or related
552.3 disorders;

552.4 (5) review of the facility's policies and procedures relating to the provision of assisted
552.5 living services and how to implement those policies and procedures;

552.6 (6) review of protection-related rights as stated in section 144I.03, subdivision 7, and
552.7 staff responsibilities related to ensuring the exercise and protection of those rights; and

552.8 (7) the principles of person-centered service planning and delivery and how they apply
552.9 to direct support services provided by the staff person.

552.10 (b) In addition to the topics in paragraph (a), annual training may also contain training
552.11 on providing services to residents with hearing loss. Any training on hearing loss provided
552.12 under this subdivision must be high quality and research based, may include online training,
552.13 and must include training on one or more of the following topics:

552.14 (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence,
552.15 and challenges it poses to communication;

552.16 (2) the health impacts related to untreated age-related hearing loss, such as increased
552.17 incidence of dementia, falls, hospitalizations, isolation, and depression; or

552.18 (3) information about strategies and technology that may enhance communication and
552.19 involvement, including communication strategies, assistive listening devices, hearing aids,
552.20 visual and tactile alerting devices, communication access in real time, and closed captions.

552.21 Subd. 7. **Documentation.** A facility must retain documentation in the employee records
552.22 of staff who have satisfied the orientation and training requirements of this section.

552.23 Subd. 8. **Implementation.** A facility must implement all orientation and training topics
552.24 covered in this section.

552.25 Sec. 14. **[144I.0392] TRAINING IN DEMENTIA CARE REQUIRED.**

552.26 (a) Assisted living facilities and assisted living facilities with dementia care must meet
552.27 the following training requirements:

552.28 (1) supervisors of direct-care staff must have at least eight hours of initial training on
552.29 topics specified under paragraph (b) within 120 working hours of the employment start
552.30 date, and must have at least two hours of training on topics related to dementia care for each
552.31 12 months of employment thereafter;

553.1 (2) direct-care employees must have completed at least eight hours of initial training on
 553.2 topics specified under paragraph (b) within 160 working hours of the employment start
 553.3 date. Until this initial training is complete, an employee must not provide direct care unless
 553.4 there is another employee on site who has completed the initial eight hours of training on
 553.5 topics related to dementia care and who can act as a resource and assist if issues arise. A
 553.6 trainer of the requirements under paragraph (b) or a supervisor meeting the requirements
 553.7 in clause (1) must be available for consultation with the new employee until the training
 553.8 requirement is complete. Direct-care employees must have at least two hours of training on
 553.9 topics related to dementia for each 12 months of employment thereafter;

553.10 (3) staff who do not provide direct care, including maintenance, housekeeping, and food
 553.11 service staff, must have at least four hours of initial training on topics specified under
 553.12 paragraph (b) within 160 working hours of the employment start date, and must have at
 553.13 least two hours of training on topics related to dementia care for each 12 months of
 553.14 employment thereafter; and

553.15 (4) new employees may satisfy the initial training requirements by producing written
 553.16 proof of previously completed required training within the past 18 months.

553.17 (b) Areas of required training include:

553.18 (1) an explanation of dementia and related disorders;

553.19 (2) assistance with activities of daily living;

553.20 (3) problem solving with challenging behaviors; and

553.21 (4) communication skills.

553.22 (c) The facility shall provide to consumers in written or electronic form a description of
 553.23 the training program, the categories of employees trained, the frequency of training, and
 553.24 the basic topics covered.

553.25 **Sec. 15. [144L.0393] CONTROLLING INDIVIDUAL RESTRICTIONS.**

553.26 Subdivision 1. **Restrictions.** The controlling individual of a facility may not include
 553.27 any person who was a controlling individual of any other nursing home, assisted living
 553.28 facility, or assisted living facility with dementia care during any period of time in the previous
 553.29 two-year period:

553.30 (1) during which time of control the nursing home, assisted living facility, or assisted
 553.31 living facility with dementia care incurred the following number of uncorrected or repeated
 553.32 violations:

554.1 (i) two or more uncorrected violations or one or more repeated violations that created
554.2 an imminent risk to direct resident care or safety; or

554.3 (ii) four or more uncorrected violations or two or more repeated violations of any nature,
554.4 including Level 2, Level 3, and Level 4 violations as defined in section 144I.11, subdivision
554.5 9; or

554.6 (2) who, during that period, was convicted of a felony or gross misdemeanor that relates
554.7 to the operation of the nursing home, assisted living facility, or assisted living facility with
554.8 dementia care, or directly affects resident safety or care.

554.9 Subd. 2. **Exception.** The provisions of subdivision 1 do not apply to any controlling
554.10 individual of the facility who had no legal authority to affect or change decisions related to
554.11 the operation of the nursing home, assisted living facility, or assisted living facility with
554.12 dementia care that incurred the uncorrected violations.

554.13 Subd. 3. **Stay of adverse action required by controlling individual restrictions.** (a)
554.14 In lieu of revoking, suspending, or refusing to renew the license of a facility where a
554.15 controlling individual was disqualified by subdivision 1, clause (1), the commissioner may
554.16 issue an order staying the revocation, suspension, or nonrenewal of the facility's license.
554.17 The order may but need not be contingent upon the facility's compliance with restrictions
554.18 and conditions imposed on the license to ensure the proper operation of the facility and to
554.19 protect the health, safety, comfort, treatment, and well-being of the residents in the facility.
554.20 The decision to issue an order for a stay must be made within 90 days of the commissioner's
554.21 determination that a controlling individual of the facility is disqualified by subdivision 1,
554.22 clause (1), from operating a facility.

554.23 (b) In determining whether to issue a stay and to impose conditions and restrictions, the
554.24 commissioner must consider the following factors:

554.25 (1) the ability of the controlling individual to operate other facilities in accordance with
554.26 the licensure rules and laws;

554.27 (2) the conditions in the nursing home, assisted living facility, or assisted living facility
554.28 with dementia care that received the number and type of uncorrected or repeated violations
554.29 described in subdivision 1, clause (1); and

554.30 (3) the conditions and compliance history of each of the nursing homes, assisted living
554.31 facilities, and assisted living facilities with dementia care owned or operated by the
554.32 controlling individuals.

555.1 (c) The commissioner's decision to exercise the authority under this subdivision in lieu
555.2 of revoking, suspending, or refusing to renew the license of the facility is not subject to
555.3 administrative or judicial review.

555.4 (d) The order for the stay of revocation, suspension, or nonrenewal of the facility license
555.5 must include any conditions and restrictions on the license that the commissioner deems
555.6 necessary based on the factors listed in paragraph (b).

555.7 (e) Prior to issuing an order for stay of revocation, suspension, or nonrenewal, the
555.8 commissioner shall inform the controlling individual in writing of any conditions and
555.9 restrictions that will be imposed. The controlling individual shall, within ten working days,
555.10 notify the commissioner in writing of a decision to accept or reject the conditions and
555.11 restrictions. If the facility rejects any of the conditions and restrictions, the commissioner
555.12 must either modify the conditions and restrictions or take action to suspend, revoke, or not
555.13 renew the facility's license.

555.14 (f) Upon issuance of the order for a stay of revocation, suspension, or nonrenewal, the
555.15 controlling individual shall be responsible for compliance with the conditions and restrictions.
555.16 Any time after the conditions and restrictions have been in place for 180 days, the controlling
555.17 individual may petition the commissioner for removal or modification of the conditions and
555.18 restrictions. The commissioner must respond to the petition within 30 days of receipt of the
555.19 written petition. If the commissioner denies the petition, the controlling individual may
555.20 request a hearing under the provisions of chapter 14. Any hearing shall be limited to a
555.21 determination of whether the conditions and restrictions shall be modified or removed. At
555.22 the hearing, the controlling individual bears the burden of proof.

555.23 (g) The failure of the controlling individual to comply with the conditions and restrictions
555.24 contained in the order for stay shall result in the immediate removal of the stay and the
555.25 commissioner shall take action to suspend, revoke, or not renew the license.

555.26 (h) The conditions and restrictions are effective for two years after the date they are
555.27 imposed.

555.28 (i) Nothing in this subdivision shall be construed to limit in any way the commissioner's
555.29 ability to impose other sanctions against a facility licensee under the standards in state or
555.30 federal law whether or not a stay of revocation, suspension, or nonrenewal is issued.

555.31 **Sec. 16. [144I.04] MANAGEMENT AGREEMENTS; GENERAL REQUIREMENTS.**

555.32 Subdivision 1. **Notification.** (a) If the proposed or current licensee uses a manager, the
555.33 licensee must have a written management agreement that is consistent with this chapter.

- 556.1 (b) The proposed or current licensee must notify the commissioner of its use of a manager
556.2 upon:
- 556.3 (1) initial application for a license;
556.4 (2) retention of a manager following initial application;
556.5 (3) change of managers; and
556.6 (4) modification of an existing management agreement.
- 556.7 (c) The proposed or current licensee must provide to the commissioner a written
556.8 management agreement, including an organizational chart showing the relationship between
556.9 the proposed or current licensee, management company, and all related organizations.
- 556.10 (d) The written management agreement must be submitted:
- 556.11 (1) 60 days before:
- 556.12 (i) the initial licensure date;
556.13 (ii) the proposed change of ownership date; or
556.14 (iii) the effective date of the management agreement; or
- 556.15 (2) 30 days before the effective date of any amendment to an existing management
556.16 agreement.
- 556.17 (e) The proposed licensee or the current licensee must notify the residents and their
556.18 representatives 60 days before entering into a new management agreement.
- 556.19 (f) A proposed licensee must submit a management agreement.
- 556.20 **Subd. 2. Management agreement; licensee.** (a) The licensee is legally responsible for:
- 556.21 (1) the daily operations and provisions of services in the facility;
556.22 (2) ensuring the facility is operated in a manner consistent with all applicable laws and
556.23 rules;
- 556.24 (3) ensuring the manager acts in conformance with the management agreement; and
556.25 (4) ensuring the manager does not present as, or give the appearance that the manager
556.26 is the licensee.
- 556.27 (b) The licensee must not give the manager responsibilities that are so extensive that the
556.28 licensee is relieved of daily responsibility for the daily operations and provision of services
556.29 in the assisted living facility. If the licensee does so, the commissioner must determine that
556.30 a change of ownership has occurred.

557.1 (c) The licensee and manager must act in accordance with the terms of the management
557.2 agreement. If the commissioner determines they are not, then the department may impose
557.3 enforcement remedies.

557.4 (d) The licensee may enter into a management agreement only if the management
557.5 agreement creates a principal/agent relationship between the licensee and manager.

557.6 (e) The manager shall not subcontract the manager's responsibilities to a third party.

557.7 Subd. 3. **Terms of agreement.** A management agreement at a minimum must:

557.8 (1) describe the responsibilities of the licensee and manager, including items, services,
557.9 and activities to be provided;

557.10 (2) require the licensee's governing body, board of directors, or similar authority to
557.11 appoint the administrator;

557.12 (3) provide for the maintenance and retention of all records in accordance with this
557.13 chapter and other applicable laws;

557.14 (4) allow unlimited access by the commissioner to documentation and records according
557.15 to applicable laws or regulations;

557.16 (5) require the manager to immediately send copies of inspections and notices of
557.17 noncompliance to the licensee;

557.18 (6) state that the licensee is responsible for reviewing, acknowledging, and signing all
557.19 facility initial and renewal license applications;

557.20 (7) state that the manager and licensee shall review the management agreement annually
557.21 and notify the commissioner of any change according to applicable regulations;

557.22 (8) acknowledge that the licensee is the party responsible for complying with all laws
557.23 and rules applicable to the facility;

557.24 (9) require the licensee to maintain ultimate responsibility over personnel issues relating
557.25 to the operation of the facility and care of the residents including but not limited to staffing
557.26 plans, hiring, and performance management of employees, orientation, and training;

557.27 (10) state the manager will not present as, or give the appearance that the manager is
557.28 the licensee; and

557.29 (11) state that a duly authorized manager may execute resident leases or agreements on
557.30 behalf of the licensee, but all such resident leases or agreements must be between the licensee
557.31 and the resident.

558.1 Subd. 4. **Commissioner review.** The commissioner may review a management agreement
558.2 at any time. Following the review, the department may require:

558.3 (1) the proposed or current licensee or manager to provide additional information or
558.4 clarification;

558.5 (2) any changes necessary to:

558.6 (i) bring the management agreement into compliance with this chapter; and

558.7 (ii) ensure that the licensee has not been relieved of the legal responsibility for the daily
558.8 operations of the facility; and

558.9 (3) the licensee to participate in monthly meetings and quarterly on-site visits to the
558.10 facility.

558.11 Subd. 5. **Resident funds.** (a) If the management agreement delegates day-to-day
558.12 management of resident funds to the manager, the licensee:

558.13 (1) retains all fiduciary and custodial responsibility for funds that have been deposited
558.14 with the facility by the resident;

558.15 (2) is directly accountable to the resident for such funds; and

558.16 (3) must ensure any party responsible for holding or managing residents' personal funds
558.17 is bonded or obtains insurance in sufficient amounts to specifically cover losses of resident
558.18 funds and provides proof of bond or insurance.

558.19 (b) If responsibilities for the day-to-day management of the resident funds are delegated
558.20 to the manager, the manager must:

558.21 (1) provide the licensee with a monthly accounting of the resident funds; and

558.22 (2) meet all legal requirements related to holding and accounting for resident funds.

558.23 Sec. 17. **[144I.05] MINIMUM SITE, PHYSICAL ENVIRONMENT AND FIRE**
558.24 **SAFETY REQUIREMENTS.**

558.25 Subdivision 1. **Requirements.** (a) Effective August 1, 2021, the following are required
558.26 for all assisted living facilities and assisted living facilities with dementia care:

558.27 (1) public utilities must be available, and working or inspected and approved water and
558.28 septic systems are in place;

558.29 (2) the location is publicly accessible to fire department services and emergency medical
558.30 services;

559.1 (3) the location's topography provides sufficient natural drainage and is not subject to
559.2 flooding;

559.3 (4) all-weather roads and walks must be provided within the lot lines to the primary
559.4 entrance and the service entrance, including employees' and visitors' parking at the site; and

559.5 (5) the location must include space for outdoor activities for residents.

559.6 (b) An assisted living facility with a dementia care unit must also meet the following
559.7 requirements:

559.8 (1) a hazard vulnerability assessment or safety risk must be performed on and around
559.9 the property. The hazards indicated on the assessment must be assessed and mitigated to
559.10 protect the residents from harm; and

559.11 (2) the facility shall be protected throughout by an approved supervised automatic
559.12 sprinkler system by August 1, 2029.

559.13 Subd. 2. **Fire protection and physical environment.** (a) Effective August 1, 2021, each
559.14 assisted living facility and assisted living facility with dementia care must have a
559.15 comprehensive fire protection system that includes:

559.16 (1) protection throughout by an approved supervised automatic sprinkler system according
559.17 to building code requirements established in Minnesota Rules, part 1305.0903, or smoke
559.18 detectors in each occupied room installed and maintained in accordance with the National
559.19 Fire Protection Association (NFPA) Standard 72;

559.20 (2) portable fire extinguishers installed and tested in accordance with the NFPA Standard
559.21 10;

559.22 (3) beginning August 1, 2021, fire drills shall be conducted in accordance with the
559.23 residential board and care requirements in the Life Safety Code; and

559.24 (4) the physical environment, including walls, floors, ceiling, all furnishings, grounds,
559.25 systems, and equipment must be kept in a continuous state of good repair and operation
559.26 with regard to the health, safety, comfort, and well-being of the residents in accordance
559.27 with a maintenance and repair program.

559.28 Subd. 3. **Local laws apply.** Assisted living facilities shall be in compliance with all
559.29 applicable state and local governing laws, regulations, standards, ordinances, and codes for
559.30 fire safety, building, and zoning requirements.

559.31 Subd. 4. **Assisted living facilities; design.** (a) After July 31, 2021, all assisted living
559.32 facilities with six or more residents must meet the provisions relevant to assisted living

560.1 facilities of the most current edition of the Facility Guidelines Institute "Guidelines for
560.2 Design and Construction of Residential Health, Care and Support Facilities" and of adopted
560.3 rules. This minimum design standard shall be met for all new licenses, new construction,
560.4 modifications, renovations, alterations, change of use, or additions. In addition to the
560.5 guidelines, assisted living facilities, and assisted living facilities with dementia care shall
560.6 provide the option of a bath in addition to a shower for all residents.

560.7 (b) The commissioner shall establish an implementation timeline for mandatory usage
560.8 of the latest published guidelines. However, the commissioner shall not enforce the latest
560.9 published guidelines before six months after the date of publication.

560.10 Subd. 5. **Assisted living facilities; life safety code.** (a) After August 1, 2021, all assisted
560.11 living facilities with six or more residents shall meet the applicable provisions of the most
560.12 current edition of the NFPA Standard 101, Life Safety Code, Residential Board and Care
560.13 Occupancies chapter. This minimum design standard shall be met for all new licenses, new
560.14 construction, modifications, renovations, alterations, change of use, or additions.

560.15 (b) The commissioner shall establish an implementation timeline for mandatory usage
560.16 of the latest published Life Safety Code. However, the commissioner shall not enforce the
560.17 latest published guidelines before six months after the date of publication.

560.18 Subd. 6. **Assisted living facilities with dementia care units; life safety code.** (a)
560.19 Beginning August 1, 2021, all assisted living facilities with dementia care units shall meet
560.20 the applicable provisions of the most current edition of the NFPA Standard 101, Life Safety
560.21 Code, Healthcare (limited care) chapter. This minimum design standard shall be met for all
560.22 new licenses, new construction, modifications, renovations, alterations, change of use or
560.23 additions.

560.24 (b) The commissioner shall establish an implementation timeline for mandatory usage
560.25 of the newest-published Life Safety Code. However, the commissioner shall not enforce
560.26 the newly-published guidelines before 6 months after the date of publication.

560.27 Subd. 7. **New construction; plans.** (a) For all new licensure and construction beginning
560.28 August 1, 2021, the following must be provided to the commissioner:

560.29 (1) architectural and engineering plans and specifications for new construction must be
560.30 prepared and signed by architects and engineers who are registered in Minnesota. Final
560.31 working drawings and specifications for proposed construction must be submitted to the
560.32 commissioner for review and approval;

561.1 (2) final architectural plans and specifications must include elevations and sections
561.2 through the building showing types of construction, and must indicate dimensions and
561.3 assignments of rooms and areas, room finishes, door types and hardware, elevations and
561.4 details of nurses' work areas, utility rooms, toilet and bathing areas, and large-scale layouts
561.5 of dietary and laundry areas. Plans must show the location of fixed equipment and sections
561.6 and details of elevators, chutes, and other conveying systems. Fire walls and smoke partitions
561.7 must be indicated. The roof plan must show all mechanical installations. The site plan must
561.8 indicate the proposed and existing buildings, topography, roadways, walks and utility service
561.9 lines; and

561.10 (3) final mechanical and electrical plans and specifications must address the complete
561.11 layout and type of all installations, systems, and equipment to be provided. Heating plans
561.12 must include heating elements, piping, thermostatic controls, pumps, tanks, heat exchangers,
561.13 boilers, breeching and accessories. Ventilation plans must include room air quantities, ducts,
561.14 fire and smoke dampers, exhaust fans, humidifiers, and air handling units. Plumbing plans
561.15 must include the fixtures and equipment fixture schedule; water supply and circulating
561.16 piping, pumps, tanks, riser diagrams, and building drains; the size, location, and elevation
561.17 of water and sewer services; and the building fire protection systems. Electrical plans must
561.18 include fixtures and equipment, receptacles, switches, power outlets, circuits, power and
561.19 light panels, transformers, and service feeders. Plans must show location of nurse call signals,
561.20 cable lines, fire alarm stations, and fire detectors and emergency lighting.

561.21 (b) Unless construction is begun within one year after approval of the final working
561.22 drawing and specifications, the drawings must be resubmitted for review and approval.

561.23 (c) The commissioner must be notified within 30 days before completion of construction
561.24 so that the commissioner can make arrangements for a final inspection by the commissioner.

561.25 (d) At least one set of complete life safety plans, including changes resulting from
561.26 remodeling or alterations, must be kept on file in the facility.

561.27 Subd. 8. **Variances or waivers.** (a) A facility may request that the commissioner grant
561.28 a variance or waiver from the provisions of this section. A request for a waiver must be
561.29 submitted to the commissioner in writing. Each request must contain:

561.30 (1) the specific requirement for which the variance or waiver is requested;

561.31 (2) the reasons for the request;

561.32 (3) the alternative measures that will be taken if a variance or waiver is granted;

561.33 (4) the length of time for which the variance or waiver is requested; and

562.1 (5) other relevant information deemed necessary by the commissioner to properly evaluate
562.2 the request for the waiver.

562.3 (b) The decision to grant or deny a variance or waiver must be based on the
562.4 commissioner's evaluation of the following criteria:

562.5 (1) whether the waiver will adversely affect the health, treatment, comfort, safety, or
562.6 well-being of a patient;

562.7 (2) whether the alternative measures to be taken, if any, are equivalent to or superior to
562.8 those prescribed in this section; and

562.9 (3) whether compliance with the requirements would impose an undue burden on the
562.10 applicant.

562.11 (c) The commissioner must notify the applicant in writing of the decision. If a variance
562.12 or waiver is granted, the notification must specify the period of time for which the variance
562.13 or waiver is effective and the alternative measures or conditions, if any, to be met by the
562.14 applicant.

562.15 (d) Alternative measures or conditions attached to a variance or waiver have the force
562.16 and effect of this chapter and are subject to the issuance of correction orders and fines in
562.17 accordance with section 144I.11, subdivisions 7 and 9. The amount of fines for a violation
562.18 of this section is that specified for the specific requirement for which the variance or waiver
562.19 was requested.

562.20 (e) A request for the renewal of a variance or waiver must be submitted in writing at
562.21 least 45 days before its expiration date. Renewal requests must contain the information
562.22 specified in paragraph (b). A variance or waiver must be renewed by the department if the
562.23 applicant continues to satisfy the criteria in paragraph (a) and demonstrates compliance
562.24 with the alternative measures or conditions imposed at the time the original variance or
562.25 waiver was granted.

562.26 (f) The department must deny, revoke, or refuse to renew a variance or waiver if it is
562.27 determined that the criteria in paragraph (a) are not met. The applicant must be notified in
562.28 writing of the reasons for the decision and informed of the right to appeal the decision.

562.29 (g) An applicant may contest the denial, revocation, or refusal to renew a variance or
562.30 waiver by requesting a contested case hearing under chapter 14. The applicant must submit,
562.31 within 15 days of the receipt of the department's decision, a written request for a hearing.
562.32 The request for hearing must set forth in detail the reasons why the applicant contends the
562.33 decision of the department should be reversed or modified. At the hearing, the applicant

563.1 has the burden of proving by a preponderance of the evidence that the applicant satisfied
563.2 the criteria specified in paragraph (b), except in a proceeding challenging the revocation of
563.3 a variance or waiver.

563.4 **Sec. 18. [144I.06] ASSISTED LIVING CONTRACT REQUIREMENTS.**

563.5 Subdivision 1. **Contract Required.** (a) An assisted living facility may not offer or
563.6 provide housing or services to a resident unless it has executed a written contract signed
563.7 by:

563.8 (1) the licensee or an agent of the licensee; and

563.9 (2) the resident or, if the resident lacks capacity, the resident's legal representative.

563.10 (b) The contract must contain all the terms concerning the provision of housing and
563.11 assisted living services, whether the services are provided directly or through a related
563.12 assisted living services provider.

563.13 Subd. 2. **Preliminary disclosure required.** (a) Before executing a contract with a
563.14 resident, an assisted living facility must disclose, orally and in writing, the facility's policies
563.15 related to waivers available under sections 256B.0915 and 256B.49, including notice of
563.16 whether the facility is enrolled with the Department of Human Services to provide customized
563.17 living services covered.

563.18 (b) If the facility accepts payments under sections 256B.0915 and 256B.49, the facility
563.19 must:

563.20 (1) indicate the limit, if any, on the number of people residing at the facility who can
563.21 receive customized living services;

563.22 (2) indicate whether the facility requires a resident to pay privately for a period of time
563.23 prior to accepting payment under sections 256B.0915 and 256B.49, and if so, the length of
563.24 time that private payment is required;

563.25 (3) provide the following verbatim statement: "The state's Medical Assistance Program
563.26 may pay for services and the Housing Support Program may pay for rent. Contact the
563.27 Minnesota Department of Human Services for more information."; and

563.28 (4) explain rent requirements for people who are eligible for waivers for customized
563.29 living services under section 256B.0915 or 256B.49 but who are not eligible for housing
563.30 assistance under section 256I.04.

563.31 Subd. 3. **Provision of blank contracts.** A facility must:

564.1 (1) offer a complete unsigned copy of its standard contract to every prospective resident
 564.2 and the resident's legal representative;

564.3 (2) provide a complete unsigned copy of its standard contract to the Ombudsman for
 564.4 Long-Term Care; and

564.5 (3) give a complete copy of any signed contract and any addendums, and all supporting
 564.6 documents and attachments, to the resident and the resident's legal representative promptly
 564.7 after a contract and any addendum has been signed by the resident.

564.8 Subd. 4. **Designation of representative.** (a) Before or at the time of execution of an
 564.9 assisted living contract, every assisted living facility must offer the resident the opportunity
 564.10 to identify a designated representative in writing in the contract and provide the following
 564.11 verbatim notice on a document separate from the contract:

564.12 **RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES**

564.13 You have the right to name anyone as your "Designated Representative" to assist you
 564.14 or, if you are unable, advocate on your behalf. A "Designated Representative" does not take
 564.15 the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health
 564.16 care power of attorney ("health care agent").

564.17 (b) The contract must contain a page or space for the name and contact information of
 564.18 the designated representative and a box the resident must initial if the resident declines to
 564.19 name a designated representative. Notwithstanding subdivision 9, the resident has the right
 564.20 at any time to add or change the name and contact information of the designated
 564.21 representative.

564.22 Subd. 5. **Contracts are consumer contracts.** A contract under this section is a consumer
 564.23 contract under sections 325G.29 to 325G.37.

564.24 Subd. 6. **Additions and amendments to contract.** The resident must agree in writing
 564.25 to any additions or amendments to the contract. Upon agreement between the resident or
 564.26 resident's designated representative and the facility, a new contract or an addendum to the
 564.27 existing contract must be executed and signed and provided to the resident and the resident's
 564.28 legal representative.

564.29 Subd. 7. **Content of contract; contact information.** (a) The contract must include in
 564.30 a conspicuous place and manner on the contract the legal name and the license number of
 564.31 the facility.

564.32 (b) The contract must include the name, telephone number, and physical mailing address,
 564.33 which may not be a public or private post office box, of:

565.1 (1) the assisted living facility and, if applicable, the related assisted living services
565.2 provider;

565.3 (2) the licensee of the facility;

565.4 (3) the managing agent of the facility, if applicable; and

565.5 (4) at least one natural person who is authorized to accept service of process on behalf
565.6 of the facility.

565.7 **Subd. 8. Content of contract; terms and conditions.** The contract must include:

565.8 (1) a description of all the terms and conditions of the contract, including a description
565.9 of and any limitations to housing or assisted living services or both to be provided for the
565.10 contracted amount;

565.11 (2) the cost and nature of any other services to be provided for an additional fee;

565.12 (3) any additional fees the resident may be required to pay if the resident's condition
565.13 changes during the term of the contract;

565.14 (4) the grounds under which the contract may be terminated; and

565.15 (5) billing and payment procedures and requirements.

565.16 **Subd. 9. Contract contents; complaint resolution procedure.** The contract must
565.17 include a description of the facility's complaint resolution process available to residents,
565.18 including the name and contact information of the person representing the facility who is
565.19 designated to handle and resolve complaints.

565.20 **Subd. 10. Contract contents; required disclosures and notices.** The contract must
565.21 contain notice of:

565.22 (1) the right under section 144J.12 to appeal a housing or service termination or to
565.23 challenge an eviction;

565.24 (2) the facility's policy regarding transfer of residents within the facility, under what
565.25 circumstances a transfer may occur, and whether or not consent of the resident being asked
565.26 to transfer is required;

565.27 (3) the toll-free complaint line for the Minnesota Adult Abuse Reporting Center
565.28 (MAARC), the Office of Health Facility Complaints, and the Ombudsman for Long-Term
565.29 Care; and

565.30 (4) the contact information to obtain long-term care consulting services under section
565.31 256B.0911.

566.1 Subd. 11. Notice of availability of public funds. (a) The contract must describe the
566.2 facility's policies related to waivers available under sections 256B.0915 and 256B.49,
566.3 including notice of whether the facility is enrolled with the Department of Human Services
566.4 to provide customized living services covered.

566.5 (b) If the facility accepts payments under sections 256B.0915 and 256B.49, the contract
566.6 must:

566.7 (1) indicate the specific limit, if any, on the number of people residing at the facility
566.8 who can receive customized living services;

566.9 (2) indicate whether the facility requires a resident to pay privately for a period of time
566.10 prior to accepting payment under sections 256B.0915 and 256B.49, and if so, the length of
566.11 time that private payment is required;

566.12 (3) state: "Minnesota's Medical Assistance Program may provide payment for services,
566.13 but does not cover the cost of rent. Residents may be eligible for assistance with room and
566.14 board expenses through the Minnesota's Housing Support Program.";

566.15 (4) explain rent requirements for people with or without public assistance for rent,
566.16 including housing support under section 256I.04; and

566.17 (5) the contact information to obtain long-term care consulting services under section
566.18 256B.0911.

566.19 Subd. 12. Additional contract requirements. (a) Assisted living facility contracts must
566.20 include the requirements in paragraph (b). A restriction of a resident's rights under this
566.21 subdivision is allowed only if determined necessary for health and safety reasons identified
566.22 by the facility's registered nurse in an initial assessment or reassessment, as defined under
566.23 section 144I.035, subdivision 9, and documented in the written service and care plan under
566.24 section 144I.035, subdivision 10. Any restrictions of those rights for individuals served
566.25 under sections 256B.0915 and 256B.49 must be documented in the resident's coordinated
566.26 service and support plan (CSSP), as defined under sections 256B.0915, subdivision 6, and
566.27 256B.49, subdivision 15.

566.28 (b) The contract must include a statement:

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

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

567.1 (3) regarding a resident's right, as provided under section 144J.05, to choose the resident's
567.2 visitors and times of visits;

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

567.4 (5) notifying the resident of the resident's right to have and use a lockable door to the
567.5 resident's unit. The facility must provide the locks on the unit. Only a staff member with a
567.6 specific need to enter the unit shall have keys, and advance notice must be given to the
567.7 resident before entrance, except in emergencies when the health or safety of the resident is
567.8 in jeopardy.

567.9 Subd. 13. **Service and care plan.** All service and care plans required under section
567.10 144I.035, subdivision 10, must be appended to the contract.

567.11 Subd. 14. **Waivers of liability prohibited.** No assisted living contract may include a
567.12 waiver of facility liability for the health and safety or personal property of a resident.

567.13 Subd. 15. **Contracts in permanent files.** The contract and related documents, including
567.14 any applicable written disclosure required under section 325F.72, must be maintained by
567.15 the facility in files from the date of execution until three years after the contract is terminated
567.16 or expires. Contracts and related documents must be made available for on-site inspection
567.17 by the commissioner upon request at any time and be made available for viewing by, or
567.18 copies shall be made available to, the resident and the resident's legal and designated
567.19 representative at any time.

567.20 **EFFECTIVE DATE.** This section is effective August 1, 2021.

567.21 Sec. 19. **[144I.07] INVOLUNTARY DISCHARGES AND SERVICE**
567.22 **TERMINATIONS.**

567.23 Subdivision 1. **Definition.** "Termination of housing or services" means a discharge,
567.24 eviction, transfer, or service termination initiated by the facility. A facility-initiated
567.25 termination is one which the resident objects to and did not originate through a resident's
567.26 verbal or written request. A resident-initiated termination is one where a resident or, if
567.27 appropriate, a designated representative provided a verbal or written notice of intent to leave
567.28 the facility. A resident-initiated termination does not include the general expression of a
567.29 desire to return home or the elopement of residents with cognitive impairment.

567.30 Subd. 2. **Prerequisite to termination of housing or services.** Before terminating a
567.31 resident's housing or services, a facility must explain in detail the reasons for the termination
567.32 and work with the resident, designated representatives, resident representatives, the resident's
567.33 family, applicable agencies, and any relevant health-related or social service professionals

568.1 to identify and offer reasonable accommodations and modifications, interventions, or
568.2 alternatives to avoid the termination.

568.3 **Subd. 3. Permissible reasons to terminate housing or services.** (a) A facility is
568.4 prohibited from terminating housing or services for grounds other than those specified in
568.5 paragraphs (b) and (c).

568.6 (b) A resident's housing or services shall not be terminated unless a termination is
568.7 necessary and there is a written determination, supported by documentation, of the necessity
568.8 of the termination. A termination is considered necessary only if:

568.9 (1) it is mandated by law or court order;

568.10 (2) the resident has engaged in a documented pattern of conduct that:

568.11 (i) endangers the health or safety of other residents or staff of the facility; or

568.12 (ii) repeatedly and substantially interferes with the rights, health, safety, or well-being
568.13 of other residents;

568.14 (3) the facility intends to cease operation;

568.15 (4) the facility's license is being restricted by the commissioner of health in a manner
568.16 that requires the termination;

568.17 (5) the resident has committed any of the acts enumerated under section 504B.171,
568.18 subdivision 1; or

568.19 (6) the resident's needs exceed the scope of the services for which the resident contracted
568.20 and:

568.21 (i) the facility administrator has certified that the resident's needs exceed the scope of
568.22 services for which the resident contracted, based on an evaluation by a disinterested, licensed
568.23 health care professional; and

568.24 (ii) the resident's needs cannot be safely met by reasonable accommodations or
568.25 modifications, interventions, or alternatives.

568.26 (c) A facility may terminate housing or services for nonpayment, provided the facility:

568.27 (1) makes reasonable efforts to accommodate temporary financial hardship and provide
568.28 information on government or private subsidies that may be available; and

568.29 (2) provides the notice required under subdivision 4.

568.30 (d) A temporary interruption in benefits does not constitute nonpayment.

569.1 Subd. 4. **Advance notice required.** A facility must provide at least 30 calendar days'
569.2 advance notice to the resident, the ombudsman for long-term care, and the resident's
569.3 designated representatives and resident representatives or, if no designated representative
569.4 or resident representative, a family member, if known, of a termination of housing or services,
569.5 except as provided in subdivision 6 or 7, paragraph (f). If the facility's license is restricted
569.6 by the commissioner, then the facility must follow the directions by the commissioner for
569.7 resident relocations or ceasing services to residents and these notice provisions do not apply.

569.8 Subd. 5. **Content of notice.** The notice required under subdivision 4 must contain, at a
569.9 minimum:

569.10 (1) the effective date of termination of housing or services;

569.11 (2) a detailed explanation of the basis for the termination, including but not limited to
569.12 clinical or other supporting rationale;

569.13 (3) a list of known facilities in the immediate geographic area;

569.14 (4) a statement that the resident has the right to appeal the termination, an explanation
569.15 of how and to whom to appeal, and contact information for the Office of Administrative
569.16 Hearings;

569.17 (5) information on how to contact the ombudsman for long-term care and the ombudsman
569.18 for mental health and developmental disabilities;

569.19 (6) a description of the steps taken to avoid termination and the issues raised in accordance
569.20 with subdivision 2, and a statement that the resident has the right to request further meetings
569.21 to attempt to resolve the proposed termination;

569.22 (7) a description of the resident's right to avoid a termination, if possible, through
569.23 reasonable accommodations or modifications, interventions, or alternatives;

569.24 (8) a statement that the facility must actively participate in a coordinated transfer of the
569.25 resident to another location or service provider, as required under subdivision 8;

569.26 (9) the name and contact information of a person employed by the facility with whom
569.27 the resident may discuss the notice of termination of housing or services;

569.28 (10) if the termination is for services, a statement, if applicable, that the notice of
569.29 termination of services does not constitute a termination of housing or an eviction from the
569.30 resident's home, and that the resident has the right to remain in the facility; and

570.1 (11) the location to which the resident is being transferred and the contact information
570.2 for any new service provider to be used by the resident, or a statement that a location or
570.3 service provider will be identified prior to termination in accordance in subdivision 8.

570.4 If any information in the notice changes prior to the housing or service termination, the
570.5 facility must update the notice and provide it to the resident, resident's designated
570.6 representatives, and resident representatives or, if no designated representative or resident
570.7 representative, a family member as soon as practicable.

570.8 Subd. 6. **Exception for emergencies.** (a) A facility may relocate a resident from a facility
570.9 with notice of less than 30 calendar days and as soon as practicable if:

570.10 (1) emergency relocation is required for a resident's urgent medical needs and is ordered
570.11 by the resident's physician;

570.12 (2) the resident needs to be immediately relocated because the resident or another resident
570.13 or staff member of the facility is at imminent risk of:

570.14 (i) death;

570.15 (ii) life-threatening harm;

570.16 (iii) substantial harm, as defined in section 609.02, subdivision 7a; or

570.17 (iv) great bodily harm, as defined in section 609.02, subdivision 8, and that harm is
570.18 identified by the facility administrator based on documented evidence; or

570.19 (3) the breach involves any of the acts enumerated in section 504B.171, subdivision 1.

570.20 (b) A facility relocating a resident under this subdivision must:

570.21 (1) ensure that the resident is moved to a safe and appropriate location;

570.22 (2) immediately notify the resident's designated representatives and resident
570.23 representatives or, if no designated representative or resident representative, a family member
570.24 or interested person, if known:

570.25 (i) that the resident has been relocated;

570.26 (ii) the reason for the relocation; and

570.27 (iii) the name, address, telephone number, and any other relevant contact information
570.28 of the location to which the resident has been transferred and any new service provider; and

570.29 (3) if the resident is not expected to or does not return to the facility within 24 hours of
570.30 the emergency relocation and a notice of termination of housing or services has not been
570.31 issued pursuant to subdivision 5, provide a written notice to the resident, ombudsman for

571.1 long-term care, resident representatives or designated representatives if known, or if no
571.2 designated representative or resident representative is known, then to a family member, if
571.3 known, stating at least:

571.4 (i) that the resident is currently expected to return to the facility or, if applicable, that
571.5 the resident is expected to return to the facility upon the removal of certain conditions
571.6 pursuant to paragraph (a) and a detailed description of those conditions;

571.7 (ii) if reasonably ascertainable, an estimated date of the resident's return to the facility;

571.8 (iii) a statement that, if the resident wishes to immediately return to the facility and is
571.9 denied readmission, the resident has the right to appeal any refusal to readmit and contact
571.10 information for the Office of Administrative Hearings;

571.11 (iv) information on how to contact the ombudsman for long-term care;

571.12 (v) the name, address, telephone number, and any other relevant contact information of
571.13 the location to which the resident has been transferred and any new service provider; and

571.14 (vi) upon removal of the conditions precipitating the emergency transfer, immediately
571.15 work and coordinate with the resident and the resident's designated representatives, resident
571.16 representatives, and family, if applicable, to enable the resident to return to the facility.

571.17 (c) If the facility determines that the resident cannot return to the facility or cannot
571.18 receive services from the facility upon return, then the resident, ombudsman for long-term
571.19 care, resident's designated representatives and resident representatives if known or, if no
571.20 designated representative or resident representative is known, then a family member, if
571.21 known, must be given as soon as practicable, but in any event no later than 24 hours after
571.22 the determination:

571.23 (1) a notice of the termination of housing or services pursuant to subdivision 5;

571.24 (2) a statement of the right to appeal pursuant to subdivision 7 and the right to appeal
571.25 the facility's refusal to readmit the resident; and

571.26 (3) a statement of the right to termination planning pursuant to subdivision 8, and that
571.27 the planning may not cease until a safe and appropriate location and, if applicable, service
571.28 provider has been identified.

571.29 **Subd. 7. Right to appeal termination of housing or services.** (a) A resident, designated
571.30 representative, resident representative, or family member has the right to appeal a termination
571.31 of housing or services under subdivision 3 or a facility's refusal to readmit the resident after
571.32 an emergency relocation under subdivision 6 and to request a hearing from the Office of

572.1 Administrative Hearings. An appeal must be filed in writing to the Office of Administrative
572.2 Hearings. An appeal of a refusal to readmit shall be construed as an appeal of any related
572.3 termination of housing or services.

572.4 (b) The Office of Administrative Hearings must conduct an expedited hearing as soon
572.5 as practicable, and in any event no later than 14 calendar days after the office receives the
572.6 request and within three business days in the event of an appeal of a refusal to readmit. The
572.7 hearing must be held at the facility where the resident lives, unless it is impractical or the
572.8 parties agree to a different place. The hearing is not a formal evidentiary hearing. The hearing
572.9 may also be attended by telephone as allowed by the administrative law judge, after
572.10 considering how a telephonic hearing will affect the resident's ability to participate. The
572.11 hearing shall be limited to the amount of time necessary for the participants to expeditiously
572.12 present the facts about the proposed termination. The administrative law judge shall issue
572.13 a recommendation to the commissioner as soon as practicable, and in any event no later
572.14 than ten calendar days after the hearing or within two days in the case of a refusal to readmit.
572.15 Attorney representation is not required at the hearing, nor does appearing without an attorney
572.16 constitute the unauthorized practice of law.

572.17 (c) The facility bears the burden of proof to establish that the termination of housing or
572.18 services or the refusal to readmit the resident is permissible.

572.19 (d) During the pendency of an appeal for a termination of housing or services and until
572.20 a final determination is made by the Office of Administrative Hearings:

572.21 (1) housing or services may not be terminated; and

572.22 (2) the resident may not be relocated except as provided for under subdivision 6. In the
572.23 event of relocation, the resident must be readmitted unless the conditions described in
572.24 subdivision 6, paragraph (a), exist.

572.25 (e) The commissioner of health may order the facility to rescind the termination of
572.26 housing or services if:

572.27 (1) the termination was in violation of state or federal law;

572.28 (2) the resident has cured or is able to cure the reason for the termination, or has identified
572.29 any reasonable accommodations or modifications, interventions, or alternatives to avoid
572.30 the termination; or

572.31 (3) termination planning is in violation of subdivision 8.

572.32 (f) If a termination of housing or services is denied only because of a failure to identify
572.33 a safe and appropriate location or service provider under subdivision 8, the facility, upon

573.1 finding such a safe and appropriate location or service provider, may reissue a termination
 573.2 of housing or services with notice of less than 30 calendar days.

573.3 (g) The commissioner of health may order the immediate readmission of a resident to
 573.4 the facility if:

573.5 (1) the refusal to readmit is in violation of state or federal law;

573.6 (2) the facility has not complied with subdivision 6 or the conditions described in
 573.7 subdivision 6, paragraph (a), do not exist; or

573.8 (3) the resident has cured or is able to cure the reason for the relocation, or has identified
 573.9 any reasonable accommodations or modifications, interventions, or alternatives to avoid
 573.10 the continuance of the relocation.

573.11 (h) Nothing in this section limits the right of a resident or the resident's designated
 573.12 representatives, resident representatives, or family to request or receive assistance from the
 573.13 ombudsman for long-term care and the protection and advocacy agency under Code of
 573.14 Federal Regulations, title 45, section 1326.21, concerning the termination of housing or
 573.15 services.

573.16 (i) Residents are not required to request a meeting with the facility prior to submitting
 573.17 an appeal hearing request.

573.18 Subd. 8. **Housing or service termination planning.** (a) If a facility terminates housing
 573.19 or services, the facility:

573.20 (1) in the event of a termination of housing, has an affirmative duty to ensure a
 573.21 coordinated and orderly transfer of the resident to a safe location that is appropriate for the
 573.22 resident, and the facility must identify that location prior to any appeal hearing;

573.23 (2) in the event of a termination of services, has an affirmative duty to ensure a
 573.24 coordinated and orderly transfer of the resident to an appropriate service provider, if services
 573.25 are still needed and desired by the resident, and the facility must identify the provider prior
 573.26 to any appeal hearing; and

573.27 (3) must consult and cooperate with the resident, the resident's designated representatives,
 573.28 resident representatives, family members, any interested professionals, including case
 573.29 managers, and applicable agencies to make arrangements to relocate the resident, including
 573.30 consideration of the resident's goals.

573.31 (b) A safe location is not a private home where the occupant is unwilling or unable to
 573.32 care for the resident, a homeless shelter, a hotel, or a motel. A facility may not terminate a

574.1 resident's housing or services if the resident will, as a result of the termination, become
574.2 homeless, as that term is defined in section 116L.361, subdivision 5, or if an adequate and
574.3 safe discharge location or adequate and needed service provider has not been identified.

574.4 (c) The facility must prepare a written relocation plan. The plan must:

574.5 (1) contain all the necessary steps to be taken to reduce transfer trauma; and

574.6 (2) specify the measures needed until relocation that protect the resident and meet the
574.7 resident's health and safety needs.

574.8 (d) A facility may not relocate the resident unless the place to which the resident will
574.9 be relocated indicates acceptance of the resident. If a resident continues to need and desire
574.10 the services provided by the facility, the facility may not terminate services unless another
574.11 service provider has indicated that it will provide those services.

574.12 (e) If a resident is relocated to another facility or a nursing home provider, the facility
574.13 must timely convey to that provider:

574.14 (1) the resident's full name, date of birth, and insurance information;

574.15 (2) the name, telephone number, and address of the resident's representatives and resident
574.16 representatives, if any;

574.17 (3) the resident's current documented diagnoses that are relevant to the services being
574.18 provided;

574.19 (4) the resident's known allergies that are relevant to the services being provided;

574.20 (5) the name and telephone number of the resident's physician, if known, and the current
574.21 physician orders that are relevant to the services being provided;

574.22 (6) all medication administration records that are relevant to the services being provided;

574.23 (7) the most recent resident assessment, if relevant to the services being provided; and

574.24 (8) copies of health care directives, "do not resuscitate" orders, and any guardianship
574.25 orders or powers of attorney.

574.26 Subd. 9. **Final accounting; return of money and property.** (a) Within 30 days of the
574.27 date of the termination of housing or services, the facility shall:

574.28 (1) provide to the resident, resident representatives, and designated representatives a
574.29 final statement of account;

574.30 (2) provide any refunds due; and

575.1 (3) return any money, property, or valuables held in trust or custody by the facility.

575.2 (b) As required by section 504B.178, a facility may not collect a nonrefundable security
575.3 deposit unless it is applied to the first month's charges.

575.4 Subd. 10. **Closure plan.** (a) In the event that a facility elects to voluntarily close the
575.5 facility, the facility must notify the commissioner and the Office of Ombudsman for
575.6 Long-Term Care in writing by submitting a proposed closure plan.

575.7 (1) The facility's proposed closure plan must include:

575.8 (i) the procedures and actions the facility will implement to notify residents of the closure,
575.9 including a copy of the written notice to be given to residents, designated representatives,
575.10 resident representatives, or family;

575.11 (ii) the procedures and actions the facility will implement to ensure all residents receive
575.12 appropriate termination planning in accordance with subdivision 8 and final accountings
575.13 and returns under subdivision 9;

575.14 (iii) assessments of the needs and preferences of individual residents; and

575.15 (iv) procedures and actions the facility will implement to maintain compliance with this
575.16 chapter until all residents have relocated.

575.17 (2) The plan shall be subject to the commissioner's approval and, subject to paragraph
575.18 (d), the facility shall take no action to close the residence prior to the commissioner's approval
575.19 of the plan. The commissioner shall approve or otherwise respond to the plan as soon as
575.20 practicable.

575.21 (3) The commissioner of health may require the facility to work with a transitional team
575.22 comprised of department staff, staff of the Office of Ombudsman for Long-Term Care, and
575.23 other professionals the commissioner deems necessary to assist in the proper relocation of
575.24 residents.

575.25 (b) Prior to termination, the facility must follow the termination planning requirements
575.26 under subdivision 8 and final accounting and return requirements under subdivision 9 for
575.27 residents. The facility must implement the plan approved by the commissioner and ensure
575.28 that arrangements for relocation and continued care that meet each resident's social,
575.29 emotional, and health needs are effectuated prior to closure.

575.30 (c) After the commissioner has approved the relocation plan and at least 60 calendar
575.31 days before closing, except as provided under paragraph (d), the facility must notify residents,
575.32 designated representatives, and resident representatives or, if a resident has no designated

576.1 representative or resident representative, a family member, if known, of the closure, the
576.2 proposed date of closure, the contact information of the ombudsman for long-term care,
576.3 and that the facility will follow the termination planning requirements under subdivision 8
576.4 and final accounting and return requirements under subdivision 9.

576.5 (d) In the event the facility must close because the commissioner deems the facility can
576.6 no longer remain open, the facility must meet all requirements in paragraphs (a) to (c),
576.7 except for any requirements the commissioner finds would endanger the health and safety
576.8 of residents. In the event the commissioner determines a closure must occur with less than
576.9 60 calendar days' notice, the facility shall provide notice to residents as soon as practicable
576.10 or as directed by the commissioner.

576.11 (e) Upon request from the commissioner, a facility must provide the commissioner with
576.12 any documentation related to the appropriateness of its relocation plan or to any assertion
576.13 that the facility lacks the funds to comply with paragraphs (a) to (c) or that remaining open
576.14 would otherwise endanger the health and safety of residents pursuant to paragraph (d).

576.15 Subd. 11. **Other rights.** Nothing in this section affects the rights and remedies available
576.16 under chapter 504B, except to the extent those rights or remedies are inconsistent with this
576.17 section.

576.18 Subd. 12. **Fine.** The commissioner may impose a fine for failure to follow the
576.19 requirements of this section.

576.20 **Sec. 20. [144I.09] RELOCATIONS WITHIN ASSISTED LIVING LOCATION.**

576.21 Subdivision 1. **Notice required before relocation within location.** (a) A facility must:

576.22 (1) notify a resident and the resident's representative, if any, at least 14 calendar days
576.23 prior to a proposed nonemergency relocation to a different room at the same location; and

576.24 (2) obtain consent from the resident and the resident's representative, if any.

576.25 (b) A resident must be allowed to stay in the resident's room. If a resident consents to a
576.26 move, any needed reasonable modifications must be made to the new room to accommodate
576.27 the resident's disabilities.

576.28 Subd. 2. **Evaluation.** A facility shall evaluate the resident's individual needs before
576.29 deciding whether the room the resident will be moved to fits the resident's psychological,
576.30 cognitive, and health care needs, including the accessibility of the bathroom.

576.31 Subd. 3. **Restriction on relocation.** A person who has been a private-pay resident for
576.32 at least one year and resides in a private room, and whose payments subsequently will be

577.1 made under the medical assistance program under chapter 256B, may not be relocated to a
577.2 shared room without the consent of the resident or the resident's representative, if any.

577.3 **EFFECTIVE DATE.** This section is effective August 1, 2021.

577.4 Sec. 21. **[144L.10] COMMISSIONER OVERSIGHT AND AUTHORITY.**

577.5 Subdivision 1. **Regulations.** The commissioner shall regulate facilities pursuant to this
577.6 chapter. The regulations shall include the following:

577.7 (1) provisions to assure, to the extent possible, the health, safety, well-being, and
577.8 appropriate treatment of residents while respecting individual autonomy and choice;

577.9 (2) requirements that facilities furnish the commissioner with specified information
577.10 necessary to implement this chapter;

577.11 (3) standards of training of facility personnel;

577.12 (4) standards for provision of services;

577.13 (5) standards for medication management;

577.14 (6) standards for supervision of services;

577.15 (7) standards for resident evaluation or assessment;

577.16 (8) standards for treatments and therapies;

577.17 (9) requirements for the involvement of a resident's health care provider, the
577.18 documentation of the health care provider's orders, if required, and the resident's service
577.19 agreement;

577.20 (10) the maintenance of accurate, current resident records;

577.21 (11) the establishment of levels of licenses based on services provided; and

577.22 (12) provisions to enforce these regulations and the assisted living bill of rights.

577.23 Subd. 2. **Regulatory functions.** (a) The commissioner shall:

577.24 (1) license, survey, and monitor without advance notice facilities in accordance with
577.25 this chapter;

577.26 (2) survey every provisional licensee within one year of the provisional license issuance
577.27 date subject to the provisional licensee providing licensed services to residents;

577.28 (3) survey facility licensees annually;

577.29 (4) investigate complaints of facilities;

578.1 (5) issue correction orders and assess civil penalties;

578.2 (6) take action as authorized in section 144I.12; and

578.3 (7) take other action reasonably required to accomplish the purposes of this chapter.

578.4 (b) Beginning August 1, 2021, the commissioner shall review blueprints for all new
578.5 facility construction and must approve the plans before construction may be commenced.

578.6 (c) The commissioner shall provide on-site review of the construction to ensure that all
578.7 physical environment standards are met before the facility license is complete.

578.8 **Sec. 22. [144I.11] SURVEYS AND INVESTIGATIONS.**

578.9 Subdivision 1. **Regulatory powers.** (a) The department of health is the exclusive state
578.10 agency charged with the responsibility and duty of surveying and investigating all facilities
578.11 required to be licensed under this chapter. The commissioner of health shall enforce all
578.12 sections of this chapter and the rules adopted under this chapter.

578.13 (b) The commissioner, upon request to the facility, must be given access to relevant
578.14 information, records, incident reports, and other documents in the possession of the facility
578.15 if the commissioner considers them necessary for the discharge of responsibilities. For
578.16 purposes of surveys and investigations, and securing information to determine compliance
578.17 with licensure laws and rules, the commissioner need not present a release, waiver, or
578.18 consent to the individual. The identities of residents must be kept private as defined in
578.19 section 13.02, subdivision 12.

578.20 Subd. 2. **Surveys.** The commissioner shall conduct surveys of each assisted living facility
578.21 and assisted living facility with dementia care. The commissioner shall conduct a survey
578.22 of each facility on a frequency of at least once each year. The commissioner may conduct
578.23 surveys more frequently than once a year based on the license level, the provider's compliance
578.24 history, the number of clients served, or other factors as determined by the department
578.25 deemed necessary to ensure the health, safety, and welfare of residents and compliance with
578.26 the law.

578.27 Subd. 3. **Follow-up surveys.** The commissioner may conduct follow-up surveys to
578.28 determine if the facility has corrected deficient issues and systems identified during a survey
578.29 or complaint investigation. Follow-up surveys may be conducted via phone, e-mail, fax,
578.30 mail, or onsite reviews. Follow-up surveys, other than complaint investigations, shall be
578.31 concluded with an exit conference and written information provided on the process for
578.32 requesting a reconsideration of the survey results.

579.1 Subd. 4. **Scheduling surveys.** Surveys and investigations shall be conducted without
579.2 advance notice to the facilities. Surveyors may contact the facility on the day of a survey
579.3 to arrange for someone to be available at the survey site. The contact does not constitute
579.4 advance notice.

579.5 Subd. 5. **Information provided by facility.** The facility shall provide accurate and
579.6 truthful information to the department during a survey, investigation, or other licensing
579.7 activities.

579.8 Subd. 6. **Providing resident records.** Upon request of a surveyor, facilities shall provide
579.9 a list of current and past residents or designated representatives that includes addresses and
579.10 telephone numbers and any other information requested about the services to residents
579.11 within a reasonable period of time.

579.12 Subd. 7. **Correction orders.** (a) A correction order may be issued whenever the
579.13 commissioner finds upon survey or during a complaint investigation that a facility, a
579.14 managerial official, or an employee of the provider is not in compliance with this chapter.
579.15 The correction order shall cite the specific statute and document areas of noncompliance
579.16 and the time allowed for correction.

579.17 (b) The commissioner shall mail or e-mail copies of any correction order to the facility
579.18 within 30 calendar days after the survey exit date. A copy of each correction order and
579.19 copies of any documentation supplied to the commissioner shall be kept on file by the
579.20 facility, and public documents shall be made available for viewing by any person upon
579.21 request. Copies may be kept electronically.

579.22 (c) By the correction order date, the facility must document in the facility's records any
579.23 action taken to comply with the correction order. The commissioner may request a copy of
579.24 this documentation and the facility's action to respond to the correction order in future
579.25 surveys, upon a complaint investigation, and as otherwise needed.

579.26 Subd. 8. **Required follow-up surveys.** For facilities that have Level 3 or Level 4
579.27 violations under subdivision 9, the department shall conduct a follow-up survey within 90
579.28 calendar days of the survey. When conducting a follow-up survey, the surveyor shall focus
579.29 on whether the previous violations have been corrected and may also address any new
579.30 violations that are observed while evaluating the corrections that have been made.

579.31 Subd. 9. **Fines.** (a) Fines and enforcement actions under this subdivision may be assessed
579.32 based on the level and scope of the violations described in paragraph (b) as follows and
579.33 imposed immediately with no opportunity to correct the violation prior to imposition:

- 580.1 (1) Level 1, no fines or enforcement;
- 580.2 (2) Level 2, a fine of \$500 per violation, in addition to any of the enforcement
580.3 mechanisms authorized in section 144I.12 for widespread violations;
- 580.4 (3) Level 3, a fine of \$3,000 per violation per incident plus \$100 for each resident affected
580.5 by the violation, in addition to any of the enforcement mechanisms authorized in section
580.6 144I.12;
- 580.7 (4) Level 4, a fine of \$5,000 per violation plus \$200 for each resident, in addition to any
580.8 of the enforcement mechanisms authorized in section 144I.12; and
- 580.9 (5) for maltreatment violations as defined in the Minnesota Vulnerable Adults Act in
580.10 section 626.557 including abuse, neglect, financial exploitation, and drug diversion that are
580.11 determined against the facility, an immediate fine shall be imposed of \$5,000 per violation,
580.12 plus \$200 for each resident affected by the violation.
- 580.13 (b) Correction orders for violations are categorized by both level and scope, and fines
580.14 shall be assessed as follows:
- 580.15 (1) level of violation:
- 580.16 (i) Level 1 is a violation that has no potential to cause more than a minimal impact on
580.17 the resident and does not affect health or safety;
- 580.18 (ii) Level 2 is a violation that did not harm a resident's health or safety but had the
580.19 potential to have harmed a resident's health or safety, but was not likely to cause serious
580.20 injury, impairment, or death;
- 580.21 (iii) Level 3 is a violation that harmed a resident's health or safety, not including serious
580.22 injury, impairment, or death, or a violation that has the potential to lead to serious injury,
580.23 impairment, or death; and
- 580.24 (iv) Level 4 is a violation that results in serious injury, impairment, or death;
- 580.25 (2) scope of violation:
- 580.26 (i) isolated, when one or a limited number of residents are affected or one or a limited
580.27 number of staff are involved or the situation has occurred only occasionally;
- 580.28 (ii) pattern, when more than a limited number of residents are affected, more than a
580.29 limited number of staff are involved, or the situation has occurred repeatedly but is not
580.30 found to be pervasive; and

581.1 (iii) widespread, when problems are pervasive or represent a systemic failure that has
581.2 affected or has the potential to affect a large portion or all of the residents.

581.3 (c) If the commissioner finds that the applicant or a facility has not corrected violations
581.4 by the date specified in the correction order or conditional license resulting from a survey
581.5 or complaint investigation, the commissioner shall provide a notice of noncompliance with
581.6 a correction order by e-mailing the notice of noncompliance to the facility. The
581.7 noncompliance notice must list the violations not corrected.

581.8 (d) For every violation, the commissioner may issue an immediate fine. The licensee
581.9 must still correct the violation in the time specified. The issuance of an immediate fine may
581.10 occur in addition to any enforcement mechanism authorized under section 144I.12. The
581.11 immediate fine may be appealed as allowed under this section.

581.12 (e) The licensee must pay the fines assessed on or before the payment date specified. If
581.13 the licensee fails to fully comply with the order, the commissioner may issue a second fine
581.14 or suspend the license until the licensee complies by paying the fine. A timely appeal shall
581.15 stay payment of the fine until the commissioner issues a final order.

581.16 (f) A licensee shall promptly notify the commissioner in writing when a violation
581.17 specified in the order is corrected. If upon reinspection the commissioner determines that
581.18 a violation has not been corrected as indicated by the order, the commissioner may issue
581.19 an additional fine. The commissioner shall notify the licensee by mail to the last known
581.20 address in the licensing record that a second fine has been assessed. The licensee may appeal
581.21 the second fine as provided under this subdivision.

581.22 (g) A facility that has been assessed a fine under this section has a right to a
581.23 reconsideration or hearing under this section and chapter 14.

581.24 (h) When a fine has been assessed, the licensee may not avoid payment by closing,
581.25 selling, or otherwise transferring the license to a third party. In such an event, the licensee
581.26 shall be liable for payment of the fine.

581.27 (i) In addition to any fine imposed under this section, the commissioner may assess a
581.28 penalty amount based on costs related to an investigation that results in a final order assessing
581.29 a fine or other enforcement action authorized by this chapter.

581.30 (j) Fines collected under this subdivision shall be deposited in a dedicated special revenue
581.31 account. The balance of the account shall be appropriated to the commissioner until spent
581.32 to improve home care in Minnesota with the input of an advisory council. The commissioner
581.33 is appropriated an amount in the state government special revenue fund equal to fines

582.1 deposited under this subdivision, which shall be immediately transferred to the dedicated
582.2 special revenue account established by this subdivision.

582.3 Subd. 10. **Reconsideration.** (a) The commissioner shall make available to facilities a
582.4 correction order reconsideration process. This process may be used to challenge the correction
582.5 order issued, including the level and scope described in subdivision 9, paragraph (b), and
582.6 any fine assessed. When a licensee requests reconsideration of a correction order, the
582.7 correction order is not stayed while it is under reconsideration. The department shall post
582.8 information on its website that the licensee requested reconsideration of the correction order
582.9 and that the review is pending.

582.10 (b) A facility may request from the commissioner, in writing, a correction order
582.11 reconsideration regarding any correction order issued to the facility. The written request
582.12 for reconsideration must be received by the commissioner within 15 calendar days of the
582.13 correction order receipt date. The correction order reconsideration shall not be reviewed by
582.14 any surveyor, investigator, or supervisor that participated in writing or reviewing the
582.15 correction order being disputed. The correction order reconsiderations may be conducted
582.16 in person, by telephone, by another electronic form, or in writing, as determined by the
582.17 commissioner. The commissioner shall respond in writing to the request from a facility for
582.18 a correction order reconsideration within 60 days of the date the facility requests a
582.19 reconsideration. The commissioner's response shall identify the commissioner's decision
582.20 regarding each citation challenged by the facility.

582.21 (c) The findings of a correction order reconsideration process shall be one or more of
582.22 the following:

582.23 (1) supported in full: the correction order is supported in full, with no deletion of findings
582.24 to the citation;

582.25 (2) supported in substance: the correction order is supported, but one or more findings
582.26 are deleted or modified without any change in the citation;

582.27 (3) correction order cited an incorrect licensing requirement: the correction order is
582.28 amended by changing the correction order to the appropriate statute or rule;

582.29 (4) correction order was issued under an incorrect citation: the correction order is amended
582.30 to be issued under the more appropriate correction order citation;

582.31 (5) the correction order is rescinded;

582.32 (6) fine is amended: it is determined that the fine assigned to the correction order was
582.33 applied incorrectly; or

583.1 (7) the level or scope of the citation is modified based on the reconsideration.

583.2 (d) If the correction order findings are changed by the commissioner, the commissioner
583.3 shall update the correction order website.

583.4 (e) This subdivision does not apply to provisional licensees.

583.5 Sec. 23. **[144I.12] ENFORCEMENT.**

583.6 Subdivision 1. **Conditions.** (a) The commissioner may refuse to grant a provisional
583.7 license, refuse to grant a license as a result of a change in ownership, renew a license,
583.8 suspend or revoke a license, or impose a conditional license if the owner, controlling
583.9 individual, or employee of an assisted living facility or assisted living facility with dementia
583.10 care:

583.11 (1) is in violation of, or during the term of the license has violated, any of the requirements
583.12 in this chapter or adopted rules;

583.13 (2) permits, aids, or abets the commission of any illegal act in the provision of assisted
583.14 living services;

583.15 (3) performs any act detrimental to the health, safety, and welfare of a resident;

583.16 (4) obtains the license by fraud or misrepresentation;

583.17 (5) knowingly made or makes a false statement of a material fact in the application for
583.18 a license or in any other record or report required by this chapter;

583.19 (6) denies representatives of the department access to any part of the facility's books,
583.20 records, files, or employees;

583.21 (7) interferes with or impedes a representative of the department in contacting the facility's
583.22 residents;

583.23 (8) interferes with or impedes a representative of the department in the enforcement of
583.24 this chapter or has failed to fully cooperate with an inspection, survey, or investigation by
583.25 the department;

583.26 (9) destroys or makes unavailable any records or other evidence relating to the assisted
583.27 living facility's compliance with this chapter;

583.28 (10) refuses to initiate a background study under section 144.057 or 245A.04;

583.29 (11) fails to timely pay any fines assessed by the commissioner;

583.30 (12) violates any local, city, or township ordinance relating to housing or services;

584.1 (13) has repeated incidents of personnel performing services beyond their competency
584.2 level; or

584.3 (14) has operated beyond the scope of the facility's license category.

584.4 (b) A violation by a contractor providing the services of the facility is a violation by
584.5 facility.

584.6 Subd. 2. **Terms to suspension or conditional license.** (a) A suspension or conditional
584.7 license designation may include terms that must be completed or met before a suspension
584.8 or conditional license designation is lifted. A conditional license designation may include
584.9 restrictions or conditions that are imposed on the facility. Terms for a suspension or
584.10 conditional license may include one or more of the following and the scope of each will be
584.11 determined by the commissioner:

584.12 (1) requiring a consultant to review, evaluate, and make recommended changes to the
584.13 facility's practices and submit reports to the commissioner at the cost of the facility;

584.14 (2) requiring supervision of the facility or staff practices at the cost of the facility by an
584.15 unrelated person who has sufficient knowledge and qualifications to oversee the practices
584.16 and who will submit reports to the commissioner;

584.17 (3) requiring the facility or employees to obtain training at the cost of the facility;

584.18 (4) requiring the facility to submit reports to the commissioner;

584.19 (5) prohibiting the facility from admitting any new residents for a specified period of
584.20 time; or

584.21 (6) any other action reasonably required to accomplish the purpose of this subdivision
584.22 and section 144I.10.

584.23 (b) A facility subject to this subdivision may continue operating during the period of
584.24 time residents are being transferred to another service provider.

584.25 Subd. 3. **Immediate temporary suspension.** (a) In addition to any other remedies
584.26 provided by law, the commissioner may, without a prior contested case hearing, immediately
584.27 temporarily suspend a license or prohibit delivery of housing or services by a facility for
584.28 not more than 90 calendar days or issue a conditional license, if the commissioner determines
584.29 that there are:

584.30 (1) Level 4 violations; or

584.31 (2) violations that pose an imminent risk of harm to the health or safety of residents.

585.1 (b) For purposes of this subdivision, "Level 4" has the meaning given in section 144I.11,
585.2 subdivision 9.

585.3 (c) A notice stating the reasons for the immediate temporary suspension or conditional
585.4 license and informing the licensee of the right to an expedited hearing under subdivision
585.5 11 must be delivered by personal service to the address shown on the application or the last
585.6 known address of the licensee. The licensee may appeal an order immediately temporarily
585.7 suspending a license or issuing a conditional license. The appeal must be made in writing
585.8 by certified mail or personal service. If mailed, the appeal must be postmarked and sent to
585.9 the commissioner within five calendar days after the licensee receives notice. If an appeal
585.10 is made by personal service, it must be received by the commissioner within five calendar
585.11 days after the licensee received the order.

585.12 (d) A licensee whose license is immediately temporarily suspended must comply with
585.13 the requirements for notification and transfer of residents in subdivision 9. The requirements
585.14 in subdivision 9 remain if an appeal is requested.

585.15 Subd. 4. **Mandatory revocation.** Notwithstanding the provisions of subdivision 7,
585.16 paragraph (a), the commissioner must revoke a license if a controlling individual of the
585.17 facility is convicted of a felony or gross misdemeanor that relates to operation of the facility
585.18 or directly affects resident safety or care. The commissioner shall notify the facility and the
585.19 Office of Ombudsman for Long-Term Care 30 calendar days in advance of the date of
585.20 revocation.

585.21 Subd. 5. **Mandatory proceedings.** (a) The commissioner must initiate proceedings
585.22 within 60 calendar days of notification to suspend or revoke a facility's license or must
585.23 refuse to renew a facility's license if within the preceding two years the facility has incurred
585.24 the following number of uncorrected or repeated violations:

585.25 (1) two or more uncorrected violations or one or more repeated violations that created
585.26 an imminent risk to direct resident care or safety; or

585.27 (2) four or more uncorrected violations or two or more repeated violations of any nature
585.28 for which the fines are in the four highest daily fine categories prescribed in rule.

585.29 (b) Notwithstanding paragraph (a), the commissioner is not required to revoke, suspend,
585.30 or refuse to renew a facility's license if the facility corrects the violation.

585.31 Subd. 6. **Notice to residents.** (a) Within five business days after proceedings are initiated
585.32 by the commissioner to revoke or suspend a facility's license, or a decision by the
585.33 commissioner not to renew a living facility's license, the controlling individual of the facility

586.1 or a designee must provide to the commissioner and the ombudsman for long-term care the
586.2 names of residents and the names and addresses of the residents' guardians, designated
586.3 representatives, and family contacts.

586.4 (b) The controlling individual or designees of the facility must provide updated
586.5 information each month until the proceeding is concluded. If the controlling individual or
586.6 designee of the facility fails to provide the information within this time, the facility is subject
586.7 to the issuance of:

586.8 (1) a correction order; and

586.9 (2) a penalty assessment by the commissioner in rule.

586.10 (c) Notwithstanding subdivisions 16 and 17, any correction order issued under this
586.11 subdivision must require that the facility immediately comply with the request for information
586.12 and that, as of the date of the issuance of the correction order, the facility shall forfeit to the
586.13 state a \$500 fine the first day of noncompliance and an increase in the \$500 fine by \$100
586.14 increments for each day the noncompliance continues.

586.15 (d) Information provided under this subdivision may be used by the commissioner or
586.16 the ombudsman for long-term care only for the purpose of providing affected consumers
586.17 information about the status of the proceedings.

586.18 (e) Within ten business days after the commissioner initiates proceedings to revoke,
586.19 suspend, or not renew a facility license, the commissioner must send a written notice of the
586.20 action and the process involved to each resident of the facility and the resident's designated
586.21 representative or, if there is no designated representative and if known, a family member
586.22 or interested person.

586.23 (f) The commissioner shall provide the ombudsman for long-term care with monthly
586.24 information on the department's actions and the status of the proceedings.

586.25 Subd. 7. **Notice to facility.** (a) Prior to any suspension, revocation, or refusal to renew
586.26 a license, the facility shall be entitled to notice and a hearing as provided by sections 14.57
586.27 to 14.69. The hearing must commence within 60 calendar days after the proceedings are
586.28 initiated. In addition to any other remedy provided by law, the commissioner may, without
586.29 a prior contested case hearing, temporarily suspend a license or prohibit delivery of services
586.30 by a provider for not more than 90 calendar days, or issue a conditional license if the
586.31 commissioner determines that there are Level 3 violations that do not pose an imminent
586.32 risk of harm to the health or safety of the facility residents, provided:

586.33 (1) advance notice is given to the facility;

587.1 (2) after notice, the facility fails to correct the problem;

587.2 (3) the commissioner has reason to believe that other administrative remedies are not
587.3 likely to be effective; and

587.4 (4) there is an opportunity for a contested case hearing within 30 calendar days unless
587.5 there is an extension granted by an administrative law judge.

587.6 (b) If the commissioner determines there are Level 4 violations or violations that pose
587.7 an imminent risk of harm to the health or safety of the facility residents, the commissioner
587.8 may immediately temporarily suspend a license, prohibit delivery of services by a facility,
587.9 or issue a conditional license without meeting the requirements of paragraph (a), clauses
587.10 (1) to (4).

587.11 For the purposes of this subdivision, "Level 3" and "Level 4" have the meanings given in
587.12 section 144I.11, subdivision 9.

587.13 Subd. 8. **Request for hearing.** A request for hearing must be in writing and must:

587.14 (1) be mailed or delivered to the commissioner or the commissioner's designee;

587.15 (2) contain a brief and plain statement describing every matter or issue contested; and

587.16 (3) contain a brief and plain statement of any new matter that the applicant or assisted
587.17 living facility believes constitutes a defense or mitigating factor.

587.18 Subd. 9. **Plan required.** (a) The process of suspending, revoking, or refusing to renew
587.19 a license must include a plan for transferring affected residents' cares to other providers by
587.20 the facility that will be monitored by the commissioner. Within three calendar days of being
587.21 notified of the final revocation, refusal to renew, or suspension, the licensee shall provide
587.22 the commissioner, the lead agencies as defined in section 256B.0911, case managers, and
587.23 the ombudsman for long-term care with the following information:

587.24 (1) a list of all residents, including full names and all contact information on file;

587.25 (2) a list of each resident's representative or emergency contact person, including full
587.26 names and all contact information on file;

587.27 (3) the location or current residence of each resident;

587.28 (4) the payor sources for each resident, including payor source identification numbers;

587.29 and

587.30 (5) for each resident, a copy of the resident's service plan and a list of the types of services
587.31 being provided.

588.1 (b) The revocation, refusal to renew, or suspension notification requirement is satisfied
588.2 by mailing the notice to the address in the license record. The licensee shall cooperate with
588.3 the commissioner and the lead agencies, county adult protection and county managers, and
588.4 the ombudsman for long-term care during the process of transferring care of residents to
588.5 qualified providers. Within three calendar days of being notified of the final revocation,
588.6 refusal to renew, or suspension action, the facility must notify and disclose to each of the
588.7 residents, or the resident's representative or emergency contact persons, that the commissioner
588.8 is taking action against the facility's license by providing a copy of the revocation or
588.9 suspension notice issued by the commissioner. If the facility does not comply with the
588.10 disclosure requirements in this section, the commissioner, lead agencies, county adult
588.11 protection and county managers, and ombudsman for long-term care shall notify the residents,
588.12 designated representatives, or emergency contact persons about the actions being taken.
588.13 The revocation, refusal to renew, or suspension notice is public data except for any private
588.14 data contained therein.

588.15 (c) A facility subject to this subdivision may continue operating while residents are being
588.16 transferred to other service providers.

588.17 Subd. 10. **Hearing.** Within 15 business days of receipt of the licensee's timely appeal
588.18 of a sanction under this section, other than for a temporary suspension, the commissioner
588.19 shall request assignment of an administrative law judge. The commissioner's request must
588.20 include a proposed date, time, and place of hearing. A hearing must be conducted by an
588.21 administrative law judge pursuant to Minnesota Rules, parts 1400.8505 to 1400.8612, within
588.22 90 calendar days of the request for assignment, unless an extension is requested by either
588.23 party and granted by the administrative law judge for good cause or for purposes of discussing
588.24 settlement. In no case shall one or more extensions be granted for a total of more than 90
588.25 calendar days unless there is a criminal action pending against the licensee. If, while a
588.26 licensee continues to operate pending an appeal of an order for revocation, suspension, or
588.27 refusal to renew a license, the commissioner identifies one or more new violations of law
588.28 that meet the requirements of Level 3 or Level 4 violations as defined in section 144I.11,
588.29 subdivision 9, the commissioner shall act immediately to temporarily suspend the license.

588.30 Subd. 11. **Expedited hearing.** (a) Within five business days of receipt of the licensee's
588.31 timely appeal of a temporary suspension or issuance of a conditional license, the
588.32 commissioner shall request assignment of an administrative law judge. The request must
588.33 include a proposed date, time, and place of a hearing. A hearing must be conducted by an
588.34 administrative law judge pursuant to Minnesota Rules, parts 1400.8505 to 1400.8612, within
588.35 30 calendar days of the request for assignment, unless an extension is requested by either

589.1 party and granted by the administrative law judge for good cause. The commissioner shall
589.2 issue a notice of hearing by certified mail or personal service at least ten business days
589.3 before the hearing. Certified mail to the last known address is sufficient. The scope of the
589.4 hearing shall be limited solely to the issue of whether the temporary suspension or issuance
589.5 of a conditional license should remain in effect and whether there is sufficient evidence to
589.6 conclude that the licensee's actions or failure to comply with applicable laws are Level 3
589.7 or Level 4 violations as defined in section 144I.11, subdivision 9, or that there were violations
589.8 that posed an imminent risk of harm to the resident's health and safety.

589.9 (b) The administrative law judge shall issue findings of fact, conclusions, and a
589.10 recommendation within ten business days from the date of hearing. The parties shall have
589.11 ten calendar days to submit exceptions to the administrative law judge's report. The record
589.12 shall close at the end of the ten-day period for submission of exceptions. The commissioner's
589.13 final order shall be issued within ten business days from the close of the record. When an
589.14 appeal of a temporary immediate suspension or conditional license is withdrawn or dismissed,
589.15 the commissioner shall issue a final order affirming the temporary immediate suspension
589.16 or conditional license within ten calendar days of the commissioner's receipt of the
589.17 withdrawal or dismissal. The licensee is prohibited from operation during the temporary
589.18 suspension period.

589.19 (c) When the final order under paragraph (b) affirms an immediate suspension, and a
589.20 final licensing sanction is issued under subdivisions 1 and 2 and the licensee appeals that
589.21 sanction, the licensee is prohibited from operation pending a final commissioner's order
589.22 after the contested case hearing conducted under chapter 14.

589.23 (d) A licensee whose license is temporarily suspended must comply with the requirements
589.24 for notification and transfer of residents under subdivision 9. These requirements remain if
589.25 an appeal is requested.

589.26 Subd. 12. **Time limits for appeals.** To appeal the assessment of civil penalties under
589.27 section 144I.10, subdivision 2, and an action against a license under this section, a licensee
589.28 must request a hearing no later than 15 business days after the licensee receives notice of
589.29 the action.

589.30 Subd. 13. **Owners and managerial officials; refusal to grant license.** (a) The owner
589.31 and managerial officials of a facility whose Minnesota license has not been renewed or that
589.32 has been revoked because of noncompliance with applicable laws or rules shall not be
589.33 eligible to apply for nor will be granted an assisted living facility license or an assisted
589.34 living facility with dementia care license, or be given status as an enrolled personal care

590.1 assistance provider agency or personal care assistant by the Department of Human Services
590.2 under section 256B.0659, for five years following the effective date of the nonrenewal or
590.3 revocation. If the owner and/or managerial officials already have enrollment status, the
590.4 enrollment will be terminated by the Department of Human Services.

590.5 (b) The commissioner shall not issue a license to a facility for five years following the
590.6 effective date of license nonrenewal or revocation if the owner or managerial official,
590.7 including any individual who was an owner or managerial official of another licensed
590.8 provider, had a Minnesota license that was not renewed or was revoked as described in
590.9 paragraph (a).

590.10 (c) Notwithstanding subdivision 1, the commissioner shall not renew, or shall suspend
590.11 or revoke, the license of a facility that includes any individual as an owner or managerial
590.12 official who was an owner or managerial official of a facility whose Minnesota license was
590.13 not renewed or was revoked as described in paragraph (a) for five years following the
590.14 effective date of the nonrenewal or revocation.

590.15 (d) The commissioner shall notify the facility 30 calendar days in advance of the date
590.16 of nonrenewal, suspension, or revocation of the license. Within ten business days after the
590.17 receipt of the notification, the facility may request, in writing, that the commissioner stay
590.18 the nonrenewal, revocation, or suspension of the license. The facility shall specify the
590.19 reasons for requesting the stay; the steps that will be taken to attain or maintain compliance
590.20 with the licensure laws and regulations; any limits on the authority or responsibility of the
590.21 owners or managerial officials whose actions resulted in the notice of nonrenewal, revocation,
590.22 or suspension; and any other information to establish that the continuing affiliation with
590.23 these individuals will not jeopardize resident health, safety, or well-being. The commissioner
590.24 shall determine whether the stay will be granted within 30 calendar days of receiving the
590.25 facility's request. The commissioner may propose additional restrictions or limitations on
590.26 the facility's license and require that granting the stay be contingent upon compliance with
590.27 those provisions. The commissioner shall take into consideration the following factors when
590.28 determining whether the stay should be granted:

590.29 (1) the threat that continued involvement of the owners and managerial officials with
590.30 the facility poses to resident health, safety, and well-being;

590.31 (2) the compliance history of the facility; and

590.32 (3) the appropriateness of any limits suggested by the facility.

590.33 If the commissioner grants the stay, the order shall include any restrictions or limitation on
590.34 the provider's license. The failure of the facility to comply with any restrictions or limitations

591.1 shall result in the immediate removal of the stay and the commissioner shall take immediate
591.2 action to suspend, revoke, or not renew the license.

591.3 Subd. 14. **Relicensing.** If a facility license is revoked, a new application for license may
591.4 be considered by the commissioner when the conditions upon which the revocation was
591.5 based have been corrected and satisfactory evidence of this fact has been furnished to the
591.6 commissioner. A new license may be granted after an inspection has been made and the
591.7 facility has complied with all provisions of this chapter and adopted rules.

591.8 Subd. 15. **Informal conference.** At any time, the applicant or facility and the
591.9 commissioner may hold an informal conference to exchange information, clarify issues, or
591.10 resolve issues.

591.11 Subd. 16. **Injunctive relief.** In addition to any other remedy provided by law, the
591.12 commissioner may bring an action in district court to enjoin a person who is involved in
591.13 the management, operation, or control of a facility or an employee of the facility from
591.14 illegally engaging in activities regulated by sections under this chapter. The commissioner
591.15 may bring an action under this subdivision in the district court in Ramsey County or in the
591.16 district in which the facility is located. The court may grant a temporary restraining order
591.17 in the proceeding if continued activity by the person who is involved in the management,
591.18 operation, or control of a facility, or by an employee of the facility, would create an imminent
591.19 risk of harm to a resident.

591.20 Subd. 17. **Subpoena.** In matters pending before the commissioner under this chapter,
591.21 the commissioner may issue subpoenas and compel the attendance of witnesses and the
591.22 production of all necessary papers, books, records, documents, and other evidentiary material.
591.23 If a person fails or refuses to comply with a subpoena or order of the commissioner to appear
591.24 or testify regarding any matter about which the person may be lawfully questioned or to
591.25 produce any papers, books, records, documents, or evidentiary materials in the matter to be
591.26 heard, the commissioner may apply to the district court in any district, and the court shall
591.27 order the person to comply with the commissioner's order or subpoena. The commissioner
591.28 of health may administer oaths to witnesses or take their affirmation. Depositions may be
591.29 taken in or outside the state in the manner provided by law for taking depositions in civil
591.30 actions. A subpoena or other process or paper may be served on a named person anywhere
591.31 in the state by an officer authorized to serve subpoenas in civil actions, with the same fees
591.32 and mileage and in the same manner as prescribed by law for a process issued out of a
591.33 district court. A person subpoenaed under this subdivision shall receive the same fees,
591.34 mileage, and other costs that are paid in proceedings in district court.

592.1 Sec. 24. **[144I.13] INNOVATION VARIANCE.**

592.2 **Subdivision 1. Definition.** For purposes of this section, "innovation variance" means a
592.3 specified alternative to a requirement of this chapter. An innovation variance may be granted
592.4 to allow a facility to offer services of a type or in a manner that is innovative, will not impair
592.5 the services provided, will not adversely affect the health, safety, or welfare of the residents,
592.6 and is likely to improve the services provided. The innovative variance cannot change any
592.7 of the resident's rights under the assisted living bill of rights under section 144I.21.

592.8 **Subd. 2. Conditions.** The commissioner may impose conditions on granting an innovation
592.9 variance that the commissioner considers necessary.

592.10 **Subd. 3. Duration and renewal.** The commissioner may limit the duration of any
592.11 innovation variance and may renew a limited innovation variance.

592.12 **Subd. 4. Applications; innovation variance.** An application for innovation variance
592.13 from the requirements of this chapter may be made at any time, must be made in writing to
592.14 the commissioner, and must specify the following:

592.15 (1) the statute or rule from which the innovation variance is requested;

592.16 (2) the time period for which the innovation variance is requested;

592.17 (3) the specific alternative action that the licensee proposes;

592.18 (4) the reasons for the request; and

592.19 (5) justification that an innovation variance will not impair the services provided, will
592.20 not adversely affect the health, safety, or welfare of residents, and is likely to improve the
592.21 services provided.

592.22 The commissioner may require additional information from the facility before acting on
592.23 the request.

592.24 **Subd. 5. Grants and denials.** The commissioner shall grant or deny each request for
592.25 an innovation variance in writing within 45 days of receipt of a complete request. Notice
592.26 of a denial shall contain the reasons for the denial. The terms of a requested innovation
592.27 variance may be modified upon agreement between the commissioner and the facility.

592.28 **Subd. 6. Violation of innovation variances.** A failure to comply with the terms of an
592.29 innovation variance shall be deemed to be a violation of this chapter.

592.30 **Subd. 7. Revocation or denial of renewal.** The commissioner shall revoke or deny
592.31 renewal of an innovation variance if:

- 593.1 (1) it is determined that the innovation variance is adversely affecting the health, safety,
 593.2 or welfare of the residents;
- 593.3 (2) the facility has failed to comply with the terms of the innovation variance;
- 593.4 (3) the facility notifies the commissioner in writing that it wishes to relinquish the
 593.5 innovation variance and be subject to the statute previously varied; or
- 593.6 (4) the revocation or denial is required by a change in law.

593.7 **Sec. 25. [144L.14] RESIDENT QUALITY OF CARE AND OUTCOMES**
 593.8 **IMPROVEMENT COUNCIL.**

593.9 Subdivision 1. **Membership.** (a) The Resident Quality of Care and Outcomes
 593.10 Improvement Council has 17 members, appointed by the commissioner, as follows:

- 593.11 (1) two members who are members of Minnesota-based organizations, exempt from
 593.12 taxation under section 501(c)(3) of the Internal Revenue Code, that are dedicated to patient
 593.13 safety or innovation in health care safety and quality;
- 593.14 (2) two members who are state employees working in the Department of Health who
 593.15 have expertise in safety and adverse health events;
- 593.16 (3) two members who are members of consumer organizations;
- 593.17 (4) two members who are direct care providers or their representatives;
- 593.18 (5) two members who are members of organizations representing long-term care providers
 593.19 in Minnesota;
- 593.20 (6) two members who are members of organizations representing home care providers
 593.21 in Minnesota;
- 593.22 (7) two members who are demonstrated experts in patient safety;
- 593.23 (8) two members who are demonstrated experts in the fields of safety and quality
 593.24 improvement; and
- 593.25 (9) one member from the Office of the Ombudsman for Long-Term Care or a designee.
- 593.26 (b) Of the members listed in clauses (1), (3), (5), and (6), the commissioner must include
 593.27 at least one public member who is or has been a resident in an assisted living setting and
 593.28 one public member who has, or has had, a family member living in an assisted living facility.

594.1 Subd. 2. **No compensation; expense reimbursement.** Members serve without
594.2 compensation, but may be reimbursed for expenses as provided in section 15.059, subdivision
594.3 3.

594.4 Subd. 3. **Chair.** The council must elect a chair or cochairs from among its members and
594.5 may elect additional officers as needed to facilitate its work.

594.6 Subd. 4. **Terms; removal.** Section 15.059, subdivision 2, applies to the terms of the
594.7 members. Members may be removed only as provided in section 15.059, subdivision 4.

594.8 Subd. 5. **Duties.** The council shall report at least twice per year to the commissioner and
594.9 to the chairs and ranking minority members of the committees in the house of representatives
594.10 and the senate with jurisdiction over long-term care providers and settings. The report must
594.11 recommend how to apply proven safety and quality improvement practices and infrastructure
594.12 to settings and providers that provide long-term services and support and must describe
594.13 changes needed to promote safety and quality improvement practices in long-term care
594.14 settings and with long-term care providers. If the recommendations require a change in rule
594.15 or law, the report must include draft legislation to make the change.

594.16 Subd. 6. **Meetings.** The council must meet at least four times per year. Meetings are
594.17 subject to chapter 13D.

594.18 Subd. 7. **Administrative support.** The commissioner of health shall provide
594.19 administrative support and meeting space to the council, on request.

594.20 Subd. 8. **Expiration.** This section expires January 1, 2029.

594.21 Sec. 26. **[144L.15] EXPEDITED RULEMAKING AUTHORIZED.**

594.22 (a) The commissioner shall adopt rules for all assisted living facilities that promote
594.23 person-centered planning and service and optimal quality of life, and that ensure resident
594.24 rights are protected, resident choice is allowed, and public health and safety is ensured.

594.25 (b) On July 1, 2019, the commissioner shall begin expedited rulemaking using the process
594.26 in section 14.389, except that the rulemaking process is exempt from section 14.389,
594.27 subdivision 5.

594.28 (c) The commissioner shall adopt rules that include but are not limited to the following:

594.29 (1) staffing minimums and ratios for each level of licensure to best protect the health
594.30 and safety of residents no matter their vulnerability;

594.31 (2) training prerequisites and ongoing training for administrators and caregiving staff;

595.1 (3) requirements for licensees to ensure minimum nutrition and dietary standards required
595.2 by section 144I.03 are provided;

595.3 (4) procedures for discharge planning and ensuring resident appeal rights;

595.4 (5) core dementia care requirements and training in all levels of licensure;

595.5 (6) requirements for assisted living facilities with dementia care in terms of training,
595.6 care standards, noticing changes of condition, assessments, and health care;

595.7 (7) preadmission criteria, initial assessments, and continuing assessments;

595.8 (8) emergency disaster and preparedness plans;

595.9 (9) uniform checklist disclosure of services;

595.10 (10) uniform consumer information guide elements and other data collected; and

595.11 (11) uniform assessment tool.

595.12 (d) The commissioner shall publish the proposed rules by December 31, 2019, and shall
595.13 publish final rules by December 31, 2020.

595.14 Sec. 27. **TRANSITION PERIOD.**

595.15 (a) From July 1, 2019, to June 30, 2020, the commissioner shall engage in the expedited
595.16 rulemaking process.

595.17 (b) From July 1, 2020, to July 31, 2021, the commissioner shall prepare for the new
595.18 assisted living facility and assisted living facility with dementia care licensure by hiring
595.19 staff, developing forms, and communicating with stakeholders about the new facility
595.20 licensing.

595.21 (c) Effective August 1, 2021, all existing housing with services establishments providing
595.22 home care services under Minnesota Statutes, chapter 144A, must convert their registration
595.23 to licensure under Minnesota Statutes, chapter 144I.

595.24 (d) Effective August 1, 2021, all new assisted living facilities and assisted living facilities
595.25 with dementia care must be licensed by the commissioner.

595.26 (e) Effective August 1, 2021, all assisted living facilities and assisted living facilities
595.27 with dementia care must be licensed by the commissioner.

596.1 Sec. 28. **RESIDENT QUALITY OF CARE AND OUTCOMES IMPROVEMENT**
596.2 **COUNCIL; FIRST APPOINTMENTS; FIRST MEETING.**

596.3 The commissioner of health must make appointments to the Resident Quality of Care
596.4 and Outcomes Improvement Council under Minnesota Statutes, section 144G.991, by July
596.5 1, 2020.

596.6 The commissioner of health or a designee must convene the first meeting of the Resident
596.7 Quality of Care and Outcomes Improvement Council under Minnesota Statutes, section
596.8 144G.991, by August 15, 2020.

596.9 Sec. 29. **REPEALER.**

596.10 Minnesota Statutes 2018, sections 144D.01; 144D.015; 144D.02; 144D.025; 144D.03;
596.11 144D.04; 144D.045; 144D.05; 144D.06; 144D.065; 144D.066; 144D.07; 144D.08; 144D.09;
596.12 144D.10; 144D.11; 144G.01; 144G.02; 144G.03; 144G.04; 144G.05; and 144G.06, are
596.13 repealed effective August 1, 2021.

596.14 **ARTICLE 15**

596.15 **DEMENTIA CARE SERVICES FOR ASSISTED LIVING FACILITIES WITH**
596.16 **DEMENTIA CARE**

596.17 Section 1. **[144I.16] ADDITIONAL REQUIREMENTS FOR ASSISTED LIVING**
596.18 **WITH DEMENTIA CARE.**

596.19 Subdivision 1. **Applicability.** This section applies only to assisted living facilities with
596.20 dementia care.

596.21 Subd. 2. **Demonstrated capacity.** (a) The applicant must have the ability to provide
596.22 services in a manner that is consistent with the requirements in this section. The commissioner
596.23 shall consider the following criteria, including, but not limited to:

596.24 (1) the experience of the applicant in managing residents with dementia or previous
596.25 long-term care experience; and

596.26 (2) the compliance history of the applicant in the operation of any care facility licensed,
596.27 certified, or registered under federal or state law.

596.28 (b) If the applicant does not have experience in managing residents with dementia, the
596.29 applicant must employ a consultant for at least the first six months of operation. The
596.30 consultant must meet the requirements in subdivision 2, paragraph (a), clause (1), and make
596.31 recommendations on providing dementia care services consistent with the requirements of
596.32 this chapter. The consultant must have experience in dementia care operations. The applicant

597.1 must implement the recommendations of the consultant and document an acceptable plan
597.2 which may be reviewed by the commissioner upon request to address the consultant's
597.3 identified concerns. The commissioner may review and approve the selection of the
597.4 consultant.

597.5 (c) The commissioner shall conduct an on-site inspection prior to the issuance of an
597.6 assisted living facility with dementia care license to ensure compliance with the physical
597.7 environment requirements.

597.8 (d) The label "Assisted Living Facility with Dementia Care" must be identified on the
597.9 license.

597.10 Subd. 3. **Relinquishing license.** The licensee must notify the commissioner in writing
597.11 at least 60 calendar days prior to the voluntary relinquishment of an assisted living facility
597.12 with dementia care license. For voluntary relinquishment, the facility must:

597.13 (1) give all residents and their designated representatives 45 calendar days' notice. The
597.14 notice must include:

597.15 (i) the proposed effective date of the relinquishment;

597.16 (ii) changes in staffing;

597.17 (iii) changes in services including the elimination or addition of services; and

597.18 (iv) staff training that shall occur when the relinquishment becomes effective;

597.19 (2) submit a transitional plan to the commissioner demonstrating how the current residents
597.20 shall be evaluated and assessed to reside in other housing settings that are not an assisted
597.21 living facility with dementia care, that are physically unsecured, or that would require
597.22 move-out or transfer to other settings;

597.23 (3) change service or care plans as appropriate to address any needs the residents may
597.24 have with the transition;

597.25 (4) notify the commissioner when the relinquishment process has been completed; and

597.26 (5) revise advertising materials and disclosure information to remove any reference that
597.27 the facility is an assisted living facility with dementia care.

597.28 Sec. 2. **[144L.17] RESPONSIBILITIES OF ADMINISTRATION FOR ASSISTED**
597.29 **LIVING FACILITIES WITH DEMENTIA CARE.**

597.30 Subdivision 1. **General.** The licensee of an assisted living facility with dementia care
597.31 is responsible for the care and housing of the persons with dementia and the provision of

598.1 person-centered care that promotes each resident's dignity, independence, and comfort. This
598.2 includes the supervision, training, and overall conduct of the staff.

598.3 Subd. 2. **Additional requirements.** (a) The licensee must follow the assisted living
598.4 license requirements and the criteria in this section.

598.5 (b) The administrator of an assisted living facility with dementia care license must
598.6 complete and document that at least ten hours of the required annual continuing educational
598.7 requirements relate to the care of individuals with dementia. Continuing education credits
598.8 must be obtained through commissioner-approved sources that may include college courses,
598.9 preceptor credits, self-directed activities, course instructor credits, corporate training,
598.10 in-service training, professional association training, web-based training, correspondence
598.11 courses, telecourses, seminars, and workshops.

598.12 Subd. 3. **Policies.** (a) In addition to the policies and procedures required in the licensing
598.13 of assisted living facilities, the assisted living facility with dementia care licensee must
598.14 develop and implement policies and procedures that address the:

598.15 (1) philosophy of how services are provided based upon the assisted living facility
598.16 licensee's values, mission, and promotion of person-centered care and how the philosophy
598.17 shall be implemented;

598.18 (2) evaluation of behavioral symptoms and design of supports for intervention plans;

598.19 (3) wandering and egress prevention that provides detailed instructions to staff in the
598.20 event a resident elopes;

598.21 (4) assessment of residents for the use and effects of medications, including psychotropic
598.22 medications;

598.23 (5) staff training specific to dementia care;

598.24 (6) description of life enrichment programs and how activities are implemented;

598.25 (7) description of family support programs and efforts to keep the family engaged;

598.26 (8) limiting the use of public address and intercom systems for emergencies and
598.27 evacuation drills only;

598.28 (9) transportation coordination and assistance to and from outside medical appointments;
598.29 and

598.30 (10) safekeeping of resident's possessions.

599.1 (b) The policies and procedures must be provided to residents and the resident's
599.2 representative at the time of move-in.

599.3 **Sec. 3. [144I.18] STAFFING AND STAFF TRAINING.**

599.4 Subdivision 1. **General.** (a) An assisted living facility with dementia care must provide
599.5 residents with dementia-trained staff who have been instructed in the person-centered care
599.6 approach. All direct care and other community staff assigned to care for dementia residents
599.7 must be specially trained to work with residents with dementia.

599.8 (b) Only staff trained as specified in subdivisions 2 and 3 shall be assigned to care for
599.9 dementia residents.

599.10 (c) Staffing levels must be sufficient to meet the scheduled and unscheduled needs of
599.11 residents. Staffing levels during nighttime hours shall be based on the sleep patterns and
599.12 needs of residents.

599.13 (d) In an emergency situation when trained staff are not available to provide services,
599.14 the facility may assign staff who have not completed the required training. The particular
599.15 emergency situation must be documented and must address:

599.16 (1) the nature of the emergency;

599.17 (2) how long the emergency lasted; and

599.18 (3) the names and positions of staff that provided coverage.

599.19 Subd. 2. **Staffing requirements.** (a) The licensee must ensure that staff who provide
599.20 support to residents with dementia have a basic understanding and fundamental knowledge
599.21 of the residents' emotional and unique health care needs using person-centered planning
599.22 delivery. Direct care dementia-trained staff and other staff must be trained on the topics
599.23 identified during the expedited rulemaking process. These requirements are in addition to
599.24 the licensing requirements for training.

599.25 (b) Failure to comply with paragraph (a) or subdivision 1 will result in a fine as defined
599.26 in section 144I.11, subdivision 9.

599.27 Subd. 3. **Supervising staff training.** Persons providing or overseeing staff training must
599.28 have experience and knowledge in the care of individuals with dementia.

599.29 Subd. 4. **Preservice and in-service training.** Preservice and in-service training may
599.30 include various methods of instruction, such as classroom style, web-based training, video,
599.31 or one-to-one training. The licensee must have a method for determining and documenting

600.1 each staff person's knowledge and understanding of the training provided. All training must
600.2 be documented.

600.3 **Sec. 4. [144I.19] SERVICES FOR RESIDENTS WITH DEMENTIA.**

600.4 Subdivision 1. **Dementia care services.** (a) In addition to the minimum services required
600.5 of assisted living facilities, an assisted living facility with dementia care must also provide
600.6 the following services:

600.7 (1) assistance with activities of daily living that address the needs of each resident with
600.8 dementia due to cognitive or physical limitations. These services must meet or be in addition
600.9 to the requirements in the licensing rules for the facility. Services must be provided in a
600.10 person-centered manner that promotes resident choice, dignity, and sustains the resident's
600.11 abilities;

600.12 (2) health care services provided according to the licensing statutes and rules of the
600.13 facility;

600.14 (3) a daily meal program for nutrition and hydration must be provided and available
600.15 throughout each resident's waking hours. The individualized nutritional plan for each resident
600.16 must be documented in the resident's service or care plan. In addition, an assisted living
600.17 facility with dementia care must provide meaningful activities that promote or help sustain
600.18 the physical and emotional well-being of residents. The activities must be person-directed
600.19 and available during residents' waking hours.

600.20 (b) Each resident must be evaluated for activities according to the licensing rules of the
600.21 facility. In addition, the evaluation must address the following:

600.22 (1) past and current interests;

600.23 (2) current abilities and skills;

600.24 (3) emotional and social needs and patterns;

600.25 (4) physical abilities and limitations;

600.26 (5) adaptations necessary for the resident to participate; and

600.27 (6) identification of activities for behavioral interventions.

600.28 (c) An individualized activity plan must be developed for each resident based on their
600.29 activity evaluation. The plan must reflect the resident's activity preferences and needs.

601.1 (d) A selection of daily structured and non-structured activities must be provided and
 601.2 included on the resident's activity service or care plan as appropriate. Daily activity options
 601.3 based on resident evaluation may include but are not limited to:

601.4 (1) occupation or chore related tasks;

601.5 (2) scheduled and planned events such as entertainment or outings;

601.6 (3) spontaneous activities for enjoyment or those that may help defuse a behavior;

601.7 (4) one-to-one activities that encourage positive relationships between residents and
 601.8 staff such as telling a life story, reminiscing, or playing music;

601.9 (5) spiritual, creative, and intellectual activities;

601.10 (6) sensory stimulation activities;

601.11 (7) physical activities that enhance or maintain a resident's ability to ambulate or move;

601.12 and

601.13 (8) outdoor activities.

601.14 (e) Behavioral symptoms that negatively impact the resident and others in the assisted
 601.15 living facility must be evaluated and included on the service or care plan. The staff must
 601.16 initiate and coordinate outside consultation or acute care when indicated.

601.17 (f) Support must be offered to family and other significant relationships on a regularly
 601.18 scheduled basis but not less than quarterly.

601.19 (g) Access to secured outdoor space and walkways that allow residents to enter and
 601.20 return without staff assistance must be provided.

601.21

ARTICLE 16

601.22

CONSUMER PROTECTIONS

601.23 Section 1. **[144I.20] DECEPTIVE MARKETING AND BUSINESS PRACTICES**
 601.24 **PROHIBITED.**

601.25 Subdivision 1. **Deceptive marketing and business practices by facilities are**
 601.26 **prohibited.** No employee or agent of any facility may:

601.27 (1) make any false, fraudulent, deceptive, or misleading statements or representations
 601.28 or material omissions in marketing, advertising, or any other description or representation
 601.29 of care or services;

602.1 (2) fail to inform a resident in writing of any limitations to care services available prior
602.2 to executing a contract or service agreement; or

602.3 (3) advertise as having an assisted living with dementia care license until the applicant
602.4 has obtained an assisted living with dementia care license from the commissioner. A
602.5 prospective applicant seeking an assisted living with dementia care license may advertise
602.6 that the applicant has submitted an application for a license to the commissioner.

602.7 Subd. 2. **Disclosure requirements.** Assisted living facilities with dementia care must
602.8 comply with disclosure requirements under section 325F.72.

602.9 Subd. 3. **Penalty.** After August 1, 2021, it shall be a criminal gross misdemeanor to
602.10 open, operate, maintain, advertise, or hold oneself out as an assisted living facility without
602.11 the appropriate license. Failure to comply may result in a civil penalty as outlined in section
602.12 609.0341, subdivision 1.

602.13 **EFFECTIVE DATE.** This section is effective August 1, 2021.

602.14 Sec. 2. **[144I.201] RETALIATION PROHIBITED.**

602.15 (a) A facility or agent of the facility may not retaliate against a resident or employee if
602.16 the resident, employee, or any person on behalf of the resident:

602.17 (1) files a complaint or grievance, makes an inquiry, or asserts any right;

602.18 (2) indicates an intention to file a complaint or grievance, make an inquiry, or assert any
602.19 right;

602.20 (3) files or indicates an intention to file a maltreatment report, whether mandatory or
602.21 voluntary, under section 626.557;

602.22 (4) seeks assistance from or reports a reasonable suspicion of a crime or systemic
602.23 problems or concerns to the administrator or manager of the facility, the long-term care
602.24 ombudsman, the mental health and developmental disabilities ombudsman, a regulatory or
602.25 other government agency, or a legal or advocacy organization;

602.26 (5) advocates or seeks advocacy assistance for necessary or improved care or services
602.27 or enforcement of rights under this section or other law;

602.28 (6) takes or indicates an intention to take civil action;

602.29 (7) participates or indicates an intention to participate in any investigation or
602.30 administrative or judicial proceeding; or

603.1 (8) contracts or indicates an intention to contract to receive services from a service
603.2 provider of the resident's choice other than the facility.

603.3 (b) For purposes of this section, to retaliate against a resident includes but is not limited
603.4 to any of the following actions taken or threatened by a facility or an agent of the facility
603.5 against a resident, or any person with a familial, personal, legal, or professional relationship
603.6 with the resident:

603.7 (1) the discharge, eviction, transfer, or termination of services;

603.8 (2) the imposition of discipline, punishment, or a sanction or penalty;

603.9 (3) any form of discrimination;

603.10 (4) restriction or prohibition of access:

603.11 (i) of the resident to the facility or visitors; or

603.12 (ii) to the resident of a family member or a person with a personal, legal, or professional
603.13 relationship with the resident;

603.14 (5) the imposition of involuntary seclusion or withholding food, care, or services;

603.15 (6) restriction of any of the rights granted to residents under state or federal law;

603.16 (7) restriction or reduction of access to or use of amenities, care, services, privileges, or
603.17 living arrangements;

603.18 (8) an arbitrary increase in charges or fees;

603.19 (9) removing, tampering with, or deprivation of technology, communication, or electronic
603.20 monitoring devices; or

603.21 (10) any oral or written communication of false information about a person advocating
603.22 on behalf of the resident.

603.23 (c) For purposes of this section, to retaliate against an employee includes but is not
603.24 limited to any of the following actions taken or threatened by the assisted living facility or
603.25 an agent of the facility against an employee:

603.26 (1) discharge or transfer;

603.27 (2) demotion or refusal to promote;

603.28 (3) reduction in compensation, benefits, or privileges;

603.29 (4) the unwarranted imposition of discipline, punishment, or a sanction or penalty; or

603.30 (5) any form of discrimination.

604.1 (d) There is a rebuttable presumption that any action described in paragraph (b) or (c)
604.2 and taken within 90 calendar days of an initial action described in paragraph (a) is retaliatory.
604.3 This presumption does not apply to a discharge, eviction, transfer, or termination of services
604.4 that occurs for a reason permitted under section 144I.07, subdivision 3 or 6, provided the
604.5 facility complied with the applicable requirements in section 144I.07 and allowed the resident
604.6 and a designated representative to exercise any rights in section 144I.07, subdivision 7, for
604.7 the discharge, eviction, transfer, or termination of services. This presumption does not apply
604.8 to actions described in paragraph (b), clause (4), if a good faith report of maltreatment
604.9 pursuant to section 626.557 is made by the facility or agent of the facility against the visitor,
604.10 family member, or other person with a personal, legal, or professional relationship that is
604.11 subject to the restrictions or prohibitions. This presumption does not apply to any oral or
604.12 written communication described in paragraph (b), clause (10), that is associated with a
604.13 good faith report of maltreatment pursuant to section 626.557 made by the facility or agent
604.14 of the facility against the person advocating on behalf of the resident.

604.15 (e) Nothing in this section affects rights available under section 626.557.

604.16 **Sec. 3. [144I.202] RESIDENT COMPLAINT AND INVESTIGATIVE PROCESS.**

604.17 (a) A facility must have a written policy and system for receiving, investigating, reporting,
604.18 and attempting to resolve complaints from its residents and designated representatives. The
604.19 policy should clearly identify the process by which residents may file a complaint or concern
604.20 about the services and an explicit statement that the facility will not discriminate or retaliate
604.21 against a resident for expressing concerns or complaints under section 144I.03, subdivision
604.22 8. A facility must have a process in place to conduct investigations of complaints made by
604.23 the resident and the designated representative about the services in the resident's plan that
604.24 are or are not being provided or other items covered in the assisted living bill of rights. This
604.25 complaint system must provide reasonable accommodations for any special needs of the
604.26 resident, if requested.

604.27 (b) The facility must document the complaint, name of the resident, investigation, and
604.28 resolution of each complaint filed. The facility must maintain a record of all activities
604.29 regarding complaints received, including the date the complaint was received, and the
604.30 facility's investigation and resolution of the complaint. This complaint record must be kept
604.31 for each event for at least two years after the date of entry and must be available to the
604.32 commissioner for review.

604.33 (c) The required complaint system must provide for written notice to each resident and
604.34 designated representative that includes:

- 605.1 (1) the resident's right to complain to the facility about the services received;
605.2 (2) the name or title of the person or persons with the facility to contact with complaints;
605.3 (3) the method of submitting a complaint to the facility; and
605.4 (4) a statement that the provider is prohibited against retaliation according to section
605.5 144I.201.

605.6 **ARTICLE 17**

605.7 **ASSISTED LIVING FACILITY RESIDENT RIGHTS**

605.8 **Section 1. [144I.21] ASSISTED LIVING FACILITY BILL OF RIGHTS.**

605.9 Subdivision 1. **Applicability.** All assisted living facilities and assisted living facilities
605.10 with dementia care licensed under this chapter must comply with this section and the
605.11 commissioner shall enforce this section against all facilities. A resident has these rights and
605.12 no facility may require or request a resident to waive any of the rights listed in this section
605.13 at any time or for any reason, including as a condition of initiating services or entering into
605.14 an assisted living facility contract.

605.15 Subd. 2. **Legislative intent.** It is the intent of the legislature to promote the interests and
605.16 well-being of residents. It is the intent of this section that every resident's civil and religious
605.17 liberties, including the right to independent personal decisions and knowledge of available
605.18 choices, shall not be infringed and that the facility must encourage and assist in the fullest
605.19 possible exercise of these rights. The rights established under this section for the benefit of
605.20 residents do not limit the rights residents have under other applicable law.

605.21 Subd. 3. **Right to information about rights.** (a) Before receiving services, residents
605.22 have the right to receive from the facility written information about rights under this section
605.23 in plain language and in terms residents can understand. The facility must make reasonable
605.24 accommodations for residents who have communication disabilities and those who speak
605.25 a language other than English. The information must include:

- 605.26 (1) what recourse residents have if their rights are violated;
605.27 (2) the name, address, telephone number, and e-mail contact information of organizations
605.28 that provide advocacy and legal services for residents to enforce their rights, including but
605.29 not limited to the designated protection and advocacy organization in Minnesota that provides
605.30 advice and representation to individuals with disabilities; and
605.31 (3) the name, address, telephone number, and e-mail contact information for government
605.32 agencies where the resident or private client may file a maltreatment report, complain, or

606.1 seek assistance, including the Office of Health Facility Complaints, the Minnesota Adult
606.2 Abuse Reporting Center (MAARC), the long-term care ombudsman, the mental health and
606.3 developmental disabilities ombudsman, and state and county agencies that regulate basic
606.4 care facilities, assisted living facilities, and assisted living facilities with dementia care.

606.5 (b) Upon request, residents and their designated and resident representatives have the
606.6 right to current facility policies, inspection findings of state and local health authorities, and
606.7 further explanation of the rights provided under this section, consistent with chapter 13 and
606.8 section 626.557.

606.9 Subd. 4. **Right to courteous treatment.** Residents have the right to be treated with
606.10 courtesy and respect, and to have the resident's property treated with respect.

606.11 Subd. 5. **Right to appropriate care and services.** (a) Residents have the right to receive
606.12 care and services that are according to a suitable and up-to-date plan, and subject to accepted
606.13 health care, medical or nursing standards, and person-centered care to take an active part
606.14 in developing, modifying, and evaluating the plan and services. All plans for care and
606.15 services must be designed to enable residents to achieve their highest level of emotional,
606.16 psychological, physical, medical, and functional well-being and safety.

606.17 (b) Residents have the right to receive medical and personal care and services with
606.18 continuity by people who are properly trained and competent to perform their duties and in
606.19 sufficient numbers to adequately provide the services agreed to in the assisted living facility
606.20 contract.

606.21 Subd. 6. **Right to information about individuals providing services.** Residents have
606.22 the right to be told before receiving services the type and disciplines of staff who will be
606.23 providing the services, the frequency of visits proposed to be furnished, and other choices
606.24 that are available for addressing the resident's needs.

606.25 Subd. 7. **Freedom from maltreatment.** Residents have the right to be free from
606.26 maltreatment.

606.27 Subd. 8. **Right to participate in care and service agreement; notice of**
606.28 **change.** Residents have the right to actively participate in the planning, modification, and
606.29 evaluation of their care and services. This right includes:

606.30 (1) the opportunity to discuss care, services, treatment, and alternatives with the
606.31 appropriate caregivers;

606.32 (2) the opportunity to request and participate in formal care conferences;

607.1 (3) the right to include a family member or the resident's designated representative, or
607.2 both; and

607.3 (4) the right to be told in advance of, and take an active part in decisions regarding, any
607.4 recommended changes in the plan for care and services.

607.5 **Subd. 9. Right to disclosure of contract services and right to purchase outside**
607.6 **services.** (a) Residents have the right to be informed, prior to receiving care or services
607.7 from a facility, of:

607.8 (1) care and services that are included under the terms of the contract;

607.9 (2) information about care and other public services or private services that may be
607.10 available in the community at additional charges; and

607.11 (3) any limits to the services available from the facility.

607.12 (b) If the assisted living facility contract permits changes in services, residents have the
607.13 right to reasonable advance notice of any change.

607.14 (c) Residents have the right to purchase or rent goods or services not included in the
607.15 contract rate from a supplier of their choice unless otherwise provided by law.

607.16 (d) Residents have the right to change services after services have begun, within the
607.17 limits of health insurance, long-term care insurance, medical assistance under chapter 256B,
607.18 and other health programs.

607.19 (e) Facilities must make every effort to assist residents in obtaining information regarding
607.20 whether the Medicare, medical assistance under chapter 256B, or other public program will
607.21 pay for any or all of the services.

607.22 **Subd. 10. Right to information about charges.** (a) Before services are initiated, residents
607.23 have the right to be notified:

607.24 (1) of charges for the services;

607.25 (2) as to what extent payment may be expected from health insurance, public programs,
607.26 or other sources, if known; and

607.27 (3) what charges the resident may be responsible for paying.

607.28 (b) If a contract permits changes in charges, residents have the right to reasonable advance
607.29 notice of any change.

607.30 **Subd. 11. Right to information about health care treatment.** Where applicable,
607.31 residents have the right to be given by their physicians complete and current information

608.1 concerning their diagnosis, cognitive functioning level, treatment, alternatives, risks, and
608.2 prognosis as required by the physician's legal duty to disclose. This information must be in
608.3 terms and language the residents can reasonably be expected to understand. This information
608.4 shall include the likely medical or major psychological results of the treatment and its
608.5 alternatives. Residents receiving services may be accompanied by a family member or other
608.6 designated representative, or both.

608.7 Subd. 12. **Right to refuse services or care.** (a) Residents have the right to refuse services
608.8 or care.

608.9 (b) The facility must document in the resident's record that the facility informed residents
608.10 who refuse care, services, treatment, medication, or dietary restrictions of the likely medical,
608.11 health-related, or psychological consequences of the refusal.

608.12 (c) In cases where a resident is incapable of understanding the circumstances but has
608.13 not been adjudicated incompetent, or when legal requirements limit the right to refuse
608.14 medical treatment, the conditions and circumstances must be fully documented by the
608.15 attending physician in the resident's record.

608.16 Subd. 13. **Right to personal, treatment, and communication policy.** (a) Residents
608.17 have the right to:

608.18 (1) every consideration of their privacy, individuality, and cultural identity as related to
608.19 their social, religious, and psychological well-being. Staff must respect the privacy of a
608.20 resident's space by knocking on the door and seeking consent before entering, except in an
608.21 emergency or where doing so is contrary to the resident's person-centered care plan;

608.22 (2) respectfulness and privacy as they relate to the resident's medical and personal care
608.23 program. Case discussion, consultation, examination, and treatment are confidential and
608.24 must be conducted discreetly. Privacy must be respected during toileting, bathing, and other
608.25 activities of personal hygiene, except as needed for resident safety or assistance;

608.26 (3) communicate privately with persons of their choice;

608.27 (4) enter and, unless residing in a secured dementia care unit and restrictions on the
608.28 ability to leave are indicated in the resident's person-centered care plan, leave the facility
608.29 as they choose;

608.30 (5) private communication with a representative of a protection and advocacy services
608.31 agency; and

608.32 (6) access Internet service at their expense, unless offered by the facility.

609.1 (b) Personal mail must be sent by the facility without interference and received unopened
609.2 unless medically or programmatically contraindicated and documented by the physician or
609.3 advanced practice registered nurse in the resident's record. Residents must be provided
609.4 access to a telephone to make and receive calls as well as speak privately. Facilities that are
609.5 unable to provide a private area must make reasonable arrangements to accommodate the
609.6 privacy of residents' calls.

609.7 Subd. 14. **Right to confidentiality of records.** Residents have the right to have personal,
609.8 financial, and medical information kept private, to approve or refuse release of information
609.9 to any outside party, and to be advised of the facility's policies and procedures regarding
609.10 disclosure of the information. Residents must be notified when personal records are requested
609.11 by any outside party.

609.12 Subd. 15. **Right to visitors and social participation.** (a) Residents have the right of
609.13 reasonable access at reasonable times, or any time when the resident's welfare is in immediate
609.14 jeopardy, to any available rights protection services and advocacy services.

609.15 (b) Residents have the right to meet with or receive visits at any time by the resident's
609.16 guardian, conservator, health care agent, family, attorney, advocate, religious or social work
609.17 counselor, or any person of the resident's choosing.

609.18 (c) Residents have the right to participate in commercial, religious, social, community,
609.19 and political activities without interference and at their discretion if the activities do not
609.20 infringe on the right to privacy of other residents.

609.21 Subd. 16. **Right to designate representative.** Residents have the right to name a
609.22 designated representative. Before or at the time of execution of an assisted living facility
609.23 contract, the facility must offer the resident the opportunity to identify a designated
609.24 representative in writing in the contract. Residents have the right at any time at or after they
609.25 enter into an assisted living contract to name a designated representative.

609.26 Subd. 17. **Right to form resident engagement and resident or family councils.** All
609.27 assisted living facilities shall engage residents, families, and designated representatives in
609.28 the operation of their facilities and document the methods and results of this engagement.
609.29 Residents have the right to create resident or family councils. Assisted living facilities shall
609.30 provide resident or family councils, if they exist, with space and privacy for council meetings
609.31 where doing so is reasonably achievable. The assisted living facility shall, with the approval
609.32 of the resident or family council, take reasonably achievable steps to make residents and
609.33 family members aware of upcoming meetings in a timely manner. Resident councils are to

610.1 be comprised of residents of the assisted living facility. Staff, visitors, or other guests may
 610.2 attend resident or family council meetings only at the respective council's invitation.

610.3 Subd. 18. **Right to complain.** Residents have the right to:

610.4 (1) complain or inquire about either care or services that are provided or not provided;

610.5 (2) complain about the lack of courtesy or respect to the resident or the resident's property;

610.6 (3) know how to contact the agent of the facility who is responsible for handling
 610.7 complaints and inquiries;

610.8 (4) have the facility conduct an investigation, attempt to resolve, and provide a timely
 610.9 response to the complaint or inquiry;

610.10 (5) recommend changes in policies and services to staff and others of their choice; and

610.11 (6) complain about any violation of the resident's rights.

610.12 Subd. 19. **Right to assert rights.** Residents, their designated representatives, or any
 610.13 person or persons on behalf of the resident have the right to assert the rights granted to
 610.14 residents under this section or any other section.

610.15 Subd. 20. **Right to choose service provider.** Residents are free to choose who provides
 610.16 the services they receive and where they receive those services. Residents shall not be
 610.17 coerced or forced to obtain services in a particular setting and may instead choose to go out
 610.18 into the community for the same services within the limits of health insurance, long-term
 610.19 care insurance, medical assistance under chapter 256B, or other health programs or public
 610.20 programs.

610.21 **EFFECTIVE DATE.** This section is effective August 1, 2021.

610.22 Sec. 2. **[144I.22] FORCED ARBITRATION; WAIVER OF RIGHTS.**

610.23 Subdivision 1. **Forced arbitration.** A facility must affirmatively disclose to the resident
 610.24 any forced arbitration provisions in any assisted living facility contract that precludes, limits,
 610.25 or delays the ability of a resident to begin a civil action. For contracts entered into on or
 610.26 after August 1, 2021, forced arbitration provisions must be conspicuously disclosed in a
 610.27 contract.

610.28 Subd. 2. **Waiver of rights is void.** Any waiver by the resident of the rights in this chapter
 610.29 is void.

610.30 **EFFECTIVE DATE.** This section is effective August 1, 2021.

ARTICLE 18

ADMINISTRATOR QUALIFICATIONS

611.1 Section 1. Minnesota Statutes 2018, section 144A.04, subdivision 5, is amended to read:

611.2
611.3
611.4 Subd. 5. **Administrators.** ~~(a)~~ Each nursing home must employ an administrator who
611.5 must be licensed or permitted as a nursing home administrator by the Board of ~~Examiners~~
611.6 ~~for Nursing Home Administrators~~ Executives for Long Term Services and Supports. The
611.7 nursing home may share the services of a licensed administrator. The administrator must
611.8 maintain a ~~sufficient~~ an on-site presence in the facility to effectively manage the facility in
611.9 compliance with applicable rules and regulations. The administrator must establish procedures
611.10 and delegate authority for on-site operations in the administrator's absence, but is ultimately
611.11 responsible for the management of the facility. Each nursing home must have posted at all
611.12 times the name of the administrator and the name of the person in charge on the premises
611.13 in the absence of the licensed administrator.

611.14 ~~(b) Notwithstanding sections 144A.18 to 144A.27, a nursing home with a director of~~
611.15 ~~nursing serving as an unlicensed nursing home administrator as of March 1, 2001, may~~
611.16 ~~continue to have a director of nursing serve in that capacity, provided the director of nursing~~
611.17 ~~has passed the state law and rules examination administered by the Board of Examiners for~~
611.18 ~~Nursing Home Administrators and maintains evidence of completion of 20 hours of~~
611.19 ~~continuing education each year on topics pertinent to nursing home administration.~~

611.20 Sec. 2. Minnesota Statutes 2018, section 144A.20, subdivision 1, is amended to read:

611.21 Subdivision 1. **Criteria.** The Board of ~~Examiners~~ Executives may issue licenses to
611.22 qualified persons as nursing home administrators, and shall establish qualification criteria
611.23 for nursing home administrators. No license shall be issued to a person as a nursing home
611.24 administrator unless that person:

611.25 (1) is at least 21 years of age ~~and otherwise suitably qualified;~~

611.26 (2) has satisfactorily met standards set by the Board of ~~Examiners~~ Executives, which
611.27 standards shall be designed to assure that nursing home administrators will be individuals
611.28 who, by training or experience are qualified to serve as nursing home administrators; and

611.29 (3) has passed an examination approved by the board and designed to test for competence
611.30 in the ~~subject matters~~ standards referred to in clause (2), or has been approved by the Board
611.31 of ~~Examiners~~ Executives through the development and application of other appropriate
611.32 techniques.

612.1 Sec. 3. Minnesota Statutes 2018, section 144A.24, is amended to read:

612.2 **144A.24 DUTIES OF THE BOARD.**

612.3 The Board of ~~Examiners~~ Executives shall:

612.4 (1) develop and enforce standards for nursing home administrator licensing, which
612.5 standards shall be designed to assure that nursing home administrators will be individuals
612.6 of good character who, by training or experience, are suitably qualified to serve as nursing
612.7 home administrators;

612.8 (2) develop appropriate techniques, including examinations and investigations, for
612.9 determining whether applicants and licensees meet the board's standards;

612.10 (3) issue licenses and permits to those individuals who are found to meet the board's
612.11 standards;

612.12 (4) establish and implement procedures designed to assure that individuals licensed as
612.13 nursing home administrators will comply with the board's standards;

612.14 (5) receive and investigate complaints and take appropriate action consistent with chapter
612.15 214, to revoke or suspend the license or permit of a nursing home administrator or acting
612.16 administrator who fails to comply with sections 144A.18 to 144A.27 or the board's standards;

612.17 (6) conduct a continuing study and investigation of nursing homes, and the administrators
612.18 of nursing homes within the state, with a view to the improvement of the standards imposed
612.19 for the licensing of administrators and improvement of the procedures and methods used
612.20 for enforcement of the board's standards; and

612.21 (7) approve or conduct courses of instruction or training designed to prepare individuals
612.22 for licensing in accordance with the board's standards. ~~Courses designed to meet license
612.23 renewal requirements shall be designed solely to improve professional skills and shall not
612.24 include classroom attendance requirements exceeding 50 hours per year.~~ The board may
612.25 approve courses conducted within or without this state.

612.26 Sec. 4. Minnesota Statutes 2018, section 144A.26, is amended to read:

612.27 **144A.26 RECIPROCITY WITH OTHER STATES AND EQUIVALENCY OF**
612.28 **HEALTH SERVICES EXECUTIVE.**

612.29 Subdivision 1. Reciprocity. The Board of ~~Examiners~~ Executives may issue a nursing
612.30 home administrator's license, without examination, to any person who holds a current license
612.31 as a nursing home administrator from another jurisdiction if the board finds that the standards

613.1 for licensure in the other jurisdiction are at least the substantial equivalent of those prevailing
613.2 in this state and that the applicant is otherwise qualified.

613.3 Subd. 2. **Health services executive license.** The Board of Executives may issue a health
613.4 services executive license to any person who (1) has been validated by the National
613.5 Association of Long Term Care Administrator Boards as a health services executive, and
613.6 (2) has met the education and practice requirements for the minimum qualifications of a
613.7 nursing home administrator, assisted living administrator, and home and community-based
613.8 service provider. Licensure decisions made by the board under this subdivision are final.

613.9 Sec. 5. **[144A.39] FEES.**

613.10 Subdivision 1. **Payment types and nonrefundability.** The fees imposed in this section
613.11 shall be paid by cash, personal check, bank draft, cashier's check, or money order made
613.12 payable to the Board of Executives for Long Term Services and Supports. All fees are
613.13 nonrefundable.

613.14 Subd. 2. **Amount.** The amount of fees may be set by the board with the approval of
613.15 Minnesota Management and Budget up to the limits provided in this section depending
613.16 upon the total amount required to sustain board operations under section 16A.1285,
613.17 subdivision 2. Information about fees in effect at any time is available from the board office.
613.18 The maximum amounts of fees are:

613.19 (1) application for licensure, \$150;

613.20 (2) for a prospective applicant for a review of education and experience advisory to the
613.21 license application, \$50, to be applied to the fee for application for licensure if the latter is
613.22 submitted within one year of the request for review of education and experience;

613.23 (3) state examination, \$75;

613.24 (4) licensed nursing home administrator initial license, \$200 if issued between July 1
613.25 and December 31, \$100 if issued between January 1 and June 30;

613.26 (5) acting administrator permit, \$250;

613.27 (6) renewal license, \$200;

613.28 (7) duplicate license, \$10;

613.29 (8) fee to a sponsor for review of individual continuing education seminars, institutes,
613.30 workshops, or home study courses:

613.31 (i) for less than seven clock hours, \$30; and

614.1 (ii) for seven or more clock hours, \$50;

614.2 (9) fee to a licensee for review of continuing education seminars, institutes, workshops,
 614.3 or home study courses not previously approved for a sponsor and submitted with an
 614.4 application for license renewal:

614.5 (i) for less than seven clock hours total, \$30; and

614.6 (ii) for seven or more clock hours total, \$50;

614.7 (10) late renewal fee, \$50;

614.8 (11) fee to a licensee for verification of licensure status and examination scores, \$30;

614.9 (12) registration as a registered continuing education sponsor, \$1,000; and

614.10 (13) health services executive initial license, \$200 if issued between July 1 and December
 614.11 31, \$100 if issued between January 1 and June 30.

614.12 Sec. 6. **REVISOR INSTRUCTION.**

614.13 The revisor of statutes shall change the phrases "Board of Examiners for Nursing Home
 614.14 Administrators" to "Board of Executives for Long Term Services and Supports" and "Board
 614.15 of Examiners" to "Board of Executives" wherever the phrases appear in Minnesota Statutes
 614.16 and apply to the board established in Minnesota Statutes, section 144A.19.

614.17 **ARTICLE 19**

614.18 **ASSISTED LIVING LICENSURE CONFORMING CHANGES**

614.19 Section 1. Minnesota Statutes 2018, section 144.051, subdivision 4, is amended to read:

614.20 Subd. 4. **Data classification; public data.** For providers regulated pursuant to sections
 614.21 144A.43 to 144A.482 and chapter 144I, the following data collected, created, or maintained
 614.22 by the commissioner are classified as public data as defined in section 13.02, subdivision
 614.23 15:

614.24 (1) all application data on licensees, license numbers, and license status;

614.25 (2) licensing information about licenses previously held under this chapter;

614.26 (3) correction orders, including information about compliance with the order and whether
 614.27 the fine was paid;

614.28 (4) final enforcement actions pursuant to chapter 14;

614.29 (5) orders for hearing, findings of fact, and conclusions of law; and

615.1 (6) when the licensee and department agree to resolve the matter without a hearing, the
615.2 agreement and specific reasons for the agreement are public data.

615.3 **EFFECTIVE DATE.** This section is effective

615.4 Sec. 2. Minnesota Statutes 2018, section 144.051, subdivision 5, is amended to read:

615.5 Subd. 5. **Data classification; confidential data.** For providers regulated pursuant to
615.6 sections 144A.43 to 144A.482 and chapter 144I, the following data collected, created, or
615.7 maintained by the Department of Health are classified as confidential data on individuals
615.8 as defined in section 13.02, subdivision 3: active investigative data relating to the
615.9 investigation of potential violations of law by a licensee including data from the survey
615.10 process before the correction order is issued by the department.

615.11 **EFFECTIVE DATE.** This section is effective

615.12 Sec. 3. Minnesota Statutes 2018, section 144.051, subdivision 6, is amended to read:

615.13 Subd. 6. **Release of private or confidential data.** For providers regulated pursuant to
615.14 sections 144A.43 to 144A.482 and chapter 144I, the department may release private or
615.15 confidential data, except Social Security numbers, to the appropriate state, federal, or local
615.16 agency and law enforcement office to enhance investigative or enforcement efforts or further
615.17 a public health protective process. Types of offices include Adult Protective Services, Office
615.18 of the Ombudsman for Long-Term Care and Office of the Ombudsman for Mental Health
615.19 and Developmental Disabilities, the health licensing boards, Department of Human Services,
615.20 county or city attorney's offices, police, and local or county public health offices.

615.21 **EFFECTIVE DATE.** This section is effective

615.22 Sec. 4. Minnesota Statutes 2018, section 144.057, subdivision 1, is amended to read:

615.23 Subdivision 1. **Background studies required.** The commissioner of health shall contract
615.24 with the commissioner of human services to conduct background studies of:

615.25 (1) individuals providing services ~~which~~ that have direct contact, as defined under section
615.26 245C.02, subdivision 11, with patients and residents in hospitals, boarding care homes,
615.27 outpatient surgical centers licensed under sections 144.50 to 144.58; nursing homes and
615.28 home care agencies licensed under chapter 144A; ~~residential care homes licensed under~~
615.29 ~~chapter 144B~~, assisted living facilities and assisted living facilities with dementia care
615.30 licensed under chapter 144I, and board and lodging establishments that are registered to
615.31 provide supportive or health supervision services under section 157.17;

616.1 (2) individuals specified in section 245C.03, subdivision 1, who perform direct contact
616.2 services in a nursing home, assisted living facility and assisted living facility with dementia
616.3 care licensed under chapter 144I, or a home care agency licensed under chapter 144A or a
616.4 boarding care home licensed under sections 144.50 to 144.58. If the individual under study
616.5 resides outside Minnesota, the study must include a check for substantiated findings of
616.6 maltreatment of adults and children in the individual's state of residence when the information
616.7 is made available by that state, and must include a check of the National Crime Information
616.8 Center database;

616.9 (3) beginning July 1, 1999, all other employees in assisted living facilities licensed under
616.10 chapter 144I, nursing homes licensed under chapter 144A, and boarding care homes licensed
616.11 under sections 144.50 to 144.58. A disqualification of an individual in this section shall
616.12 disqualify the individual from positions allowing direct contact or access to patients or
616.13 residents receiving services. "Access" means physical access to a client or the client's
616.14 personal property without continuous, direct supervision as defined in section 245C.02,
616.15 subdivision 8, when the employee's employment responsibilities do not include providing
616.16 direct contact services;

616.17 (4) individuals employed by a supplemental nursing services agency, as defined under
616.18 section 144A.70, who are providing services in health care facilities; and

616.19 (5) controlling persons of a supplemental nursing services agency, as defined under
616.20 section 144A.70.

616.21 If a facility or program is licensed by the Department of Human Services and subject to
616.22 the background study provisions of chapter 245C and is also licensed by the Department
616.23 of Health, the Department of Human Services is solely responsible for the background
616.24 studies of individuals in the jointly licensed programs.

616.25 **EFFECTIVE DATE.** This section is effective

616.26 Sec. 5. Minnesota Statutes 2018, section 144.122, is amended to read:

616.27 **144.122 LICENSE, PERMIT, AND SURVEY FEES.**

616.28 (a) The state commissioner of health, by rule, may prescribe procedures and fees for
616.29 filing with the commissioner as prescribed by statute and for the issuance of original and
616.30 renewal permits, licenses, registrations, and certifications issued under authority of the
616.31 commissioner. The expiration dates of the various licenses, permits, registrations, and
616.32 certifications as prescribed by the rules shall be plainly marked thereon. Fees may include
616.33 application and examination fees and a penalty fee for renewal applications submitted after

617.1 the expiration date of the previously issued permit, license, registration, and certification.
 617.2 The commissioner may also prescribe, by rule, reduced fees for permits, licenses,
 617.3 registrations, and certifications when the application therefor is submitted during the last
 617.4 three months of the permit, license, registration, or certification period. Fees proposed to
 617.5 be prescribed in the rules shall be first approved by the Department of Management and
 617.6 Budget. All fees proposed to be prescribed in rules shall be reasonable. The fees shall be
 617.7 in an amount so that the total fees collected by the commissioner will, where practical,
 617.8 approximate the cost to the commissioner in administering the program. All fees collected
 617.9 shall be deposited in the state treasury and credited to the state government special revenue
 617.10 fund unless otherwise specifically appropriated by law for specific purposes.

617.11 (b) The commissioner may charge a fee for voluntary certification of medical laboratories
 617.12 and environmental laboratories, and for environmental and medical laboratory services
 617.13 provided by the department, without complying with paragraph (a) or chapter 14. Fees
 617.14 charged for environment and medical laboratory services provided by the department must
 617.15 be approximately equal to the costs of providing the services.

617.16 (c) The commissioner may develop a schedule of fees for diagnostic evaluations
 617.17 conducted at clinics held by the services for children with disabilities program. All receipts
 617.18 generated by the program are annually appropriated to the commissioner for use in the
 617.19 maternal and child health program.

617.20 (d) The commissioner shall set license fees for hospitals and nursing homes that are not
 617.21 boarding care homes at the following levels:

617.22	Joint Commission on Accreditation of	\$7,655 plus \$16 per bed
617.23	Healthcare Organizations (JCAHO) and	
617.24	American Osteopathic Association (AOA)	
617.25	hospitals	
617.26	Non-JCAHO and non-AOA hospitals	\$5,280 plus \$250 per bed
617.27	Nursing home	\$183 plus \$91 per bed until June 30, 2018.
617.28		\$183 plus \$100 per bed between July 1, 2018,
617.29		and June 30, 2020. \$183 plus \$105 per bed
617.30		beginning July 1, 2020.

617.31 The commissioner shall set license fees for outpatient surgical centers, boarding care
 617.32 homes, ~~and supervised living facilities,~~ assisted living facilities, and assisted living facilities
 617.33 with dementia care at the following levels:

617.34	Outpatient surgical centers	\$3,712
617.35	Boarding care homes	\$183 plus \$91 per bed
617.36	Supervised living facilities	\$183 plus \$91 per bed.

618.1 Assisted living facilities with dementia care \$..... plus \$..... per bed.

618.2 Assisted living facilities \$..... plus \$..... per bed.

618.3 Fees collected under this paragraph are nonrefundable. The fees are nonrefundable even if
618.4 received before July 1, 2017, for licenses or registrations being issued effective July 1, 2017,
618.5 or later.

618.6 (e) Unless prohibited by federal law, the commissioner of health shall charge applicants
618.7 the following fees to cover the cost of any initial certification surveys required to determine
618.8 a provider's eligibility to participate in the Medicare or Medicaid program:

618.9	Prospective payment surveys for hospitals	\$	900
618.10	Swing bed surveys for nursing homes	\$	1,200
618.11	Psychiatric hospitals	\$	1,400
618.12	Rural health facilities	\$	1,100
618.13	Portable x-ray providers	\$	500
618.14	Home health agencies	\$	1,800
618.15	Outpatient therapy agencies	\$	800
618.16	End stage renal dialysis providers	\$	2,100
618.17	Independent therapists	\$	800
618.18	Comprehensive rehabilitation outpatient facilities	\$	1,200
618.19	Hospice providers	\$	1,700
618.20	Ambulatory surgical providers	\$	1,800
618.21	Hospitals	\$	4,200
618.22	Other provider categories or additional	Actual surveyor costs: average	
618.23	resurveys required to complete initial	surveyor cost x number of hours for	
618.24	certification	the survey process.	

618.25 These fees shall be submitted at the time of the application for federal certification and
618.26 shall not be refunded. All fees collected after the date that the imposition of fees is not
618.27 prohibited by federal law shall be deposited in the state treasury and credited to the state
618.28 government special revenue fund.

618.29 **EFFECTIVE DATE.** This section is effective

618.30 Sec. 6. Minnesota Statutes 2018, section 144A.44, subdivision 1, is amended to read:

618.31 Subdivision 1. **Statement of rights.** (a) A person client who receives home care services
618.32 in the community or in an assisted living facility licensed under chapter 144I has these
618.33 rights:

- 619.1 (1) ~~the right to~~ receive written information, in plain language, about rights before
619.2 receiving services, including what to do if rights are violated;
- 619.3 (2) ~~the right to~~ receive care and services according to a suitable and up-to-date plan, and
619.4 subject to accepted health care, medical or nursing standards and person-centered care, to
619.5 take an active part in developing, modifying, and evaluating the plan and services;
- 619.6 (3) ~~the right to~~ be told before receiving services the type and disciplines of staff who
619.7 will be providing the services, the frequency of visits proposed to be furnished, other choices
619.8 that are available for addressing home care needs, and the potential consequences of refusing
619.9 these services;
- 619.10 (4) ~~the right to~~ be told in advance of any recommended changes by the provider in the
619.11 service ~~plan~~ agreement and to take an active part in any decisions about changes to the
619.12 service ~~plan~~ agreement;
- 619.13 (5) ~~the right to~~ refuse services or treatment;
- 619.14 (6) ~~the right to~~ know, before receiving services or during the initial visit, any limits to
619.15 the services available from a home care provider;
- 619.16 (7) ~~the right to~~ be told before services are initiated what the provider charges for the
619.17 services; to what extent payment may be expected from health insurance, public programs,
619.18 or other sources, if known; and what charges the client may be responsible for paying;
- 619.19 (8) ~~the right to~~ know that there may be other services available in the community,
619.20 including other home care services and providers, and to know where to find information
619.21 about these services;
- 619.22 (9) ~~the right to~~ choose freely among available providers and to change providers after
619.23 services have begun, within the limits of health insurance, long-term care insurance, medical
619.24 assistance, ~~or~~ other health programs, or public programs;
- 619.25 (10) ~~the right to~~ have personal, financial, and medical information kept private, and to
619.26 be advised of the provider's policies and procedures regarding disclosure of such information;
- 619.27 (11) ~~the right to~~ access the client's own records and written information from those
619.28 records in accordance with sections 144.291 to 144.298;
- 619.29 (12) ~~the right to~~ be served by people who are properly trained and competent to perform
619.30 their duties;
- 619.31 (13) ~~the right to~~ be treated with courtesy and respect, and to have the client's property
619.32 treated with respect;

620.1 (14) ~~the right to~~ be free from physical and verbal abuse, neglect, financial exploitation,
620.2 and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment
620.3 of Minors Act;

620.4 (15) ~~the right to~~ reasonable, advance notice of changes in services or charges;

620.5 (16) ~~the right to~~ know the provider's reason for termination of services;

620.6 (17) ~~the right to~~ at least ~~ten~~ 30 calendar days' advance notice of the termination of a
620.7 service or housing by a provider, except in cases where:

620.8 (i) the client engages in conduct that significantly alters the terms of the service ~~plan~~
620.9 agreement with the home care provider;

620.10 (ii) the client, person who lives with the client, or others create an abusive or unsafe
620.11 work environment for the person providing home care services; or

620.12 (iii) an emergency or a significant change in the client's condition has resulted in service
620.13 needs that exceed the current service ~~plan~~ agreement and that cannot be safely met by the
620.14 home care provider;

620.15 (18) ~~the right to~~ a coordinated transfer when there will be a change in the provider of
620.16 services;

620.17 (19) ~~the right to~~ complain to staff and others of the client's choice about services that
620.18 are provided, or fail to be provided, and the lack of courtesy or respect to the client or the
620.19 client's property and the right to recommend changes in policies and services, free from
620.20 retaliation including the threat of termination of services;

620.21 (20) ~~the right to~~ know how to contact an individual associated with the home care provider
620.22 who is responsible for handling problems and to have the home care provider investigate
620.23 and attempt to resolve the grievance or complaint;

620.24 (21) ~~the right to~~ know the name and address of the state or county agency to contact for
620.25 additional information or assistance; ~~and~~

620.26 (22) ~~the right to~~ assert these rights personally, or have them asserted by the client's
620.27 representative or by anyone on behalf of the client, without retaliation; and

620.28 (23) place an electronic monitoring device in the client's or resident's space in compliance
620.29 with state requirements.

620.30 (b) When providers violate the rights in this section, they are subject to the fines and
620.31 license actions in sections 144A.474, subdivision 11, and 144A.475.

621.1 (c) Providers must do all of the following:

621.2 (1) encourage and assist in the fullest possible exercise of these rights;

621.3 (2) provide the names and telephone numbers of individuals and organizations that
 621.4 provide advocacy and legal services for clients and residents seeking to assert their rights;

621.5 (3) make every effort to assist clients or residents in obtaining information regarding
 621.6 whether Medicare, medical assistance, other health programs, or public programs will pay
 621.7 for services;

621.8 (4) make reasonable accommodations for people who have communication disabilities,
 621.9 or those who speak a language other than English; and

621.10 (5) provide all information and notices in plain language and in terms the client or
 621.11 resident can understand.

621.12 (d) No provider may require or request a client or resident to waive any of the rights
 621.13 listed in this section at any time or for any reasons, including as a condition of initiating
 621.14 services or entering into an assisted living facility contract.

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

621.16 Sec. 7. Minnesota Statutes 2018, section 144A.45, subdivision 1, is amended to read:

621.17 Subdivision 1. **Regulations.** The commissioner shall regulate home care providers
 621.18 pursuant to sections 144A.43 to 144A.482. The regulations shall include the following:

621.19 (1) provisions to assure, to the extent possible, the health, safety, well-being, and
 621.20 appropriate treatment of persons who receive home care services while respecting a client's
 621.21 autonomy and choice;

621.22 (2) requirements that home care providers furnish the commissioner with specified
 621.23 information necessary to implement sections 144A.43 to 144A.482;

621.24 (3) standards of training of home care provider personnel;

621.25 (4) standards for provision of home care services;

621.26 (5) standards for medication management;

621.27 (6) standards for supervision of home care services;

621.28 (7) standards for client evaluation or assessment;

621.29 (8) requirements for the involvement of a client's health care provider, the documentation
 621.30 of health care providers' orders, if required, and the client's service ~~plan~~ agreement;

622.1 (9) the maintenance of accurate, current client records;

622.2 (10) the establishment of basic and comprehensive levels of licenses based on services
622.3 provided; and

622.4 (11) provisions to enforce these regulations and the home care bill of rights.

622.5 **EFFECTIVE DATE.** This section is effective

622.6 Sec. 8. Minnesota Statutes 2018, section 144A.471, subdivision 7, is amended to read:

622.7 Subd. 7. **Comprehensive home care license provider.** Home care services that may
622.8 be provided with a comprehensive home care license include any of the basic home care
622.9 services listed in subdivision 6, and one or more of the following:

622.10 (1) services of an advanced practice nurse, registered nurse, licensed practical nurse,
622.11 physical therapist, respiratory therapist, occupational therapist, speech-language pathologist,
622.12 dietitian or nutritionist, or social worker;

622.13 (2) tasks delegated to unlicensed personnel by a registered nurse or assigned by a licensed
622.14 health professional within the person's scope of practice;

622.15 (3) medication management services;

622.16 (4) hands-on assistance with transfers and mobility;

622.17 (5) treatment and therapies;

622.18 (6) assisting clients with eating when the clients have complicating eating problems as
622.19 identified in the client record or through an assessment such as difficulty swallowing,
622.20 recurrent lung aspirations, or requiring the use of a tube or parenteral or intravenous
622.21 instruments to be fed; or

622.22 ~~(6)~~ (7) providing other complex or specialty health care services.

622.23 **EFFECTIVE DATE.** This section is effective

622.24 Sec. 9. Minnesota Statutes 2018, section 144A.471, subdivision 9, is amended to read:

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

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

- 623.1 (i) determination of whether a client needs home care services, or assisting a client in
623.2 determining what services are needed;
- 623.3 (ii) referral of clients to a home care provider;
- 623.4 (iii) administration of payments for home care services; or
- 623.5 (iv) administration of a health care home established under section 256B.0751;
- 623.6 (2) an individual who is not an employee of a licensed home care provider if the
623.7 individual:
- 623.8 (i) only provides services as an independent contractor to one or more licensed home
623.9 care providers;
- 623.10 (ii) provides no services under direct agreements or contracts with clients; and
- 623.11 (iii) is contractually bound to perform services in compliance with the contracting home
623.12 care provider's policies and service ~~plans~~ agreements;
- 623.13 (3) a business that provides staff to home care providers, such as a temporary employment
623.14 agency, if the business:
- 623.15 (i) only provides staff under contract to licensed or exempt providers;
- 623.16 (ii) provides no services under direct agreements with clients; and
- 623.17 (iii) is contractually bound to perform services under the contracting home care provider's
623.18 direction and supervision;
- 623.19 (4) any home care services conducted by and for the adherents of any recognized church
623.20 or religious denomination for its members through spiritual means, or by prayer for healing;
- 623.21 (5) an individual who only provides home care services to a relative;
- 623.22 (6) an individual not connected with a home care provider that provides assistance with
623.23 basic home care needs if the assistance is provided primarily as a contribution and not as a
623.24 business;
- 623.25 (7) an individual not connected with a home care provider that shares housing with and
623.26 provides primarily housekeeping or homemaking services to an elderly or disabled person
623.27 in return for free or reduced-cost housing;
- 623.28 (8) an individual or provider providing home-delivered meal services;

624.1 (9) an individual providing senior companion services and other older American volunteer
624.2 programs (OAVP) established under the Domestic Volunteer Service Act of 1973, United
624.3 States Code, title 42, chapter 66;

624.4 ~~(10) an employee of a nursing home or home care provider licensed under this chapter~~
624.5 ~~or an employee of a boarding care home licensed under sections 144.50 to 144.56 when~~
624.6 ~~responding to occasional emergency calls from individuals residing in a residential setting~~
624.7 ~~that is attached to or located on property contiguous to the nursing home, boarding care~~
624.8 ~~home, or location where home care services are also provided;~~

624.9 ~~(11) an employee of a nursing home or home care provider licensed under this chapter~~
624.10 ~~or an employee of a boarding care home licensed under sections 144.50 to 144.56 when~~
624.11 ~~providing occasional minor services free of charge to individuals residing in a residential~~
624.12 ~~setting that is attached to or located on property contiguous to the nursing home, boarding~~
624.13 ~~care home, or location where home care services are also provided;~~

624.14 (12) a member of a professional corporation organized under chapter 319B that does
624.15 not regularly offer or provide home care services as defined in section 144A.43, subdivision
624.16 3;

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

624.22 (14) an individual or agency that provides medical supplies or durable medical equipment,
624.23 except when the provision of supplies or equipment is accompanied by a home care service;

624.24 (15) a physician licensed under chapter 147;

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

624.27 (17) a business that only provides services that are primarily instructional and not medical
624.28 services or health-related support services;

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

624.31 (19) an individual or business licensed as hospice as defined in sections 144A.75 to
624.32 144A.755 who is not providing home care services independent of hospice service;

625.1 (20) activities conducted by the commissioner of health or a community health board
 625.2 as defined in section 145A.02, subdivision 5, including communicable disease investigations
 625.3 or testing; or

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

625.7 **EFFECTIVE DATE.** The amendments to clauses (10) and (11) are effective July 1,
 625.8 2021.

625.9 Sec. 10. Minnesota Statutes 2018, section 144A.472, subdivision 7, is amended to read:

625.10 Subd. 7. **Fees; application, change of ownership, and renewal, and failure to**
 625.11 **notify.** (a) An initial applicant seeking temporary home care licensure must submit the
 625.12 following application fee to the commissioner along with a completed application:

625.13 (1) for a basic home care provider, \$2,100; or

625.14 (2) for a comprehensive home care provider, \$4,200.

625.15 (b) A home care provider who is filing a change of ownership as required under
 625.16 subdivision 5 must submit the following application fee to the commissioner, along with
 625.17 the documentation required for the change of ownership:

625.18 (1) for a basic home care provider, \$2,100; or

625.19 (2) for a comprehensive home care provider, \$4,200.

625.20 (c) For the period ending June 30, 2018, a home care provider who is seeking to renew
 625.21 the provider's license shall pay a fee to the commissioner based on revenues derived from
 625.22 the provision of home care services during the calendar year prior to the year in which the
 625.23 application is submitted, according to the following schedule:

625.24 **License Renewal Fee**

625.25 Provider Annual Revenue	Fee
625.26 greater than \$1,500,000	\$6,625
625.27 greater than \$1,275,000 and no more than 625.28 \$1,500,000	\$5,797
625.29 greater than \$1,100,000 and no more than 625.30 \$1,275,000	\$4,969
625.31 greater than \$950,000 and no more than 625.32 \$1,100,000	\$4,141
625.33 greater than \$850,000 and no more than \$950,000	\$3,727

626.1	greater than \$750,000 and no more than \$850,000	\$3,313
626.2	greater than \$650,000 and no more than \$750,000	\$2,898
626.3	greater than \$550,000 and no more than \$650,000	\$2,485
626.4	greater than \$450,000 and no more than \$550,000	\$2,070
626.5	greater than \$350,000 and no more than \$450,000	\$1,656
626.6	greater than \$250,000 and no more than \$350,000	\$1,242
626.7	greater than \$100,000 and no more than \$250,000	\$828
626.8	greater than \$50,000 and no more than \$100,000	\$500
626.9	greater than \$25,000 and no more than \$50,000	\$400
626.10	no more than \$25,000	\$200

626.11 (d) For the period between July 1, 2018, and June 30, 2020, a home care provider who
 626.12 is seeking to renew the provider's license shall pay a fee to the commissioner in an amount
 626.13 that is ten percent higher than the applicable fee in paragraph (c). A home care provider's
 626.14 fee shall be based on revenues derived from the provision of home care services during the
 626.15 calendar year prior to the year in which the application is submitted.

626.16 (e) Beginning July 1, 2020, a home care provider who is seeking to renew the provider's
 626.17 license shall pay a fee to the commissioner based on revenues derived from the provision
 626.18 of home care services during the calendar year prior to the year in which the application is
 626.19 submitted, according to the following schedule:

626.20 **License Renewal Fee**

626.21	Provider Annual Revenue	Fee
626.22	greater than \$1,500,000	\$7,651
626.23	greater than \$1,275,000 and no more than	
626.24	\$1,500,000	\$6,695
626.25	greater than \$1,100,000 and no more than	
626.26	\$1,275,000	\$5,739
626.27	greater than \$950,000 and no more than	
626.28	\$1,100,000	\$4,783
626.29	greater than \$850,000 and no more than \$950,000	\$4,304
626.30	greater than \$750,000 and no more than \$850,000	\$3,826
626.31	greater than \$650,000 and no more than \$750,000	\$3,347
626.32	greater than \$550,000 and no more than \$650,000	\$2,870
626.33	greater than \$450,000 and no more than \$550,000	\$2,391
626.34	greater than \$350,000 and no more than \$450,000	\$1,913
626.35	greater than \$250,000 and no more than \$350,000	\$1,434
626.36	greater than \$100,000 and no more than \$250,000	\$957
626.37	greater than \$50,000 and no more than \$100,000	\$577

627.1 greater than \$25,000 and no more than \$50,000 \$462

627.2 no more than \$25,000 \$231

627.3 (f) If requested, the home care provider shall provide the commissioner information to
627.4 verify the provider's annual revenues or other information as needed, including copies of
627.5 documents submitted to the Department of Revenue.

627.6 (g) At each annual renewal, a home care provider may elect to pay the highest renewal
627.7 fee for its license category, and not provide annual revenue information to the commissioner.

627.8 (h) A temporary license or license applicant, or temporary licensee or licensee that
627.9 knowingly provides the commissioner incorrect revenue amounts for the purpose of paying
627.10 a lower license fee, shall be subject to a civil penalty in the amount of double the fee the
627.11 provider should have paid.

627.12 (i) The fee for failure to comply with the notification requirements in section 144A.473,
627.13 subdivision 2, paragraph (c), is \$1,000.

627.14 ~~(j)~~ (j) Fees and penalties collected under this section shall be deposited in the state
627.15 treasury and credited to the state government special revenue fund. All fees are
627.16 nonrefundable. Fees collected under paragraphs (c), (d), and (e) are nonrefundable even if
627.17 received before July 1, 2017, for temporary licenses or licenses being issued effective July
627.18 1, 2017, or later.

627.19 (k) Fines collected under this subdivision shall be deposited in a dedicated special revenue
627.20 account. On an annual basis, the balance in the special revenue account will be appropriated
627.21 to the commissioner to implement the recommendations of the advisory council established
627.22 in section 144A.4799. Fines collected in state fiscal years 2018 and 2019 shall be deposited
627.23 in the dedicated special revenue account as described in this section.

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

627.25 Sec. 11. Minnesota Statutes 2018, section 144A.474, subdivision 9, is amended to read:

627.26 Subd. 9. **Follow-up surveys.** For providers that have Level 3 or Level 4 violations under
627.27 subdivision 11, or any violations determined to be widespread, the department shall conduct
627.28 a follow-up survey within 90 calendar days of the survey. When conducting a follow-up
627.29 survey, the surveyor will focus on whether the previous violations have been corrected and
627.30 may also address any new violations that are observed while evaluating the corrections that
627.31 have been made. ~~If a new violation is identified on a follow-up survey, no fine will be~~
627.32 ~~imposed unless it is not corrected on the next follow-up survey.~~

628.1 **EFFECTIVE DATE.** This section is effective

628.2 Sec. 12. Minnesota Statutes 2018, section 144A.474, subdivision 11, is amended to read:

628.3 Subd. 11. **Fines.** (a) Fines and enforcement actions under this subdivision may be assessed
628.4 based on the level and scope of the violations described in paragraph ~~(e)~~ (b) and imposed
628.5 immediately with no opportunity to correct the violation first as follows:

628.6 (1) Level 1, no fines or enforcement;

628.7 (2) Level 2, ~~finer ranging from \$0 to a fine of \$500 per violation~~, in addition to any of
628.8 the enforcement mechanisms authorized in section 144A.475 for widespread violations;

628.9 (3) Level 3, ~~finer ranging from \$500 to \$1,000 a fine of \$3,000 per incident plus \$100~~
628.10 for each resident affected by the violation, in addition to any of the enforcement mechanisms
628.11 authorized in section 144A.475; ~~and~~

628.12 (4) Level 4, ~~finer ranging from \$1,000 to a fine of \$5,000 per incident plus \$200 for~~
628.13 each resident affected by the violation, in addition to any of the enforcement mechanisms
628.14 authorized in section 144A.475;

628.15 (5) for maltreatment violations as defined in section 626.557 including abuse, neglect,
628.16 financial exploitation, and drug diversion, that are determined against the provider, an
628.17 immediate fine shall be imposed of \$5,000 per incident plus \$200 for each resident affected
628.18 by the violation; and

628.19 (6) the fines in clauses (1) to (4) are increased and immediate fine imposition is authorized
628.20 for both surveys and investigations conducted.

628.21 (b) Correction orders for violations are categorized by both level and scope and fines
628.22 shall be assessed as follows:

628.23 (1) level of violation:

628.24 (i) Level 1 is a violation that has no potential to cause more than a minimal impact on
628.25 the client and does not affect health or safety;

628.26 (ii) Level 2 is a violation that did not harm a client's health or safety but had the potential
628.27 to have harmed a client's health or safety, but was not likely to cause serious injury,
628.28 impairment, or death;

628.29 (iii) Level 3 is a violation that harmed a client's health or safety, not including serious
628.30 injury, impairment, or death, or a violation that has the potential to lead to serious injury,
628.31 impairment, or death; and

629.1 (iv) Level 4 is a violation that results in serious injury, impairment, or death;

629.2 (2) scope of violation:

629.3 (i) isolated, when one or a limited number of clients are affected or one or a limited
629.4 number of staff are involved or the situation has occurred only occasionally;

629.5 (ii) pattern, when more than a limited number of clients are affected, more than a limited
629.6 number of staff are involved, or the situation has occurred repeatedly but is not found to be
629.7 pervasive; and

629.8 (iii) widespread, when problems are pervasive or represent a systemic failure that has
629.9 affected or has the potential to affect a large portion or all of the clients.

629.10 (c) If the commissioner finds that the applicant or a home care provider ~~required to be~~
629.11 ~~licensed under sections 144A.43 to 144A.482~~ has not corrected violations by the date
629.12 specified in the correction order or conditional license resulting from a survey or complaint
629.13 investigation, the commissioner ~~may impose a fine.~~ A shall provide a notice of
629.14 noncompliance with a correction order must be mailed by e-mail to the applicant's or
629.15 provider's last known e-mail address. The noncompliance notice must list the violations not
629.16 corrected.

629.17 (d) For every violation identified by the commissioner, the commissioner shall issue an
629.18 immediate fine pursuant to paragraph (a), clause (6). The license holder must still correct
629.19 the violation in the time specified. The issuance of an immediate fine can occur in addition
629.20 to any enforcement mechanism authorized under section 144A.475. The immediate fine
629.21 may be appealed as allowed under this subdivision.

629.22 ~~(d)~~ (e) The license holder must pay the fines assessed on or before the payment date
629.23 specified. If the license holder fails to fully comply with the order, the commissioner may
629.24 issue a second fine or suspend the license until the license holder complies by paying the
629.25 fine. A timely appeal shall stay payment of the fine until the commissioner issues a final
629.26 order.

629.27 ~~(e)~~ (f) A license holder shall promptly notify the commissioner in writing when a violation
629.28 specified in the order is corrected. If upon reinspection the commissioner determines that
629.29 a violation has not been corrected as indicated by the order, the commissioner may issue a
629.30 second fine. The commissioner shall notify the license holder by mail to the last known
629.31 address in the licensing record that a second fine has been assessed. The license holder may
629.32 appeal the second fine as provided under this subdivision.

630.1 ~~(f)~~ (g) A home care provider that has been assessed a fine under this subdivision has a
 630.2 right to a reconsideration or a hearing under this section and chapter 14.

630.3 ~~(g)~~ (h) When a fine has been assessed, the license holder may not avoid payment by
 630.4 closing, selling, or otherwise transferring the licensed program to a third party. In such an
 630.5 event, the license holder shall be liable for payment of the fine.

630.6 ~~(h)~~ (i) In addition to any fine imposed under this section, the commissioner may assess
 630.7 a penalty amount based on costs related to an investigation that results in a final order
 630.8 assessing a fine or other enforcement action authorized by this chapter.

630.9 ~~(i)~~ (j) Fines collected under this subdivision shall be deposited in ~~the state government~~
 630.10 a dedicated special revenue fund and credited to an account separate from the revenue
 630.11 collected under section 144A.472. Subject to an appropriation by the legislature, the revenue
 630.12 from the fines collected must be used by the commissioner for special projects to improve
 630.13 home care in Minnesota as recommended by account. On an annual basis, the balance in
 630.14 the special revenue account shall be appropriated to the commissioner to implement the
 630.15 recommendations of the advisory council established in section 144A.4799. Fines collected
 630.16 in state fiscal years 2018 and 2019 shall be deposited in the dedicated special revenue
 630.17 account as described in this section.

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

630.19 Sec. 13. Minnesota Statutes 2018, section 144A.475, subdivision 3b, is amended to read:

630.20 Subd. 3b. **Expedited hearing.** (a) Within five business days of receipt of the license
 630.21 holder's timely appeal of a temporary suspension or issuance of a conditional license, the
 630.22 commissioner shall request assignment of an administrative law judge. The request must
 630.23 include a proposed date, time, and place of a hearing. A hearing must be conducted by an
 630.24 administrative law judge pursuant to Minnesota Rules, parts 1400.8505 to 1400.8612, within
 630.25 30 calendar days of the request for assignment, unless an extension is requested by either
 630.26 party and granted by the administrative law judge for good cause. The commissioner shall
 630.27 issue a notice of hearing by certified mail or personal service at least ten business days
 630.28 before the hearing. Certified mail to the last known address is sufficient. The scope of the
 630.29 hearing shall be limited solely to the issue of whether the temporary suspension or issuance
 630.30 of a conditional license should remain in effect and whether there is sufficient evidence to
 630.31 conclude that the licensee's actions or failure to comply with applicable laws are level 3 or
 630.32 4 violations as defined in section 144A.474, subdivision 11, paragraph (b), or that there
 630.33 were violations that posed an imminent risk of harm to the health and safety of persons in
 630.34 the provider's care.

631.1 (b) The administrative law judge shall issue findings of fact, conclusions, and a
 631.2 recommendation within ten business days from the date of hearing. The parties shall have
 631.3 ten calendar days to submit exceptions to the administrative law judge's report. The record
 631.4 shall close at the end of the ten-day period for submission of exceptions. The commissioner's
 631.5 final order shall be issued within ten business days from the close of the record. When an
 631.6 appeal of a temporary immediate suspension or conditional license is withdrawn or dismissed,
 631.7 the commissioner shall issue a final order affirming the temporary immediate suspension
 631.8 or conditional license within ten calendar days of the commissioner's receipt of the
 631.9 withdrawal or dismissal. The license holder is prohibited from operation during the temporary
 631.10 suspension period.

631.11 (c) When the final order under paragraph (b) affirms an immediate suspension, and a
 631.12 final licensing sanction is issued under subdivisions 1 and 2 and the licensee appeals that
 631.13 sanction, the licensee is prohibited from operation pending a final commissioner's order
 631.14 after the contested case hearing conducted under chapter 14.

631.15 (d) A licensee whose license is temporarily suspended must comply with the requirements
 631.16 for notification and transfer of clients in subdivision 5. These requirements remain if an
 631.17 appeal is requested.

631.18 **EFFECTIVE DATE.** This section is effective

631.19 Sec. 14. Minnesota Statutes 2018, section 144A.475, subdivision 5, is amended to read:

631.20 Subd. 5. **Plan required.** (a) The process of suspending ~~or~~, revoking, or refusing to renew
 631.21 a license must include a plan for transferring affected ~~clients~~ clients' care to other providers
 631.22 by the home care provider, which will be monitored by the commissioner. Within three
 631.23 ~~business~~ calendar days of being notified of the ~~final~~ revocation, refusal to renew, or
 631.24 suspension action, the home care provider shall provide the commissioner, the lead agencies
 631.25 as defined in section 256B.0911, county adult protection and case managers, and the
 631.26 ombudsman for long-term care with the following information:

631.27 (1) a list of all clients, including full names and all contact information on file;

631.28 (2) a list of each client's representative or emergency contact person, including full names
 631.29 and all contact information on file;

631.30 (3) the location or current residence of each client;

631.31 (4) the payor sources for each client, including payor source identification numbers; and

632.1 (5) for each client, a copy of the client's service ~~plan~~ agreement, and a list of the types
632.2 of services being provided.

632.3 (b) The revocation, refusal to renew, or suspension notification requirement is satisfied
632.4 by mailing the notice to the address in the license record. The home care provider shall
632.5 cooperate with the commissioner and the lead agencies, county adult protection and county
632.6 managers, and the ombudsman for long term care during the process of transferring care of
632.7 clients to qualified providers. Within three business calendar days of being notified of the
632.8 final revocation, refusal to renew, or suspension ~~action~~, the home care provider must notify
632.9 and disclose to each of the home care provider's clients, or the client's representative or
632.10 emergency contact persons, that the commissioner is taking action against the home care
632.11 provider's license by providing a copy of the revocation, refusal to renew, or suspension
632.12 notice issued by the commissioner. If the provider does not comply with the disclosure
632.13 requirements in this section, the commissioner, lead agencies, county adult protection and
632.14 county managers, and ombudsman for long-term care shall notify the clients, client
632.15 representatives, or emergency contact persons, about the action being taken. The revocation,
632.16 refusal to renew, or suspension notice is public data except for any private data contained
632.17 therein.

632.18 (c) A home care provider subject to this subdivision may continue operating during the
632.19 period of time home care clients are being transferred to other providers.

632.20 **EFFECTIVE DATE.** This section is effective

632.21 Sec. 15. Minnesota Statutes 2018, section 144A.476, subdivision 1, is amended to read:

632.22 Subdivision 1. **Prior criminal convictions; owner and managerial officials.** (a) Before
632.23 the commissioner issues a temporary license, issues a license as a result of an approved
632.24 change in ownership, or renews a license, an owner or managerial official is required to
632.25 complete a background study under section 144.057. No person may be involved in the
632.26 management, operation, or control of a home care provider if the person has been disqualified
632.27 under chapter 245C. If an individual is disqualified under section 144.057 or chapter 245C,
632.28 the individual may request reconsideration of the disqualification. If the individual requests
632.29 reconsideration and the commissioner sets aside or rescinds the disqualification, the individual
632.30 is eligible to be involved in the management, operation, or control of the provider. If an
632.31 individual has a disqualification under section 245C.15, subdivision 1, and the disqualification
632.32 is affirmed, the individual's disqualification is barred from a set aside, and the individual
632.33 must not be involved in the management, operation, or control of the provider.

633.1 (b) For purposes of this section, owners of a home care provider subject to the background
 633.2 check requirement are those individuals whose ownership interest provides sufficient
 633.3 authority or control to affect or change decisions related to the operation of the home care
 633.4 provider. An owner includes a sole proprietor, a general partner, or any other individual
 633.5 whose individual ownership interest can affect the management and direction of the policies
 633.6 of the home care provider.

633.7 (c) For the purposes of this section, managerial officials subject to the background check
 633.8 requirement are individuals who provide direct contact as defined in section 245C.02,
 633.9 subdivision 11, or individuals who have the responsibility for the ongoing management or
 633.10 direction of the policies, services, or employees of the home care provider. Data collected
 633.11 under this subdivision shall be classified as private data on individuals under section 13.02,
 633.12 subdivision 12.

633.13 (d) The department shall not issue any license if the applicant or owner or managerial
 633.14 official has been unsuccessful in having a background study disqualification set aside under
 633.15 section 144.057 and chapter 245C; if the owner or managerial official, as an owner or
 633.16 managerial official of another home care provider, was substantially responsible for the
 633.17 other home care provider's failure to substantially comply with sections 144A.43 to
 633.18 144A.482; or if an owner that has ceased doing business, either individually or as an owner
 633.19 of a home care provider, was issued a correction order for failing to assist clients in violation
 633.20 of this chapter.

633.21 **EFFECTIVE DATE.** This section is effective

633.22 Sec. 16. Minnesota Statutes 2018, section 144A.4791, subdivision 10, is amended to read:

633.23 Subd. 10. **Termination of service ~~plan~~ agreement.** (a) If a home care provider terminates
 633.24 a service ~~plan~~ agreement with a client, and the client continues to need home care services,
 633.25 the home care provider shall provide the client and the client's representative, if any, with
 633.26 a 30-day written notice of termination which includes the following information:

633.27 (1) the effective date of termination;

633.28 (2) the reason for termination;

633.29 (3) a list of known licensed home care providers in the client's immediate geographic
 633.30 area;

633.31 (4) a statement that the home care provider will participate in a coordinated transfer of
 633.32 care of the client to another home care provider, health care provider, or caregiver, as
 633.33 required by the home care bill of rights, section 144A.44, subdivision 1, clause (17);

634.1 (5) the name and contact information of a person employed by the home care provider
634.2 with whom the client may discuss the notice of termination; and

634.3 (6) if applicable, a statement that the notice of termination of home care services does
634.4 not constitute notice of termination of the housing with services contract with a housing
634.5 with services establishment.

634.6 (b) When the home care provider voluntarily discontinues services to all clients, the
634.7 home care provider must notify the commissioner, lead agencies, and ombudsman for
634.8 long-term care about its clients and comply with the requirements in this subdivision.

634.9 **EFFECTIVE DATE.** This section is effective

634.10 Sec. 17. Minnesota Statutes 2018, section 144A.4799, is amended to read:

634.11 **144A.4799 DEPARTMENT OF HEALTH LICENSED HOME CARE PROVIDER**
634.12 **ADVISORY COUNCIL.**

634.13 Subdivision 1. **Membership.** The commissioner of health shall appoint eight persons
634.14 to a home care and assisted living program advisory council consisting of the following:

634.15 (1) three public members as defined in section 214.02 who shall be ~~either~~ persons who
634.16 are currently receiving home care services ~~or~~, persons who have received home care within
634.17 five years of the application date, persons who have family members receiving home care
634.18 services, or persons who have family members who have received home care services within
634.19 five years of the application date;

634.20 (2) three Minnesota home care licensees representing basic and comprehensive levels
634.21 of licensure who may be a managerial official, an administrator, a supervising registered
634.22 nurse, or an unlicensed personnel performing home care tasks;

634.23 (3) one member representing the Minnesota Board of Nursing; ~~and~~

634.24 (4) one member representing the office of ombudsman for long-term care; and

634.25 (5) beginning July 1, 2021, a member of a county health and human services or county
634.26 adult protection office.

634.27 Subd. 2. **Organizations and meetings.** The advisory council shall be organized and
634.28 administered under section 15.059 with per diems and costs paid within the limits of available
634.29 appropriations. Meetings will be held quarterly and hosted by the department. Subcommittees
634.30 may be developed as necessary by the commissioner. Advisory council meetings are subject
634.31 to the Open Meeting Law under chapter 13D.

635.1 Subd. 3. **Duties.** (a) At the commissioner's request, the advisory council shall provide
635.2 advice regarding regulations of Department of Health licensed home care providers in this
635.3 chapter, including advice on the following:

635.4 (1) community standards for home care practices;

635.5 (2) enforcement of licensing standards and whether certain disciplinary actions are
635.6 appropriate;

635.7 (3) ways of distributing information to licensees and consumers of home care;

635.8 (4) training standards;

635.9 (5) identifying emerging issues and opportunities in the home care field, including;

635.10 (6) identifying the use of technology in home and telehealth capabilities;

635.11 ~~(6)~~ (7) allowable home care licensing modifications and exemptions, including a method
635.12 for an integrated license with an existing license for rural licensed nursing homes to provide
635.13 limited home care services in an adjacent independent living apartment building owned by
635.14 the licensed nursing home; and

635.15 ~~(7)~~ (8) recommendations for studies using the data in section 62U.04, subdivision 4,
635.16 including but not limited to studies concerning costs related to dementia and chronic disease
635.17 among an elderly population over 60 and additional long-term care costs, as described in
635.18 section 62U.10, subdivision 6.

635.19 (b) The advisory council shall perform other duties as directed by the commissioner.

635.20 (c) The advisory council shall annually ~~review the balance of the account in the state~~
635.21 ~~government special revenue fund described in section 144A.474, subdivision 11, paragraph~~
635.22 ~~(i), and make annual recommendations by January 15 directly to the chairs and ranking~~
635.23 ~~minority members of the legislative committees with jurisdiction over health and human~~
635.24 ~~services regarding appropriations to the commissioner for the purposes in section 144A.474,~~
635.25 ~~subdivision 11, paragraph (i). The recommendations shall address ways the commissioner~~
635.26 may improve protection of the public under existing statutes and laws and include but are
635.27 not limited to projects that create and administer training of licensees and their employees
635.28 to improve residents lives, supporting ways that licensees can improve and enhance quality
635.29 care, ways to provide technical assistance to licensees to improve compliance; information
635.30 technology and data projects that analyze and communicate information about trends of
635.31 violations or lead to ways of improving client care; communications strategies to licensees
635.32 and the public; and other projects or pilots that benefit clients, families, and the public.

636.1 **EFFECTIVE DATE.** This section is effective

636.2 Sec. 18. Minnesota Statutes 2018, section 256I.03, subdivision 15, is amended to read:

636.3 Subd. 15. **Supportive housing.** "Supportive housing" means housing ~~with support~~
 636.4 ~~services according to the continuum of care coordinated assessment system established~~
 636.5 ~~under Code of Federal Regulations, title 24, section 578.3~~ that is not time-limited and
 636.6 provides or coordinates services necessary for a resident to maintain housing stability.

636.7 **EFFECTIVE DATE.** This section is effective

636.8 Sec. 19. Minnesota Statutes 2018, section 256I.04, subdivision 2a, is amended to read:

636.9 Subd. 2a. **License required; staffing qualifications.** (a) Except as provided in paragraph
 636.10 (b), an agency may not enter into an agreement with an establishment to provide housing
 636.11 support unless:

636.12 (1) the establishment is licensed by the Department of Health as a hotel and restaurant;
 636.13 a board and lodging establishment; a boarding care home before March 1, 1985; or a
 636.14 supervised living facility, and the service provider for residents of the facility is licensed
 636.15 under chapter 245A. However, an establishment licensed by the Department of Health to
 636.16 provide lodging need not also be licensed to provide board if meals are being supplied to
 636.17 residents under a contract with a food vendor who is licensed by the Department of Health;

636.18 (2) the residence is: (i) licensed by the commissioner of human services under Minnesota
 636.19 Rules, parts 9555.5050 to 9555.6265; (ii) certified by a county human services agency prior
 636.20 to July 1, 1992, using the standards under Minnesota Rules, parts 9555.5050 to 9555.6265;
 636.21 (iii) licensed by the commissioner under Minnesota Rules, parts 2960.0010 to 2960.0120,
 636.22 with a variance under section 245A.04, subdivision 9; or (iv) licensed under section 245D.02,
 636.23 subdivision 4a, as a community residential setting by the commissioner of human services;
 636.24 or

636.25 (3) ~~the establishment facility is registered~~ licensed under chapter 144D chapter 144I and
 636.26 provides three meals a day.

636.27 (b) The requirements under paragraph (a) do not apply to establishments exempt from
 636.28 state licensure because they are:

636.29 (1) located on Indian reservations and subject to tribal health and safety requirements;
 636.30 or

637.1 (2) ~~a supportive housing establishment that has an approved habitability inspection and~~
 637.2 ~~an individual lease agreement and that serves people who have experienced long-term~~
 637.3 ~~homelessness and were referred through a coordinated assessment in section 256I.03,~~
 637.4 ~~subdivision 15~~ supportive housing establishments where an individual has an approved
 637.5 habitability inspection and an individual lease agreement.

637.6 (c) Supportive housing establishments that serve individuals who have experienced
 637.7 long-term homelessness and emergency shelters must participate in the homeless management
 637.8 information system and a coordinated assessment system as defined by the commissioner.

637.9 (d) Effective July 1, 2016, an agency shall not have an agreement with a provider of
 637.10 housing support unless all staff members who have direct contact with recipients:

637.11 (1) have skills and knowledge acquired through one or more of the following:

637.12 (i) a course of study in a health- or human services-related field leading to a bachelor
 637.13 of arts, bachelor of science, or associate's degree;

637.14 (ii) one year of experience with the target population served;

637.15 (iii) experience as a mental health certified peer specialist according to section 256B.0615;
 637.16 or

637.17 (iv) meeting the requirements for unlicensed personnel under sections 144A.43 to
 637.18 144A.483;

637.19 (2) hold a current driver's license appropriate to the vehicle driven if transporting
 637.20 recipients;

637.21 (3) complete training on vulnerable adults mandated reporting and child maltreatment
 637.22 mandated reporting, where applicable; and

637.23 (4) complete housing support orientation training offered by the commissioner.

637.24 **EFFECTIVE DATE.** This section is effective

637.25 Sec. 20. Minnesota Statutes 2018, section 325F.72, is amended to read:

637.26 **325F.72 DISCLOSURE OF SPECIAL CARE STATUS DEMENTIA CARE**
 637.27 **SERVICES REQUIRED.**

637.28 Subdivision 1. **Persons to whom disclosure is required.** ~~Housing with services~~
 637.29 ~~establishments, as defined in sections 144D.01 to 144D.07, that secure, segregate, or provide~~
 637.30 ~~a special program or special unit for residents with a diagnosis of probable Alzheimer's~~
 637.31 ~~disease or a related disorder or that advertise, market, or otherwise promote the establishment~~

638.1 ~~as providing specialized care for Alzheimer's disease or a related disorder are considered a~~
 638.2 ~~"special care unit."~~ All ~~special care units~~ assisted living facilities with dementia care, as
 638.3 defined in section 144I.01, shall provide a written disclosure to the following:

- 638.4 (1) the commissioner of health, if requested;
- 638.5 (2) the Office of Ombudsman for Long-Term Care; and
- 638.6 (3) each person seeking placement within a residence, or the person's authorized
 638.7 representative, before an agreement to provide the care is entered into.

638.8 Subd. 2. **Content.** Written disclosure shall include, but is not limited to, the following:

- 638.9 (1) a statement of the overall philosophy and how it reflects the special needs of residents
 638.10 with Alzheimer's disease or other dementias;
- 638.11 (2) the criteria for determining who may reside in the ~~special~~ dementia care unit;
- 638.12 (3) the process used for assessment and establishment of the service ~~plan or~~ agreement,
 638.13 including how the plan is responsive to changes in the resident's condition;
- 638.14 (4) staffing credentials, job descriptions, and staff duties and availability, including any
 638.15 training specific to dementia;
- 638.16 (5) physical environment as well as design and security features that specifically address
 638.17 the needs of residents with Alzheimer's disease or other dementias;
- 638.18 (6) frequency and type of programs and activities for residents ~~of the special care unit~~;
- 638.19 (7) involvement of families in resident care and availability of family support programs;
- 638.20 (8) fee schedules for additional services to the residents ~~of the special care unit~~; and
- 638.21 (9) a statement that residents will be given a written notice 30 calendar days prior to
 638.22 changes in the fee schedule.

638.23 Subd. 3. **Duty to update.** Substantial changes to disclosures must be reported to the
 638.24 parties listed in subdivision 1 at the time the change is made.

638.25 Subd. 4. **Remedy.** The attorney general may seek the remedies set forth in section 8.31
 638.26 for repeated and intentional violations of this section. However, no private right of action
 638.27 may be maintained as provided under section 8.31, subdivision 3a.

638.28 **EFFECTIVE DATE.** This section is effective

639.1 Sec. 21. Minnesota Statutes 2018, section 626.5572, subdivision 6, is amended to read:

639.2 Subd. 6. **Facility.** (a) "Facility" means a hospital or other entity required to be licensed
 639.3 under sections 144.50 to 144.58; a nursing home required to be licensed to serve adults
 639.4 under section 144A.02; a facility or service required to be licensed under chapter 245A; an
 639.5 assisted living facility required to be licensed under chapter 144I; a home care provider
 639.6 licensed or required to be licensed under sections 144A.43 to 144A.482; a hospice provider
 639.7 licensed under sections 144A.75 to 144A.755; or a person or organization that offers,
 639.8 provides, or arranges for personal care assistance services under the medical assistance
 639.9 program as authorized under sections 256B.0625, subdivision 19a, 256B.0651 to 256B.0654,
 639.10 256B.0659, or 256B.85.

639.11 (b) For services identified in paragraph (a) that are provided in the vulnerable adult's
 639.12 own home or in another unlicensed location, the term "facility" refers to the provider, person,
 639.13 or organization that offers, provides, or arranges for personal care services, and does not
 639.14 refer to the vulnerable adult's home or other location at which services are rendered.

639.15 **EFFECTIVE DATE.** This section is effective

639.16 Sec. 22. Minnesota Statutes 2018, section 626.5572, subdivision 21, is amended to read:

639.17 Subd. 21. **Vulnerable adult.** (a) "Vulnerable adult" means any person 18 years of age
 639.18 or older who:

639.19 (1) is a resident or inpatient of a facility;

639.20 (2) receives services required to be licensed under chapter 245A, except that a person
 639.21 receiving outpatient services for treatment of chemical dependency or mental illness, or one
 639.22 who is served in the Minnesota sex offender program on a court-hold order for commitment,
 639.23 or is committed as a sexual psychopathic personality or as a sexually dangerous person
 639.24 under chapter 253B, is not considered a vulnerable adult unless the person meets the
 639.25 requirements of clause (4);

639.26 (3) is a resident of an assisted living facility or an assisted living facility with dementia
 639.27 care required to be licensed under chapter 144I;

639.28 ~~(3)~~(4) receives services from a home care provider required to be licensed under sections
 639.29 144A.43 to 144A.482; or from a person or organization that offers, provides, or arranges
 639.30 for personal care assistance services under the medical assistance program as authorized
 639.31 under section 256B.0625, subdivision 19a, 256B.0651, 256B.0653, 256B.0654, 256B.0659,
 639.32 or 256B.85; or

641.1	<u>General</u>	<u>(317,538,000)</u>	
641.2	<u>Health Care Access</u>	<u>8,410,000</u>	
641.3	<u>Federal TANF</u>	<u>(9,295,000)</u>	
641.4	<u>Subd. 2. Forecasted Programs</u>		
641.5	<u>(a) Minnesota Family</u>		
641.6	<u>Investment Program</u>		
641.7	<u>(MFIP)/Diversionary Work</u>		
641.8	<u>Program (DWP)</u>		
641.9	<u>Appropriations by Fund</u>		
641.10	<u>General</u>	<u>(19,361,000)</u>	
641.11	<u>Federal TANF</u>	<u>(8,893,000)</u>	
641.12	<u>(b) MFIP Child Care Assistance</u>		<u>(16,789,000)</u>
641.13	<u>(c) General Assistance</u>		<u>(7,928,000)</u>
641.14	<u>(d) Minnesota Supplemental Aid</u>		<u>(549,000)</u>
641.15	<u>(e) Housing Support</u>		<u>(13,836,000)</u>
641.16	<u>(f) Northstar Care for Children</u>		<u>(19,027,000)</u>
641.17	<u>(g) MinnesotaCare</u>		<u>8,410,000</u>
641.18	<u>This appropriation is from the health care</u>		
641.19	<u>access fund.</u>		
641.20	<u>(h) Medical Assistance</u>		
641.21	<u>Appropriations by Fund</u>		
641.22	<u>General</u>	<u>(222,176,000)</u>	
641.23	<u>Health Care Access</u>	<u>-0-</u>	
641.24	<u>(i) Alternative Care</u>		<u>-0-</u>
641.25	<u>(j) Consolidated Chemical Dependency</u>		
641.26	<u>Treatment Fund (CCDTF) Entitlement</u>		<u>(17,872,000)</u>
641.27	<u>Subd. 3. Technical Activities</u>		<u>(402,000)</u>
641.28	<u>This appropriation is from the federal TANF</u>		
641.29	<u>fund.</u>		
641.30	<u>Sec. 3. EFFECTIVE DATE.</u>		
641.31	<u>Sections 1 and 2 are effective the day following final enactment.</u>		

642.1

ARTICLE 21

642.2

APPROPRIATIONS

642.3

Section 1. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

642.4

The sums shown in the columns marked "Appropriations" are appropriated to the agencies

642.5

and for the purposes specified in this article. The appropriations are from the general fund,

642.6

or another named fund, and are available for the fiscal years indicated for each purpose.

642.7

The figures "2020" and "2021" used in this article mean that the appropriations listed under

642.8

them are available for the fiscal year ending June 30, 2020, or June 30, 2021, respectively.

642.9

"The first year" is fiscal year 2020. "The second year" is fiscal year 2021. "The biennium"

642.10

is fiscal years 2020 and 2021.

642.11

APPROPRIATIONS

642.12

Available for the Year

642.13

Ending June 30

642.14

2020**2021**

642.15

Sec. 2. **COMMISSIONER OF HUMAN**

642.16

SERVICES

642.17

Subdivision 1. **Total Appropriation****\$ 8,216,623,000 \$ 8,386,579,000**

642.18

Appropriations by Fund

642.19

2020**2021**

642.20

General**7,400,061,000 7,543,037,000**

642.21

State Government

642.22

Special Revenue**5,575,000 5,566,000**

642.23

Health Care Access**528,853,000 553,338,000**

642.24

Federal TANF**273,620,000 271,992,000**

642.25

Lottery Prize**1,896,000 1,896,000**

642.26

Opioid Stewardship**6,618,000 10,750,000**

642.27

The amounts that may be spent for each

642.28

purpose are specified in the following

642.29

subdivisions.

642.30

Subd. 2. **TANF Maintenance of Effort**

642.31

(a) Nonfederal Expenditures. The

642.32

commissioner shall ensure that sufficient

642.33

qualified nonfederal expenditures are made

643.1 each year to meet the state's maintenance of
643.2 effort (MOE) requirements of the TANF block
643.3 grant specified under Code of Federal
643.4 Regulations, title 45, section 263.1. In order
643.5 to meet these basic TANF/MOE requirements,
643.6 the commissioner may report as TANF/MOE
643.7 expenditures only nonfederal money expended
643.8 for allowable activities listed in the following
643.9 clauses:

643.10 (1) MFIP cash, diversionary work program,
643.11 and food assistance benefits under Minnesota
643.12 Statutes, chapter 256J;

643.13 (2) the child care assistance programs under
643.14 Minnesota Statutes, sections 119B.03 and
643.15 119B.05, and county child care administrative
643.16 costs under Minnesota Statutes, section
643.17 119B.15;

643.18 (3) state and county MFIP administrative costs
643.19 under Minnesota Statutes, chapters 256J and
643.20 256K;

643.21 (4) state, county, and tribal MFIP employment
643.22 services under Minnesota Statutes, chapters
643.23 256J and 256K;

643.24 (5) expenditures made on behalf of legal
643.25 noncitizen MFIP recipients who qualify for
643.26 the MinnesotaCare program under Minnesota
643.27 Statutes, chapter 256L;

643.28 (6) qualifying working family credit
643.29 expenditures under Minnesota Statutes, section
643.30 290.0671;

643.31 (7) qualifying Minnesota education credit
643.32 expenditures under Minnesota Statutes, section
643.33 290.0674; and

644.1 (8) qualifying Head Start expenditures under
644.2 Minnesota Statutes, section 119A.50.

644.3 **(b) Nonfederal Expenditures; Reporting.**
644.4 For the activities listed in paragraph (a),
644.5 clauses (2) to (8), the commissioner may
644.6 report only expenditures that are excluded
644.7 from the definition of assistance under Code
644.8 of Federal Regulations, title 45, section
644.9 260.31.

644.10 **(c) Certain Expenditures Required.** The
644.11 commissioner shall ensure that the MOE used
644.12 by the commissioner of management and
644.13 budget for the February and November
644.14 forecasts required under Minnesota Statutes,
644.15 section 16A.103, contains expenditures under
644.16 paragraph (a), clause (1), equal to at least 16
644.17 percent of the total required under Code of
644.18 Federal Regulations, title 45, section 263.1.

644.19 **(d) Limitation; Exceptions.** The
644.20 commissioner must not claim an amount of
644.21 TANF/MOE in excess of the 75 percent
644.22 standard in Code of Federal Regulations, title
644.23 45, section 263.1(a)(2), except:

644.24 (1) to the extent necessary to meet the 80
644.25 percent standard under Code of Federal
644.26 Regulations, title 45, section 263.1(a)(1), if it
644.27 is determined by the commissioner that the
644.28 state will not meet the TANF work
644.29 participation target rate for the current year;

644.30 (2) to provide any additional amounts under
644.31 Code of Federal Regulations, title 45, section
644.32 264.5, that relate to replacement of TANF
644.33 funds due to the operation of TANF penalties;
644.34 and

645.1 (3) to provide any additional amounts that may
645.2 contribute to avoiding or reducing TANF work
645.3 participation penalties through the operation
645.4 of the excess MOE provisions of Code of
645.5 Federal Regulations, title 45, section 261.43
645.6 (a)(2).

645.7 **(e) Supplemental Expenditures.** For the
645.8 purposes of paragraph (d), the commissioner
645.9 may supplement the MOE claim with working
645.10 family credit expenditures or other qualified
645.11 expenditures to the extent such expenditures
645.12 are otherwise available after considering the
645.13 expenditures allowed in this subdivision.

645.14 **(f) Reduction of Appropriations; Exception.**
645.15 The requirement in Minnesota Statutes, section
645.16 256.011, subdivision 3, that federal grants or
645.17 aids secured or obtained under that subdivision
645.18 be used to reduce any direct appropriations
645.19 provided by law, does not apply if the grants
645.20 or aids are federal TANF funds.

645.21 **(g) IT Appropriations Generally.** This
645.22 appropriation includes funds for information
645.23 technology projects, services, and support.
645.24 Notwithstanding Minnesota Statutes, section
645.25 16E.0466, funding for information technology
645.26 project costs shall be incorporated into the
645.27 service level agreement and paid to the Office
645.28 of MN.IT Services by the Department of
645.29 Human Services under the rates and
645.30 mechanism specified in that agreement.

645.31 **(h) Receipts for Systems Project.**
645.32 Appropriations and federal receipts for
645.33 information systems projects for MAXIS,
645.34 PRISM, MMIS, ISDS, METS, and SSIS must
645.35 be deposited in the state systems account

646.1 authorized in Minnesota Statutes, section
 646.2 256.014. Money appropriated for computer
 646.3 projects approved by the commissioner of the
 646.4 Office of MN.IT Services, funded by the
 646.5 legislature, and approved by the commissioner
 646.6 of management and budget may be transferred
 646.7 from one project to another and from
 646.8 development to operations as the
 646.9 commissioner of human services considers
 646.10 necessary. Any unexpended balance in the
 646.11 appropriation for these projects does not
 646.12 cancel and is available for ongoing
 646.13 development and operations.

646.14 **(i) Federal SNAP Education and Training**
 646.15 **Grants.** Federal funds available during fiscal
 646.16 years 2020 and 2021 for Supplemental
 646.17 Nutrition Assistance Program Education and
 646.18 Training and SNAP Quality Control
 646.19 Performance Bonus grants are appropriated
 646.20 to the commissioner of human services for the
 646.21 purposes allowable under the terms of the
 646.22 federal award. This paragraph is effective the
 646.23 day following final enactment.

646.24 **Subd. 3. Working Family Credit as TANF/MOE**

646.25 The commissioner may claim as TANF/MOE
 646.26 up to \$6,707,000 per year of working family
 646.27 credit expenditures in each fiscal year.

646.28 **Subd. 4. Central Office; Operations**

646.29	<u>Appropriations by Fund</u>		
646.30	<u>General</u>	<u>155,159,000</u>	<u>152,787,000</u>
646.31	<u>State Government</u>		
646.32	<u>Special Revenue</u>	<u>5,450,000</u>	<u>5,441,000</u>
646.33	<u>Health Care Access</u>	<u>21,620,000</u>	<u>22,656,000</u>
646.34	<u>Federal TANF</u>	<u>100,000</u>	<u>100,000</u>

647.1 (a) **Administrative Recovery; Set-Aside.** The
 647.2 commissioner may invoice local entities
 647.3 through the SWIFT accounting system as an
 647.4 alternative means to recover the actual cost of
 647.5 administering the following provisions:

647.6 (1) Minnesota Statutes, section 125A.744,
 647.7 subdivision 3;

647.8 (2) Minnesota Statutes, section 245.495,
 647.9 paragraph (b);

647.10 (3) Minnesota Statutes, section 256B.0625,
 647.11 subdivision 20, paragraph (k);

647.12 (4) Minnesota Statutes, section 256B.0924,
 647.13 subdivision 6, paragraph (g);

647.14 (5) Minnesota Statutes, section 256B.0945,
 647.15 subdivision 4, paragraph (d); and

647.16 (6) Minnesota Statutes, section 256F.10,
 647.17 subdivision 6, paragraph (b).

647.18 (b) **Base Level Adjustment.** The general fund
 647.19 base is \$145,459,000 in fiscal year 2022 and
 647.20 \$147,941,000 in fiscal year 2023. The health
 647.21 care access fund base is \$22,644,000 in fiscal
 647.22 year 2022 and \$20,894,000 in fiscal year 2023.
 647.23 The state government special revenue fund
 647.24 base is \$5,442,000 in fiscal year 2023.

647.25 Subd. 5. **Central Office; Children and Families**

647.26	<u>Appropriations by Fund</u>	
647.27	<u>General</u>	<u>13,558,000</u> <u>14,424,000</u>
647.28	<u>Federal TANF</u>	<u>2,582,000</u> <u>2,582,000</u>

647.29 (a) **Financial Institution Data Match and**
 647.30 **Payment of Fees.** The commissioner is
 647.31 authorized to allocate up to \$310,000 each
 647.32 year in fiscal year 2020 and fiscal year 2021
 647.33 from the systems special revenue account to

648.1 make payments to financial institutions in
 648.2 exchange for performing data matches
 648.3 between account information held by financial
 648.4 institutions and the public authority's database
 648.5 of child support obligors as authorized by
 648.6 Minnesota Statutes, section 13B.06,
 648.7 subdivision 7.

648.8 **(b) Child Welfare Training Academy.**
 648.9 **\$1,371,000 in fiscal year 2020 and \$2,517,000**
 648.10 **in fiscal year 2021 are for the Child Welfare**
 648.11 **Training Academy for the provision of child**
 648.12 **protection worker training under Minnesota**
 648.13 **Statutes, section 626.5591, subdivision 2.**

648.14 **(c) Base Level Adjustment.** The general fund
 648.15 base is \$14,540,000 in fiscal year 2022 and
 648.16 \$14,793,000 in fiscal year 2023.

648.17 **Subd. 6. Central Office; Health Care**

648.18	<u>Appropriations by Fund</u>	
648.19	<u>General</u>	<u>22,737,000</u> <u>23,744,000</u>
648.20	<u>Health Care Access</u>	<u>25,456,000</u> <u>25,344,000</u>

648.21 **(a) Nonemergency Medical Transportation**
 648.22 **Program Audits.** \$557,000 in fiscal year 2020
 648.23 and \$1,119,000 in fiscal year 2021 are from
 648.24 the general fund to conduct audits of the
 648.25 nonemergency medical transportation
 648.26 program.

648.27 **(b) Outpatient Pharmacy.** \$113,000 in fiscal
 648.28 year 2020 and \$50,000 in fiscal year 2021 are
 648.29 from the general fund to contract for 340B
 648.30 pharmacy data in order to perform the new
 648.31 pricing calculations and conduct a cost of
 648.32 dispensing survey.

648.33 **(c) Base Level Adjustment.** The general fund
 648.34 base is \$26,938,000 in fiscal year 2022 and

649.1 \$29,254,000 in fiscal year 2023. The health
 649.2 care access fund base is \$26,449,000 in fiscal
 649.3 year 2022 and \$27,197,000 in fiscal year 2023.

649.4 **Subd. 7. Central Office; Continuing Care for**
 649.5 **Older Adults**

649.6	<u>Appropriations by Fund</u>		
649.7	<u>General</u>	<u>20,330,000</u>	<u>17,991,000</u>
649.8	<u>State Government</u>		
649.9	<u>Special Revenue</u>	<u>125,000</u>	<u>125,000</u>

649.10 **(a) Assisted Living Survey. Beginning in**
 649.11 **fiscal year 2020, \$2,500,000 is appropriated**
 649.12 **in the even numbered year of each biennium**
 649.13 **to fund a resident experience survey and**
 649.14 **family survey for all housing with services**
 649.15 **sites. This paragraph does not expire.**

649.16 **(b) Information and Assistance Grant**
 649.17 **Transfer. \$1,000,000 in fiscal year 2020 and**
 649.18 **\$1,000,000 in fiscal year 2021 are transferred**
 649.19 **to the continuing care for older adults**
 649.20 **administration from the aging and adult**
 649.21 **services grants for developing the Home and**
 649.22 **Community-Based Report Card for assisted**
 649.23 **living. This transfer is ongoing.**

649.24 **(c) Base Level Adjustment. The general fund**
 649.25 **base is \$20,486,000 in fiscal year 2022 and**
 649.26 **\$18,006,000 in fiscal year 2023.**

649.27 **Subd. 8. Central Office; Community Supports**

649.28	<u>Appropriations by Fund</u>		
649.29	<u>General</u>	<u>35,989,000</u>	<u>35,965,000</u>
649.30	<u>Lottery Prize</u>	<u>163,000</u>	<u>163,000</u>
649.31	<u>Opioid Stewardship</u>	<u>218,000</u>	<u>350,000</u>

649.32 **(a) Certified Community Behavioral Health**
 649.33 **Center (CCBHC) Expansion. \$310,000 in**
 649.34 **fiscal year 2020 and \$285,000 in fiscal year**

650.1 2021 are from the general fund to support
 650.2 CCBHC expansion.

650.3 **(b) Base Level Adjustment.** The general fund
 650.4 base is \$35,645,000 in fiscal year 2022 and
 650.5 \$35,345,000 in fiscal year 2023. The opioid
 650.6 stewardship fund base is \$336,000 in fiscal
 650.7 year 2022 and \$336,000 in fiscal year 2023.

650.8 **Subd. 9. Forecasted Programs; MFIP/DWP**

650.9	<u>Appropriations by Fund</u>	
650.10	<u>General</u>	<u>89,448,000</u> <u>111,069,000</u>
650.11	<u>Federal TANF</u>	<u>78,705,000</u> <u>76,851,000</u>

650.12 **MFIP Rate Increase.** Effective February 1,
 650.13 2020, the amount of the MFIP cash assistance
 650.14 portion of the transitional standard is increased
 650.15 \$100 per month per household. This increase
 650.16 shall be reflected in the MFIP cash assistance
 650.17 portion of the transitional standard published
 650.18 annually by the Department of Human
 650.19 Services. This paragraph does not expire.

650.20	<u>Subd. 10. Forecasted Programs; MFIP Child</u>		
650.21	<u>Care Assistance</u>	<u>107,038,000</u>	<u>124,304,000</u>

650.22	<u>Subd. 11. Forecasted Programs; General</u>		
650.23	<u>Assistance</u>	<u>49,959,000</u>	<u>50,586,000</u>

650.24 **(a) General Assistance Standard.** The
 650.25 commissioner shall set the monthly standard
 650.26 of assistance for general assistance units
 650.27 consisting of an adult recipient who is
 650.28 childless and unmarried or living apart from
 650.29 parents or a legal guardian at \$203. The
 650.30 commissioner may reduce this amount
 650.31 according to Laws 1997, chapter 85, article 3,
 650.32 section 54.

650.33 **(b) Emergency General Assistance Limit.**
 650.34 The amount appropriated for emergency

651.1 general assistance is limited to no more than
 651.2 \$6,729,812 in fiscal year 2020 and \$6,729,812
 651.3 in fiscal year 2021. Funds to counties shall be
 651.4 allocated by the commissioner using the
 651.5 allocation method under Minnesota Statutes,
 651.6 section 256D.06.

651.7 **Subd. 12. Forecasted Programs; Minnesota**
 651.8 **Supplemental Aid**

42,348,000

46,420,000

651.9 **Subd. 13. Forecasted Programs; Housing**
 651.10 **Support**

167,645,000

170,218,000

651.11 **Subd. 14. Forecasted Programs; Northstar Care**
 651.12 **for Children**

86,497,000

94,095,000

651.13 **Subd. 15. Forecasted Programs; MinnesotaCare**

25,100,000

31,274,000

651.14 **(a) Generally.** This appropriation is from the
 651.15 health care access fund.

651.16 **(b) OneCare Buy-In Option.** The fiscal year
 651.17 2023 base for MinnesotaCare is increased by
 651.18 \$112,000,000 to serve as a reserve for the
 651.19 Department of Human Services to
 651.20 operationalize the OneCare Buy-In Option
 651.21 under Minnesota Statutes, chapter 256T. This
 651.22 is a onetime increase.

651.23 **Subd. 16. Forecasted Programs; Medical**
 651.24 **Assistance**

651.25 Appropriations by Fund

651.26 General 5,651,225,000 5,716,569,000

651.27 Health Care Access 452,462,000 469,849,000

651.28 **(a) Behavioral Health Services.** \$1,000,000
 651.29 in fiscal year 2020 and \$1,000,000 in fiscal
 651.30 year 2021 are for behavioral health services
 651.31 provided by hospitals identified under
 651.32 Minnesota Statutes, section 256.969,
 651.33 subdivision 2b, paragraph (a), clause (4). The
 651.34 increase in payments shall be made by
 651.35 increasing the adjustment under Minnesota

652.1	<u>Statutes, section 256.969, subdivision 2b,</u>		
652.2	<u>paragraph (e), clause (2).</u>		
652.3	<u>(b) Base Level Adjustment.</u> The health care		
652.4	<u>access fund base is \$492,550,000 in fiscal year</u>		
652.5	<u>2022 and \$499,310,000 in fiscal year 2023.</u>		
652.6	<u>Subd. 17. Forecasted Programs; Alternative</u>		
652.7	<u>Care</u>	<u>45,243,000</u>	<u>45,245,000</u>
652.8	<u>Alternative Care Transfer.</u> Any money		
652.9	<u>allocated to the alternative care program that</u>		
652.10	<u>is not spent for the purposes indicated does</u>		
652.11	<u>not cancel but must be transferred to the</u>		
652.12	<u>medical assistance account.</u>		
652.13	<u>Subd. 18. Forecasted Programs; Chemical</u>		
652.14	<u>Dependency Treatment Fund</u>	<u>131,372,000</u>	<u>135,609,000</u>
652.15	<u>Subd. 19. Grant Programs; Support Services</u>		
652.16	<u>Grants</u>		
652.17	<u>Appropriations by Fund</u>		
652.18	<u>General</u>	<u>8,715,000</u>	<u>8,715,000</u>
652.19	<u>Federal TANF</u>	<u>96,312,000</u>	<u>96,311,000</u>
652.20	<u>Subd. 20. Grant Programs; Basic Sliding Fee</u>		
652.21	<u>Child Care Assistance Grants</u>	<u>63,935,000</u>	<u>75,046,000</u>
652.22	<u>(a) Basic Sliding Fee Waiting List</u>		
652.23	<u>Allocation.</u> Notwithstanding Minnesota		
652.24	<u>Statutes, section 119B.03, \$7,821,000 in fiscal</u>		
652.25	<u>year 2020 and \$17,901,000 in fiscal year 2021</u>		
652.26	<u>are to reduce the basic sliding fee program</u>		
652.27	<u>waiting list as follows:</u>		
652.28	<u>(1) the calendar year 2020 allocation shall be</u>		
652.29	<u>increased to serve families on the waiting list.</u>		
652.30	<u>To receive funds appropriated for this purpose,</u>		
652.31	<u>a county must have a waiting list in the most</u>		
652.32	<u>recent published waiting list month;</u>		
652.33	<u>(2) funds shall be distributed proportionately</u>		
652.34	<u>based on the average of the most recent six</u>		

653.1 months of published waiting lists to counties
 653.2 that meet the criteria in clause (1);
 653.3 (3) allocations in calendar years 2021 and
 653.4 beyond shall be calculated using the allocation
 653.5 formula in Minnesota Statutes, section
 653.6 119B.03; and
 653.7 (4) the guaranteed floor for calendar year 2021
 653.8 shall be based on the revised calendar year
 653.9 2020 allocation.

653.10 **(b) Increase for Maximum Rates.**
 653.11 Notwithstanding Minnesota Statutes, section
 653.12 119B.03, subdivisions 6, 6a, and 6b, the
 653.13 commissioner must allocate the additional
 653.14 basic sliding fee child care funds for calendar
 653.15 year 2020 to counties for updated maximum
 653.16 rates based on relative need to cover maximum
 653.17 rate increases. In distributing the additional
 653.18 funds, the commissioner shall consider the
 653.19 following factors by county:

653.20 (1) number of children;
 653.21 (2) provider type;
 653.22 (3) age of children; and
 653.23 (4) amount of the increase in maximum rates.

653.24 **(c) Base Level Adjustment.** The general fund
 653.25 base is \$79,556,000 in fiscal year 2022 and
 653.26 \$86,527,000 in fiscal year 2023.

653.27	<u>Subd. 21. Grant Programs; Child Care</u>		
653.28	<u>Development Grants</u>	<u>1,737,000</u>	<u>1,737,000</u>
653.29	<u>Subd. 22. Grant Programs; Child Support</u>		
653.30	<u>Enforcement Grants</u>	<u>50,000</u>	<u>50,000</u>
653.31	<u>Subd. 23. Grant Programs; Children's Services</u>		
653.32	<u>Grants</u>		

654.1	<u>Appropriations by Fund</u>		
654.2	<u>General</u>	<u>44,057,000</u>	<u>48,635,000</u>
654.3	<u>Federal TANF</u>	<u>140,000</u>	<u>140,000</u>
654.4	<u>(a) Title IV-E Adoption Assistance. (1) The</u>		
654.5	<u>commissioner shall allocate funds from the</u>		
654.6	<u>Title IV-E reimbursement to the state from</u>		
654.7	<u>the Fostering Connections to Success and</u>		
654.8	<u>Increasing Adoptions Act for adoptive, foster,</u>		
654.9	<u>and kinship families as required in Minnesota</u>		
654.10	<u>Statutes, section 256N.261.</u>		
654.11	<u>(2) Additional federal reimbursement to the</u>		
654.12	<u>state as a result of the Fostering Connections</u>		
654.13	<u>to Success and Increasing Adoptions Act's</u>		
654.14	<u>expanded eligibility for title IV-E adoption</u>		
654.15	<u>assistance is for postadoption, foster care,</u>		
654.16	<u>adoption, and kinship services, including a</u>		
654.17	<u>parent-to-parent support network.</u>		
654.18	<u>(b) Base Level Adjustment. The general fund</u>		
654.19	<u>base is \$51,483,000 in fiscal year 2022 and</u>		
654.20	<u>\$51,198,000 in fiscal year 2023.</u>		
654.21	<u>Subd. 24. Grant Programs; Children and</u>		
654.22	<u>Community Service Grants</u>	<u>59,201,000</u>	<u>59,701,000</u>
654.23	<u>(a) Adult Protection Grants. \$1,000,000 in</u>		
654.24	<u>fiscal year 2020 and \$1,500,000 in fiscal year</u>		
654.25	<u>2021 are for grant funding for adult abuse</u>		
654.26	<u>maltreatment investigations and adult</u>		
654.27	<u>protective services to counties and tribes as</u>		
654.28	<u>allocated and specified under Minnesota</u>		
654.29	<u>Statutes, section 256M.42.</u>		
654.30	<u>(b) Base Level Adjustment. The general fund</u>		
654.31	<u>base is \$60,251,000 in fiscal year 2022 and</u>		
654.32	<u>\$60,856,000 in fiscal year 2023.</u>		
654.33	<u>Subd. 25. Grant Programs; Children and</u>		
654.34	<u>Economic Support Grants</u>		

655.1	<u>Appropriations by Fund</u>		
655.2	<u>General</u>	<u>22,065,000</u>	<u>22,065,000</u>
655.3	<u>Opioid Stewardship</u>	<u>4,000,000</u>	<u>4,000,000</u>
655.4	<u>(a) Minnesota Food Assistance Program.</u>		
655.5	<u>Unexpended funds for the Minnesota food</u>		
655.6	<u>assistance program for fiscal year 2020 do not</u>		
655.7	<u>cancel but are available for this purpose in</u>		
655.8	<u>fiscal year 2021.</u>		
655.9	<u>(b) Opioid Stewardship Fee Distribution to</u>		
655.10	<u>Counties and Tribes. \$4,000,000 in fiscal</u>		
655.11	<u>year 2020 and \$4,000,000 in fiscal year 2021</u>		
655.12	<u>are from the opioid stewardship fund for</u>		
655.13	<u>allocation to county and tribal social service</u>		
655.14	<u>agencies by a formula determined by the</u>		
655.15	<u>commissioner of human services in</u>		
655.16	<u>consultation with counties and tribes.</u>		
655.17	<u>Subd. 26. Grant Programs; Health Care Grants</u>		
655.18	<u>Appropriations by Fund</u>		
655.19	<u>General</u>	<u>3,711,000</u>	<u>3,711,000</u>
655.20	<u>Health Care Access</u>	<u>3,465,000</u>	<u>3,465,000</u>
655.21	<u>Subd. 27. Grant Programs; Other Long-Term</u>		
655.22	<u>Care Grants</u>	<u>1,925,000</u>	<u>1,925,000</u>
655.23	<u>Subd. 28. Grant Programs; Aging and Adult</u>		
655.24	<u>Services Grants</u>	<u>31,811,000</u>	<u>31,995,000</u>
655.25	<u>Subd. 29. Grant Programs; Deaf and</u>		
655.26	<u>Hard-of-Hearing Grants</u>	<u>2,886,000</u>	<u>2,886,000</u>
655.27	<u>Subd. 30. Grant Programs; Disabilities Grants</u>		
655.28	<u>(a) Training of Direct Support Services</u>		
655.29	<u>Providers. \$375,000 in fiscal year 2020 and</u>		
655.30	<u>\$375,000 in fiscal year 2021 are for stipends</u>		
655.31	<u>to pay for training of individual providers of</u>		
655.32	<u>direct support services as defined in Minnesota</u>		
655.33	<u>Statutes, section 256B.0711, subdivision 1.</u>		
655.34	<u>This training is available to individual</u>		
655.35	<u>providers who have completed designated</u>		

656.1 voluntary trainings made available through
656.2 the State Service Employees International
656.3 Union Healthcare Minnesota Committee. This
656.4 is a onetime appropriation. This appropriation
656.5 is available only if the labor agreement
656.6 between the state of Minnesota and the Service
656.7 Employees International Union Healthcare
656.8 Minnesota under Minnesota Statutes, section
656.9 179A.54, is approved under Minnesota
656.10 Statutes, section 3.855.

656.11 **(b) Training for New Worker Orientation.**
656.12 \$125,000 in fiscal year 2020 and \$125,000 in
656.13 fiscal year 2021 are for new worker orientation
656.14 training and is allocated to the Minnesota State
656.15 Service Employees International Union
656.16 Healthcare Minnesota Committee. This is a
656.17 onetime appropriation. This appropriation is
656.18 available only if the labor agreement between
656.19 the state of Minnesota and the Service
656.20 Employees International Union Healthcare
656.21 Minnesota under Minnesota Statutes, section
656.22 179A.54, is approved under Minnesota
656.23 Statutes, section 3.855.

656.24 **(c) Benefits Planning Grants. \$600,000 in**
656.25 fiscal year 2020 and \$600,000 in fiscal year
656.26 2021 are to provide grant funding to the
656.27 Disability Hub for benefits planning to people
656.28 with disabilities.

656.29 **(d) Regional Support for Person-Centered**
656.30 **Practices Grants. \$374,000 in fiscal year**
656.31 **2020 and \$486,000 in fiscal year 2021 are to**
656.32 **extend and expand regional capacity for**
656.33 **person-centered planning. This grant funding**
656.34 **must be allocated to regional cohorts for**
656.35 **training, coaching, and mentoring for**

657.1 person-centered and collaborative safety
 657.2 practices benefiting people with disabilities,
 657.3 and employees, organizations, and
 657.4 communities serving people with disabilities.

657.5 **(e) Disability Hub for Families Grants.**
 657.6 \$100,000 in fiscal year 2020 and \$200,000 in
 657.7 fiscal year 2021 are for grants to connect
 657.8 families through innovation grants, life
 657.9 planning tools, and website information as
 657.10 they support a child or family member with
 657.11 disabilities.

657.12 **(f) Electronic Visit Verification. \$500,000**
 657.13 in fiscal year 2021 is for grants to providers
 657.14 who use a different vendor than the contract
 657.15 with the State of Minnesota for electronic visit
 657.16 verification.

657.17 **(g) Base Level Adjustment.** The general fund
 657.18 base is \$22,556,000 in fiscal year 2022 and
 657.19 \$22,168,000 in fiscal year 2023.

657.20 **Subd. 31. Grant Programs; Housing Support**
 657.21 **Grants**

10,264,000

11,364,000

657.22 **Subd. 32. Grant Programs; Adult Mental Health**
 657.23 **Grants**

657.24 Appropriations by Fund

657.25 General 78,808,000 78,377,000

657.26 Health Care Access 750,000 750,000

657.27 Opioid Stewardship 2,400,000 2,400,000

657.28 **(a) Certified Community Behavioral Health**
 657.29 **Center (CCBHC) Expansion. \$200,000 in**
 657.30 fiscal year 2021 is from the general fund for
 657.31 grants for planning, staff training, and other
 657.32 quality improvements that are required to
 657.33 comply with federal CCBHC criteria for three
 657.34 expansion sites.

658.1 (b) Traditional Healing. \$2,400,000 in fiscal
 658.2 year 2020 and \$2,400,000 in fiscal year 2021
 658.3 are from the opioid stewardship fund
 658.4 appropriation to provide grant funding to
 658.5 Tribal Nations and five urban Indian
 658.6 communities for traditional healing practices
 658.7 to American Indians and increase the capacity
 658.8 of culturally specific providers in the
 658.9 behavioral health workforce.

658.10 (c) Base Level Adjustment. The general fund
 658.11 base is \$78,177,000 in fiscal year 2022 and
 658.12 \$78,177,000 in fiscal year 2023.

658.13 Subd. 33. Grant Programs; Child Mental Health
 658.14 Grants

25,726,000

25,726,000

658.15 (a) Children's Intensive Services Reform.
 658.16 \$400,000 in fiscal year 2020 and \$400,000 in
 658.17 fiscal year 2021 are appropriated from the
 658.18 general fund for start-up grants to prospective
 658.19 psychiatric residential treatment facility sites
 658.20 for administrative expenses, consulting
 658.21 services, Health Insurance Portability and
 658.22 Accountability Act of 1996 (HIPAA)
 658.23 compliance, therapeutic resources including
 658.24 evidence-based, culturally appropriate
 658.25 curriculums, and training programs for staff
 658.26 and clients as well as allowable physical
 658.27 renovations to the property.

658.28 (b) Base Level Adjustment. The general fund
 658.29 base is \$26,226,000 in fiscal year 2022 and
 658.30 \$26,226,000 in fiscal year 2023.

658.31 Subd. 34. Grant Programs; Chemical
 658.32 Dependency Treatment Support Grants

658.33 Appropriations by Fund

658.34 General 2,136,000 2,136,000

659.1	<u>Lottery Prize</u>	<u>1,733,000</u>	<u>1,733,000</u>
659.2	<u>Opioid Stewardship</u>	<u>0</u>	<u>4,000,000</u>
659.3	<u>(a) Problem Gambling. \$225,000 in fiscal</u>		
659.4	<u>year 2020 and \$225,000 in fiscal year 2021</u>		
659.5	<u>are from the lottery prize fund for a grant to</u>		
659.6	<u>the state affiliate recognized by the National</u>		
659.7	<u>Council on Problem Gambling. The affiliate</u>		
659.8	<u>must provide services to increase public</u>		
659.9	<u>awareness of problem gambling, education,</u>		
659.10	<u>and training for individuals and organizations</u>		
659.11	<u>providing effective treatment services to</u>		
659.12	<u>problem gamblers and their families, and</u>		
659.13	<u>research related to problem gambling.</u>		
659.14	<u>(b) Opioid Stewardship Fund Initiatives.</u>		
659.15	<u>\$4,000,000 in fiscal year 2021 is from the</u>		
659.16	<u>opioid stewardship fund for initiatives related</u>		
659.17	<u>to prevention, education, treatment, and</u>		
659.18	<u>services that promote innovation and capacity</u>		
659.19	<u>building to address the opioid addiction and</u>		
659.20	<u>overdose epidemic.</u>		
659.21	<u>Subd. 35. Direct Care and Treatment -</u>		
659.22	<u>Generally</u>		
659.23	<u>(a) Transfer Authority. Money appropriated</u>		
659.24	<u>to budget activities under this subdivision and</u>		
659.25	<u>subdivisions 36, 37, 38, and 39 may be</u>		
659.26	<u>transferred between budget activities and</u>		
659.27	<u>between years of the biennium with the</u>		
659.28	<u>approval of the commissioner of management</u>		
659.29	<u>and budget.</u>		
659.30	<u>(b) State Operated Services Account. Any</u>		
659.31	<u>balance remaining in the state operated</u>		
659.32	<u>services account at the end of fiscal year 2019</u>		
659.33	<u>shall be transferred to the general fund.</u>		
659.34	<u>Subd. 36. Direct Care and Treatment - Mental</u>		
659.35	<u>Health and Substance Abuse</u>		

129,209,000129,201,000

660.1 (a) Transfer Authority. Money previously
 660.2 appropriated to support the continued
 660.3 operations of the Community Addiction
 660.4 Enterprise (C.A.R.E.) program may be
 660.5 transferred to the enterprise fund for C.A.R.E.

660.6 (b) Base Level Adjustment. The general fund
 660.7 base is \$129,197,000 in fiscal year 2022 and
 660.8 \$129,197,000 in fiscal year 2023.

660.9 Subd. 37. Direct Care and Treatment -
 660.10 Community-Based Services

16,630,000

17,177,000

660.11 (a) Transfer Authority. Money previously
 660.12 appropriated to support the continued
 660.13 operations of the Minnesota State Operated
 660.14 Community Services (MSOCS) program may
 660.15 be transferred to the enterprise fund for
 660.16 MSOCS.

660.17 (b) MSOCS Operating Adjustment.
 660.18 \$1,594,000 in fiscal year 2020 and \$3,729,000
 660.19 in fiscal year 2021 are from the general fund
 660.20 for the Minnesota State Operated Community
 660.21 Services program. The commissioner shall
 660.22 transfer \$1,594,000 in fiscal year 2020 and
 660.23 \$3,729,000 in fiscal year 2021 to the enterprise
 660.24 fund for MSOCS.

660.25 (c) Base Level Adjustment. The general fund
 660.26 base is \$17,176,000 in fiscal year 2022 and
 660.27 \$17,176,000 in fiscal year 2023.

660.28 Subd. 38. Direct Care and Treatment - Forensic
 660.29 Services

112,126,000

115,342,000

660.30 Base Level Adjustment. The general fund
 660.31 base is \$115,944,000 in fiscal year 2022 and
 660.32 \$115,944,000 in fiscal year 2023.

660.33 Subd. 39. Direct Care and Treatment - Sex
 660.34 Offender Program

97,072,000

97,621,000

661.1 (a) Transfer Authority. Money appropriated
 661.2 for the Minnesota sex offender program may
 661.3 be transferred between fiscal years of the
 661.4 biennium with the approval of the
 661.5 commissioner of management and budget.

661.6 (b) Base Level Adjustment. The general fund
 661.7 base is \$98,166,000 in fiscal year 2022 and
 661.8 \$98,166,000 in fiscal year 2023.

661.9 Subd. 40. Direct Care and Treatment -
 661.10 Operations

47,398,000

47,657,000

661.11 Base Level Adjustment. The general fund
 661.12 base is \$47,656,000 in fiscal year 2022 and
 661.13 \$47,656,000 in fiscal year 2023.

661.14 Subd. 41. Technical Activities

95,781,000

96,008,000

661.15 (a) Generally. This appropriation is from the
 661.16 federal TANF fund.

661.17 (b) Base Level Adjustment. The TANF fund
 661.18 base is \$96,360,000 in fiscal year 2022 and
 661.19 \$96,620,000 in fiscal year 2023.

661.20 Sec. 3. COMMISSIONER OF HEALTH

661.21 Subdivision 1. Total Appropriation

\$

251,332,000

\$ 258,914,000

661.22 Appropriations by Fund

	<u>2020</u>	<u>2021</u>
661.23		
661.24 <u>General</u>	<u>136,447,000</u>	<u>139,429,000</u>
661.25 <u>State Government</u>		
661.26 <u>Special Revenue</u>	<u>59,662,000</u>	<u>61,914,000</u>
661.27 <u>Health Care Access</u>	<u>37,510,000</u>	<u>36,607,000</u>
661.28 <u>Federal TANF</u>	<u>11,713,000</u>	<u>11,713,000</u>
661.29 <u>Opioid Stewardship</u>		
661.30 <u>Fund</u>	<u>6,000,000</u>	<u>9,251,000</u>

661.31 The amounts that may be spent for each
 661.32 purpose are specified in the following
 661.33 subdivisions.

661.34 Subd. 2. Health Improvement

662.1	<u>Appropriations by Fund</u>		
662.2	<u>General</u>	<u>96,731,000</u>	<u>96,096,000</u>
662.3	<u>State Government</u>		
662.4	<u>Special Revenue</u>	<u>7,232,000</u>	<u>7,162,000</u>
662.5	<u>Health Care Access</u>	<u>37,510,000</u>	<u>36,607,000</u>
662.6	<u>Federal TANF</u>	<u>11,713,000</u>	<u>11,713,000</u>
662.7	<u>(a) TANF Appropriations. (1) \$3,579,000</u>		
662.8	<u>of the TANF fund each year is for home</u>		
662.9	<u>visiting and nutritional services listed under</u>		
662.10	<u>Minnesota Statutes, section 145.882,</u>		
662.11	<u>subdivision 7, clauses (6) and (7). Funds must</u>		
662.12	<u>be distributed to community health boards</u>		
662.13	<u>according to Minnesota Statutes, section</u>		
662.14	<u>145A.131, subdivision 1;</u>		
662.15	<u>(2) \$2,000,000 of the TANF fund each year</u>		
662.16	<u>is for decreasing racial and ethnic disparities</u>		
662.17	<u>in infant mortality rates under Minnesota</u>		
662.18	<u>Statutes, section 145.928, subdivision 7;</u>		
662.19	<u>(3) \$4,978,000 of the TANF fund each year</u>		
662.20	<u>is for the family home visiting grant program</u>		
662.21	<u>according to Minnesota Statutes, section</u>		
662.22	<u>145A.17. \$4,000,000 of the funding must be</u>		
662.23	<u>distributed to community health boards</u>		
662.24	<u>according to Minnesota Statutes, section</u>		
662.25	<u>145A.131, subdivision 1. \$978,000 of the</u>		
662.26	<u>funding must be distributed to tribal</u>		
662.27	<u>governments according to Minnesota Statutes,</u>		
662.28	<u>section 145A.14, subdivision 2a;</u>		
662.29	<u>(4) \$1,156,000 of the TANF fund each year</u>		
662.30	<u>is for family planning grants under Minnesota</u>		
662.31	<u>Statutes, section 145.925; and</u>		
662.32	<u>(5) The commissioner may use up to 6.23</u>		
662.33	<u>percent of the funds appropriated each year to</u>		
662.34	<u>conduct the ongoing evaluations required</u>		
662.35	<u>under Minnesota Statutes, section 145A.17,</u>		

663.1 subdivision 7, and training and technical
663.2 assistance as required under Minnesota
663.3 Statutes, section 145A.17, subdivisions 4 and
663.4 5.

663.5 (b) **TANF Carryforward.** Any unexpended
663.6 balance of the TANF appropriation in the first
663.7 year of the biennium does not cancel but is
663.8 available for the second year.

663.9 (c) **Opioid and Other Drug Abuse**
663.10 **Prevention.** \$6,000,000 in fiscal year 2020
663.11 and \$9,251,000 in fiscal year 2021 are
663.12 appropriated from the opioid stewardship fund
663.13 to the commissioner of health to support a
663.14 comprehensive, community-based opioid and
663.15 other drug abuse prevention program. The
663.16 commissioner may use up to 19 percent in
663.17 fiscal year 2020 and up to 14 percent in fiscal
663.18 year 2021 for administration. The remaining
663.19 funds are allocated as follows:

663.20 (1) \$1,000,000 each fiscal year is for grants
663.21 to regional emergency medical services and
663.22 law enforcement agencies and organizations
663.23 to purchase opioid antagonists, including
663.24 Narcan or Naloxone, and to train first
663.25 responders across Minnesota;

663.26 (2) \$1,000,000 in fiscal year 2020 and
663.27 \$2,000,000 in fiscal year 2021 are for
663.28 community grants authorized in Minnesota
663.29 Statutes, section 145.9275, subdivision 1;

663.30 (3) \$2,000,000 in fiscal year 2020 and
663.31 \$4,000,000 in fiscal year 2021 are for tribal
663.32 government grants in Minnesota Statutes,
663.33 section 145.9275, subdivision 2; and

664.1 (4) \$875,000 in fiscal year 2020 and
664.2 \$1,000,000 in fiscal year 2021 are for
664.3 overdose fatality review grants across
664.4 Minnesota.

664.5 **(d) Comprehensive Suicide Prevention.**
664.6 \$3,730,000 each fiscal year from the general
664.7 fund appropriations is to support a
664.8 comprehensive, community-based suicide
664.9 prevention strategy. The funds are allocated
664.10 as follows:

664.11 (1) \$1,291,000 each fiscal year is for
664.12 community-based suicide prevention grants
664.13 authorized in Minnesota Statutes, section
664.14 145.56, subdivision 2. Specific emphasis must
664.15 be placed on those communities with the
664.16 greatest disparities;

664.17 (2) \$913,000 each fiscal year is to support
664.18 evidence-based training for educators and
664.19 school staff and purchase suicide prevention
664.20 curriculum for student use statewide, as
664.21 authorized in Minnesota Statutes, section
664.22 145.56, subdivision 2;

664.23 (3) \$205,000 each fiscal year is to implement
664.24 the Zero Suicide framework with up to 20
664.25 behavioral and health care organizations each
664.26 year to treat individuals at risk for suicide and
664.27 support those individuals across systems of
664.28 care upon discharge;

664.29 (4) \$1,321,000 each fiscal year is to develop
664.30 and fund a Minnesota-based network of
664.31 National Suicide Prevention Lifeline,
664.32 providing statewide coverage; and

664.33 (5) the commissioner may retain up to 18.23
664.34 percent of the appropriation under this

665.1 subdivision to administer the comprehensive
665.2 suicide prevention strategy.

665.3 **(e) Statewide Tobacco Cessation. \$1,598,000**
665.4 in fiscal year 2020 and \$2,748,000 in fiscal
665.5 year 2021 are from the general fund to the
665.6 commissioner of health for statewide tobacco
665.7 cessation services under Minnesota Statutes,
665.8 section 144.397. The general fund base for
665.9 this activity is \$2,878,000 in fiscal year 2022
665.10 and \$2,878,000 in fiscal year 2023.

665.11 **(f) Health Care Access Survey. \$450,000 in**
665.12 fiscal year 2020 is from the health care access
665.13 fund for the commissioner to continue and
665.14 improve the Minnesota Health Care Access
665.15 Survey. This appropriation is added to the
665.16 department's base budget for even-numbered
665.17 fiscal years.

665.18 **(g) Community Solutions for Healthy Child**
665.19 **Development Grant Program. \$2,000,000**
665.20 in fiscal year 2020 is for the community
665.21 solutions for healthy child development grant
665.22 program to promote health and racial equity
665.23 for young children and their families under
665.24 Minnesota Statutes, section 145.9285. The
665.25 commissioner may use up to 23.5 percent of
665.26 the total appropriation for administration. This
665.27 is a onetime appropriation and is available
665.28 until June 30, 2023.

665.29 **(h) Base Level Adjustments.** The general
665.30 fund base is \$96,226,000 in fiscal year 2022
665.31 and \$96,226,000 in fiscal year 2023. The
665.32 health care access fund base is \$37,657,000
665.33 in fiscal year 2022 and \$36,607,000 in fiscal
665.34 year 2023.

666.1 **Subd. 3. Health Protection**666.2 Appropriations by Fund666.3 General 28,904,000 32,421,000666.4 State Government666.5 Special Revenue 52,430,000 54,752,000666.6 **(a) Vulnerable Adults Program**666.7 **Improvements.** \$7,438,000 in fiscal year 2020666.8 and \$4,302,000 in fiscal year 2021 are from666.9 the general fund for the commissioner to666.10 continue necessary current operations666.11 improvements to the regulatory activities,666.12 systems, analysis, reporting, and666.13 communications that contribute to the health,666.14 safety, care quality, and abuse prevention for666.15 vulnerable adults in Minnesota. \$1,103,000 in666.16 fiscal year 2020 and \$1,103,000 in fiscal year666.17 2021 are from the state government special666.18 revenue fund to improve the frequency of666.19 home care provider inspections. The state666.20 government special revenue appropriations666.21 under this paragraph are onetime666.22 appropriations.666.23 **(b) Vulnerable Adults Regulatory Reform.**666.24 \$2,432,000 in fiscal year 2020 and \$8,114,000666.25 in fiscal year 2021 are from the general fund666.26 for the commissioner to establish the assisted666.27 living licensure under Minnesota Statutes,666.28 section 144I.01. This is a onetime666.29 appropriation. The commissioner shall transfer666.30 fine revenue previously deposited to the state666.31 government special revenue fund under666.32 Minnesota Statutes, section 144A.474,666.33 subdivision 11, which is estimated to be666.34 \$632,000, to a dedicated account in the state666.35 treasury.

667.1 (c) **Laboratory Equipment.** \$840,000 in
 667.2 fiscal year 2020 and \$655,000 in fiscal year
 667.3 2021 are from the general fund for the
 667.4 commissioner to purchase equipment for the
 667.5 public health laboratory. These appropriations
 667.6 are onetime appropriations and available until
 667.7 June 30, 2023.

667.8 (d) **Provider Network Adequacy Reviews.**
 667.9 \$231,000 in fiscal year 2020 and \$231,000 in
 667.10 fiscal year 2021 are from the general fund for
 667.11 health plan product reviews and licensing of
 667.12 health maintenance organizations. The
 667.13 \$77,000 annual transfer from the state
 667.14 government special revenue fund to the
 667.15 general fund required by Laws 2008, chapter
 667.16 364, section 17, paragraph (b), shall end in
 667.17 fiscal year 2019.

667.18 (e) **Base Level Adjustment.** The general fund
 667.19 base is \$25,150,000 in fiscal year 2022 and
 667.20 \$24,719,000 in fiscal year 2023. The state
 667.21 government special revenue fund base is
 667.22 \$67,107,000 in fiscal year 2022 and
 667.23 \$67,067,000 in fiscal year 2023.

667.24	<u>Subd. 4. Health Operations</u>	<u>10,812,000</u>	<u>10,912,000</u>
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667.25 Sec. 4. **HEALTH-RELATED BOARDS**

667.26	<u>Subdivision 1. Total Appropriation</u>	<u>\$ 26,498,000</u>	<u>\$ 25,888,000</u>
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667.27 This appropriation is from the state
 667.28 government special revenue fund unless
 667.29 specified otherwise. The amounts that may be
 667.30 spent for each purpose are specified in the
 667.31 following subdivisions.

667.32	<u>Subd. 2. Board of Chiropractic Examiners</u>	<u>629,000</u>	<u>641,000</u>
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667.33	<u>Subd. 3. Board of Dentistry</u>	<u>1,503,000</u>	<u>1,450,000</u>
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668.1	Subd. 4. <u>Board of Dietetics and Nutrition</u>		
668.2	<u>Practice</u>	<u>147,000</u>	<u>149,000</u>
668.3	Subd. 5. <u>Board of Marriage and Family Therapy</u>	<u>384,000</u>	<u>389,000</u>
668.4	<u>Base Level Adjustment.</u> The base is \$384,000		
668.5	<u>in fiscal year 2022 and \$384,000 in fiscal year</u>		
668.6	<u>2023.</u>		
668.7	Subd. 6. <u>Board of Medical Practice</u>	<u>6,013,000</u>	<u>5,996,000</u>
668.8	<u>(a) Health Professional Services Program.</u>		
668.9	<u>This appropriation includes \$1,023,000 in</u>		
668.10	<u>fiscal year 2020 and \$1,002,000 in fiscal year</u>		
668.11	<u>2021 for the health professional services</u>		
668.12	<u>program.</u>		
668.13	<u>(b) Base Level Adjustment.</u> The base is		
668.14	<u>\$5,912,000 in fiscal year 2022 and \$5,868,000</u>		
668.15	<u>in fiscal year 2023.</u>		
668.16	Subd. 7. <u>Board of Nursing</u>	<u>4,993,000</u>	<u>4,993,000</u>
668.17	Subd. 8. <u>Board of Nursing Home Administrators</u>	<u>3,733,000</u>	<u>3,201,000</u>
668.18	<u>(a) Administrative Services Unit - Operating</u>		
668.19	<u>Costs.</u> Of this appropriation, \$3,445,000 in		
668.20	<u>fiscal year 2020 and \$2,910,000 in fiscal year</u>		
668.21	<u>2021 are for operating costs of the</u>		
668.22	<u>administrative services unit. The</u>		
668.23	<u>administrative services unit may receive and</u>		
668.24	<u>expend reimbursements for services it</u>		
668.25	<u>performs for other agencies.</u>		
668.26	<u>(b) Administrative Services Unit - Volunteer</u>		
668.27	<u>Health Care Provider Program.</u> Of this		
668.28	<u>appropriation, \$150,000 in fiscal year 2020</u>		
668.29	<u>and \$150,000 in fiscal year 2021 are to pay</u>		
668.30	<u>for medical professional liability coverage</u>		
668.31	<u>required under Minnesota Statutes, section</u>		
668.32	<u>214.40.</u>		

669.1 **(c) Administrative Services Unit -**
669.2 **Retirement Costs.** Of this appropriation,
669.3 \$558,000 in fiscal year 2020 is a onetime
669.4 appropriation to the administrative services
669.5 unit to pay for the retirement costs of
669.6 health-related board employees. This funding
669.7 may be transferred to the health board
669.8 incurring retirement costs. Any board that has
669.9 an unexpended balance for an amount
669.10 transferred under this paragraph shall transfer
669.11 the unexpended amount to the administrative
669.12 services unit. These funds are available either
669.13 year of the biennium.

669.14 **(d) Administrative Services Unit - Contested**
669.15 **Cases and Other Legal Proceedings.** Of this
669.16 appropriation, \$200,000 in fiscal year 2020
669.17 and \$200,000 in fiscal year 2021 are for costs
669.18 of contested case hearings and other
669.19 unanticipated costs of legal proceedings
669.20 involving health-related boards funded under
669.21 this section. Upon certification by a
669.22 health-related board to the administrative
669.23 services unit that costs will be incurred and
669.24 that there is insufficient money available to
669.25 pay for the costs out of money currently
669.26 available to that board, the administrative
669.27 services unit is authorized to transfer money
669.28 from this appropriation to the board for
669.29 payment of those costs with the approval of
669.30 the commissioner of management and budget.
669.31 The commissioner of management and budget
669.32 must require any board that has an unexpended
669.33 balance for an amount transferred under this
669.34 paragraph to transfer the unexpended amount
669.35 to the administrative services unit to be

670.1	<u>deposited in the state government special</u>		
670.2	<u>revenue fund.</u>		
670.3	<u>Subd. 9. Board of Optometry</u>	<u>200,000</u>	<u>201,000</u>
670.4	<u>Subd. 10. Board of Pharmacy</u>	<u>3,599,000</u>	<u>3,629,000</u>
670.5	<u>\$1,643,000 in fiscal year 2020 and \$1,285,000</u>		
670.6	<u>in fiscal year 2021 are from the opioid</u>		
670.7	<u>stewardship fund.</u>		
670.8	<u>Subd. 11. Board of Physical Therapy</u>	<u>547,000</u>	<u>549,000</u>
670.9	<u>Subd. 12. Board of Podiatric Medicine</u>	<u>199,000</u>	<u>199,000</u>
670.10	<u>Subd. 13. Board of Psychology</u>	<u>1,357,000</u>	<u>1,395,000</u>
670.11	<u>Base Level Adjustment. The base is</u>		
670.12	<u>\$1,355,000 in fiscal year 2022 and \$1,355,000</u>		
670.13	<u>in fiscal year 2023.</u>		
670.14	<u>Subd. 14. Board of Social Work</u>	<u>1,437,000</u>	<u>1,404,000</u>
670.15	<u>Subd. 15. Board of Veterinary Medicine</u>	<u>345,000</u>	<u>353,000</u>
670.16	<u>Subd. 16. Board of Behavioral Health and</u>		
670.17	<u>Therapy</u>	<u>937,000</u>	<u>858,000</u>
670.18	<u>Base Level Adjustment. The base is \$833,000</u>		
670.19	<u>in fiscal year 2022 and \$833,000 in fiscal year</u>		
670.20	<u>2023.</u>		
670.21	<u>Subd. 17. Board of Occupational Therapy</u>		
670.22	<u>Practice</u>	<u>450,000</u>	<u>456,000</u>
670.23	<u>Sec. 5. EMERGENCY MEDICAL SERVICES</u>		
670.24	<u>REGULATORY BOARD</u>	<u>\$ 3,747,000</u>	<u>\$ 3,809,000</u>
670.25	<u>(a) Cooper/Sams Volunteer Ambulance</u>		
670.26	<u>Program. \$950,000 in fiscal year 2020 and</u>		
670.27	<u>\$950,000 in fiscal year 2021 are for the</u>		
670.28	<u>Cooper/Sams volunteer ambulance program</u>		
670.29	<u>under Minnesota Statutes, section 144E.40.</u>		
670.30	<u>(1) Of this amount, \$861,000 in fiscal year</u>		
670.31	<u>2020 and \$861,000 in fiscal year 2021 are for</u>		
670.32	<u>the ambulance service personnel longevity</u>		

672.1 Sec. 8. **OMBUDSPERSONS FOR FAMILIES** \$ 714,000 \$ 723,000

672.2 Sec. 9. Laws 2017, First Special Session chapter 6, article 18, section 2, subdivision 1, is
672.3 amended to read:

672.4 Subdivision 1. **Total Appropriation** \$ 7,548,395,000 \$ 7,654,331,000
672.5

672.6 Appropriations by Fund

672.7		2018	2019
672.8			6,880,153,000
672.9	General	6,819,523,000	<u>6,880,253,000</u>
672.10	State Government		
672.11	Special Revenue	4,274,000	4,274,000
672.12			501,104,000
672.13	Health Care Access	446,453,000	<u>501,268,000</u>
672.14	Federal TANF	276,249,000	266,904,000
672.15	Lottery Prize	1,896,000	1,896,000

672.16 The amounts that may be spent for each
672.17 purpose are specified in the following
672.18 subdivisions.

672.19 **EFFECTIVE DATE.** This section is effective retroactively from April 1, 2019.

672.20 Sec. 10. Laws 2017, First Special Session chapter 6, article 18, section 2, subdivision 3,
672.21 is amended to read:

672.22 Subd. 3. **Central Office; Operations**

672.23 Appropriations by Fund

672.24			121,009,000
672.25	General	136,778,000	<u>121,024,000</u>
672.26	State Government		
672.27	Special Revenue	4,149,000	4,149,000
672.28	Health Care Access	21,019,000	21,019,000
672.29	Federal TANF	100,000	100,000

672.30 (a) **Administrative Recovery; Set-Aside.** The
672.31 commissioner may invoice local entities
672.32 through the SWIFT accounting system as an
672.33 alternative means to recover the actual cost of
672.34 administering the following provisions:

673.1 (1) Minnesota Statutes, section 125A.744,
673.2 subdivision 3;

673.3 (2) Minnesota Statutes, section 245.495,
673.4 paragraph (b);

673.5 (3) Minnesota Statutes, section 256B.0625,
673.6 subdivision 20, paragraph (k);

673.7 (4) Minnesota Statutes, section 256B.0924,
673.8 subdivision 6, paragraph (g);

673.9 (5) Minnesota Statutes, section 256B.0945,
673.10 subdivision 4, paragraph (d); and

673.11 (6) Minnesota Statutes, section 256F.10,
673.12 subdivision 6, paragraph (b).

673.13 (b) **Transfer to Office of Legislative**

673.14 **Auditor.** \$600,000 in fiscal year 2018 and
673.15 \$600,000 in fiscal year 2019 are for transfer
673.16 to the Office of the Legislative Auditor for
673.17 audit activities under Minnesota Statutes,
673.18 section 3.972, subdivision 2b.

673.19 (c) **Base Level Adjustment.** The general fund
673.20 base is \$133,378,000 in fiscal year 2020 and
673.21 \$133,418,000 in fiscal year 2021.

673.22 **EFFECTIVE DATE.** This section is effective retroactively from April 1, 2019.

673.23 Sec. 11. Laws 2017, First Special Session chapter 6, article 18, section 2, subdivision 5,
673.24 is amended to read:

673.25 Subd. 5. **Central Office; Health Care**

Appropriations by Fund			
673.27			21,249,000
673.28	General	20,719,000	<u>21,336,000</u>
673.29	Health Care Access	23,697,000	23,804,000

673.30 (a) **Integrated Health Partnership Health**
673.31 **Information Exchange.** \$125,000 in fiscal
673.32 year 2018 and \$250,000 in fiscal year 2019

674.1 are from the general fund to contract with
 674.2 state-certified health information exchange
 674.3 vendors to support providers participating in
 674.4 an integrated health partnership under
 674.5 Minnesota Statutes, section 256B.0755, to
 674.6 connect enrollees with community supports
 674.7 and social services and improve collaboration
 674.8 among participating and authorized providers.

674.9 **(b) Transfer to Legislative Auditor.** 153,000
 674.10 in fiscal year 2018 and \$153,000 in fiscal year
 674.11 2019 are from the general fund for transfer to
 674.12 the Office of the Legislative Auditor for the
 674.13 auditor to establish and maintain a team of
 674.14 auditors with the training and experience
 674.15 necessary to fulfill the requirements in
 674.16 Minnesota Statutes, section 3.972, subdivision
 674.17 2a.

674.18 **(c) Outpatient Pharmacy.** \$87,000 in fiscal
 674.19 year 2019 is from the general fund to contract
 674.20 for 340B pharmacy data in order to perform
 674.21 the new pricing calculations and conduct a
 674.22 cost of dispensing survey.

674.23 ~~(e)~~ **(d) Base Level Adjustment.** The general
 674.24 fund base is \$21,257,000 in fiscal year 2020
 674.25 and \$21,302,000 in fiscal year 2021.

674.26 **EFFECTIVE DATE.** This section is effective retroactively from April 1, 2019.

674.27 Sec. 12. Laws 2017, First Special Session chapter 6, article 18, section 2, subdivision 15,
 674.28 is amended to read:

674.29 Subd. 15. **Forecasted Programs; Medical**
 674.30 **Assistance**

Appropriations by Fund		
		5,172,292,000
674.32		5,172,292,000
674.33	General	5,174,139,000 <u>5,172,290,000</u>
674.34		438,848,000
674.35	Health Care Access	385,159,000 <u>439,012,000</u>

675.1 (a) **Behavioral Health Services.** \$1,000,000
675.2 in fiscal year 2018 and \$1,000,000 in fiscal
675.3 year 2019 are for behavioral health services
675.4 provided by hospitals identified under
675.5 Minnesota Statutes, section 256.969,
675.6 subdivision 2b, paragraph (a), clause (4). The
675.7 increase in payments shall be made by
675.8 increasing the adjustment under Minnesota
675.9 Statutes, section 256.969, subdivision 2b,
675.10 paragraph (e), clause (2).

675.11 (b) **Self-Directed Workforce Collective**
675.12 **Bargaining Agreement.** (1) This
675.13 appropriation includes money to implement a
675.14 collective bargaining agreement between the
675.15 state and the Service Employees International
675.16 Union Healthcare Minnesota (SEIU). This
675.17 appropriation is not available until the
675.18 collective bargaining agreement between the
675.19 state of Minnesota and the Service Employees
675.20 International Union Healthcare Minnesota
675.21 under Minnesota Statutes, section 179A.54,
675.22 is approved as provided in clause (3).

675.23 (2) The commissioner of management and
675.24 budget is authorized to negotiate and enter
675.25 into a collective bargaining agreement with
675.26 SEIU under Minnesota Statutes, section
675.27 179A.54, subject to clause (1), and subdivision
675.28 7, paragraph (f). The economic terms of the
675.29 collective bargaining agreement may include
675.30 wage floor increases for direct support
675.31 workers, paid time off, holiday pay, wage
675.32 increases for workers serving people with
675.33 complex needs, training stipends, and training
675.34 for direct support workers and for

676.1 implementation of the registry as outlined in
676.2 the collective bargaining agreement.

676.3 (3) Notwithstanding Minnesota Statutes,
676.4 sections 3.855, 179A.22, subdivision 4, and
676.5 179A.54, subdivision 5, upon approval of a
676.6 negotiated collective bargaining agreement by
676.7 the SEIU and the commissioner of
676.8 management and budget, the commissioner
676.9 of human services is authorized to implement
676.10 the negotiated collective bargaining
676.11 agreement.

676.12 **EFFECTIVE DATE.** This section is effective retroactively from April 1, 2019.

676.13 Sec. 13. **TRANSFER; OPIOID STEWARDSHIP FUND.**

676.14 In fiscal year 2020, the commissioner of management and budget shall transfer
676.15 \$13,000,000 from the health care access fund to the opioid stewardship fund. This is a
676.16 onetime transfer.

676.17 Sec. 14. **RETURN OF PAYMENTS FOR JENSEN SETTLEMENT COSTS.**

676.18 Any money not used for payment of court-ordered costs or money returned by the court
676.19 in United States District Court, case 0:09-cv-01775-DWF-BRT, Jensen et al. v. Minnesota
676.20 Department of Human Services et al., is appropriated to the commissioner of human services
676.21 for expenses related to direct care and treatment programs and notwithstanding any other
676.22 provision is available until June 30, 2020.

676.23 Sec. 15. **TRANSFERS; HUMAN SERVICES.**

676.24 Subdivision 1. **Grants.** The commissioner of human services, with the approval of the
676.25 commissioner of management and budget, may transfer unencumbered appropriation balances
676.26 for the biennium ending June 30, 2021, within fiscal years among the MFIP, general
676.27 assistance, medical assistance, MinnesotaCare, MFIP child care assistance under Minnesota
676.28 Statutes, section 119B.05, Minnesota supplemental aid program, group residential housing
676.29 program, the entitlement portion of Northstar Care for Children under Minnesota Statutes,
676.30 chapter 256N, and the entitlement portion of the chemical dependency consolidated treatment
676.31 fund, and between fiscal years of the biennium. The commissioner shall inform the chairs
676.32 and ranking minority members of the senate Health and Human Services Finance Division

677.1 and the house of representatives Health and Human Services Finance Committee quarterly
677.2 about transfers made under this subdivision.

677.3 Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative money
677.4 may be transferred within the Departments of Health and Human Services as the
677.5 commissioners consider necessary, with the advance approval of the commissioner of
677.6 management and budget. The commissioner shall inform the chairs and ranking minority
677.7 members of the senate Health and Human Services Finance Division and the house of
677.8 representatives Health and Human Services Finance Committee quarterly about transfers
677.9 made under this subdivision.

677.10 Sec. 16. **INDIRECT COSTS NOT TO FUND PROGRAMS.**

677.11 The commissioners of health and human services shall not use indirect cost allocations
677.12 to pay for the operational costs of any program for which they are responsible.

677.13 Sec. 17. **EXPIRATION OF UNCODIFIED LANGUAGE.**

677.14 All uncodified language contained in this article expires on June 30, 2021, unless a
677.15 different expiration date is explicit.

677.16 Sec. 18. **EFFECTIVE DATE.**

677.17 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

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.441 ASSISTED LIVING BILL OF RIGHTS ADDENDUM.

Assisted living clients, as defined in section 144G.01, subdivision 3, shall be provided with the home care bill of rights required by section 144A.44, except that the home care bill of rights provided to these clients must include the following provision in place of the provision in section 144A.44, subdivision 1, clause (17):

"(17) the right to reasonable, advance notice of changes in services or charges, including at least 30 days' advance notice of the termination of a service by a provider, except in cases where:

(i) the recipient of services engages in conduct that alters the conditions of employment as specified in the employment contract between the home care provider and the individual providing home care services, or creates an abusive or unsafe work environment for the individual providing home care services;

(ii) an emergency for the informal caregiver or a significant change in the recipient's condition has resulted in service needs that exceed the current service provider agreement and that cannot be safely met by the home care provider; or

(iii) the provider has not received payment for services, for which at least ten days' advance notice of the termination of a service shall be provided."

144A.442 ASSISTED LIVING CLIENTS; SERVICE TERMINATION.

If an arranged home care provider, as defined in section 144D.01, subdivision 2a, who is not also Medicare certified terminates a service agreement or service plan with an assisted living client, as defined in section 144G.01, subdivision 3, the home care provider shall provide the assisted living client and the legal or designated representatives of the client, if any, with a written notice of termination which includes the following information:

(1) the effective date of termination;

(2) the reason for termination;

(3) without extending the termination notice period, an affirmative offer to meet with the assisted living client or client representatives within no more than five business days of the date of the termination notice to discuss the termination;

(4) contact information for a reasonable number of other home care providers in the geographic area of the assisted living client, as required by section 144A.4791, subdivision 10;

(5) a statement that the provider will participate in a coordinated transfer of the care of the client to another provider or caregiver, as required by section 144A.44, subdivision 1, clause (18);

(6) the name and contact information of a representative of the home care provider with whom the client may discuss the notice of termination;

(7) a copy of the home care bill of rights; and

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(8) a statement that the notice of termination of home care services by the home care provider does not constitute notice of termination of the housing with services contract with a housing with services establishment.

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.

Subdivision 1. **Scope.** As used in sections 144D.01 to 144D.06, the following terms have the meanings given them.

Subd. 2. **Adult.** "Adult" means a natural person who has attained the age of 18 years.

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. 3. **Commissioner.** "Commissioner" means the commissioner of health or the commissioner's designee.

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. 4. **Housing with services establishment or establishment.** (a) "Housing with services establishment" or "establishment" means:

(1) an establishment providing sleeping accommodations to one or more adult residents, at least 80 percent of which are 55 years of age or older, and offering or providing, for a fee, one or more regularly scheduled health-related services or two or more regularly scheduled supportive services, whether offered or provided directly by the establishment or by another entity arranged for by the establishment; or

(2) an establishment that registers under section 144D.025.

(b) Housing with services establishment does not include:

(1) a nursing home licensed under chapter 144A;

(2) a hospital, certified boarding care home, or supervised living facility licensed under sections 144.50 to 144.56;

(3) a board and lodging establishment licensed under chapter 157 and Minnesota Rules, parts 9520.0500 to 9520.0670, or under chapter 245D or 245G;

(4) a board and lodging establishment which serves as a shelter for battered women or other similar purpose;

(5) a family adult foster care home licensed by the Department of Human Services;

(6) private homes in which the residents are related by kinship, law, or affinity with the providers of services;

(7) residential settings for persons with developmental disabilities in which the services are licensed under chapter 245D;

(8) a home-sharing arrangement such as when an elderly or disabled person or single-parent family makes lodging in a private residence available to another person in exchange for services or rent, or both;

(9) a duly organized condominium, cooperative, common interest community, or owners' association of the foregoing where at least 80 percent of the units that comprise the condominium, cooperative, or common interest community are occupied by individuals who are the owners, members, or shareholders of the units;

(10) services for persons with developmental disabilities that are provided under a license under chapter 245D; or

(11) a temporary family health care dwelling as defined in sections 394.307 and 462.3593.

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Subd. 5. **Supportive services.** "Supportive services" means help with personal laundry, handling or assisting with personal funds of residents, or arranging for medical services, health-related services, social services, or transportation to medical or social services appointments. Arranging for services does not include making referrals, assisting a resident in contacting a service provider of the resident's choice, or contacting a service provider in an emergency.

Subd. 6. **Health-related services.** "Health-related services" include professional nursing services, home health aide tasks, or the central storage of medication for residents.

Subd. 7. **Family adult foster care home.** "Family adult foster care home" means an adult foster care home that is licensed by the Department of Human Services, that is the primary residence of the license holder, and in which the license holder is the primary caregiver.

144D.015 DEFINITION FOR PURPOSES OF LONG-TERM CARE INSURANCE.

For purposes of consistency with terminology commonly used in long-term care insurance policies and notwithstanding chapter 144G, a housing with services establishment that is registered under section 144D.03 and that holds, or makes arrangements with an individual or entity that holds any type of home care license and all other licenses, permits, registrations, or other governmental approvals legally required for delivery of the services the establishment offers or provides to its residents, constitutes an "assisted living facility" or "assisted living residence."

144D.02 REGISTRATION REQUIRED.

No entity may establish, operate, conduct, or maintain a housing with services establishment in this state without registering and operating as required in sections 144D.01 to 144D.06.

144D.025 OPTIONAL REGISTRATION.

An establishment that meets all the requirements of this chapter except that fewer than 80 percent of the adult residents are age 55 or older, or a supportive housing establishment developed and funded in whole or in part with funds provided specifically as part of the plan to end long-term homelessness required under Laws 2003, chapter 128, article 15, section 9, may, at its option, register as a housing with services establishment.

144D.03 REGISTRATION.

Subdivision 1. **Registration procedures.** The commissioner shall establish forms and procedures for annual registration of housing with services establishments. The commissioner shall charge an annual registration fee of \$155. No fee shall be refunded. A registered establishment shall notify the commissioner within 30 days of the date it is no longer required to be registered under this chapter or of any change in the business name or address of the establishment, the name or mailing address of the owner or owners, or the name or mailing address of the managing agent. There shall be no fee for submission of the notice.

Subd. 1a. **Surcharge for injunctive relief actions.** The commissioner shall assess each housing with services establishment that offers or provides assisted living under chapter 144G a surcharge on the annual registration fee paid under subdivision 1, to pay for the commissioner's costs related to bringing actions for injunctive relief under section 144G.02, subdivision 2, paragraph (b), on or after July 1, 2007. The commissioner shall assess surcharges using a sliding scale under which the surcharge amount increases with the client capacity of an establishment. The commissioner shall adjust the surcharge as necessary to recover the projected costs of bringing actions for injunctive relief. The commissioner shall adjust the surcharge in accordance with section 16A.1285.

Subd. 2. **Registration information.** The establishment shall provide the following information to the commissioner in order to be registered:

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

(2) the name and mailing address of the owner or owners of the establishment and, if the owner or owners are not natural persons, identification of the type of business entity of the owner or owners, and the names and addresses of the officers and members of the governing body, or comparable persons for partnerships, limited liability corporations, or other types of business organizations of the owner or owners;

(3) the name and mailing address of the managing agent, whether through management agreement or lease agreement, of the establishment, if different from the owner or owners, and the name of the on-site manager, if any;

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(4) verification that the establishment has entered into a housing with services contract, as required in section 144D.04, with each resident or resident's representative;

(5) verification that the establishment is complying with the requirements of section 325F.72, if applicable;

(6) the name and address of at least one natural person who shall be responsible for dealing with the commissioner on all matters provided for in sections 144D.01 to 144D.06, and on whom personal service of all notices and orders shall be made, and who shall be authorized to accept service on behalf of the owner or owners and the managing agent, if any;

(7) the signature of the authorized representative of the owner or owners or, if the owner or owners are not natural persons, signatures of at least two authorized representatives of each owner, one of which shall be an officer of the owner; and

(8) whether services are included in the base rate to be paid by the resident.

Personal service on the person identified under clause (6) by the owner or owners in the registration shall be considered service on the owner or owners, and it shall not be a defense to any action that personal service was not made on each individual or entity. The designation of one or more individuals under this subdivision shall not affect the legal responsibility of the owner or owners under sections 144D.01 to 144D.06.

144D.04 HOUSING WITH SERVICES CONTRACTS.

Subdivision 1. **Contract required.** No housing with services establishment may operate in this state unless a written housing with services contract, as defined in subdivision 2, is executed between the establishment and each resident or resident's representative and unless the establishment operates in accordance with the terms of the contract. The resident or the resident's representative shall be given a complete copy of the contract and all supporting documents and attachments and any changes whenever changes are made.

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

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

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

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

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

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

(6) the term of the contract;

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

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

(9) a conspicuous notice informing the tenant of the policy concerning the conditions under which and the process through which the contract may be modified, amended, or terminated, including whether a move to a different room or sharing a room would be required in the event that the tenant can no longer pay the current rent;

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

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

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

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

(14) billing and payment procedures and requirements;

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

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

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

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.

Subd. 3. **Contracts in permanent files.** Housing with services contracts and related documents executed by each resident or resident's representative shall be maintained by the establishment in files from the date of execution until three years after the contract is terminated. The contracts and the written disclosures required under section 325F.72, if applicable, shall be made available for on-site inspection by the commissioner upon request at any time.

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.05 AUTHORITY OF COMMISSIONER.

The commissioner shall, upon receipt of information which may indicate the failure of the housing with services establishment, a resident, a resident's representative, or a service provider to

comply with a legal requirement to which one or more of them may be subject, 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.

The commissioner shall have standing to bring an action for injunctive relief in the district court in the district in which an establishment is located to compel the housing with services establishment 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 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.

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.065 TRAINING IN DEMENTIA CARE REQUIRED.

(a) If a housing with services establishment registered under this chapter has a special program or special care unit for residents with Alzheimer's disease or other dementias or advertises, markets, or otherwise promotes the establishment as providing services for persons with Alzheimer's disease or other dementias, whether in a segregated or general unit, employees of the establishment and of the establishment's arranged home care provider must meet the following training requirements:

(1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter;

(2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b), or a supervisor meeting the requirements in clause (1), must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;

(3) staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least four hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; and

(4) new employees may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months.

(b) Areas of required training include:

(1) an explanation of Alzheimer's disease and related disorders;

(2) assistance with activities of daily living;

(3) problem solving with challenging behaviors; and

(4) communication skills.

(c) The establishment shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. This information satisfies the disclosure requirements of section 325F.72, subdivision 2, clause (4).

(d) Housing with services establishments not included in paragraph (a) that provide assisted living services under chapter 144G must meet the following training requirements:

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(1) supervisors of direct-care staff must have at least four hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter;

(2) direct-care employees must have completed at least four hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial four hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or supervisor meeting the requirements under paragraph (a), clause (1), must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;

(3) staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least four hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; and

(4) new employees may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months.

144D.066 ENFORCEMENT OF DEMENTIA CARE TRAINING REQUIREMENTS.

Subdivision 1. **Enforcement.** (a) The commissioner shall enforce the dementia care training standards for staff working in housing with services settings and for housing managers according to clauses (1) to (3):

(1) for dementia care training requirements in section 144D.065, the commissioner shall review training records as part of the home care provider survey process for direct care staff and supervisors of direct care staff, in accordance with section 144A.474. The commissioner may also request and review training records at any time during the year;

(2) for dementia care training standards in section 144D.065, the commissioner shall review training records for maintenance, housekeeping, and food service staff and other staff not providing direct care working in housing with services settings as part of the housing with services registration application and renewal application process in accordance with section 144D.03. The commissioner may also request and review training records at any time during the year; and

(3) for housing managers, the commissioner shall review the statement verifying compliance with the required training described in section 144D.10, paragraph (d), through the housing with services registration application and renewal application process in accordance with section 144D.03. The commissioner may also request and review training records at any time during the year.

(b) The commissioner shall specify the required forms and what constitutes sufficient training records for the items listed in paragraph (a), clauses (1) to (3).

Subd. 2. **Fines for noncompliance.** (a) Beginning January 1, 2017, the commissioner may impose a \$200 fine for every staff person required to obtain dementia care training who does not have training records to show compliance. For violations of subdivision 1, paragraph (a), clause (1), the fine will be imposed upon the home care provider, and may be appealed under the contested case procedure in section 144A.475, subdivisions 3a, 4, and 7. For violations of subdivision 1, paragraph (a), clauses (2) and (3), the fine will be imposed on the housing with services registrant and may be appealed under the contested case procedure in section 144A.475, subdivisions 3a, 4, and 7. Prior to imposing the fine, the commissioner must allow two weeks for staff to complete the required training. Fines collected under this section shall be deposited in the state treasury and credited to the state government special revenue fund.

(b) The housing with services registrant and home care provider must allow for the required training as part of employee and staff duties. Imposition of a fine by the commissioner does not negate the need for the required training. Continued noncompliance with the requirements of sections 144D.065 and 144D.10 may result in revocation or nonrenewal of the housing with services registration or home care license. The commissioner shall make public the list of all housing with services establishments that have complied with the training requirements.

Subd. 3. **Technical assistance.** From January 1, 2016, to December 31, 2016, the commissioner shall provide technical assistance instead of imposing fines for noncompliance with the training

requirements. During the year of technical assistance, the commissioner shall review the training records to determine if the records meet the requirements and inform the home care provider. The commissioner shall also provide information about available training resources.

144D.07 RESTRAINTS.

Residents must be free from any physical or chemical restraints imposed for purposes of discipline or convenience.

144D.08 UNIFORM CONSUMER INFORMATION GUIDE.

All housing with services establishments shall make available to all prospective and current residents information consistent with the uniform format and the required components adopted by the commissioner under section 144G.06. This section does not apply to an establishment registered under section 144D.025 serving the homeless.

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.

144D.11 EMERGENCY PLANNING.

(a) Each registered housing with services establishment must meet the following requirements:

(1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in-place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency;

(2) post an emergency disaster plan prominently;

(3) provide building emergency exit diagrams to all tenants upon signing a lease;

(4) post emergency exit diagrams on each floor; and

(5) have a written policy and procedure regarding missing tenants.

(b) Each registered housing with services establishment must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make

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emergency and disaster training available to all tenants annually. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site.

(c) Each registered housing with services location must conduct and document a fire drill or other emergency drill at least every six months. To the extent possible, drills must be coordinated with local fire departments or other community emergency resources.

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

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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, 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

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(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

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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;

(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

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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 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

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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:

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- (1) the factual basis for the department's determination;
- (2) the sanction the department intends to take;
- (3) the dollar amount of the monetary recovery or recoupment, if any;
- (4) how the dollar amount was computed;
- (5) the right to dispute the department's determination and to provide evidence;
- (6) the right to appeal the department's proposed sanction; and
- (7) the option to meet informally with department staff, and to bring additional documentation or information, to resolve the issues.

(c) In cases of determinations resulting in denial or termination of payments, in addition to the requirements of paragraph (b), the notice must state:

- (1) the length of the denial or termination;
- (2) the requirements and procedures for reinstatement; and
- (3) the provider's right to submit documents and written arguments against the denial or termination of payments for review by the department before the effective date of denial or termination.

(d) The submission of documents and written argument for review by the department under paragraph (b), clause (5) or (7), or paragraph (c), clause (3), does not stay the deadline for filing an appeal.

(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.

245H.10 BACKGROUND STUDIES.

Subd. 2. Direct contact. (a) The subject of the background study may not provide direct contact services to a child served by a certified center unless the subject is under continuous direct supervision pending completion of the background study.

(b) The certified center must document in the staff person's personnel file the date the program initiates a background study and the date the subject of the study first had direct contact with a child served by the center.

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;

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- (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

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habilitation services may enter into written agreements with qualified businesses to provide additional training and supervision needed by individuals to maintain their employment.

Subd. 3. **Agreement specifications.** Agreements must include the following:

(1) the type and amount of supervision and support to be provided by the business to the individual in accordance with their needs as identified in their individual service plan;

(2) the methods used to periodically assess the individual's satisfaction with their work, training, and support;

(3) the measures taken by the qualified business and the vendor to ensure the health, safety, and protection of the individual during working hours, including the reporting of abuse and neglect under state law and rules;

(4) the training and support services the vendor will provide to the qualified business, including the frequency of on-site supervision and support; and

(5) any payment to be made to the qualified business by the vendor. Payment to the business must be limited to:

(i) additional costs of training coworkers and managers that exceed ordinary and customary training costs and are a direct result of employing a person with a developmental disability; and

(ii) additional costs for training, supervising, and assisting the person with a developmental disability that exceed normal and customary costs required for performing similar tasks or duties.

Payments made to a qualified business under this section must not include incentive payments to the qualified business or salary supplementation for the person with a developmental disability.

Subd. 4. **Client protection.** Persons receiving training and support under this section may not be denied their rights or procedural protections under section 256.045, subdivision 4a, or 256B.092, including the county agency's responsibility to arrange for appropriate services, as necessary, in the event that persons lose their job or the contract with the qualified business is terminated.

Subd. 5. **Vendor payment.** (a) For purposes of this section, the vendor shall bill and the commissioner shall reimburse the vendor for full-day or partial-day services to a client that would otherwise have been paid to the vendor for providing direct services, provided that both of the following criteria are met:

(1) the vendor provides services and payments to the qualified business that enable the business to perform support and supervision services for the client that the vendor would otherwise need to perform; and

(2) the client for whom a rate will be billed will receive full-day or partial-day services from the vendor and the rate to be paid the vendor will allow the client to work with this support and supervision at the qualified business instead of receiving these services from the vendor.

(b) Medical assistance reimbursement of services provided to persons receiving day training and habilitation services under this section is subject to the limitations on reimbursement for vocational services under federal law and regulation.

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.0624 ADULT CRISIS RESPONSE SERVICES COVERED.

Subd. 10. **Recipient file.** Providers of mobile crisis intervention or crisis stabilization services must maintain a file for each recipient containing 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 as to why the recipient would not sign the plan;
- (2) signed release forms;
- (3) recipient health information and current medications;

(4) emergency contacts for the recipient;

(5) case records which 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;

(7) summary of the recipient's case reviews by staff;

(8) any written information by the recipient that the recipient wants in the file; and

(9) an advance directive, if there is one available.

Documentation in the file must comply with all requirements of the commissioner.

256B.0625 COVERED SERVICES.

Subd. 63. **Payment for multiple services provided on the same day.** The commissioner shall not prohibit payment, including supplemental payments, for mental health services or dental services provided to a patient by a clinic or health care professional solely because the mental health or dental services were provided on the same day as other covered health services furnished by the same provider.

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;

(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

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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;

(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

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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.

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(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 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

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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 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

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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

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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.

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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 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

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(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.

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Facilities completing projects after January 1, 2018, are eligible for a property rate adjustment effective on the first day of the month of January or July, whichever occurs immediately following the completion date.

(b) Notwithstanding subdivision 18, as of July 14, 2005, facilities with rates set under section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080, that commenced a construction project on or after October 1, 2004, and do not have a contract under subdivision 3 by September 30, 2006, are eligible to request a rate adjustment under section 256B.431, subdivision 10, through September 30, 2006. If the request results in the commissioner determining a rate adjustment is allowable, the rate adjustment is effective on the first of the month following project completion. These facilities shall be allowed to accumulate construction project costs for the period October 1, 2004, to September 30, 2006.

(c) Facilities shall be allowed construction project rate adjustments no sooner than 12 months after completing a previous construction project. Facilities must request the rate adjustment according to section 256B.431, subdivision 10.

(d) Capacity days shall be computed according to Minnesota Rules, part 9549.0060, subpart 11. For rate calculations under this section, the number of licensed beds in the nursing facility shall be the number existing after the construction project is completed and the number of days in the nursing facility's reporting period shall be 365.

(e) The value of assets to be recognized for a total replacement project as defined in section 256B.431, subdivision 17d, shall be computed as described in clause (1). The value of assets to be recognized for all other projects shall be computed as described in clause (2).

(1) Replacement-cost-new limits under section 256B.431, subdivision 17e, and the number of beds allowed under subdivision 3a, paragraph (c), shall be used to compute the maximum amount of assets allowable in a facility's property rate calculation. If a facility's current request for a rate adjustment results from the completion of a construction project that was previously approved under section 144A.073, the assets to be used in the rate calculation cannot exceed the lesser of the amount determined under sections 144A.071, subdivision 2, and 144A.073, subdivision 3b, or the actual allowable costs of the construction project. A current request that is not the result of a project under section 144A.073 cannot exceed the limit under section 144A.071, subdivision 2, paragraph (a). Applicable credits must be deducted from the cost of the construction project.

(2)(i) Replacement-cost-new limits under section 256B.431, subdivision 17e, and the number of beds allowed under section 256B.431, subdivision 3a, paragraph (c), shall be used to compute the maximum amount of assets allowable in a facility's property rate calculation.

(ii) The value of a facility's assets to be compared to the amount in item (i) begins with the total appraised value from the last rate notice a facility received when its rates were set under section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080. This value shall be indexed by the factor in section 256B.431, subdivision 3f, paragraph (a), for each rate year the facility received an inflation factor on its property-related rate when its rates were set under this section. The value of assets listed as previous capital additions, capital additions, and special projects on the facility's base year rate notice and the value of assets related to a construction project for which the facility received a rate adjustment when its rates were determined under this section shall be added to the indexed appraised value.

(iii) The maximum amount of assets to be recognized in computing a facility's rate adjustment after a project is completed is the lesser of the aggregate replacement-cost-new limit computed in (i) minus the assets recognized in (ii) or the actual allowable costs of the construction project.

(iv) If a facility's current request for a rate adjustment results from the completion of a construction project that was previously approved under section 144A.073, the assets to be added to the rate calculation cannot exceed the lesser of the amount determined under sections 144A.071, subdivision 2, and 144A.073, subdivision 3b, or the actual allowable costs of the construction project. A current request that is not the result of a project under section 144A.073 cannot exceed the limit stated in section 144A.071, subdivision 2, paragraph (a). Assets disposed of as a result of a construction project and applicable credits must be deducted from the cost of the construction project.

(f) For construction projects approved under section 144A.073, allowable debt may never exceed the lesser of the cost of the assets purchased, the threshold limit in section 144A.071, subdivision 2, or the replacement-cost-new limit less previously existing capital debt.

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(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

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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. 2a. **Payment rates; services for families and children under the MinnesotaCare health care reform waiver.** Subdivision 2 shall not apply to services provided to families with children who are eligible according to section 256L.04, subdivision 1, paragraph (a).

Subd. 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.

(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:

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(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.

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(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 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.

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(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:

(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;

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- 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.

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

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(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

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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;

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(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

(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, erythematosis, 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.

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 5l.

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.

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(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;

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(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

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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.

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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.