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S.F. No. 800

(SENATE AUTHORS: BENSON and Abeler)

DATE	D-PG	OFFICIAL STATUS
02/09/2017	554	Introduction and first reading
		Referred to Health and Human Services Finance and Policy
03/27/2017	1966	Author added Abeler
03/28/2017	2190a	Comm report: To pass as amended and re-refer to Finance
03/29/2017		Comm report: To pass as amended
		Second reading

A bill for an act

relating to human services finance and policy; appropriating money for human services and health-related programs; modifying various provisions governing community supports, housing, continuing care, health care, managed care organizations, health insurance, direct care and treatment, children and families, chemical and mental health services, Department of Human Services operations, Department of Health policy, and health licensing boards; establishing a license for substance abuse disorder treatment; authorizing transfers; providing for supplemental rates; modifying reimbursement rates and premium scales; making forecast adjustments; providing for audits; authorizing pilot projects; requiring reports; establishing a legislative commission; making technical and terminology changes; amending Minnesota Statutes 2016, sections 3.972, by adding a subdivision; 13.32, by adding a subdivision; 13.46, subdivisions 1, 2, 4; 13.69, subdivision 1; 13.84, subdivision 5; 62A.04, subdivision 1; 62A.21, subdivision 2a; 62A.3075; 62A.65, subdivisions 2, 5, by adding a subdivision; 62D.105, subdivisions 1, 2; 62E.04, subdivision 11; 62E.05, subdivision 1; 62E.06, by adding a subdivision; 62Q.18, subdivision 7; 62U.02; 62V.05, subdivision 12; 103I.101, subdivisions 2, 5; 103I.111, subdivisions 6, 7, 8; 103I.205; 103I.301; 103I.501; 103I.505; 103I.515; 103I.535, subdivisions 3, 6, by adding a subdivision; 103I.541; 103I.545, subdivisions 1, 2; 103I.711, subdivision 1; 103I.715, subdivision 2; 119B.011, by adding subdivisions; 119B.02, subdivision 5; 119B.09, subdivision 9a; 119B.125, subdivisions 4, 6; 119B.13, subdivisions 1, 6; 119B.16, subdivisions 1, 1a, 1b, by adding subdivisions; 144.05, subdivision 6; 144.0724, subdivisions 4, 6; 144.122; 144.1501, subdivision 2; 144.551, subdivision 1; 144A.071, subdivision 4d; 144A.351; 144A.472, subdivision 7; 144A.474, subdivision 11; 144A.4799, subdivision 3; 144A.70, subdivision 6, by adding a subdivision; 144D.04, subdivision 2, by adding a subdivision; 144D.06; 145.4716, subdivision 2; 145.986, subdivision 1a; 146B.02, subdivisions 2, 5, 8, by adding subdivisions; 146B.03, subdivisions 6, 7; 146B.07, subdivision 4; 146B.10, subdivision 1; 147.01, subdivision 7; 147.02, subdivision 1; 147.03, subdivision 1; 147B.08, by adding a subdivision; 147C.40, by adding a subdivision; 148.5194, subdivision 7; 148.6402, subdivision 4; 148.6405; 148.6408, subdivision 2; 148.6410, subdivision 2; 148.6412, subdivision 2; 148.6415; 148.6418, subdivisions 1, 2, 4, 5; 148.6420, subdivisions 1, 3, 5; 148.6423; 148.6425, subdivisions 2, 3; 148.6428; 148.6443, subdivisions 5, 6, 7, 8; 148.6445, subdivisions 1, 10; 148.6448; 157.16, subdivision 1; 214.01, subdivision 2; 245.4889, subdivision 1; 245.91, subdivisions 4, 6; 245.97, subdivision 6; 245A.02, subdivision 2b, by adding a subdivision; 245A.03, subdivisions 2, 7; 245A.04, subdivision 14; 245A.06, subdivision 2; 245A.07, subdivision 3; 245A.11, by adding subdivisions; 245A.191; 245A.50, subdivision

5; 245D.03, subdivision 1; 245D.04, subdivision 3; 245D.071, subdivision 3; 245D.11, subdivision 4; 245D.24, subdivision 3; 245E.01, by adding a subdivision; 245E.02, subdivisions 1, 3, 4; 245E.03, subdivisions 2, 4; 245E.04; 245E.05, subdivision 1; 245E.06, subdivisions 1, 2, 3; 245E.07, subdivision 1; 252.27, subdivision 2a; 252.41, subdivision 3; 253B.10, subdivision 1; 253B.22, subdivision 1; 254A.01; 254A.02, subdivisions 2, 3, 5, 6, 8, 10, by adding subdivisions; 254A.03; 254A.035, subdivision 1; 254A.04; 254A.08; 254A.09; 254A.19, subdivision 3; 254B.01, subdivision 3, by adding a subdivision; 254B.03, subdivision 2; 254B.04, subdivisions 1, 2b; 254B.05, subdivisions 1, 1a, 5; 254B.051; 254B.07; 254B.08; 254B.09; 254B.12, subdivision 2; 254B.13, subdivision 2a; 256.01, subdivision 41, by adding a subdivision; 256.045, subdivision 3; 256.969, subdivisions 2b, 4b, by adding a subdivision; 256.975, subdivision 7, by adding a subdivision; 256.98, subdivision 8; 256B.04, subdivisions 21, 22; 256B.055, subdivision 2; 256B.0621, subdivision 10; 256B.0625, subdivisions 7, 20, 45a, 57, 64, by adding subdivisions; 256B.0659, subdivisions 1, 2, 11, 21, by adding a subdivision; 256B.072; 256B.0755, subdivisions 1, 3, 4, by adding a subdivision; 256B.0911, subdivisions 1a, 3a, 4d, by adding subdivisions; 256B.0915, subdivisions 1, 1a, 3a, 3e, 3h, 5, by adding subdivisions; 256B.092, subdivision 4; 256B.0922, subdivision 1; 256B.0924, by adding a subdivision; 256B.0943, subdivision 13; 256B.0945, subdivisions 2, 4; 256B.196, subdivision 2; 256B.431, subdivisions 10, 16, 30; 256B.434, subdivisions 4, 4f; 256B.49, subdivisions 11, 15; 256B.4913, subdivision 4a, by adding a subdivision; 256B.4914, subdivisions 2, 3, 5, 6, 7, 8, 9, 10, 16; 256B.493, subdivisions 1, 2, by adding a subdivision; 256B.50, subdivision 1b; 256B.5012, by adding a subdivision; 256B.69, subdivision 9e; 256B.76, subdivisions 1, 2; 256B.766; 256B.85, subdivisions 3, 5, 6; 256C.23, subdivision 2, by adding subdivisions; 256C.233, subdivisions 1, 2; 256C.24, subdivisions 1, 2, by adding a subdivision; 256C.261; 256D.44, subdivisions 4, 5; 256E.30, subdivision 2; 256I.03, subdivision 8; 256I.04, subdivisions 1, 2d, 2g, 3; 256I.05, subdivisions 1a, 1c, 1e, 1j, 1m, 8, by adding subdivisions; 256I.06, subdivisions 2, 8; 256J.24, subdivision 5; 256J.45, subdivision 2; 256L.03, subdivisions 1, 1a, 5; 256L.15, subdivision 2; 256P.06, subdivision 2; 256R.02, subdivisions 4, 18; 256R.07, by adding a subdivision; 256R.10, by adding a subdivision; 256R.37; 256R.40, subdivision 5; 256R.41; 256R.47; 256R.49, subdivision 1; 260C.451, subdivision 6; 317A.811, subdivision 1, by adding a subdivision; 327.15, subdivision 3; 609.5315, subdivision 5c; 626.556, subdivisions 2, 3, 3c, 10d, 10j; Laws 2009, chapter 101, article 1, section 12; Laws 2012, chapter 247, article 6, section 2, subdivision 2; Laws 2013, chapter 108, article 15, section 2, subdivision 2; Laws 2014, chapter 312, article 23, section 9, subdivision 8, by adding a subdivision; Laws 2015, chapter 71, article 14, section 3, subdivision 2, as amended; Laws 2017, chapter 2, article 1, sections 1, subdivision 3; 2, subdivision 4, by adding a subdivision; 3; 5; 7; article 2, section 13; proposing coding for new law in Minnesota Statutes, chapters 62Q; 119B; 144; 144D; 145; 147A; 148; 245; 245A; 256; 256B; 256I; 256N; 256R; 317A; proposing coding for new law as Minnesota Statutes, chapters 144H; 245G; repealing Minnesota Statutes 2016, sections 13.468; 147A.21; 147B.08, subdivisions 1, 2, 3; 147C.40, subdivisions 1, 2, 3, 4; 148.6402, subdivision 2; 148.6450; 245A.1915; 245A.192; 254A.02, subdivision 4; 256B.0659, subdivision 22; 256B.19, subdivision 1c; 256B.4914, subdivision 16; 256B.64; 256C.23, subdivision 3; 256C.233, subdivision 4; 256C.25, subdivisions 1, 2; 256J.626, subdivision 5; Laws 2014, chapter 312, article 23, section 9, subdivision 5; Minnesota Rules, parts 5600.2500; 9530.6405, subparts 1, 1a, 2, 3, 4, 5, 6, 7, 7a, 8, 9, 10, 11, 12, 13, 14, 14a, 15, 15a, 16, 17, 17a, 17b, 17c, 18, 20, 21; 9530.6410; 9530.6415; 9530.6420; 9530.6422; 9530.6425; 9530.6430; 9530.6435; 9530.6440; 9530.6445; 9530.6450; 9530.6455; 9530.6460; 9530.6465; 9530.6470; 9530.6475; 9530.6480; 9530.6485; 9530.6490; 9530.6495; 9530.6500; 9530.6505.

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

ARTICLE 1

COMMUNITY SUPPORTS

Section 1. Minnesota Statutes 2016, section 144A.351, is amended to read:

144A.351 BALANCING LONG-TERM CARE SERVICES AND SUPPORTS: REPORT ~~AND STUDY~~ REQUIRED.

Subdivision 1. **Report requirements.** The commissioners of health and human services, with the cooperation of counties and in consultation with stakeholders, including persons who need or are using long-term care services and supports, lead agencies, regional entities, senior, disability, and mental health organization representatives, service providers, and community members shall prepare a report to the legislature by August 15, 2013, and biennially thereafter, regarding the status of the full range of long-term care services and supports for the elderly and children and adults with disabilities and mental illnesses in Minnesota. Any amounts appropriated for this report are available in either year of the biennium. The report shall address:

(1) demographics and need for long-term care services and supports in Minnesota;

(2) summary of county and regional reports on long-term care gaps, surpluses, imbalances, and corrective action plans;

(3) status of long-term care services and related mental health services, housing options, and supports by county and region including:

(i) changes in availability of the range of long-term care services and housing options;

(ii) access problems, including access to the least restrictive and most integrated services and settings, regarding long-term care services; and

(iii) comparative measures of long-term care services availability, including serving people in their home areas near family, and changes over time; and

(4) recommendations regarding goals for the future of long-term care services and supports, policy and fiscal changes, and resource development and transition needs.

~~Subd. 2. **Critical access study.** The commissioner of human services shall conduct a onetime study to assess local capacity and availability of home and community-based services for older adults, people with disabilities, and people with mental illnesses. The study must assess critical access at the community level and identify potential strategies to build home and community-based service capacity in critical access areas. The report shall be submitted to the legislature no later than August 15, 2015.~~

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

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

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

(1) in-home and out-of-home respite care services as defined in section 245A.02, subdivision 15, and under the brain injury, community alternative care, community access for disability inclusion, developmental disability, and elderly waiver plans, excluding out-of-home respite care provided to children in a family child foster care home licensed under Minnesota Rules, parts 2960.3000 to 2960.3100, when the child foster care license holder complies with the requirements under section 245D.06, subdivisions 5, 6, 7, and 8, or successor provisions; and section 245D.061 or successor provisions, which must be stipulated in the statement of intended use required under Minnesota Rules, part 2960.3000, subpart 4;

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

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

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

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

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

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

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

(1) intervention services, including:

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

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

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

(2) in-home support services, including:

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

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

(iii) semi-independent living services; and

(iv) individualized home supports services as defined under the brain injury, community alternative care, and community access for disability inclusion waiver plans;

(3) residential supports and services, including:

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

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

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

(4) day services, including:

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

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

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

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

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

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

EFFECTIVE DATE. (a) The amendment to paragraphs (b) and (c), clause (2), is effective the day following final enactment.

(b) The amendments to paragraph (c), clauses (5) to (7), are effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

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

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

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

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

(b) Day training and habilitation services reimbursable under this section do not include special education and related services as defined in the Education of the Individuals with

Disabilities Act, United States Code, title 20, chapter 33, section 1401, clauses (6) and (17), or vocational services funded under section 110 of the Rehabilitation Act of 1973, United States Code, title 29, section 720, as amended.

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

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

Sec. 4. **[256.477] SELF-ADVOCACY GRANTS.**

(a) The commissioner shall make available a grant for the purposes of establishing and maintaining a statewide self-advocacy network for persons with intellectual and developmental disabilities. The self-advocacy network shall:

(1) ensure that persons with intellectual and developmental disabilities are informed of their rights in employment, housing, transportation, voting, government policy, and other issues pertinent to the intellectual and developmental disability community;

(2) provide public education and awareness of the civil and human rights issues persons with intellectual and developmental disabilities face;

(3) provide funds, technical assistance, and other resources for self-advocacy groups across the state; and

(4) organize systems of communications to facilitate an exchange of information between self-advocacy groups.

(b) An organization receiving a grant under paragraph (a) must be an organization governed by people with intellectual and developmental disabilities that administers a statewide network of disability groups in order to maintain and promote self-advocacy services and supports for persons with intellectual and developmental disabilities throughout the state.

(c) An organization receiving a grant under paragraph (a) must use the funds for the following purposes:

(1) to maintain the infrastructure needed to train and support the activities of a statewide network of peer-to-peer mentors for people with developmental disabilities, focused on building awareness of service options and advocacy skills necessary to move toward full

inclusion in community life, including the development and delivery of the curriculum to support the peer-to-peer network;

(2) to provide outreach activities, including statewide conferences and disability networking opportunities focused on self-advocacy, informed choice, and community engagement skills;

(3) to provide an annual leadership program for persons with intellectual and developmental disabilities; and

(4) to provide for administrative and general operating costs associated with managing and maintaining facilities, program delivery, evaluation, staff, and technology.

Sec. 5. Minnesota Statutes 2016, section 256B.0659, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms defined in paragraphs (b) to ~~(r)~~ (s) have the meanings given unless otherwise provided in text.

(b) "Activities of daily living" means grooming, dressing, bathing, transferring, mobility, positioning, eating, and toileting.

(c) "Behavior," effective January 1, 2010, means a category to determine the home care rating and is based on the criteria found in this section. "Level I behavior" means physical aggression towards self, others, or destruction of property that requires the immediate response of another person.

(d) "Complex health-related needs," effective January 1, 2010, means a category to determine the home care rating and is based on the criteria found in this section.

(e) "Complex personal care assistance services" means personal care assistance services:

(1) for a person who qualifies for ten hours or more of personal care assistance services per day; and

(2) provided by a personal care assistant who is qualified to provide complex personal assistance services under subdivision 11, paragraph (d).

~~(e)~~ (f) "Critical activities of daily living," effective January 1, 2010, means transferring, mobility, eating, and toileting.

~~(f)~~ (g) "Dependency in activities of daily living" means a person requires assistance to begin and complete one or more of the activities of daily living.

~~(g)~~ (h) "Extended personal care assistance service" means personal care assistance services included in a service plan under one of the home and community-based services

waivers authorized under sections 256B.0915, 256B.092, subdivision 5, and 256B.49, which exceed the amount, duration, and frequency of the state plan personal care assistance services for participants who:

(1) need assistance provided periodically during a week, but less than daily will not be able to remain in their homes without the assistance, and other replacement services are more expensive or are not available when personal care assistance services are to be reduced; or

(2) need additional personal care assistance services beyond the amount authorized by the state plan personal care assistance assessment in order to ensure that their safety, health, and welfare are provided for in their homes.

~~(h)~~ (i) "Health-related procedures and tasks" means procedures and tasks that can be delegated or assigned by a licensed health care professional under state law to be performed by a personal care assistant.

~~(i)~~ (j) "Instrumental activities of daily living" means activities to include meal planning and preparation; basic assistance with paying bills; shopping for food, clothing, and other essential items; performing household tasks integral to the personal care assistance services; communication by telephone and other media; and traveling, including to medical appointments and to participate in the community.

~~(j)~~ (k) "Managing employee" has the same definition as Code of Federal Regulations, title 42, section 455.

~~(k)~~ (l) "Qualified professional" means a professional providing supervision of personal care assistance services and staff as defined in section 256B.0625, subdivision 19c.

~~(l)~~ (m) "Personal care assistance provider agency" means a medical assistance enrolled provider that provides or assists with providing personal care assistance services and includes a personal care assistance provider organization, personal care assistance choice agency, class A licensed nursing agency, and Medicare-certified home health agency.

~~(m)~~ (n) "Personal care assistant" or "PCA" means an individual employed by a personal care assistance agency who provides personal care assistance services.

~~(n)~~ (o) "Personal care assistance care plan" means a written description of personal care assistance services developed by the personal care assistance provider according to the service plan.

~~(o)~~ (p) "Responsible party" means an individual who is capable of providing the support necessary to assist the recipient to live in the community.

~~(p)~~ (q) "Self-administered medication" means medication taken orally, by injection, nebulizer, or insertion, or applied topically without the need for assistance.

~~(q)~~ (r) "Service plan" means a written summary of the assessment and description of the services needed by the recipient.

~~(r)~~ (s) "Wages and benefits" means wages and salaries, the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, mileage reimbursement, health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, and contributions to employee retirement accounts.

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

Sec. 6. Minnesota Statutes 2016, section 256B.0659, subdivision 2, is amended to read:

Subd. 2. **Personal care assistance services; covered services.** (a) The personal care assistance services eligible for payment include services and supports furnished to an individual, as needed, to assist in:

(1) activities of daily living;

(2) health-related procedures and tasks;

(3) observation and redirection of behaviors; and

(4) instrumental activities of daily living.

(b) Activities of daily living include the following covered services:

(1) dressing, including assistance with choosing, application, and changing of clothing and application of special appliances, wraps, or clothing;

(2) grooming, including assistance with basic hair care, oral care, shaving, applying cosmetics and deodorant, and care of eyeglasses and hearing aids. Nail care is included, except for recipients who are diabetic or have poor circulation;

(3) bathing, including assistance with basic personal hygiene and skin care;

(4) eating, including assistance with hand washing and application of orthotics required for eating, transfers, and feeding;

(5) transfers, including assistance with transferring the recipient from one seating or reclining area to another;

(6) mobility, including assistance with ambulation, including use of a wheelchair. Mobility does not include providing transportation for a recipient;

(7) positioning, including assistance with positioning or turning a recipient for necessary care and comfort; and

(8) toileting, including assistance with helping recipient with bowel or bladder elimination and care including transfers, mobility, positioning, feminine hygiene, use of toileting equipment or supplies, cleansing the perineal area, inspection of the skin, and adjusting clothing.

(c) Health-related procedures and tasks include the following covered services:

(1) range of motion and passive exercise to maintain a recipient's strength and muscle functioning;

(2) assistance with self-administered medication as defined by this section, including reminders to take medication, bringing medication to the recipient, and assistance with opening medication under the direction of the recipient or responsible party, including medications given through a nebulizer;

(3) interventions for seizure disorders, including monitoring and observation; and

(4) other activities considered within the scope of the personal care service and meeting the definition of health-related procedures and tasks under this section.

(d) A personal care assistant may provide health-related procedures and tasks associated with the complex health-related needs of a recipient if the procedures and tasks meet the definition of health-related procedures and tasks under this section and the personal care assistant is trained by a qualified professional and demonstrates competency to safely complete the procedures and tasks. Delegation of health-related procedures and tasks and all training must be documented in the personal care assistance care plan and the recipient's and personal care assistant's files. A personal care assistant must not determine the medication dose or time for medication.

(e) Effective January 1, 2010, for a personal care assistant to provide the health-related procedures and tasks of tracheostomy suctioning and services to recipients on ventilator support there must be:

(1) delegation and training by a registered nurse, certified or licensed respiratory therapist, or a physician;

(2) utilization of clean rather than sterile procedure;

(3) specialized training about the health-related procedures and tasks and equipment, including ventilator operation and maintenance;

(4) individualized training regarding the needs of the recipient; and

(5) supervision by a qualified professional who is a registered nurse.

(f) Effective January 1, 2010, a personal care assistant may observe and redirect the recipient for episodes where there is a need for redirection due to behaviors. Training of the personal care assistant must occur based on the needs of the recipient, the personal care assistance care plan, and any other support services provided.

(g) Instrumental activities of daily living under subdivision 1, paragraph ~~(i)~~ (j).

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

Sec. 7. Minnesota Statutes 2016, section 256B.0659, subdivision 11, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) A personal care assistant is qualified to provide complex personal care assistance services defined in subdivision 1, paragraph (e), if the personal care assistant:

(1) provides services according to the care plan in subdivision 7 to an individual described in subdivision 1, paragraph (e), clause (1); and

(2) beginning July 1, 2018, satisfies the current requirements of Medicare for training and competency or competency evaluation of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483.151 or 484.36, or alternative, comparable, state-approved training and competency requirements.

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

Sec. 8. Minnesota Statutes 2016, section 256B.0659, is amended by adding a subdivision to read:

Subd. 17a. **Rate for complex personal care assistance services.** The rate paid to a provider for complex personal care assistance services shall be 110 percent of the rate paid for personal care assistance services.

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

Sec. 9. Minnesota Statutes 2016, section 256B.0659, subdivision 21, is amended to read:

Subd. 21. **Requirements for provider enrollment of personal care assistance provider agencies.** (a) All personal care assistance provider agencies must provide, at the time of enrollment, reenrollment, and revalidation as a personal care assistance provider agency in a format determined by the commissioner, information and documentation that includes, but is not limited to, the following:

(1) the personal care assistance provider agency's current contact information including address, telephone number, and e-mail address;

(2) proof of surety bond coverage. Upon new enrollment, or if the provider's Medicaid revenue in the previous calendar year is up to and including $300,000, the provider agency must purchase a surety bond of $50,000. If the Medicaid revenue in the previous year is over $300,000, the provider agency must purchase a surety bond of $100,000. The surety bond must be in a form approved by the commissioner, must be renewed annually, and must allow for recovery of costs and fees in pursuing a claim on the bond;

(3) proof of fidelity bond coverage in the amount of $20,000;

(4) proof of workers' compensation insurance coverage;

(5) proof of liability insurance;

(6) a description of the personal care assistance provider agency's organization identifying the names of all owners, managing employees, staff, board of directors, and the affiliations of the directors, owners, or staff to other service providers;

(7) a copy of the personal care assistance provider agency's written policies and procedures including: hiring of employees; training requirements; service delivery; and employee and consumer safety including process for notification and resolution of consumer grievances, identification and prevention of communicable diseases, and employee misconduct;

(8) copies of all other forms the personal care assistance provider agency uses in the course of daily business including, but not limited to:

(i) a copy of the personal care assistance provider agency's time sheet if the time sheet varies from the standard time sheet for personal care assistance services approved by the commissioner, and a letter requesting approval of the personal care assistance provider agency's nonstandard time sheet;

(ii) the personal care assistance provider agency's template for the personal care assistance care plan; and

(iii) the personal care assistance provider agency's template for the written agreement in subdivision 20 for recipients using the personal care assistance choice option, if applicable;

(9) a list of all training and classes that the personal care assistance provider agency requires of its staff providing personal care assistance services;

(10) documentation that the personal care assistance provider agency and staff have successfully completed all the training required by this section, including the requirements under subdivision 11, paragraph (d), if complex personal care assistance services are provided and submitted for payment;

(11) documentation of the agency's marketing practices;

(12) disclosure of ownership, leasing, or management of all residential properties that is used or could be used for providing home care services;

(13) documentation that the agency will use the following percentages of revenue generated from the medical assistance rate paid for personal care assistance services for employee personal care assistant wages and benefits: 72.5 percent of revenue in the personal care assistance choice option and 72.5 percent of revenue from other personal care assistance providers. The revenue generated by the qualified professional and the reasonable costs associated with the qualified professional shall not be used in making this calculation; and

(14) effective May 15, 2010, documentation that the agency does not burden recipients' free exercise of their right to choose service providers by requiring personal care assistants to sign an agreement not to work with any particular personal care assistance recipient or for another personal care assistance provider agency after leaving the agency and that the agency is not taking action on any such agreements or requirements regardless of the date signed.

(b) Personal care assistance provider agencies shall provide the information specified in paragraph (a) to the commissioner at the time the personal care assistance provider agency

enrolls as a vendor or upon request from the commissioner. The commissioner shall collect the information specified in paragraph (a) from all personal care assistance providers beginning July 1, 2009.

(c) All personal care assistance provider agencies shall require all employees in management and supervisory positions and owners of the agency who are active in the day-to-day management and operations of the agency to complete mandatory training as determined by the commissioner before enrollment of the agency as a provider. Employees in management and supervisory positions and owners who are active in the day-to-day operations of an agency who have completed the required training as an employee with a personal care assistance provider agency do not need to repeat the required training if they are hired by another agency, if they have completed the training within the past three years. By September 1, 2010, the required training must be available with meaningful access according to title VI of the Civil Rights Act and federal regulations adopted under that law or any guidance from the United States Health and Human Services Department. The required training must be available online or by electronic remote connection. The required training must provide for competency testing. Personal care assistance provider agency billing staff shall complete training about personal care assistance program financial management. This training is effective July 1, 2009. Any personal care assistance provider agency enrolled before that date shall, if it has not already, complete the provider training within 18 months of July 1, 2009. Any new owners or employees in management and supervisory positions involved in the day-to-day operations are required to complete mandatory training as a requisite of working for the agency. Personal care assistance provider agencies certified for participation in Medicare as home health agencies are exempt from the training required in this subdivision. When available, Medicare-certified home health agency owners, supervisors, or managers must successfully complete the competency test.

Sec. 10. Minnesota Statutes 2016, section 256B.0911, subdivision 1a, is amended to read:

Subd. 1a. **Definitions.** For purposes of this section, the following definitions apply:

(a) Until additional requirements apply under paragraph (b), "long-term care consultation services" means:

(1) intake for and access to assistance in identifying services needed to maintain an individual in the most inclusive environment;

(2) providing recommendations for and referrals to cost-effective community services that are available to the individual;

(3) development of an individual's person-centered community support plan;

(4) providing information regarding eligibility for Minnesota health care programs;

(5) face-to-face long-term care consultation assessments, which may be completed in a hospital, nursing facility, intermediate care facility for persons with developmental disabilities (ICF/DDs), regional treatment centers, or the person's current or planned residence;

(6) determination of home and community-based waiver and other service eligibility as required under sections 256B.0913, 256B.0915, and 256B.49, including level of care determination for individuals who need an institutional level of care as determined under subdivision 4e, based on assessment and community support plan development, appropriate referrals to obtain necessary diagnostic information, and including an eligibility determination for consumer-directed community supports;

(7) providing recommendations for institutional placement when there are no cost-effective community services available;

(8) providing access to assistance to transition people back to community settings after institutional admission; and

(9) providing information about competitive employment, with or without supports, for school-age youth and working-age adults and referrals to the Disability Linkage Line and Disability Benefits 101 to ensure that an informed choice about competitive employment can be made. For the purposes of this subdivision, "competitive employment" means work in the competitive labor market that is performed on a full-time or part-time basis in an integrated setting, and for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

(b) Upon statewide implementation of lead agency requirements in subdivisions 2b, 2c, and 3a, "long-term care consultation services" also means:

(1) service eligibility determination for state plan home care services identified in:

(i) section 256B.0625, subdivisions 7, 19a, and 19c;

(ii) consumer support grants under section 256.476; or

(iii) section 256B.85;

(2) notwithstanding provisions in Minnesota Rules, parts 9525.0004 to 9525.0024, determination of eligibility for case management services available under sections 256B.0621, subdivision 2, paragraph (4), and 256B.0924 and Minnesota Rules, part 9525.0016;

(3) determination of institutional level of care, home and community-based service waiver, and other service eligibility as required under section 256B.092, determination of eligibility for family support grants under section 252.32, semi-independent living services under section 252.275, and day training and habilitation services under section 256B.092; and

(4) obtaining necessary diagnostic information to determine eligibility under clauses (2) and (3).

(c) "Long-term care options counseling" means the services provided by the linkage lines as mandated by sections 256.01, subdivision 24, and 256.975, subdivision 7, and also includes telephone assistance and follow up once a long-term care consultation assessment has been completed.

(d) "Minnesota health care programs" means the medical assistance program under this chapter and the alternative care program under section 256B.0913.

(e) "Lead agencies" means counties administering or tribes and health plans under contract with the commissioner to administer long-term care consultation assessment and support planning services.

(f) "Person-centered planning" includes the active participation of a person with a disability in the person's services and program, including in making meaningful and informed choices about the person's own goals and objectives, as well as making meaningful and informed choices about the services the person receives. For the purposes of this paragraph, "informed choice" means the process of the person with a disability choosing from all available service options based on accurate and complete information concerning all available service options and concerning the person's own preferences, abilities, goals, and objectives. In order for a person to make an informed choice, all available options must be developed and presented to the person by a partnership consisting of the person and the individuals that will empower the consumer to make decisions.

Sec. 11. Minnesota Statutes 2016, section 256B.0911, subdivision 3a, is amended to read:

Subd. 3a. **Initial assessment and support planning.** (a) Persons requesting initial assessment, initial services planning, or other assistance intended to support community-based living, including persons who need assessment in order to determine initial waiver or alternative care program eligibility, must be visited by a long-term care consultation team within 20 calendar days after the date on which an initial assessment was requested or recommended. ~~Upon statewide implementation of subdivisions 2b, 2c, and 5,~~ This

requirement also applies to an initial assessment of a person requesting personal care assistance services and home care nursing. ~~The commissioner shall provide at least a 90-day notice to lead agencies prior to the effective date of this requirement.~~ Face-to-face initial assessments must be conducted according to paragraphs (b) to (i).

(b) ~~Upon implementation of subdivisions 2b, 2c, and 5,~~ Lead agencies shall use certified assessors to conduct the initial assessment. For a person with complex health care needs, a public health or registered nurse from the team must be consulted.

(c) The MnCHOICES assessment provided by the commissioner to lead agencies must be used to complete ~~a~~ an initial comprehensive, person-centered assessment. The initial assessment must include the health, psychological, functional, environmental, and social needs of the individual necessary to develop a community support plan that meets the individual's needs and preferences.

(d) The initial assessment must be conducted in a face-to-face interview with the person being assessed and the person's legal representative. At the request of the person, other individuals may participate in the assessment to provide information on the needs, strengths, and preferences of the person necessary to develop a community support plan that ensures the person's health and safety. Except for legal representatives or family members invited by the person, persons participating in the assessment may not be a provider of service or have any financial interest in the provision of services. For persons who are to be initially assessed for elderly waiver customized living services under section 256B.0915, with the permission of the person being assessed or the person's designated or legal representative, the client's current or proposed provider of services may submit a copy of the provider's nursing assessment or written report outlining its recommendations regarding the client's care needs. The person conducting the assessment must notify the provider of the date by which this information is to be submitted. This information shall be provided to the person conducting the assessment prior to the assessment. For a person who is to be initially assessed for waiver services under section 256B.092 or 256B.49, with the permission of the person being assessed or the person's designated legal representative, the person's current provider of services may submit a written report outlining recommendations regarding the person's care needs prepared by a direct service employee with at least 20 hours of service to that client. The person conducting the assessment ~~or reassessment~~ must notify the provider of the date by which this information is to be submitted. This information shall be provided to the person conducting the assessment and the person or the person's legal representative, and must be considered prior to the finalization of the assessment or reassessment.

(e) The person or the person's legal representative must be provided with a written community support plan within 40 calendar days of the initial assessment visit, regardless of whether the individual is eligible for Minnesota health care programs. The written community support plan must include:

(1) a summary of assessed needs as defined in paragraphs (c) and (d);

(2) the individual's options and choices to meet identified needs, including all available options for case management services and providers;

(3) identification of health and safety risks and how those risks will be addressed, including practical personal risk management strategies;

(4) referral information; and

(5) informal caregiver supports, if applicable.

For a person determined eligible for state plan home care under subdivision 1a, paragraph (b), clause (1), the person or person's representative must also receive a copy of the home care service plan developed by the certified assessor.

(f) A person may request assistance in identifying community supports without participating in a complete assessment. Upon a request for assistance identifying community support, the person must be transferred or referred to long-term care options counseling services available under sections 256.975, subdivision 7, and 256.01, subdivision 24, for telephone assistance and follow up.

(g) The person has the right to make the final decision between institutional placement and community placement after the recommendations have been provided, except as provided in section 256.975, subdivision 7a, paragraph (d).

(h) The lead agency must give the person receiving initial assessment or support planning, or the person's legal representative, materials, and forms supplied by the commissioner containing the following information:

(1) written recommendations for community-based services and consumer-directed options;

(2) documentation that the most cost-effective alternatives available, including independent living, were offered to the individual. For purposes of this clause, "cost-effective" means community services and living arrangements that cost the same as or less than institutional care or corporate foster care. For an individual found to meet eligibility criteria for home and community-based service programs under section 256B.0915

or 256B.49, "cost-effectiveness" has the meaning found in the federally approved waiver plan for each program;

(3) the need for and purpose of preadmission screening conducted by long-term care options counselors according to section 256.975, subdivisions 7a to 7c, if the person selects nursing facility placement. If the individual selects nursing facility placement, the lead agency shall forward information needed to complete the level of care determinations and screening for developmental disability and mental illness collected during the assessment to the long-term care options counselor using forms provided by the commissioner;

(4) the role of long-term care consultation assessment and support planning in eligibility determination for waiver and alternative care programs, and state plan home care, case management, and other services as defined in subdivision 1a, paragraphs (a), clause (6), and (b);

(5) information about Minnesota health care programs;

(6) the person's freedom to accept or reject the recommendations of the team;

(7) the person's right to confidentiality under the Minnesota Government Data Practices Act, chapter 13;

(8) the certified assessor's decision regarding the person's need for institutional level of care as determined under criteria established in subdivision 4e, the certified assessor's decision regarding the person's need for corporate foster care, and the certified assessor's decision regarding the person's eligibility for all services and programs ~~as~~ defined in subdivision 1a, paragraphs (a), clause (6), and (b); and

(9) the person's right to appeal the certified assessor's decision regarding eligibility for all services and programs ~~as~~ defined in subdivision 1a, paragraphs (a), clauses (6), (7), and (8), and (b), ~~and incorporating~~ the certified assessor's decision regarding the need for institutional level of care, the certified assessor's decision regarding the need for corporate foster care, or the lead agency's final decisions regarding public programs eligibility according to section 256.045, subdivision 3.

(i) Face-to-face assessment completed as part of an initial eligibility determination for the alternative care, elderly waiver, community access for disability inclusion, community alternative care, and brain injury waiver programs under sections 256B.0913, 256B.0915, and 256B.49 is valid to establish service eligibility for no more than 60 calendar days after the date of assessment.

(j) The effective eligibility start date for programs in paragraph (i) can never be prior to the date of initial assessment. If an initial assessment was completed more than 60 days before the effective waiver or alternative care program eligibility start date, assessment and support plan information must be updated and documented in the department's Medicaid Management Information System (MMIS). Notwithstanding retroactive medical assistance coverage of state plan services, the effective date of eligibility for programs included in paragraph (i) cannot be prior to the date the ~~most recent updated~~ initial assessment is completed.

Sec. 12. Minnesota Statutes 2016, section 256B.0911, is amended by adding a subdivision to read:

Subd. 3f. **Service updates and modifications.** (a) A service update may substitute for an annual reassessment under this section and Minnesota Rules, part 9525.0016, whenever permitted by federal law and either there is not a significant change in a person's condition or there is not a change in the person's needs for services. Service updates must be completed face-to-face annually unless completed by phone. A service update may be completed by telephone only if the person is able to participate in the update by telephone and no more than two consecutive service updates are completed by phone.

(b) A service update must include a review of the most recent written community support plan and home care plan, as well as a review of the initial baseline data, evaluation of service effectiveness, modification of service plan and appropriate referrals, update of initial assessment or most recent reassessment forms, obtaining service authorizations, and ongoing consumer education.

(c) To the extent permitted by federal law, a service modification may substitute for a reassessment otherwise required under this chapter following a change in condition or a change in eligibility.

(d) A service update or service modification must be documented in a manner determined by the commissioner.

(e) If the person receiving services or the person's legal representative requests a reassessment under subdivision 3g, a service update or service modification must not be substituted for a reassessment.

Sec. 13. Minnesota Statutes 2016, section 256B.0911, is amended by adding a subdivision to read:

Subd. 3g. **Annual reassessments and other reassessments.** (a) All reassessments must be conducted according to subdivision 3a.

(b) Any person who received an initial assessment under subdivision 3a and whose continued eligibility for medical assistance services under federal law requires an annual reassessment must be reassessed annually.

(c) If an annual reassessment is not required under federal law for a person who received an initial assessment under subdivision 3a, lead agencies are not required to perform an annual reassessment unless the person or the person's legal representative requests an annual reassessment or the person has experienced a significant change in condition.

Sec. 14. Minnesota Statutes 2016, section 256B.0911, subdivision 4d, is amended to read:

Subd. 4d. **Preadmission screening of individuals under 65 years of age.** (a) It is the policy of the state of Minnesota to ensure that individuals with disabilities or chronic illness are served in the most integrated setting appropriate to their needs and have the necessary information to make informed choices about home and community-based service options.

(b) Individuals under 65 years of age who are admitted to a Medicaid-certified nursing facility must be screened prior to admission according to the requirements outlined in section 256.975, subdivisions 7a to 7c. This shall be provided by the Senior LinkAge Line as required under section 256.975, subdivision 7.

(c) Individuals under 65 years of age who are admitted to nursing facilities with only a telephone screening must receive a face-to-face initial assessment from the long-term care consultation team member of the county in which the facility is located or from the recipient's county case manager within 40 calendar days of admission.

(d) At the face-to-face initial assessment, the long-term care consultation team member or county case manager must perform the activities required under subdivision 3b.

(e) For individuals under 21 years of age, a screening interview which recommends nursing facility admission must be face-to-face and approved by the commissioner before the individual is admitted to the nursing facility.

(f) In the event that an individual under 65 years of age is admitted to a nursing facility on an emergency basis, the Senior LinkAge Line must be notified of the admission on the

next working day, and a face-to-face initial assessment as described in paragraph (c) must be conducted within 40 calendar days of admission.

(g) At the face-to-face initial assessment, the long-term care consultation team member or the case manager must present information about home and community-based options, including consumer-directed options, so the individual can make informed choices. If the individual chooses home and community-based services, the long-term care consultation team member or case manager must complete a written relocation plan within 20 working days of the visit. The plan shall describe the services needed to move out of the facility and a time line for the move which is designed to ensure a smooth transition to the individual's home and community.

(h) An individual under 65 years of age residing in a nursing facility whose condition is likely to change shall receive a face-to-face ~~assessment~~ reassessment under subdivision 3g at least every 12 months to review the person's service choices and available alternatives unless the individual indicates, in writing, that annual visits are not desired. In this case, the individual must receive a face-to-face ~~assessment~~ reassessment at least once every 36 months for the same purposes.

(i) An individual under 65 years of age residing in a nursing facility whose condition is unlikely to change may, upon request, receive a face-to-face reassessment under subdivision 3g. An individual who does not request a reassessment under this paragraph must receive an annual service update under subdivision 3f.

(j) Notwithstanding the provisions of subdivision 6, the commissioner may pay county agencies directly for face-to-face initial assessments or reassessments for individuals under 65 years of age who are being considered for placement or residing in a nursing facility.

~~(j)~~ (k) Funding for preadmission screening follow-up shall be provided to the Disability Linkage Line for the under-60 population by the Department of Human Services to cover options counseling salaries and expenses to provide the services described in subdivisions 7a to 7c. The Disability Linkage Line shall employ, or contract with other agencies to employ, within the limits of available funding, sufficient personnel to provide preadmission screening follow-up services and shall seek to maximize federal funding for the service as provided under section 256.01, subdivision 2, paragraph (dd).

Sec. 15. Minnesota Statutes 2016, section 256B.0915, subdivision 1a, is amended to read:

Subd. 1a. **Elderly waiver case management services.** (a) Except as provided to individuals under prepaid medical assistance programs as described in paragraph (h), case

management services under the home and community-based services waiver for elderly individuals are available from providers meeting qualification requirements and the standards specified in subdivision 1b. Eligible recipients may choose any qualified provider of case management services.

(b) Case management services assist individuals who receive waiver services in gaining access to needed waiver and other state plan services and assist individuals in appeals under section 256.045, as well as needed medical, social, educational, and other services regardless of the funding source for the services to which access is gained. Case managers shall collaborate with consumers, families, legal representatives, and relevant medical experts and service providers in the development and periodic review of the coordinated service and support plan.

(c) A case aide shall provide assistance to the case manager in carrying out administrative activities of the case management function. The case aide may not assume responsibilities that require professional judgment including assessments, reassessments, and care plan development. The case manager is responsible for providing oversight of the case aide.

(d) Case managers shall be responsible for ongoing monitoring of the provision of services included in the individual's plan of care. Case managers shall initiate the process of reassessment of the individual's coordinated service and support plan and review the plan at intervals specified in the federally approved waiver plan.

(e) The county of service or tribe must provide access to and arrange for case management services. County of service has the meaning given it in Minnesota Rules, part 9505.0015, subpart 11.

(f) Except as described in paragraph (h), case management services must be provided by a public or private agency that is enrolled as a medical assistance provider determined by the commissioner to meet all of the requirements in subdivision 1b. Case management services must not be provided to a recipient by a private agency that has a financial interest in the provision of any other services included in the recipient's coordinated service and support plan. For purposes of this section, "private agency" means any agency that is not identified as a lead agency under section 256B.0911, subdivision 1a, paragraph (e).

(g) Case management service activities provided to or arranged for a person include:

(1) development of the coordinated service and support plan under subdivision 6;

(2) informing the individual or the individual's legal guardian or conservator of service options, and options for case management services and providers;

(3) consulting with relevant medical experts or service providers;

(4) assisting the person in the identification of potential providers;

(5) assisting the person to access services;

(6) coordination of services; and

(7) evaluation and monitoring of the services identified in the plan, which must ~~incorporate at least one annual~~ include a face-to-face visit ~~by the case manager with each person~~ at the request of the individual or the individual's legal guardian or conservator of service options.

(h) Notwithstanding any requirements in this section, for individuals enrolled in prepaid medical assistance programs under section 256B.69, subdivisions 6b and 23, the health plan shall provide or arrange to provide elderly waiver case management services in paragraph (g), in accordance with contract requirements established by the commissioner.

Sec. 16. Minnesota Statutes 2016, section 256B.0915, subdivision 5, is amended to read:

Subd. 5. **Assessments and reassessments for waiver clients.** (a) Each client shall receive an initial assessment of strengths, informal supports, and need for services in accordance with section 256B.0911, subdivisions 3, 3a, and 3b. A reassessment ~~of a client served~~ under the elderly waiver must be conducted ~~at least every 12 months and at other times~~ according to section 256B.0911, subdivision 3g, when the case manager determines that there has been significant change in the client's functioning or at the request of the client or the client's legal guardian or conservator of service options. This may include instances where the client is discharged from the hospital. There must be a determination that the client requires nursing facility level of care as defined in section 256B.0911, subdivision 4e, at an initial assessment under section 256B.0911, subdivision 3a, and any subsequent ~~assessments~~ reassessments under section 256B.0911, subdivision 3g, or annual service updates under section 256B.0911, subdivision 3f, to initiate and maintain participation in the waiver program.

(b) Regardless of other assessments identified in section 144.0724, subdivision 4, as appropriate to determine nursing facility level of care for purposes of medical assistance payment for nursing facility services, only face-to-face initial assessments conducted according to section 256B.0911, subdivisions 3a and 3b, that result in a nursing facility level of care determination will be accepted for purposes of initial ~~and ongoing~~ access to waiver service payment. Only reassessments conducted according to section 256B.0911, subdivision 3g, that result in a nursing facility level of need determination or annual service

updates conducted according to section 256B.0911, subdivision 3f, that demonstrate no improvement in the client's condition shall be accepted for the purposes of ongoing access to waiver service payments.

Sec. 17. Minnesota Statutes 2016, section 256B.49, subdivision 15, is amended to read:

Subd. 15. **Coordinated service and support plan; comprehensive transitional service plan; maintenance service plan.** (a) Each recipient of home and community-based waivered services shall be provided a copy of the written coordinated service and support plan which meets the requirements in section 256B.092, subdivision 1b.

(b) In developing the comprehensive transitional service plan, the individual receiving services, the case manager, and the guardian, if applicable, will identify the transitional service plan fundamental service outcome and anticipated timeline to achieve this outcome. Within the first 20 days following a recipient's request for an assessment or reassessment, the transitional service planning team must be identified. A team leader must be identified who will be responsible for assigning responsibility and communicating with team members to ensure implementation of the transition plan and ongoing assessment and communication process. The team leader should be an individual, such as the case manager or guardian, who has the opportunity to follow the recipient to the next level of service.

Within ten days following an assessment, a comprehensive transitional service plan must be developed incorporating elements of a comprehensive functional assessment and including short-term measurable outcomes and timelines for achievement of and reporting on these outcomes. Functional milestones must also be identified and reported according to the timelines agreed upon by the transitional service planning team. In addition, the comprehensive transitional service plan must identify additional supports that may assist in the achievement of the fundamental service outcome such as the development of greater natural community support, increased collaboration among agencies, and technological supports.

The timelines for reporting on functional milestones will prompt a reassessment of services provided, the units of services, rates, and appropriate service providers. It is the responsibility of the transitional service planning team leader to review functional milestone reporting to determine if the milestones are consistent with observable skills and that milestone achievement prompts any needed changes to the comprehensive transitional service plan.

For those whose fundamental transitional service outcome involves the need to procure housing, a plan for the recipient to seek the resources necessary to secure the least restrictive

housing possible should be incorporated into the plan, including employment and public supports such as housing access and shelter needy funding.

(c) Counties and other agencies responsible for funding community placement and ongoing community supportive services are responsible for the implementation of the comprehensive transitional service plans. Oversight responsibilities include both ensuring effective transitional service delivery and efficient utilization of funding resources.

(d) Following one year of transitional services, the transitional services planning team will make a determination as to whether or not the individual receiving services requires the current level of continuous and consistent support in order to maintain the recipient's current level of functioning. Recipients who are determined to have not had a significant change in functioning for 12 months must move from a transitional to a maintenance service plan. Recipients on a maintenance service plan must be reassessed to determine if the recipient would benefit from a transitional service plan ~~at least every 12 months and at other times~~ when there has been a significant change in the recipient's functioning or at the request of the recipient or the recipient's guardian. This assessment should consider any changes to technological or natural community supports.

(e) When a county is evaluating denials, reductions, or terminations of home and community-based services under this section for an individual, the case manager shall offer to meet with the individual or the individual's guardian in order to discuss the prioritization of service needs within the coordinated service and support plan, comprehensive transitional service plan, or maintenance service plan. The reduction in the authorized services for an individual due to changes in funding for waivered services may not exceed the amount needed to ensure medically necessary services to meet the individual's health, safety, and welfare.

(f) At the time of reassessment, local agency case managers shall assess each recipient of community access for disability inclusion or brain injury waivered services currently residing in a licensed adult foster home that is not the primary residence of the license holder, or in which the license holder is not the primary caregiver, to determine if that recipient could appropriately be served in a community-living setting. If appropriate for the recipient, the case manager shall offer the recipient, through a person-centered planning process, the option to receive alternative housing and service options. In the event that the recipient chooses to transfer from the adult foster home, the vacated bed shall not be filled with another recipient of waiver services and group residential housing and the licensed capacity shall be reduced accordingly, unless the savings required by the licensed bed closure reductions under Laws 2011, First Special Session chapter 9, article 7, sections 1 and 40,

paragraph (f), for foster care settings where the physical location is not the primary residence of the license holder are met through voluntary changes described in section 245A.03, subdivision 7, paragraph (e), or as provided under paragraph (a), clauses (3) and (4). If the adult foster home becomes no longer viable due to these transfers, the county agency, with the assistance of the department, shall facilitate a consolidation of settings or closure. This reassessment process shall be completed by July 1, 2013.

Sec. 18. Minnesota Statutes 2016, section 256B.4913, subdivision 4a, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

(7) one percent from the rate in effect in clause (6) for the 12-month period immediately following the time period of clause (6).

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

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

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

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

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

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

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

EFFECTIVE DATE. (a) The amendment to paragraph (b) is effective the day following final enactment.

(b) The amendment to paragraph (c) is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 19. Minnesota Statutes 2016, section 256B.4913, is amended by adding a subdivision to read:

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

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

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

Sec. 20. Minnesota Statutes 2016, section 256B.4914, subdivision 2, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) for day services under subdivision 7:

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 21. Minnesota Statutes 2016, section 256B.4914, subdivision 3, is amended to read:

Subd. 3. **Applicable services.** Applicable services are those authorized under the state's home and community-based services waivers under sections 256B.092 and 256B.49,

including the following, as defined in the federally approved home and community-based services plan:

(1) 24-hour customized living;

(2) adult day care;

(3) adult day care bath;

(4) behavioral programming;

(5) companion services;

(6) customized living;

(7) day training and habilitation;

(8) housing access coordination;

(9) independent living skills;

(10) in-home family support;

(11) night supervision;

(12) personal support;

(13) prevocational services;

(14) residential care services;

(15) residential support services;

(16) respite services;

(17) structured day services;

~~(18) supported employment services;~~

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

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

(20) individualized home supports;

(21) independent living skills specialist services;

(22) employment exploration services;

(23) employment development services;

(24) employment support services; and

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

EFFECTIVE DATE. (a) Clause (20) is effective the day following final enactment.

(b) Clauses (21) to (24) are effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 22. Minnesota Statutes 2016, section 256B.4914, subdivision 5, is amended to read:

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

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

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

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

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

(3) for residential asleep-overnight staff, the wage ~~will be $7.66 per hour~~ is the minimum wage in Minnesota for large employers, except in a family foster care setting, the wage is ~~$2.80 per hour~~ 36 percent of the minimum wage in Minnesota for large employers;

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

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

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

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

(8) for housing access coordination staff, ~~50~~ 100 percent of the median wage for community and social services specialist (SOC code 21-1099); ~~and 50 percent of the median wage for social and human services aide (SOC code 21-1093);~~

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

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

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

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

~~(11)~~ (13) for ~~supported~~ employment support services staff, ~~20~~ 50 percent of the median wage for ~~nursing aide~~ rehabilitation counselor (SOC code ~~31-1012~~ 21-1015); ~~20 percent of the median wage for psychiatric technician (SOC code 29-2053);~~ and ~~60~~ 50 percent of the median wage for community and social ~~and human~~ services ~~aide~~ specialist (SOC code ~~21-1093~~ 21-1099);

(14) for employment exploration services staff, 50 percent of the median wage for rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for community and social services specialist (SOC code 21-1099);

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

~~(12)~~ (16) for adult companion staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing ~~aides, orderlies, and attendants~~ assistant (SOC code ~~31-1012~~ 31-1014);

~~(13)~~ (17) for night supervision staff, 20 percent of the median wage for home health aide (SOC code 31-1011); 20 percent of the median wage for personal and home health aide (SOC code 39-9021); 20 percent of the median wage for nursing ~~aide~~ assistant (SOC code ~~31-1012~~ 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

~~(14)~~ (18) for respite staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing ~~aides, orderlies, and attendants~~ assistant (SOC code ~~31-1012~~ 31-1014);

~~(15)~~ (19) for personal support staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing ~~aides, orderlies, and attendants~~ assistant (SOC code ~~31-1012~~ 31-1014);

~~(16)~~ (20) for supervisory staff, ~~the basic wage is $17.43 per hour~~, 100 percent of the median wage for community and social services specialist (SOC code 21-1099), with the exception of the supervisor of behavior professional, behavior analyst, and behavior specialists, which ~~must be $30.75 per hour~~ is 100 percent of the median wage for clinical counseling and school psychologist (SOC code 19-3031);

~~(17)~~ (21) for registered nurse staff, ~~the basic wage is $30.82 per hour~~, 100 percent of the median wage for registered nurses (SOC code 29-1141); and

~~(18)~~ (22) for licensed practical nurse staff, ~~the basic wage is $18.64 per hour~~ 100 percent of the median wage for licensed practical nurses (SOC code 29-2061).

(b) Component values for residential support services are:

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

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

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

(4) general administrative support ratio: 13.25 percent;

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

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

(c) Component values for family foster care are:

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

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

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

(4) general administrative support ratio: 3.3 percent;

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

(6) absence factor: 1.7 percent.

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

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

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

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

(4) program plan support ratio: 5.6 percent;

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

(6) general administrative support ratio: 13.25 percent;

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

(8) absence and utilization factor ratio: ~~3.9~~ 9.4 percent.

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

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

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

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

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

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

(6) general administrative support ratio: 13.25 percent;

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

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

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

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

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

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

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

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

(6) general administrative support ratio: 13.25 percent;

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

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

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

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

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

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

(4) general administrative support ratio: 13.25 percent;

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

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

(h) On July 1, 2017, the commissioner shall update the base wage index in paragraph (a) based on the wage data by standard occupational code (SOC) from the Bureau of Labor Statistics available on December 31, 2016. The commissioner shall publish these updated values and load them into the rate management system. ~~This adjustment occurs every five years. For adjustments in 2021 and beyond, the commissioner shall use the data available on December 31 of the calendar year five years prior.~~ On January 1, 2022, and every two years thereafter, the commissioner shall update the base wage index in paragraph (a) based on the most recently available wage data by SOC from the Bureau of Labor Statistics. The commissioner shall publish these updated values and load them into the rate management system.

(i) On July 1, 2017, the commissioner shall update the framework components in ~~paragraphs (b) to (g)~~ paragraph (d), clause (5); paragraph (e), clause (5); and paragraph (f), clause (5); subdivision 6, clauses (8) and (9); and subdivision 7, clauses (10), (16), and (17), for changes in the Consumer Price Index. The commissioner will adjust these values higher or lower by the percentage change in the Consumer Price Index-All Items, United States city average (CPI-U) from January 1, 2014, to January 1, 2017. The commissioner shall publish these updated values and load them into the rate management system. ~~This adjustment occurs every five years. For adjustments in 2021 and beyond, the commissioner shall use the data available on January 1 of the calendar year four years prior and January 1 of the current calendar year.~~ On January 1, 2022, and every two years thereafter, the commissioner shall update the framework components in paragraph (d), clause (5); paragraph (e), clause (5); and paragraph (f), clause (5); subdivision 6, clauses (8) and (9); and subdivision 7, clauses (10), (16), and (17), for changes in the Consumer Price Index. The commissioner shall adjust these values higher or lower by the percentage change in the CPI-U from the date of the previous update to the date of the data most recently available prior to the scheduled update. The commissioner shall publish these updated values and load them into the rate management system.

(j) If Bureau of Labor Statistics SOC or Consumer Price Index items are unavailable in the future, the commissioner shall recommend to the legislature codes or items to update and replace missing component values.

(k) The commissioner must ensure that wage values and component values in subdivisions 5 to 9 reflect the cost to provide the service. As determined by the commissioner, in consultation with stakeholders identified in section 256B.4913, subdivision 5, a provider enrolled to provide services with rates determined under this section must submit business cost data to the commissioner to support research on the cost of providing services that have rates determined by the disability waiver rates system. Required business cost data includes, but is not limited to:

(1) worker wage costs;

(2) benefits paid;

(3) supervisor wage costs;

(4) executive wage costs;

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

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

(7) administrative costs paid;

(8) program costs paid;

(9) transportation costs paid;

(10) vacancy rates; and

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

(l) A provider must submit cost component data at least once in any five-year period, on a schedule determined by the commissioner, in consultation with stakeholders identified in section 256B.4913, subdivision 5. If a provider fails to submit required reporting data, the commissioner shall provide notice to providers that have not provided required data 30 days after the required submission date, and a second notice for providers who have not provided required data 60 days after the required submission date. The commissioner shall temporarily suspend payments to the provider if cost component data is not received 90 days after the required submission date. Withheld payments shall be made once data is received by the commissioner.

(m) The commissioner shall conduct a random audit of data submitted under paragraph (k) to ensure data accuracy. The commissioner shall analyze cost documentation in paragraph (k) and provide recommendations for adjustments to cost components.

(n) The commissioner shall analyze cost documentation in paragraph (k) and, in consultation with stakeholders identified in section 256B.4913, subdivision 5, may submit recommendations on component values and inflationary factor adjustments to the chairs and ranking minority members of the legislative committees with jurisdiction over human services every four years beginning January 1, 2020. The commissioner shall make recommendations in conjunction with reports submitted to the legislature according to subdivision 10, paragraph (e). The commissioner shall release business cost data in an aggregate form, and business cost data from individual providers shall not be released except as provided for in current law.

(o) The commissioner, in consultation with stakeholders identified in section 256B.4913, subdivision 5, shall develop and implement a process for providing training and technical assistance necessary to support provider submission of cost documentation required under paragraph (k).

EFFECTIVE DATE. (a) The amendments to paragraphs (a) to (g) are effective January 1, 2018, except the amendment to paragraph (d), clause (8), which is effective January 1,

2019, and the amendment to paragraph (a), clause (10), which is effective the day following final enactment.

(b) The amendments to paragraphs (h) to (o) are effective the day following final enactment.

Sec. 23. Minnesota Statutes 2016, section 256B.4914, subdivision 6, is amended to read:

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

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

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

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

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

(5) multiply the number of shared and individual direct staff hours provided on site or through monitoring technology and nursing hours by the product of the supervision span of control ratio in subdivision 5, paragraph (b), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause ~~(16)~~ (20);

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 24. Minnesota Statutes 2016, section 256B.4914, subdivision 7, is amended to read:

Subd. 7. **Payments for day programs.** Payments for services with day programs including adult day care, day treatment and habilitation, prevocational services, and structured day services must be calculated as follows:

(1) determine the number of units of service and staffing ratio to meet a recipient's needs:

(i) the staffing ratios for the units of service provided to a recipient in a typical week must be averaged to determine an individual's staffing ratio; and

(ii) the commissioner, in consultation with service providers, shall develop a uniform staffing ratio worksheet to be used to determine staffing ratios under this subdivision;

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

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

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

(5) multiply the number of day direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph (d), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause ~~(16)~~ (20);

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

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

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

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

(10) for program facility costs, add $19.30 per week with consideration of staffing ratios to meet individual needs;

(11) for adult day bath services, add $7.01 per 15 minute unit;

(12) this is the subtotal rate;

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

(14) divide the result of clause (12) by one minus the result of clause (13). This is the total payment amount;

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

(16) for transportation provided as part of day training and habilitation for an individual who does not require a lift, add:

(i) $10.50 for a trip between zero and ten miles for a nonshared ride in a vehicle without a lift, $8.83 for a shared ride in a vehicle without a lift, and $9.25 for a shared ride in a vehicle with a lift;

(ii) $15.75 for a trip between 11 and 20 miles for a nonshared ride in a vehicle without a lift, $10.58 for a shared ride in a vehicle without a lift, and $11.88 for a shared ride in a vehicle with a lift;

(iii) $25.75 for a trip between 21 and 50 miles for a nonshared ride in a vehicle without a lift, $13.92 for a shared ride in a vehicle without a lift, and $16.88 for a shared ride in a vehicle with a lift; or

(iv) $33.50 for a trip of 51 miles or more for a nonshared ride in a vehicle without a lift, $16.50 for a shared ride in a vehicle without a lift, and $20.75 for a shared ride in a vehicle with a lift;

(17) for transportation provided as part of day training and habilitation for an individual who does require a lift, add:

(i) $19.05 for a trip between zero and ten miles for a nonshared ride in a vehicle with a lift, and $15.05 for a shared ride in a vehicle with a lift;

(ii) $32.16 for a trip between 11 and 20 miles for a nonshared ride in a vehicle with a lift, and $28.16 for a shared ride in a vehicle with a lift;

(iii) $58.76 for a trip between 21 and 50 miles for a nonshared ride in a vehicle with a lift, and $58.76 for a shared ride in a vehicle with a lift; or

(iv) $80.93 for a trip of 51 miles or more for a nonshared ride in a vehicle with a lift, and $80.93 for a shared ride in a vehicle with a lift.

Sec. 25. Minnesota Statutes 2016, section 256B.4914, subdivision 8, is amended to read:

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

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

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

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

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

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

(5) multiply the number of direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph (e), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause ~~(16)~~ (20);

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

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

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

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

(10) this is the subtotal rate;

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

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

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

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

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

Sec. 26. Minnesota Statutes 2016, section 256B.4914, subdivision 9, is amended to read:

Subd. 9. **Payments for unit-based services without programming.** Payments for unit-based services without programming, including night supervision, personal support, respite, and companion care provided to an individual outside of any day or residential service plan must be calculated as follows unless the services are authorized separately under subdivision 6 or 7:

(1) for all services except respite, determine the number of units of service to meet a recipient's needs;

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

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

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

(5) multiply the number of direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph (f), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause ~~(16)~~ (20);

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

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

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

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

(10) this is the subtotal rate;

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

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

(13) for respite services, determine the number of day units of service to meet an individual's needs;

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

(15) for a recipient requiring deaf and hard-of-hearing customization under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (14). This is defined as the customized direct care rate;

(16) multiply the number of direct staff hours by the appropriate staff wage in subdivision 5, paragraph (a);

(17) multiply the number of direct staff hours by the product of the supervisory span of control ratio in subdivision 5, paragraph (g), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause ~~(16)~~ (20);

(18) combine the results of clauses (16) and (17), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (g), clause (2). This is defined as the direct staffing rate;

(19) for employee-related expenses, multiply the result of clause (18) by one plus the employee-related cost ratio in subdivision 5, paragraph (g), clause (3);

(20) this is the subtotal rate;

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

(22) divide the result of clause (20) by one minus the result of clause (21). This is the total payment amount; and

(23) adjust the result of clauses (12) and (22) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

Sec. 27. Minnesota Statutes 2016, section 256B.4914, subdivision 10, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~After January 15, 2015, the commissioner may make recommendations to the legislature to address potential issues.~~

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

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

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

(2) service utilization;

(3) county and tribal allocation changes; and

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

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

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

~~(j)~~ (h) When the available shared staffing hours in a residential setting are insufficient to meet the needs of an individual who enrolled in residential services after January 1, 2014, or insufficient to meet the needs of an individual with a service agreement adjustment described in section 256B.4913, subdivision 4a, paragraph (f), then individual staffing hours shall be used.

(i) The commissioner shall study the underlying cost of absence and utilization for day services. Based on the commissioner's evaluation of the data collected under this paragraph,

the commissioner shall make recommendations to the legislature by January 15, 2018, for changes, if any, to the absence and utilization factor ratio component value for day services.

(j) Beginning July 1, 2017, the commissioner shall collect transportation and trip information for all day services through the rates management system.

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

Sec. 28. Minnesota Statutes 2016, section 256B.4914, subdivision 16, is amended to read:

Subd. 16. **Budget neutrality adjustments.** (a) The commissioner shall use the following adjustments to the rate generated by the framework to assure budget neutrality until the rate information is available to implement paragraph (b). The rate generated by the framework shall be multiplied by the appropriate factor, as designated below:

(1) for residential services: 1.003;

(2) for day services: 1.000;

(3) for unit-based services with programming: 0.941; and

(4) for unit-based services without programming: 0.796.

(b) Within 12 months of January 1, 2014, the commissioner shall compare estimated spending for all home and community-based waiver services under the new payment rates defined in subdivisions 6 to 9 with estimated spending for the same recipients and services under the rates in effect on July 1, 2013. This comparison must distinguish spending under each of subdivisions 6, 7, 8, and 9. The comparison must be based on actual recipients and services for one or more service months after the new rates have gone into effect. The commissioner shall consult with the commissioner of management and budget on this analysis to ensure budget neutrality. If estimated spending under the new rates for services under one or more subdivisions differs in this comparison by 0.3 percent or more, the commissioner shall assure aggregate budget neutrality across all service areas by adjusting the budget neutrality factor in paragraph (a) in each subdivision so that total estimated spending for each subdivision under the new rates matches estimated spending under the rates in effect on July 1, 2013.

(c) A service rate developed using values in subdivision 5, paragraph (a), clause (10), is not subject to budget neutrality adjustments.

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

Sec. 29. Minnesota Statutes 2016, section 256B.85, subdivision 3, is amended to read:

Subd. 3. **Eligibility.** (a) CFSS is available to a person who meets one of the following:

(1) is an enrollee of medical assistance as determined under section 256B.055, 256B.056, or 256B.057, subdivisions 5 and 9;

(2) is a participant in the alternative care program under section 256B.0913;

(3) is a waiver participant as defined under section 256B.0915, 256B.092, 256B.093, or 256B.49; or

(4) has medical services identified in a person's individualized education program and is eligible for services as determined in section 256B.0625, subdivision 26.

(b) In addition to meeting the eligibility criteria in paragraph (a), a person must also meet all of the following:

(1) require assistance and be determined dependent in one activity of daily living or Level I behavior based on an initial assessment under section 256B.0911, subdivision 3a, a reassessment under section 256B.0911, subdivision 3g, or an annual service update under section 256B.0911, subdivision 3f; and

(2) is not a participant under a family support grant under section 252.32.

Sec. 30. Minnesota Statutes 2016, section 256B.85, subdivision 5, is amended to read:

Subd. 5. **Assessment requirements.** (a) The initial assessment of functional need must:

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

(2) be conducted face-to-face, initially ~~and at least annually thereafter,~~ or when there is a significant change in the participant's condition or a change in the need for services and supports, or at the request of the participant when the participant experiences a change in condition or needs a change in the services or supports; and

(3) be completed using the format established by the commissioner.

(b) The results of the assessment and any recommendations and authorizations for CFSS must be determined and communicated in writing by the lead agency's certified assessor as defined in section 256B.0911 to the participant and the agency-provider or FMS provider chosen by the participant within 40 calendar days and must include the participant's right to appeal under section 256.045, subdivision 3.

(c) The lead agency assessor may authorize a temporary authorization for CFSS services to be provided under the agency-provider model. Authorization for a temporary level of CFSS services under the agency-provider model is limited to the time specified by the commissioner, but shall not exceed 45 days. The level of services authorized under this paragraph shall have no bearing on a future authorization. Participants approved for a temporary authorization shall access the consultation service to complete their orientation and selection of a service model.

Sec. 31. Minnesota Statutes 2016, section 256B.85, subdivision 6, is amended to read:

Subd. 6. **Community first services and supports service delivery plan.** (a) The CFSS service delivery plan must be developed and evaluated through a person-centered planning process by the participant, or the participant's representative or legal representative who may be assisted by a consultation services provider. The CFSS service delivery plan must reflect the services and supports that are important to the participant and for the participant to meet the needs assessed by the certified assessor and identified in the coordinated service and support plan identified in section 256B.0915, subdivision 6. The CFSS service delivery plan must be reviewed by the participant, the consultation services provider, and the agency-provider or FMS provider prior to starting services and ~~at least annually upon reassessment, or~~ as necessary when there is a significant change in the participant's condition, or a change in the need for services and supports, or at the request of the participant or the participant's representative.

(b) The commissioner shall establish the format and criteria for the CFSS service delivery plan.

(c) The CFSS service delivery plan must be person-centered and:

(1) specify the consultation services provider, agency-provider, or FMS provider selected by the participant;

(2) reflect the setting in which the participant resides that is chosen by the participant;

(3) reflect the participant's strengths and preferences;

(4) include the methods and supports used to address the needs as identified through an assessment of functional needs;

(5) include the participant's identified goals and desired outcomes;

(6) reflect the services and supports, paid and unpaid, that will assist the participant to achieve identified goals, including the costs of the services and supports, and the providers of those services and supports, including natural supports;

(7) identify the amount and frequency of face-to-face supports and amount and frequency of remote supports and technology that will be used;

(8) identify risk factors and measures in place to minimize them, including individualized backup plans;

(9) be understandable to the participant and the individuals providing support;

(10) identify the individual or entity responsible for monitoring the plan;

(11) be finalized and agreed to in writing by the participant and signed by all individuals and providers responsible for its implementation;

(12) be distributed to the participant and other people involved in the plan;

(13) prevent the provision of unnecessary or inappropriate care;

(14) include a detailed budget for expenditures for budget model participants or participants under the agency-provider model if purchasing goods; and

(15) include a plan for worker training and development provided according to subdivision 18a detailing what service components will be used, when the service components will be used, how they will be provided, and how these service components relate to the participant's individual needs and CFSS support worker services.

(d) The total units of agency-provider services or the service budget amount for the budget model include both annual totals and a monthly average amount that cover the number of months of the service agreement. The amount used each month may vary, but additional funds must not be provided above the annual service authorization amount, determined according to subdivision 8, unless a change in condition is assessed and authorized by the certified assessor and documented in the coordinated service and support plan and CFSS service delivery plan.

(e) In assisting with the development or modification of the CFSS service delivery plan during the authorization time period, the consultation services provider shall:

(1) consult with the FMS provider on the spending budget when applicable; and

(2) consult with the participant or participant's representative, agency-provider, and case manager/care coordinator.

(f) The CFSS service delivery plan must be approved by the consultation services provider for participants without a case manager or care coordinator who is responsible for authorizing services. A case manager or care coordinator must approve the plan for a waiver or alternative care program participant.

Sec. 32. Minnesota Statutes 2016, section 256C.23, is amended by adding a subdivision to read:

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

Sec. 33. Minnesota Statutes 2016, section 256C.23, subdivision 2, is amended to read:

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

Sec. 34. Minnesota Statutes 2016, section 256C.23, is amended by adding a subdivision to read:

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

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

(2) interpreting between a spoken language and a visual representation of a spoken language, such as cued speech and signing systems in English;

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

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

(5) interpreting between one communication mode or language into another communication mode or language that is linguistically and culturally appropriate for the participants in the communication exchange.

Sec. 35. Minnesota Statutes 2016, section 256C.23, is amended by adding a subdivision to read:

Subd. 6. **Real-time captioning.** "Real-time captioning" means a method of captioning in which a caption is simultaneously prepared and displayed or transmitted at the time of origination by specially trained real-time captioners.

Sec. 36. Minnesota Statutes 2016, section 256C.233, subdivision 1, is amended to read:

Subdivision 1. **Deaf and Hard-of-Hearing Services Division.** The commissioners of ~~human services,~~ education, employment and economic development, and health shall ~~create a distinct and separate organizational unit to be known as~~ advise the commissioner of human services on the activities of the Deaf and Hard-of-Hearing Services Division ~~to address~~. This division addresses the developmental~~, social, educational, and occupational~~ and social-emotional needs of persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing ~~persons~~ through a statewide network of ~~collaborative~~ services and ~~by coordinating the promulgation of public policies, regulations, legislation, and programs affecting~~ advocates on behalf of and provides information and training about how to best serve persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing ~~persons~~. ~~An interdepartmental management team shall advise the activities of the Deaf and Hard-of-Hearing Services Division.~~ The commissioner of human services shall coordinate the work of the interagency ~~management team~~ advisers and receive legislative appropriations for the division.

Sec. 37. Minnesota Statutes 2016, section 256C.233, subdivision 2, is amended to read:

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

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

(2) ~~assist~~ work across divisions within the ~~Departments~~ Department of Human Services, ~~Education, and Employment and Economic Development to coordinate the promulgation and implementation of public policies, regulations, legislation, programs, and services affecting~~ as well as with other agencies and counties, to ensure that there is an understanding of:

(i) the communication challenges faced by persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing ~~persons~~;

(ii) the best practices for accommodating and mitigating communication challenges; and

(iii) the legal requirements for providing access to and effective communication with persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing; ~~and~~

(3) ~~provide a coordinated system of~~ assess the supply and demand statewide ~~interpreting or~~ for interpreter ~~referral~~ services~~.~~ and real-time captioning services, implement strategies to provide greater access to these services in areas without sufficient supply, and build the base of service providers across the state;

(4) maintain a statewide information resource that includes contact information and professional certification credentials of interpreting service providers and real-time captioning service providers;

(5) provide culturally affirmative mental health services to persons who are deaf, persons who are hard-of-hearing, and persons who are deafblind, who:

(i) use a visual language such as American Sign Language or a tactile form of a language; or

(ii) otherwise need culturally affirmative therapeutic services;

(6) research and develop best practices and recommendations for emerging issues;

(7) provide as much information as practicable on the division's stand-alone Web site in American Sign Language; and

(8) report to the chairs and ranking minority members of the legislative committees with jurisdiction over human services biennially, beginning on January 1, 2019, on the following:

(i) the number of regional service center staff, the location of the office of each staff person, other service providers with which they are colocated, the number of people served by each staff person, and a breakdown of whether each person was served on-site or off-site, and for those served off-site, a list of locations where services were delivered, and the number who were served in-person and the number who were served via technology;

(ii) the amount and percentage of the division budget spent on reasonable accommodations for staff;

(iii) the number of people who use demonstration equipment and consumer evaluations of the experience;

(iv) the number of training sessions provided by division staff, the topics covered, the number of participants, and consumer evaluations, including a breakdown by delivery method such as in-person or via technology;

(v) the number of training sessions hosted at a division location provided by another service provider, the topics covered, the number of participants, and consumer evaluations, including a breakdown by delivery method such as in-person or via technology;

(vi) for each grant awarded, the amount awarded to the grantee and a summary of the grantee's results, including consumer evaluations of the services or products provided;

(vii) the number of people on waiting lists for any services provided by division staff or for services or equipment funded through grants awarded by the division;

(viii) the amount of time staff spent driving to appointments to deliver direct one-to-one client services in locations outside of the regional service centers;

(ix) the amount spent on mileage reimbursement and the number of clients who received mileage reimbursement for traveling to the regional service centers for services; and

(x) the regional needs and feedback on addressing service gaps identified by the advisory committee.

Sec. 38. Minnesota Statutes 2016, section 256C.24, subdivision 1, is amended to read:

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

Sec. 39. Minnesota Statutes 2016, section 256C.24, subdivision 2, is amended to read:

Subd. 2. **Responsibilities.** Each regional service center shall:

(1) ~~serve as a central entry point for~~ establish connections and collaborations colocating with other public and private entities providing services to persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing ~~persons in need of services and make referrals to the services needed~~ in the region;

(2) for those in need of services, assist in coordinating services between service providers and persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing, and the persons' families, and make referrals to the services needed;

~~(2)~~ (3) employ staff trained to work with persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing ~~persons~~;

~~(3)~~ (4) if adequate services are not available from another public or private service provider in the region, provide ~~to all~~ individual assistance to persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing ~~persons access to interpreter services which are necessary to help them obtain services~~, and the persons' families. Individual culturally affirmative assistance may be provided using technology only in areas of the state when a person has access to sufficient quality telecommunications or broadband services to allow effective communication. When a person who is deaf, a person who is deafblind, or a person who is hard-of-hearing does not have access to sufficient telecommunications or broadband service, individual assistance shall be available in person;

(5) identify regional training needs, work with deaf and hard-of-hearing services training staff, and collaborate with others to deliver training for persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing, and the persons' families, and other service providers about subjects including the persons' rights under the law, American Sign Language, and the impact of hearing loss and options for accommodating it;

~~(4) implement a plan to provide loaned equipment and resource materials to deaf, deafblind, and hard-of-hearing~~ (6) have a mobile or permanent lab where persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing can try a selection of modern assistive technology and equipment to determine what would best meet the persons' needs;

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

~~(6)~~ (7) collaborate with the Resource Center for the Deaf and Hard-of-Hearing Persons, other divisions of the Department of Education~~,~~ and local school districts to develop and deliver programs and services for families with children who are deaf, children who are deafblind, or children who are hard-of-hearing ~~children~~ and to support school personnel serving these children;

~~(7) when possible,~~ (8) provide training to the social service or income maintenance staff employed by counties or by organizations with whom counties contract for services to ensure that communication barriers which prevent persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing ~~persons~~ from using services are removed;

~~(8) when possible,~~ (9) provide training to ~~state and regional~~ human service agencies in the region regarding program access for persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing ~~persons~~; ~~and~~

~~(9)~~ (10) assess the ongoing need and supply of services for persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing ~~persons~~ in all parts of the state, annually consult with the division's advisory committees to identify regional needs and solicit feedback on addressing service gaps, and cooperate with public and private service providers to develop these services~~.~~;

(11) provide culturally affirmative mental health services to persons who are deaf, persons who are hard-of-hearing, and persons who are deafblind, who:

(i) use a visual language such as American Sign Language or a tactile form of a language; or

(ii) otherwise need culturally affirmative therapeutic services; and

(12) establish partnerships with state and regional entities statewide with the technological capacity to provide Minnesotans with virtual access to the division's services and division-sponsored training via technology.

Sec. 40. Minnesota Statutes 2016, section 256C.24, is amended by adding a subdivision to read:

Subd. 4. **Transportation cost reimbursement.** Persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing, and the person's family members who travel more than 50 miles round-trip from the person's home or work location to receive services at the regional service center may be reimbursed by the Deaf and Hard-of-Hearing Division for mileage at the reimbursement rate established by the Internal Revenue Service.

Sec. 41. Minnesota Statutes 2016, section 256C.261, is amended to read:

256C.261 SERVICES FOR PERSONS WHO ARE DEAFBLIND ~~PERSONS~~.

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

use at least 25 percent of the deafblind services biennial base level grant funding for services and other supports for an adult who is deafblind.

The commissioner shall award grants for the purposes of:

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

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

(b) The commissioner may make grants:

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

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

(c) Consumer-directed services shall be provided in whole by grant-funded providers. The deaf and hard-of-hearing regional service centers shall not provide any aspect of a grant-funded consumer-directed services program.

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

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

Sec. 42. **CONSUMER-DIRECTED COMMUNITY SUPPORTS BUDGET METHODOLOGY EXCEPTION FOR PERSONS LEAVING INSTITUTIONS AND CRISIS RESIDENTIAL SETTINGS.**

(a) By September 30, 2017, the commissioner shall establish an institutional and crisis bed consumer-directed community supports budget exception process in the home and community-based services waivers under Minnesota Statutes, sections 256B.092 and 256B.49. This budget exception process shall be available for any individual who:

(1) is not offered available and appropriate services within 60 days since approval for discharge from the individual's current institutional setting; and

(2) requires services that are more expensive than appropriate services provided in a noninstitutional setting using the consumer-directed community supports option.

(b) Institutional settings for purposes of this exception include intermediate care facilities for persons with developmental disabilities; nursing facilities; acute care hospitals; Anoka Metro Regional Treatment Center; Minnesota Security Hospital; and crisis beds. The budget exception shall be limited to no more than the amount of appropriate services provided in a noninstitutional setting as determined by the lead agency managing the individual's home and community-based services waiver. The lead agency shall notify the Department of Human Services of the budget exception.

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

Sec. 43. **FEDERAL WAIVER REQUESTS.**

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

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

Sec. 44. **TRANSPORTATION STUDY.**

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

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

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

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

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

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

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

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

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

Sec. 45. **DIRECTION TO COMMISSIONER; TELECOMMUNICATION EQUIPMENT PROGRAM.**

(a) The commissioner of human services shall work in consultation with the Commission of Deaf, Deafblind, and Hard-of-Hearing Minnesotans to provide recommendations by January 15, 2018, to the chairs and ranking minority members of the house of representatives and senate committees with jurisdiction over human services to modernize the telecommunication equipment program. The recommendations must address:

(1) types of equipment and supports the program should provide to ensure people with communication difficulties have equitable access to telecommunications services;

(2) additional services the program should provide such as education about technology options that can improve a person's access to telecommunications service; and

(3) how the current program's service delivery structure might be improved to better meet the needs of people with communication disabilities.

(b) The commissioner shall also provide draft legislative language to accomplish the recommendations. Final recommendations, the final report, and draft legislative language must be approved by both the commissioner and the chair of the commission.

Sec. 46. **DIRECTION TO COMMISSIONER; BILLING FOR MENTAL HEALTH SERVICES.**

By January 1, 2018, the commissioner of human services shall report to the chairs and ranking minority members of the house of representatives and senate committees with jurisdiction over deaf and hard-of-hearing services on the potential costs and benefits of the Deaf and Hard-of-Hearing Services Division billing for the cost of providing mental health services.

Sec. 47. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES.**

The commissioner of human services shall work with lead agencies responsible for conducting long-term consultation services under Minnesota Statutes, section 256B.0911, to modify the MnCHOICES assessment tool and related policies to:

(1) reduce assessment times;

(2) create efficiencies within the tool and within practice and policy for conducting assessments and support planning;

(3) implement policy changes reducing the frequency and depth of assessment and reassessment, while ensuring federal compliance with medical assistance and disability waiver eligibility requirements; and

(4) evaluate alternative payment methods.

Sec. 48. **EXPANSION OF CONSUMER-DIRECTED COMMUNITY SUPPORTS BUDGET METHODOLOGY EXCEPTION.**

(a) No later than September 30, 2017, if necessary, the commissioner of human services shall submit an amendment to the Centers for Medicare and Medicaid Services for the home and community-based services waivers authorized under Minnesota Statutes, sections 256B.092 and 256B.49, to expand the exception to the consumer-directed community supports budget methodology under Laws 2015, chapter 71, article 7, section 54, to increase consumer-directed community support budgets up to 30 percent for the following:

(1) consumer-directed community support participants whose current consumer-directed community support budget cannot accommodate increased services and supports identified in the participant's coordinated service and support plan and that are required in order to:

(i) increase the amount of time a participant works or otherwise improves employment opportunity;

(ii) plan a transition to, move to, or live in a setting described in Minnesota Statutes, section 256D.44, subdivision 5, paragraph (f), clause (1), item (ii), or paragraph (g); or

(iii) develop and implement a positive support plan; or

(2) home and community-based waiver participants who are currently using licensed providers for residential services that cost more annually than the participant would spend under a consumer-directed community support plan for any and all of the services and supports needed to meet the goals identified in clause (1).

(b) The exception under paragraph (a), clause (1), is limited to those consumer-directed community participants who can demonstrate that the participant shall discontinue consumer-directed community supports and accept other nonself-directed waiver services because the participant cannot meet the goals described in paragraph (a), clause (1), within the participant's current consumer-directed community support budget limits.

(c) The exception under paragraph (a), clause (2), is limited to those home and community-based waiver participants who can demonstrate that, upon choosing to become a consumer-directed community support participant, the total cost of services, including the exception, would be less than the cost of the waiver services the participant would otherwise receive.

Sec. 49. **REPEALER.**

Minnesota Statutes 2016, sections 256B.4914, subdivision 16; 256C.23, subdivision 3; 256C.233, subdivision 4; and 256C.25, subdivisions 1 and 2, are repealed.

ARTICLE 2

HOUSING

Section 1. Minnesota Statutes 2016, section 144D.04, subdivision 2, is amended to read:

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 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 description of 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;

(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 ~~residents~~ 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.

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

Sec. 2. Minnesota Statutes 2016, section 144D.04, is amended by adding a subdivision to read:

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.

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

Sec. 3. Minnesota Statutes 2016, section 245A.03, subdivision 7, is amended to read:

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

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

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

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

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

(5) new foster care licenses or community residential setting licenses determined to be needed by the commissioner for the transition of people from personal care assistance to the home and community-based services. When approving an exception under this paragraph, the commissioner shall consider the resource need determination process in paragraph (h), the availability of foster care licensed beds in the geographic area in which the licensee seeks to operate, the results of a person's choices during their annual assessment and service plan review, and the recommendation of the local county board. The determination by the commissioner is final and not subject to appeal;

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

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

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

(7) new foster care licenses or community residential setting licenses for people receiving services under chapter 245D and residing in an unlicensed setting before May 1, 2017, and for which a license is required. This exception does not apply to people living in their own home. For purposes of this clause, there is a presumption that a foster care or community residential setting license is required for services provided to three or more people in a dwelling unit when the setting is controlled by the provider. A license holder subject to this exception may rebut the presumption that a license is required by seeking a reconsideration of the commissioner's determination. The commissioner's disposition of a request for

reconsideration is final and not subject to appeal under chapter 14. The exception is available until June 30, 2018. This exception is available when:

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

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

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

(c) When an adult resident served by the program moves out of a foster home that is not the primary residence of the license holder according to section 256B.49, subdivision 15, paragraph (f), or the adult community residential setting, the county shall immediately inform the Department of Human Services Licensing Division. The department ~~shall~~ may decrease the statewide licensed capacity for adult foster care settings ~~where the physical location is not the primary residence of the license holder, or for adult community residential settings, if the voluntary changes described in paragraph (e) are not sufficient to meet the savings required by reductions in licensed bed capacity under Laws 2011, First Special Session chapter 9, article 7, sections 1 and 40, paragraph (f), and maintain statewide long-term care residential services capacity within budgetary limits. Implementation of the statewide licensed capacity reduction shall begin on July 1, 2013. The commissioner shall delicense up to 128 beds by June 30, 2014, using the needs determination process. Prior to any involuntary reduction of licensed capacity, the commissioner shall consult with lead agencies and license holders to determine which adult foster care settings, where the physical location is not the primary residence of the license holder, or community residential settings, are licensed for up to five beds, but have operated at less than full capacity for 12 or more months as of March 1, 2014. The settings that meet these criteria must be the first to be considered for an involuntary decrease in statewide licensed capacity, up to a maximum of 35 beds. If more than 35 beds are identified that meet these criteria, the commissioner shall prioritize the selection of those beds to be closed based on the length of time the beds have been vacant. The longer a bed has been vacant, the higher priority it must be given for~~

~~closure. Under this paragraph, the commissioner has the authority to reduce unused licensed capacity of a current foster care program, or the community residential settings, to accomplish the consolidation or closure of settings. Under this paragraph, the commissioner has the authority to manage statewide capacity, including adjusting the capacity available to each county and adjusting statewide available capacity, to meet the statewide needs identified through the process in paragraph (e). A decreased licensed capacity according to this paragraph is not subject to appeal under this chapter~~.

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

(e) A resource need determination process, managed at the state level, using the available reports required by section 144A.351, and other data and information shall be used to determine where the reduced capacity ~~required~~ determined under ~~paragraph (c)~~ section 256B.493 will be implemented. The commissioner shall consult with the stakeholders described in section 144A.351, and employ a variety of methods to improve the state's capacity to meet the informed decisions of those people who want to move out of corporate foster care or community residential settings, long-term ~~care~~ service needs within budgetary limits, including seeking proposals from service providers or lead agencies to change service type, capacity, or location to improve services, increase the independence of residents, and better meet needs identified by the long-term ~~care~~ services and supports reports and statewide data and information. By February 1, 2013, and August 1, 2014, and each following year, the commissioner shall provide information and data and targets on ~~the overall~~ capacity of licensed long-term ~~care~~ services and supports, actions taken under this subdivision to manage statewide long-term ~~care~~ services and supports resources, and any recommendations for change to the legislative committees with jurisdiction over health and human services budget.

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

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

(h) The commissioner may adjust capacity to address needs identified in section 144A.351. Under this authority, the commissioner may approve new licensed settings or delicense exiting settings. Delicensing of settings will be accomplished through a process identified in section 256B.493. Annually, by August 1, the commissioner shall provide information and data on capacity of licensed long-term services and supports, actions taken under the subdivision to manage statewide long-term services and supports resources, and any recommendations for change to the legislative committees with jurisdiction over the health and human services budget.

(i) The commissioner must notify a license holder when its corporate foster care or community residential setting licensed beds are reduced under this section. The notice of reduction of licensed beds must be in writing and delivered to the license holder by certified mail or personal service. The notice must state why the licensed beds are reduced and must inform the license holder of its right to request reconsideration by the commissioner. The license holder's request for reconsideration must be in writing. If mailed, the request for reconsideration must be postmarked and sent to the commissioner within 20 calendar days after the license holder's receipt of the notice of reduction of licensed beds. If a request for reconsideration is made by personal service, it must be received by the commissioner within 20 calendar days after the license holder's receipt of the notice of reduction of licensed beds.

(j) The commissioner shall not issue an initial license for children's residential treatment services licensed under Minnesota Rules, parts 2960.0580 to 2960.0700, under this chapter for a program that Centers for Medicare and Medicaid Services would consider an institution for mental diseases.

Sec. 4. Minnesota Statutes 2016, section 245A.04, subdivision 14, is amended to read:

Subd. 14. **Policies and procedures for program administration required and enforceable.** (a) The license holder shall develop program policies and procedures necessary to maintain compliance with licensing requirements under Minnesota Statutes and Minnesota Rules.

(b) The license holder shall:

(1) provide training to program staff related to their duties in implementing the program's policies and procedures developed under paragraph (a);

(2) document the provision of this training; and

(3) monitor implementation of policies and procedures by program staff.

(c) The license holder shall keep program policies and procedures readily accessible to staff and index the policies and procedures with a table of contents or another method approved by the commissioner.

(d) An adult foster care license holder that provides foster care services to a resident under section 256B.0915 must annually provide a copy of the resident termination policy under section 245A.11, subdivision 11, to a resident covered by the policy.

Sec. 5. Minnesota Statutes 2016, section 245A.11, is amended by adding a subdivision to read:

Subd. 9. **Adult foster care bedrooms.** (a) A resident receiving services must have a choice of roommate. Each roommate must consent in writing to sharing a bedroom with one another. The license holder is responsible for notifying a resident of the resident's right to request a change of roommate.

(b) The license holder must provide a lock for each resident's bedroom door, unless otherwise indicated for the resident's health, safety, or well-being. A restriction on the use of the lock must be documented and justified in the resident's individual abuse prevention plan required by sections 245A.65, subdivision 2, paragraph (b), and 626.557, subdivision 14.For a resident served under section 256B.0915, the case manager must be part of the interdisciplinary team under section 245A.65, subdivision 2, paragraph (b).

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

Sec. 6. Minnesota Statutes 2016, section 245A.11, is amended by adding a subdivision to read:

Subd. 10. **Adult foster care resident rights.** (a) The license holder shall ensure that a resident and a resident's legal representative are given, at admission:

(1) an explanation and copy of the resident's rights specified in paragraph (b);

(2) a written summary of the Vulnerable Adults Protection Act prepared by the department; and

(3) the name, address, and telephone number of the local agency to which a resident or a resident's legal representative may submit an oral or written complaint.

(b) Adult foster care resident rights include the right to:

(1) have daily, private access to and use of a non-coin-operated telephone for local and long-distance telephone calls made collect or paid for by the resident;

(2) receive and send, without interference, uncensored, unopened mail or electronic correspondence or communication;

(3) have use of and free access to common areas in the residence and the freedom to come and go from the residence at will;

(4) have privacy for visits with the resident's spouse, next of kin, legal counsel, religious adviser, or others, according to section 363A.09 of the Human Rights Act, including privacy in the resident's bedroom;

(5) keep, use, and access the resident's personal clothing and possessions as space permits, unless this right infringes on the health, safety, or rights of another resident or household member, including the right to access the resident's personal possessions at any time;

(6) choose the resident's visitors and time of visits and participate in activities of commercial, religious, political, and community groups without interference if the activities do not infringe on the rights of another resident or household member;

(7) if married, privacy for visits by the resident's spouse, and, if both spouses are residents of the adult foster home, the residents have the right to share a bedroom and bed;

(8) privacy, including use of the lock on the resident's bedroom door or unit door. A resident's privacy must be respected by license holders, caregivers, household members, and volunteers by knocking on the door of a resident's bedroom or bathroom and seeking consent before entering, except in an emergency;

(9) furnish and decorate the resident's bedroom or living unit;

(10) engage in chosen activities and have an individual schedule supported by the license holder that meets the resident's preferences;

(11) freedom and support to access food at any time;

(12) have personal, financial, service, health, and medical information kept private, and be advised of disclosure of this information by the license holder;

(13) access records and recorded information about the resident according to applicable state and federal law, regulation, or rule;

(14) be free from maltreatment;

(15) be treated with courtesy and respect and receive respectful treatment of the resident's property;

(16) reasonable observance of cultural and ethnic practice and religion;

(17) be free from bias and harassment regarding race, gender, age, disability, spirituality, and sexual orientation;

(18) be informed of and use the license holder's grievance policy and procedures, including how to contact the highest level of authority in the program;

(19) assert the resident's rights personally, or have the rights asserted by the resident's family, authorized representative, or legal representative, without retaliation; and

(20) give or withhold written informed consent to participate in any research or experimental treatment.

(c) A restriction of a resident's rights under paragraph (b), clauses (1) to (4), (6), (8), (10), and (11), is allowed only if determined necessary to ensure the health, safety, and well-being of the resident. Any restriction of a resident's right must be documented and justified in the resident's individual abuse prevention plan required by sections 245A.65, subdivision 2, paragraph (b) and 626.557, subdivision 14. For a resident served under section 256B.0915, the case manager must be part of the interdisciplinary team under section 245A.65, subdivision 2, paragraph (b). The restriction must be implemented in the least restrictive manner necessary to protect the resident and provide support to reduce or eliminate the need for the restriction.

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

Sec. 7. Minnesota Statutes 2016, section 245A.11, is amended by adding a subdivision to read:

Subd. 11. **Adult foster care service termination for elderly waiver participants.** (a) This subdivision applies to foster care services for a resident served under section 256B.0915.

(b) The foster care license holder must establish policies and procedures for service termination that promote continuity of care and service coordination with the resident and the case manager and with another licensed caregiver, if any, who also provides support to the resident. The policy must include the requirements specified in paragraphs (c) to (h).

(c) The license holder must allow a resident to remain in the program and cannot terminate services unless:

(1) the termination is necessary for the resident's health, safety, and well-being and the resident's needs cannot be met in the facility;

(2) the safety of the resident or another resident in the program is endangered and positive support strategies were attempted and have not achieved and effectively maintained safety for the resident or another resident in the program;

(3) the health, safety, and well-being of the resident or another resident in the program would otherwise be endangered;

(4) the program was not paid for services;

(5) the program ceases to operate; or

(6) the resident was terminated by the lead agency from waiver eligibility.

(d) Before giving notice of service termination, the license holder must document the action taken to minimize or eliminate the need for termination. The action taken by the license holder must include, at a minimum:

(1) consultation with the resident's interdisciplinary team to identify and resolve issues leading to a notice of service termination; and

(2) a request to the case manager or other professional consultation or intervention services to support the resident in the program. This requirement does not apply to a notice of service termination issued under paragraph (c), clause (4) or (5).

(e) If, based on the best interests of the resident, the circumstances at the time of notice were such that the license holder was unable to take the action specified in paragraph (d), the license holder must document the specific circumstances and the reason the license holder was unable to take the action.

(f) The license holder must notify the resident or the resident's legal representative and the case manager in writing of the intended service termination. The notice must include:

(1) the reason for the action;

(2) except for service termination under paragraph (c), clause (4) or (5), a summary of the action taken to minimize or eliminate the need for termination and the reason the action failed to prevent the termination;

(3) the resident's right to appeal the service termination under section 256.045, subdivision 3, paragraph (a); and

(4) the resident's right to seek a temporary order staying the service termination according to the procedures in section 256.045, subdivision 4a, or subdivision 6, paragraph (c).

(g) Notice of the proposed service termination must be given at least 30 days before terminating a resident's service.

(h) After the resident receives the notice of service termination and before the services are terminated, the license holder must:

(1) work with the support team or expanded support team to develop reasonable alternatives to support continuity of care and to protect the resident;

(2) provide information requested by the resident or case manager; and

(3) maintain information about the service termination, including the written notice of service termination, in the resident's record.

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

Sec. 8. Minnesota Statutes 2016, section 245D.04, subdivision 3, is amended to read:

Subd. 3. **Protection-related rights.** (a) A person's protection-related rights include the right to:

(1) have personal, financial, service, health, and medical information kept private, and be advised of disclosure of this information by the license holder;

(2) access records and recorded information about the person in accordance with applicable state and federal law, regulation, or rule;

(3) be free from maltreatment;

(4) be free from restraint, time out, seclusion, restrictive intervention, or other prohibited procedure identified in section 245D.06, subdivision 5, or successor provisions, except for: (i) emergency use of manual restraint to protect the person from imminent danger to self or others according to the requirements in section 245D.061 or successor provisions; or (ii) the use of safety interventions as part of a positive support transition plan under section 245D.06, subdivision 8, or successor provisions;

(5) receive services in a clean and safe environment when the license holder is the owner, lessor, or tenant of the service site;

(6) be treated with courtesy and respect and receive respectful treatment of the person's property;

(7) reasonable observance of cultural and ethnic practice and religion;

(8) be free from bias and harassment regarding race, gender, age, disability, spirituality, and sexual orientation;

(9) be informed of and use the license holder's grievance policy and procedures, including knowing how to contact persons responsible for addressing problems and to appeal under section 256.045;

(10) know the name, telephone number, and the Web site, e-mail, and street addresses of protection and advocacy services, including the appropriate state-appointed ombudsman, and a brief description of how to file a complaint with these offices;

(11) assert these rights personally, or have them asserted by the person's family, authorized representative, or legal representative, without retaliation;

(12) give or withhold written informed consent to participate in any research or experimental treatment;

(13) associate with other persons of the person's choice;

(14) personal privacy, including the right to use the lock on the person's bedroom or unit door; ~~and~~

(15) engage in chosen activities; and

(16) access to the person's personal possessions at any time, including financial resources.

(b) For a person residing in a residential site licensed according to chapter 245A, or where the license holder is the owner, lessor, or tenant of the residential service site, protection-related rights also include the right to:

(1) have daily, private access to and use of a non-coin-operated telephone for local calls and long-distance calls made collect or paid for by the person;

(2) receive and send, without interference, uncensored, unopened mail or electronic correspondence or communication;

(3) have use of and free access to common areas in the residence and the freedom to come and go from the residence at will; ~~and~~

(4) choose the person's visitors and time of visits and have privacy for visits with the person's spouse, next of kin, legal counsel, religious ~~advisor~~ adviser, or others, in accordance with section 363A.09 of the Human Rights Act, including privacy in the person's bedroom~~.~~;

(5) the freedom and support to access food at any time;

(6) the freedom to furnish and decorate the person's bedroom or living unit;

(7) a setting that is clean and free from accumulation of dirt, grease, garbage, peeling paint, mold, vermin, and insects;

(8) a setting that is free from hazards that threaten the person's health or safety;

(9) a setting that meets state and local building and zoning definitions of a dwelling unit in a residential occupancy; and

(10) have access to potable water and three nutritionally balanced meals and nutritious snacks between meals each day.

(c) Restriction of a person's rights under paragraph (a), clauses (13) to ~~(15)~~ (16), or paragraph (b) is allowed only if determined necessary to ensure the health, safety, and well-being of the person. Any restriction of those rights must be documented in the person's coordinated service and support plan or coordinated service and support plan addendum. The restriction must be implemented in the least restrictive alternative manner necessary to protect the person and provide support to reduce or eliminate the need for the restriction in the most integrated setting and inclusive manner. The documentation must include the following information:

(1) the justification for the restriction based on an assessment of the person's vulnerability related to exercising the right without restriction;

(2) the objective measures set as conditions for ending the restriction;

(3) a schedule for reviewing the need for the restriction based on the conditions for ending the restriction to occur semiannually from the date of initial approval, at a minimum, or more frequently if requested by the person, the person's legal representative, if any, and case manager; and

(4) signed and dated approval for the restriction from the person, or the person's legal representative, if any. A restriction may be implemented only when the required approval has been obtained. Approval may be withdrawn at any time. If approval is withdrawn, the right must be immediately and fully restored.

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

Sec. 9. Minnesota Statutes 2016, section 245D.071, subdivision 3, is amended to read:

Subd. 3. **Assessment and initial service planning.** (a) Within 15 days of service initiation the license holder must complete a preliminary coordinated service and support plan addendum based on the coordinated service and support plan.

(b) Within the scope of services, the license holder must, at a minimum, complete assessments in the following areas before the 45-day planning meeting:

(1) the person's ability to self-manage health and medical needs to maintain or improve physical, mental, and emotional well-being, including, when applicable, allergies, seizures, choking, special dietary needs, chronic medical conditions, self-administration of medication or treatment orders, preventative screening, and medical and dental appointments;

(2) the person's ability to self-manage personal safety to avoid injury or accident in the service setting, including, when applicable, risk of falling, mobility, regulating water temperature, community survival skills, water safety skills, and sensory disabilities; and

(3) the person's ability to self-manage symptoms or behavior that may otherwise result in an incident as defined in section 245D.02, subdivision 11, clauses (4) to (7), suspension or termination of services by the license holder, or other symptoms or behaviors that may jeopardize the health and welfare of the person or others.

Assessments must produce information about the person that describes the person's overall strengths, functional skills and abilities, and behaviors or symptoms. Assessments must be based on the person's status within the last 12 months at the time of service initiation. Assessments based on older information must be documented and justified. Assessments must be conducted annually at a minimum or within 30 days of a written request from the person or the person's legal representative or case manager. The results must be reviewed by the support team or expanded support team as part of a service plan review.

(c) Within 45 days of service initiation, the license holder must meet with the person, the person's legal representative, the case manager, and other members of the support team or expanded support team to determine the following based on information obtained from the assessments identified in paragraph (b), the person's identified needs in the coordinated service and support plan, and the requirements in subdivision 4 and section 245D.07, subdivision 1a:

(1) the scope of the services to be provided to support the person's daily needs and activities;

(2) the person's desired outcomes and the supports necessary to accomplish the person's desired outcomes;

(3) the person's preferences for how services and supports are provided, including how the provider will support the person to have control of the person's schedule;

(4) whether the current service setting is the most integrated setting available and appropriate for the person; and

(5) how services must be coordinated across other providers licensed under this chapter serving the person and members of the support team or expanded support team to ensure continuity of care and coordination of services for the person.

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

Sec. 10. Minnesota Statutes 2016, section 245D.11, subdivision 4, is amended to read:

Subd. 4. **Admission criteria.** The license holder must establish policies and procedures that promote continuity of care by ensuring that admission or service initiation criteria:

(1) is consistent with the service-related rights identified in section 245D.04, subdivisions 2, clauses (4) to (7), and 3, clause (8);

(2) identifies the criteria to be applied in determining whether the license holder can develop services to meet the needs specified in the person's coordinated service and support plan;

(3) requires a license holder providing services in a health care facility to comply with the requirements in section 243.166, subdivision 4b, to provide notification to residents when a registered predatory offender is admitted into the program or to a potential admission when the facility was already serving a registered predatory offender. For purposes of this clause, "health care facility" means a facility licensed by the commissioner as a residential facility under chapter 245A to provide adult foster care or residential services to persons with disabilities; ~~and~~

(4) requires that when a person or the person's legal representative requests services from the license holder, a refusal to admit the person must be based on an evaluation of the person's assessed needs and the license holder's lack of capacity to meet the needs of the person. The license holder must not refuse to admit a person based solely on the type of residential services the person is receiving, or solely on the person's severity of disability, orthopedic or neurological handicaps, sight or hearing impairments, lack of communication skills, physical disabilities, toilet habits, behavioral disorders, or past failure to make progress.

Documentation of the basis for refusal must be provided to the person or the person's legal representative and case manager upon request.; and

(5) requires the person or the person's legal representative and license holder to sign and date the residency agreement when the license holder provides foster care or supported living services under section 245D.03, subdivision 1, paragraph (c), clause (3), item (i) or (ii), to a person living in a community residential setting defined in section 245D.02, subdivision 4a; an adult foster home defined in Minnesota Rules, part 9555.5105, subpart 5; or a foster family home defined in Minnesota Rules, part 9560.0521, subpart 12. The residency agreement must include service termination requirements specified in section 245D.10, subdivision 3a, paragraphs (b) to (f). The residency agreement must be reviewed annually, dated, and signed by the person or the person's legal representative and license holder.

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

Sec. 11. Minnesota Statutes 2016, section 245D.24, subdivision 3, is amended to read:

Subd. 3. **Bedrooms.** (a) ~~People~~ Each person receiving services must have a choice of roommate and must mutually consent, in writing, to sharing a bedroom with one another. No more than two people receiving services may share one bedroom.

(b) A single occupancy bedroom must have at least 80 square feet of floor space with a 7-1/2 foot ceiling. A double occupancy room must have at least 120 square feet of floor space with a 7-1/2 foot ceiling. Bedrooms must be separated from halls, corridors, and other habitable rooms by floor-to-ceiling walls containing no openings except doorways and must not serve as a corridor to another room used in daily living.

(c) A person's personal possessions and items for the person's own use are the only items permitted to be stored in a person's bedroom.

(d) Unless otherwise documented through assessment as a safety concern for the person, each person must be provided with the following furnishings:

(1) a separate bed of proper size and height for the convenience and comfort of the person, with a clean mattress in good repair;

(2) clean bedding appropriate for the season for each person;

(3) an individual cabinet, or dresser, shelves, and a closet, for storage of personal possessions and clothing; and

(4) a mirror for grooming.

(e) When possible, a person must be allowed to have items of furniture that the person personally owns in the bedroom, unless doing so would interfere with safety precautions, violate a building or fire code, or interfere with another person's use of the bedroom. A person may choose not to have a cabinet, dresser, shelves, or a mirror in the bedroom, as otherwise required under paragraph (d), clause (3) or (4). A person may choose to use a mattress other than an innerspring mattress and may choose not to have the mattress on a mattress frame or support. If a person chooses not to have a piece of required furniture, the license holder must document this choice and is not required to provide the item. If a person chooses to use a mattress other than an innerspring mattress or chooses not to have a mattress frame or support, the license holder must document this choice and allow the alternative desired by the person.

(f) A person must be allowed to bring personal possessions into the bedroom and other designated storage space, if such space is available, in the residence. The person must be allowed to accumulate possessions to the extent the residence is able to accommodate them, unless doing so is contraindicated for the person's physical or mental health, would interfere with safety precautions or another person's use of the bedroom, or would violate a building or fire code. The license holder must allow for locked storage of personal items. Any restriction on the possession or locked storage of personal items, including requiring a person to use a lock provided by the license holder, must comply with section 245D.04, subdivision 3, paragraph (c), and allow the person to be present if and when the license holder opens the lock.

(g) A person must be allowed to lock the person's bedroom door. The license holder must document and assess the physical plant and the environment, and the population served, and identify the risk factors that require using locked doors, and the specific action taken to minimize the safety risk to a person receiving services at the site.

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

Sec. 12. Minnesota Statutes 2016, section 256.045, subdivision 3, is amended to read:

Subd. 3. **State agency hearings.** (a) State agency hearings are available for the following:

(1) any person applying for, receiving or having received public assistance, medical care, or a program of social services granted by the state agency or a county agency or the federal Food Stamp Act whose application for assistance is denied, not acted upon with reasonable promptness, or whose assistance is suspended, reduced, terminated, or claimed to have been incorrectly paid;

(2) any patient or relative aggrieved by an order of the commissioner under section 252.27;

(3) a party aggrieved by a ruling of a prepaid health plan;

(4) except as provided under chapter 245C, any individual or facility determined by a lead investigative agency to have maltreated a vulnerable adult under section 626.557 after they have exercised their right to administrative reconsideration under section 626.557;

(5) any person whose claim for foster care payment according to a placement of the child resulting from a child protection assessment under section 626.556 is denied or not acted upon with reasonable promptness, regardless of funding source;

(6) any person to whom a right of appeal according to this section is given by other provision of law;

(7) an applicant aggrieved by an adverse decision to an application for a hardship waiver under section 256B.15;

(8) an applicant aggrieved by an adverse decision to an application or redetermination for a Medicare Part D prescription drug subsidy under section 256B.04, subdivision 4a;

(9) except as provided under chapter 245A, an individual or facility determined to have maltreated a minor under section 626.556, after the individual or facility has exercised the right to administrative reconsideration under section 626.556;

(10) except as provided under chapter 245C, an individual disqualified under sections 245C.14 and 245C.15, following a reconsideration decision issued under section 245C.23, on the basis of serious or recurring maltreatment; a preponderance of the evidence that the individual has committed an act or acts that meet the definition of any of the crimes listed in section 245C.15, subdivisions 1 to 4; or for failing to make reports required under section 626.556, subdivision 3, or 626.557, subdivision 3. Hearings regarding a maltreatment determination under clause (4) or (9) and a disqualification under this clause in which the basis for a disqualification is serious or recurring maltreatment, shall be consolidated into a single fair hearing. In such cases, the scope of review by the human services judge shall include both the maltreatment determination and the disqualification. The failure to exercise the right to an administrative reconsideration shall not be a bar to a hearing under this section if federal law provides an individual the right to a hearing to dispute a finding of maltreatment;

(11) any person with an outstanding debt resulting from receipt of public assistance, medical care, or the federal Food Stamp Act who is contesting a setoff claim by the

Department of Human Services or a county agency. The scope of the appeal is the validity of the claimant agency's intention to request a setoff of a refund under chapter 270A against the debt;

(12) a person issued a notice of service termination under section 245D.10, subdivision 3a, from residential supports and services as defined in section 245D.03, subdivision 1, paragraph (c), clause (3), that is not otherwise subject to appeal under subdivision 4a; ~~or~~

(13) an individual disability waiver recipient based on a denial of a request for a rate exception under section 256B.4914~~.~~; or

(14) a person issued a notice of service termination under section 245A.11, subdivision 11, that is not otherwise subject to appeal under subdivision 4a.

(b) The hearing for an individual or facility under paragraph (a), clause (4), (9), or (10), is the only administrative appeal to the final agency determination specifically, including a challenge to the accuracy and completeness of data under section 13.04. Hearings requested under paragraph (a), clause (4), apply only to incidents of maltreatment that occur on or after October 1, 1995. Hearings requested by nursing assistants in nursing homes alleged to have maltreated a resident prior to October 1, 1995, shall be held as a contested case proceeding under the provisions of chapter 14. Hearings requested under paragraph (a), clause (9), apply only to incidents of maltreatment that occur on or after July 1, 1997. A hearing for an individual or facility under paragraph (a), clauses (4), (9), and (10), is only available when there is no district court action pending. If such action is filed in district court while an administrative review is pending that arises out of some or all of the events or circumstances on which the appeal is based, the administrative review must be suspended until the judicial actions are completed. If the district court proceedings are completed, dismissed, or overturned, the matter may be considered in an administrative hearing.

(c) For purposes of this section, bargaining unit grievance procedures are not an administrative appeal.

(d) The scope of hearings involving claims to foster care payments under paragraph (a), clause (5), shall be limited to the issue of whether the county is legally responsible for a child's placement under court order or voluntary placement agreement and, if so, the correct amount of foster care payment to be made on the child's behalf and shall not include review of the propriety of the county's child protection determination or child placement decision.

(e) The scope of hearings under paragraph (a), ~~clause~~ clauses (12) and (14), shall be limited to whether the proposed termination of services is authorized under section 245D.10, subdivision 3a, paragraph (b), or 245A.11, subdivision 11, and whether the requirements

of section 245D.10, subdivision 3a, ~~paragraph~~ paragraphs (c) to (e), or 245A.11, subdivision 2a, paragraphs (d) to (f), were met. If the appeal includes a request for a temporary stay of termination of services, the scope of the hearing shall also include whether the case management provider has finalized arrangements for a residential facility, a program, or services that will meet the assessed needs of the recipient by the effective date of the service termination.

(f) A vendor of medical care as defined in section 256B.02, subdivision 7, or a vendor under contract with a county agency to provide social services is not a party and may not request a hearing under this section, except if assisting a recipient as provided in subdivision 4.

(g) An applicant or recipient is not entitled to receive social services beyond the services prescribed under chapter 256M or other social services the person is eligible for under state law.

(h) The commissioner may summarily affirm the county or state agency's proposed action without a hearing when the sole issue is an automatic change due to a change in state or federal law.

(i) Unless federal or Minnesota law specifies a different time frame in which to file an appeal, an individual or organization specified in this section may contest the specified action, decision, or final disposition before the state agency by submitting a written request for a hearing to the state agency within 30 days after receiving written notice of the action, decision, or final disposition, or within 90 days of such written notice if the applicant, recipient, patient, or relative shows good cause, as defined in section 256.0451, subdivision 13, why the request was not submitted within the 30-day time limit. The individual filing the appeal has the burden of proving good cause by a preponderance of the evidence.

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

Sec. 13. **[256B.051] HOUSING SUPPORT SERVICES.**

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

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

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

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

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

(e) "Individual with a disability" means:

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

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

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

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

(1) is 18 years of age or older;

(2) is enrolled in medical assistance;

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

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

(5) has housing instability evidenced by:

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

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

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

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

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

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

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

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

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

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

(b) Housing transition services are defined as:

(1) tenant screening and housing assessment;

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

(3) identifying resources to cover onetime moving expenses;

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

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

(6) developing a housing support crisis plan.

(c) Housing and tenancy sustaining services include:

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

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

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

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

(5) assistance with housing recertification process;

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

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

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

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

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

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

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

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

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

EFFECTIVE DATE. (a) Subdivisions 1 to 6 are contingent upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

(b) Subdivision 7 is contingent upon federal approval of subdivisions 1 to 6. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 14. Minnesota Statutes 2016, section 256B.0911, subdivision 3a, is amended to read:

Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment, services planning, or other assistance intended to support community-based living, including persons who need assessment in order to determine waiver or alternative care program eligibility, must be visited by a long-term care consultation team within 20 calendar days after the date on which an assessment was requested or recommended. Upon statewide implementation of subdivisions 2b, 2c, and 5, this requirement also applies to an assessment of a person requesting personal care assistance services and home care nursing. The commissioner shall provide at least a 90-day notice to lead agencies prior to the effective date of this requirement. Face-to-face assessments must be conducted according to paragraphs (b) to (i).

(b) Upon implementation of subdivisions 2b, 2c, and 5, lead agencies shall use certified assessors to conduct the assessment. For a person with complex health care needs, a public health or registered nurse from the team must be consulted.

(c) The MnCHOICES assessment provided by the commissioner to lead agencies must be used to complete a comprehensive, person-centered assessment. The assessment must include the health, psychological, functional, environmental, and social needs of the individual necessary to develop a community support plan that meets the individual's needs and preferences.

(d) The assessment must be conducted in a face-to-face interview with the person being assessed and the person's legal representative. At the request of the person, other individuals may participate in the assessment to provide information on the needs, strengths, and preferences of the person necessary to develop a community support plan that ensures the person's health and safety. Except for legal representatives or family members invited by the person, persons participating in the assessment may not be a provider of service or have any financial interest in the provision of services. For persons who are to be assessed for elderly waiver customized living services under section 256B.0915, with the permission of the person being assessed or the person's designated or legal representative, the client's current or proposed provider of services may submit a copy of the provider's nursing assessment or written report outlining its recommendations regarding the client's care needs. The person conducting the assessment must notify the provider of the date by which this information is to be submitted. This information shall be provided to the person conducting the assessment prior to the assessment. For a person who is to be assessed for waiver services under section 256B.092 or 256B.49, with the permission of the person being assessed or the person's designated legal representative, the person's current provider of services may submit a written report outlining recommendations regarding the person's care needs prepared

by a direct service employee with at least 20 hours of service to that client. The person conducting the assessment or reassessment must notify the provider of the date by which this information is to be submitted. This information shall be provided to the person conducting the assessment and the person or the person's legal representative, and must be considered prior to the finalization of the assessment or reassessment.

(e) The person or the person's legal representative must be provided with a written community support plan within 40 calendar days of the assessment visit, regardless of whether the individual is eligible for Minnesota health care programs. The written community support plan must include:

(1) a summary of assessed needs as defined in paragraphs (c) and (d);

(2) the individual's options and choices to meet identified needs, including all available options for case management services and providers;

(3) identification of health and safety risks and how those risks will be addressed, including personal risk management strategies;

(4) referral information; and

(5) informal caregiver supports, if applicable.

For a person determined eligible for state plan home care under subdivision 1a, paragraph (b), clause (1), the person or person's representative must also receive a copy of the home care service plan developed by the certified assessor.

(f) A person may request assistance in identifying community supports without participating in a complete assessment. Upon a request for assistance identifying community support, the person must be transferred or referred to long-term care options counseling services available under sections 256.975, subdivision 7, and 256.01, subdivision 24, for telephone assistance and follow up.

(g) The person has the right to make the final decision between institutional placement and community placement after the recommendations have been provided, except as provided in section 256.975, subdivision 7a, paragraph (d).

(h) The lead agency must give the person receiving assessment or support planning, or the person's legal representative, materials, and forms supplied by the commissioner containing the following information:

(1) written recommendations for community-based services and consumer-directed options;

(2) documentation that the most cost-effective alternatives available were offered to the individual. For purposes of this clause, "cost-effective" means community services and living arrangements that cost the same as or less than institutional care. For an individual found to meet eligibility criteria for home and community-based service programs under section 256B.0915 or 256B.49, "cost-effectiveness" has the meaning found in the federally approved waiver plan for each program;

(3) the need for and purpose of preadmission screening conducted by long-term care options counselors according to section 256.975, subdivisions 7a to 7c, if the person selects nursing facility placement. If the individual selects nursing facility placement, the lead agency shall forward information needed to complete the level of care determinations and screening for developmental disability and mental illness collected during the assessment to the long-term care options counselor using forms provided by the commissioner;

(4) the role of long-term care consultation assessment and support planning in eligibility determination for waiver and alternative care programs, and state plan home care, case management, and other services as defined in subdivision 1a, paragraphs (a), clause (6), and (b);

(5) information about Minnesota health care programs;

(6) the person's freedom to accept or reject the recommendations of the team;

(7) the person's right to confidentiality under the Minnesota Government Data Practices Act, chapter 13;

(8) the certified assessor's decision regarding the person's need for institutional level of care as determined under criteria established in subdivision 4e and the certified assessor's decision regarding eligibility for all services and programs as defined in subdivision 1a, paragraphs (a), clause (6), and (b); and

(9) the person's right to appeal the certified assessor's decision regarding eligibility for all services and programs as defined in subdivision 1a, paragraphs (a), clauses (6), (7), and (8), and (b), and incorporating the decision regarding the need for institutional level of care or the lead agency's final decisions regarding public programs eligibility according to section 256.045, subdivision 3.

(i) Face-to-face assessment completed as part of eligibility determination for the alternative care, elderly waiver, community access for disability inclusion, community alternative care, and brain injury waiver programs under sections 256B.0913, 256B.0915,

and 256B.49 is valid to establish service eligibility for no more than 60 calendar days after the date of assessment.

(j) The effective eligibility start date for programs in paragraph (i) can never be prior to the date of assessment. If an assessment was completed more than 60 days before the effective waiver or alternative care program eligibility start date, assessment and support plan information must be updated and documented in the department's Medicaid Management Information System (MMIS). Notwithstanding retroactive medical assistance coverage of state plan services, the effective date of eligibility for programs included in paragraph (i) cannot be prior to the date the most recent updated assessment is completed.

(k) At the time of reassessment, the certified assessor shall assess each person receiving waiver services currently residing in a community residential setting, or licensed adult foster care home that is not the primary residence of the license holder, or in which the license holder is not the primary caregiver, to determine if that person would prefer to be served in a community-living settings as defined in section 256B.49, subdivision 23. The certified assessor shall offer the person, through a person-centered planning process, the option to receive alternative housing and service options.

Sec. 15. Minnesota Statutes 2016, section 256B.0915, subdivision 1, is amended to read:

Subdivision 1. **Authority.** (a) The commissioner is authorized to apply for a home and community-based services waiver for the elderly, authorized under section 1915(c) of the Social Security Act, in order to obtain federal financial participation to expand the availability of services for persons who are eligible for medical assistance. The commissioner may apply for additional waivers or pursue other federal financial participation which is advantageous to the state for funding home care services for the frail elderly who are eligible for medical assistance. The provision of waivered services to elderly and disabled medical assistance recipients must comply with the criteria for service definitions and provider standards approved in the waiver.

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

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

Sec. 16. Minnesota Statutes 2016, section 256B.092, subdivision 4, is amended to read:

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

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

(c) Home and community-based resources for all recipients shall be managed by the county of financial responsibility within an allowable reimbursement average established for each county. Payments for home and community-based services provided to individual recipients shall not exceed amounts authorized by the county of financial responsibility. For specifically identified former residents of nursing facilities, the commissioner shall be responsible for authorizing payments and payment limits under the appropriate home and community-based service program. Payment is available under this subdivision only for persons who, if not provided these services, would require the level of care provided in an intermediate care facility for persons with developmental disabilities.

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

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

Sec. 17. Minnesota Statutes 2016, section 256B.49, subdivision 11, is amended to read:

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

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

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

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

(4) obtain federal financial participation.

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

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

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

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

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

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

Sec. 18. Minnesota Statutes 2016, section 256B.49, subdivision 15, is amended to read:

Subd. 15. **Coordinated service and support plan; comprehensive transitional service plan; maintenance service plan.** (a) Each recipient of home and community-based waivered services shall be provided a copy of the written coordinated service and support plan which meets the requirements in section 256B.092, subdivision 1b.

(b) In developing the comprehensive transitional service plan, the individual receiving services, the case manager, and the guardian, if applicable, will identify the transitional service plan fundamental service outcome and anticipated timeline to achieve this outcome. Within the first 20 days following a recipient's request for an assessment or reassessment, the transitional service planning team must be identified. A team leader must be identified who will be responsible for assigning responsibility and communicating with team members to ensure implementation of the transition plan and ongoing assessment and communication process. The team leader should be an individual, such as the case manager or guardian, who has the opportunity to follow the recipient to the next level of service.

Within ten days following an assessment, a comprehensive transitional service plan must be developed incorporating elements of a comprehensive functional assessment and including short-term measurable outcomes and timelines for achievement of and reporting on these outcomes. Functional milestones must also be identified and reported according to the timelines agreed upon by the transitional service planning team. In addition, the comprehensive transitional service plan must identify additional supports that may assist in the achievement of the fundamental service outcome such as the development of greater natural community support, increased collaboration among agencies, and technological supports.

The timelines for reporting on functional milestones will prompt a reassessment of services provided, the units of services, rates, and appropriate service providers. It is the responsibility of the transitional service planning team leader to review functional milestone reporting to determine if the milestones are consistent with observable skills and that milestone achievement prompts any needed changes to the comprehensive transitional service plan.

For those whose fundamental transitional service outcome involves the need to procure housing, a plan for the recipient to seek the resources necessary to secure the least restrictive housing possible should be incorporated into the plan, including employment and public supports such as housing access and shelter needy funding.

(c) Counties and other agencies responsible for funding community placement and ongoing community supportive services are responsible for the implementation of the comprehensive transitional service plans. Oversight responsibilities include both ensuring effective transitional service delivery and efficient utilization of funding resources.

(d) Following one year of transitional services, the transitional services planning team will make a determination as to whether or not the individual receiving services requires the current level of continuous and consistent support in order to maintain the recipient's current level of functioning. Recipients who are determined to have not had a significant change in functioning for 12 months must move from a transitional to a maintenance service plan. Recipients on a maintenance service plan must be reassessed to determine if the recipient would benefit from a transitional service plan at least every 12 months and at other times when there has been a significant change in the recipient's functioning. This assessment should consider any changes to technological or natural community supports.

(e) When a county is evaluating denials, reductions, or terminations of home and community-based services under this section for an individual, the case manager shall offer to meet with the individual or the individual's guardian in order to discuss the prioritization of service needs within the coordinated service and support plan, comprehensive transitional service plan, or maintenance service plan. The reduction in the authorized services for an individual due to changes in funding for waivered services may not exceed the amount needed to ensure medically necessary services to meet the individual's health, safety, and welfare.

~~(f) At the time of reassessment, local agency case managers shall assess each recipient of community access for disability inclusion or brain injury waivered services currently residing in a licensed adult foster home that is not the primary residence of the license holder, or in which the license holder is not the primary caregiver, to determine if that recipient could appropriately be served in a community-living setting. If appropriate for the recipient, the case manager shall offer the recipient, through a person-centered planning process, the option to receive alternative housing and service options. In the event that the recipient chooses to transfer from the adult foster home, the vacated bed shall not be filled with another recipient of waiver services and group residential housing and the licensed capacity shall be reduced accordingly, unless the savings required by the licensed bed closure reductions under Laws 2011, First Special Session chapter 9, article 7, sections 1 and 40, paragraph (f), for foster care settings where the physical location is not the primary residence of the license holder are met through voluntary changes described in section 245A.03, subdivision 7, paragraph (e), or as provided under paragraph (a), clauses (3) and (4). If the~~

~~adult foster home becomes no longer viable due to these transfers, the county agency, with the assistance of the department, shall facilitate a consolidation of settings or closure. This reassessment process shall be completed by July 1, 2013.~~

Sec. 19. Minnesota Statutes 2016, section 256B.493, subdivision 1, is amended to read:

Subdivision 1. **Commissioner's duties; report.** The commissioner of human services ~~shall solicit proposals for the conversion of services provided for persons with disabilities in settings licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, or community residential settings licensed under chapter 245D, to other types of community settings in conjunction with the closure of identified licensed adult foster care settings~~ has the authority to manage statewide licensed corporate foster care or community residential settings capacity, including the reduction and realignment of licensed capacity of a current foster care or community residential settings to accomplish the consolidation or closure of settings. The commissioner shall implement a program for planned closure of licensed corporate adult foster care or community residential settings, necessary as a preferred method to: (1) respond to the informed decisions of those individuals who want to move out of these settings into other types of community settings; and (2) achieve necessary budgetary savings required in section 245A.03, subdivision 7, paragraphs (c) and (d).

Sec. 20. Minnesota Statutes 2016, section 256B.493, subdivision 2, is amended to read:

Subd. 2. **Planned closure process needs determination.** ~~The commissioner shall announce and implement a program for planned closure of adult foster care homes. Planned closure shall be the preferred method for achieving necessary budgetary savings required by the licensed bed closure budget reduction in section 245A.03, subdivision 7, paragraph (c). If additional closures are required to achieve the necessary savings, the commissioner shall use the process and priorities in section 245A.03, subdivision 7, paragraph (c)~~ A resource need determination process, managed at the state level, using available reports required by section 144A.351 and other data and information shall be used by the commissioner to align capacity where needed.

Sec. 21. Minnesota Statutes 2016, section 256B.493, is amended by adding a subdivision to read:

Subd. 2a. **Closure process.** (a) The commissioner shall work with stakeholders to establish a process for the application, review, approval, and implementation of setting closures. Voluntary proposals from license holders for consolidation and closure of adult

foster care or community residential settings are encouraged. Whether voluntary or involuntary, all closure plans must include:

(1) a description of the proposed closure plan, identifying the home or homes and occupied beds;

(2) the proposed timetable for the proposed closure, including the proposed dates for notification to people living there and the affected lead agencies, commencement of closure, and completion of closure;

(3) the proposed relocation plan jointly developed by the counties of financial responsibility, the people living there and their legal representatives, if any, who wish to continue to receive services from the provider, and the providers for current residents of any adult foster care home designated for closure; and

(4) documentation from the provider in a format approved by the commissioner that all the adult foster care homes or community residential settings receiving a planned closure rate adjustment under the plan have accepted joint and severable for recovery of overpayments under section 256B.0641, subdivision 2, for the facilities designated for closure under this plan.

(b) The commissioner shall give first priority to closure plans which:

(1) target counties and geographic areas which have:

(i) need for other types of services;

(ii) need for specialized services;

(iii) higher than average per capita use of licensed corporate foster care or community residential settings; or

(iv) residents not living in the geographic area of their choice;

(2) demonstrate savings of medical assistance expenditures; and

(3) demonstrate that alternative services are based on the recipient's choice of provider and are consistent with federal law, state law, and federally approved waiver plans.

The commissioner shall also consider any information provided by people using services, their legal representatives, family members, or the lead agency on the impact of the planned closure on people and the services they need.

(c) For each closure plan approved by the commissioner, a contract must be established between the commissioner, the counties of financial responsibility, and the participating license holder.

Sec. 22. Minnesota Statutes 2016, section 256D.44, subdivision 4, is amended to read:

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

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

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

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

Sec. 23. Minnesota Statutes 2016, section 256D.44, subdivision 5, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(f)~~ (g)(1) Notwithstanding the language in this subdivision, an amount equal to one-half of the maximum ~~allotment authorized by the federal Food Stamp Program for a~~ federal Supplemental Security Income payment amount for a single individual which is in effect

on the first day of July of each year will be added to the standards of assistance established in subdivisions 1 to 4 for adults under the age of 65 who qualify as ~~shelter needy~~ in need of housing assistance and are:

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

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

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

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

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

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

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

Sec. 24. Minnesota Statutes 2016, section 256I.03, subdivision 8, is amended to read:

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

Sec. 25. Minnesota Statutes 2016, section 256I.04, subdivision 1, is amended to read:

Subdivision 1. **Individual eligibility requirements.** An individual is eligible for and entitled to a ~~group residential~~ housing support payment to be made on the individual's behalf if the agency has approved the ~~individual's residence in a group residential~~ setting where the individual will receive housing ~~setting~~ support and the individual meets the requirements in paragraph (a) ~~or~~, (b), or (c).

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

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

(c) The individual receives licensed residential crisis stabilization services under section 256B.0624, subdivision 7, and is receiving medical assistance. The individual may receive

concurrent group residential housing payments if receiving licensed residential crisis stabilization services under section 256B.0624, subdivision 7.

EFFECTIVE DATE. Paragraph (c) is effective October 1, 2017.

Sec. 26. Minnesota Statutes 2016, section 256I.04, subdivision 2d, is amended to read:

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

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

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

Sec. 27. Minnesota Statutes 2016, section 256I.04, subdivision 2g, is amended to read:

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

Sec. 28. Minnesota Statutes 2016, section 256I.04, subdivision 3, is amended to read:

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

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

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

(3) notwithstanding the provisions of subdivision 2a, for up to ~~190~~ 226 supportive housing units in Anoka, Dakota, Hennepin, or Ramsey County for homeless adults with a mental illness, a history of substance abuse, or human immunodeficiency virus or acquired immunodeficiency syndrome. For purposes of this section, "homeless adult" means a person who is living on the street or in a shelter or discharged from a regional treatment center, community hospital, or residential treatment program and has no appropriate housing available and lacks the resources and support necessary to access appropriate housing. At least 70 percent of the supportive housing units must serve homeless adults with mental illness, substance abuse problems, or human immunodeficiency virus or acquired immunodeficiency syndrome who are about to be or, within the previous six months, has been discharged from a regional treatment center, or a state-contracted psychiatric bed in a community hospital, or a residential mental health or chemical dependency treatment program. If a person meets the requirements of subdivision 1, paragraph (a), and receives a federal or state housing subsidy, the ~~group residential~~ housing support rate for that person is limited to the supplementary rate under section 256I.05, subdivision 1a, and is determined by subtracting the amount of the person's countable income that exceeds the MSA equivalent rate from the ~~group residential~~ housing support supplementary service rate. A resident in a demonstration project site who no longer participates in the demonstration program shall retain eligibility for a ~~group residential~~ housing support payment in an amount determined under section 256I.06, subdivision 8, using the MSA equivalent rate. Service funding under section 256I.05, subdivision 1a, will end June 30, 1997, if federal matching funds are available and the services can be provided through a managed care entity. If federal matching funds are not available, then service funding will continue under section 256I.05, subdivision 1a;

(4) for an additional two beds, resulting in a total of 32 beds, for a facility located in Hennepin County providing services for recovering and chemically dependent men that has

had a ~~group residential~~ housing support contract with the county and has been licensed as a board and lodge facility with special services since 1980;

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

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

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

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

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

Sec. 29. Minnesota Statutes 2016, section 256I.05, subdivision 1a, is amended to read:

Subd. 1a. **Supplementary service rates.** (a) Subject to the provisions of section 256I.04, subdivision 3, the county agency may negotiate a payment not to exceed $426.37 for other services necessary to provide room and board ~~provided by the group residence~~ if the residence is licensed by or registered by the Department of Health, or licensed by the Department of Human Services to provide services in addition to room and board, and if the provider of services is not also concurrently receiving funding for services for a recipient under a home and community-based waiver under title XIX of the Social Security Act; or funding from

the medical assistance program under section 256B.0659, for personal care services for residents in the setting; or residing in a setting which receives funding under section 245.73. If funding is available for other necessary services through a home and community-based waiver, or personal care services under section 256B.0659, then the ~~GRH~~ housing support rate is limited to the rate set in subdivision 1. Unless otherwise provided in law, in no case may the supplementary service rate exceed $426.37. The registration and licensure requirement does not apply to establishments which are exempt from state licensure because they are located on Indian reservations and for which the tribe has prescribed health and safety requirements. Service payments under this section may be prohibited under rules to prevent the supplanting of federal funds with state funds. The commissioner shall pursue the feasibility of obtaining the approval of the Secretary of Health and Human Services to provide home and community-based waiver services under title XIX of the Social Security Act for residents who are not eligible for an existing home and community-based waiver due to a primary diagnosis of mental illness or chemical dependency and shall apply for a waiver if it is determined to be cost-effective.

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

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

Sec. 30. Minnesota Statutes 2016, section 256I.05, subdivision 1c, is amended to read:

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

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

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

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

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

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

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

Sec. 31. Minnesota Statutes 2016, section 256I.05, subdivision 1e, is amended to read:

Subd. 1e. **Supplementary rate for certain facilities.** (a) Notwithstanding the provisions of subdivisions 1a and 1c, beginning July 1, 2005, a county agency shall negotiate a supplementary rate in addition to the rate specified in subdivision 1, not to exceed $700 per

month, including any legislatively authorized inflationary adjustments, for a ~~group residential~~ housing support provider that:

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

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

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

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

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

(2) operates a 62-bed facility; and

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

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

Sec. 32. Minnesota Statutes 2016, section 256I.05, subdivision 1j, is amended to read:

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

operates a 304-bed facility in Minneapolis and a 44-bed facility in Duluth which opened in January of 2006.

Sec. 33. Minnesota Statutes 2016, section 256I.05, subdivision 1m, is amended to read:

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

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

Sec. 34. Minnesota Statutes 2016, section 256I.05, is amended by adding a subdivision to read:

Subd. 1p. **Supplementary rate; St. Louis County.** Notwithstanding the provisions of subdivisions 1a and 1c, beginning July 1, 2017, a county agency shall negotiate a supplementary rate in addition to the rate specified in subdivision 1, not to exceed $700 per month, including any legislatively authorized inflationary adjustments, for a housing support provider that:

(1) is located in St. Louis County and has had a group residential housing contract with the county since July 2016;

(2) operates a 35-bed facility;

(3) serves women who are chemically dependent, mentally ill, or both;

(4) provides 24-hour per day supervision;

(5) provides onsite support with skilled professionals, including a licensed practical nurse, registered nurses, peer specialists, and resident counselors; and

(6) provides independent living skills training and assistance with family reunification.

Sec. 35. Minnesota Statutes 2016, section 256I.05, is amended by adding a subdivision to read:

Subd. 1q. **Supplemental rate; Olmsted County.** Notwithstanding the provisions of subdivisions 1a and 1c, beginning July 1, 2017, a county agency shall negotiate a supplementary rate in addition to the rate specified in subdivision 1, not to exceed $750 per month, including any legislatively authorized inflationary adjustments, for a housing support provider located in Olmsted County that operates long-term residential facilities with a total of 104 beds that serve chemically dependent men and women and provide 24-hour-a-day supervision and other support services.

Sec. 36. Minnesota Statutes 2016, section 256I.05, is amended by adding a subdivision to read:

Subd. 1r. **Supplemental rate; Anoka County.** Notwithstanding the provisions in this section, a county agency shall negotiate a supplemental rate for 42 beds in addition to the rate specified in subdivision 1, not to exceed the maximum rate in subdivision 1a per month, including any legislatively authorized inflationary adjustments, for a housing support provider that is located in Anoka County and provides emergency housing on the former Anoka Regional Treatment Center campus.

Sec. 37. Minnesota Statutes 2016, section 256I.05, subdivision 8, is amended to read:

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

Sec. 38. Minnesota Statutes 2016, section 256I.05, is amended by adding a subdivision to read:

Subd. 11. **Transfer of emergency shelter funds.** (a) The commissioner shall make a cost-neutral transfer of funding from the group residential housing fund to county human service agencies for emergency shelter beds removed from the group residential housing census under a biennial plan submitted by the county and approved by the commissioner. The biennial plan is due August 1, beginning August 1, 2017. The plan must describe: (1) anticipated and actual outcomes for persons experiencing homelessness in emergency

shelters; (2) improved efficiencies in administration; (3) requirements for individual eligibility; and (4) plans for quality assurance monitoring and quality assurance outcomes. The commissioner shall review the county plan to monitor implementation and outcomes at least biennially, and more frequently if the commissioner deems necessary.

(b) The funding under paragraph (a) may be used for the provision of room and board or supplemental services according to section 256I.03, subdivisions 2 and 8. Providers must meet the requirements of section 256I.04, subdivisions 2a to 2f. Funding will be allocated annually, and the room and board portion of the allocation shall be adjusted according to the percentage change in the group residential housing room and board rate. The room and board portion of the allocation shall be determined at the time of transfer. The commissioner or county may return beds to the group residential housing fund with 180 days' notice, including financial reconciliation.

Sec. 39. Minnesota Statutes 2016, section 256I.05, is amended by adding a subdivision to read:

Subd. 12. **Decrease in supplementary service rate.** For every housing support provider with a supplementary service rate of $300 or higher, the commissioner shall reduce by five percent the difference between the total supplementary service rate in effect on July 1, 2017, and $300, and shall reduce by ten percent the difference between the total supplementary service rate in effect on July 1, 2019, and $300.

Sec. 40. Minnesota Statutes 2016, section 256I.06, subdivision 2, is amended to read:

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

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

Sec. 41. Minnesota Statutes 2016, section 256I.06, subdivision 8, is amended to read:

Subd. 8. **Amount of ~~group residential~~ housing support payment.** (a) The amount of a ~~group residential housing~~ room and board payment to be made on behalf of an eligible individual is determined by subtracting the individual's countable income under section 256I.04, subdivision 1, for a whole calendar month from the ~~group residential housing~~

~~charge~~ room and board rate for that same month. The ~~group residential~~ housing ~~charge~~ support payment is determined by multiplying the ~~group residential~~ housing support rate times the period of time the individual was a resident or temporarily absent under section 256I.05, subdivision 1c, paragraph (d).

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

(c) For an individual who receives licensed residential crisis stabilization services under section 256B.0624, subdivision 7, the amount of group residential housing payment is determined by multiplying the group residential housing rate times the period of time the individual was a resident.

EFFECTIVE DATE. Paragraph (c) is effective October 1, 2017.

Sec. 42. **[256I.09] COMMUNITY LIVING INFRASTRUCTURE.**

The commissioner shall awards grants to agencies through an annual competitive process. Grants awarded under this section may be used for: (1) outreach to locate and engage people who are homeless or residing in segregated settings to screen for basic needs and assist with referral to community living resources; (2) building capacity to provide technical assistance and consultation on housing and related support service resources for persons with both disabilities and low income; or (3) streamlining the administration and monitoring activities related to housing support funds. Agencies may collaborate and submit a joint application for funding under this section.

Sec. 43. **REVISOR'S INSTRUCTION.**

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

Column A	Column B	Column C
144A.071, subdivision 4d	group residential housing	housing support under chapter 256I

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

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

ARTICLE 3

CONTINUING CARE

Section 1. Minnesota Statutes 2016, section 144.0724, subdivision 4, is amended to read:

Subd. 4. **Resident assessment schedule.** (a) A facility must conduct and electronically submit to the commissioner of health MDS assessments that conform with the assessment schedule defined by Code of Federal Regulations, title 42, section 483.20, and published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, in the Long Term Care Assessment Instrument User's Manual, version 3.0, and subsequent updates when issued by the Centers for Medicare and Medicaid Services.

The commissioner of health may substitute successor manuals or question and answer documents published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, to replace or supplement the current version of the manual or document.

(b) The assessments used to determine a case mix classification for reimbursement include the following:

(1) a new admission assessment;

(2) an annual assessment which must have an assessment reference date (ARD) within 92 days of the previous assessment and the previous comprehensive assessment;

(3) a significant change in status assessment must be completed within 14 days of the identification of a significant change, whether improvement or decline, and regardless of the amount of time since the last significant change in status assessment;

(4) all quarterly assessments must have an assessment reference date (ARD) within 92 days of the ARD of the previous assessment;

(5) any significant correction to a prior comprehensive assessment, if the assessment being corrected is the current one being used for RUG classification; and

(6) any significant correction to a prior quarterly assessment, if the assessment being corrected is the current one being used for RUG classification.

(c) In addition to the assessments listed in paragraph (b), the assessments used to determine nursing facility level of care include the following:

(1) preadmission screening completed under section 256.975, subdivisions 7a to 7c, by the Senior LinkAge Line or other organization under contract with the Minnesota Board on Aging; and

(2) a nursing facility level of care determination as provided for under section 256B.0911, subdivision 4e, as part of a face-to-face long-term care consultation assessment completed under section 256B.0911, by a county, tribe, or managed care organization under contract with the Department of Human Services.

Sec. 2. Minnesota Statutes 2016, section 144.0724, subdivision 6, is amended to read:

Subd. 6. **Penalties for late or nonsubmission.** (a) A facility that fails to complete or submit an assessment according to subdivisions 4 and 5 for a RUG-IV classification within seven days of the time requirements listed in the Long-Term Care Facility Resident Assessment Instrument User's Manual is subject to a reduced rate for that resident. The

reduced rate shall be the lowest rate for that facility. The reduced rate is effective on the day of admission for new admission assessments, on the ARD for significant change in status assessments, or on the day that the assessment was due for all other assessments and continues in effect until the first day of the month following the date of submission and acceptance of the resident's assessment.

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

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

Sec. 3. Minnesota Statutes 2016, section 144A.071, subdivision 4d, is amended to read:

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

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

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

(3) the payment rate for external fixed costs for a remaining facility or facilities shall be increased by an amount equal to 65 percent of the projected net cost savings to the state calculated in paragraph (b), divided by the state's medical assistance percentage of medical assistance dollars, and then divided by estimated medical assistance resident days, as determined in paragraph (c), of the remaining nursing facility or facilities in the request in

this paragraph. The rate adjustment is effective on the ~~later of the first day of the month following~~ first day of the month of January or July, whichever date occurs first following both the completion of the construction upgrades in the consolidation plan ~~or the first day of the month following~~ and the complete ~~closure of a facility~~ closure of the facility or facilities designated for closure in the consolidation plan. If more than one facility is receiving upgrades in the consolidation plan, each facility's date of construction completion must be evaluated separately.

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

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

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

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

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

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

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

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

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

(d) For purposes of net cost of savings to the state in paragraph (b), the average occupancy percentages will be those reported on the facility's or facilities' most recent nursing facility statistical and cost report filed before the plan of closure is submitted, and the average

payment rates shall be calculated based on the approved payment rates in effect at the time the consolidation request is submitted.

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

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

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

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

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

Sec. 4. Minnesota Statutes 2016, section 256.975, subdivision 7, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(12) using risk management and support planning protocols, provide long-term care options counseling under clause (13) to current residents of nursing homes deemed appropriate for discharge by the commissioner~~, former residents of nursing homes who~~

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

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

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

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

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

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

(d) The Senior LinkAge Line shall determine when it is appropriate to refer a consumer who receives long-term care options counseling under paragraph (b), clause (12) or (13),

and who uses an unpaid caregiver to the self-directed caregiver service under subdivision 12.

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

Sec. 5. Minnesota Statutes 2016, section 256.975, is amended by adding a subdivision to read:

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

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

Sec. 6. Minnesota Statutes 2016, section 256B.0911, subdivision 3a, is amended to read:

Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment, services planning, or other assistance intended to support community-based living, including persons who need assessment in order to determine waiver or alternative care program eligibility, must be visited by a long-term care consultation team within 20 calendar days after the date on which an assessment was requested or recommended. Upon statewide implementation of subdivisions 2b, 2c, and 5, this requirement also applies to an assessment of a person requesting personal care assistance services and home care nursing. The commissioner shall provide at least a 90-day notice to lead agencies prior to the effective date of this requirement. Face-to-face assessments must be conducted according to paragraphs (b) to (i).

(b) Upon implementation of subdivisions 2b, 2c, and 5, lead agencies shall use certified assessors to conduct the assessment. For a person with complex health care needs, a public health or registered nurse from the team must be consulted.

(c) The MnCHOICES assessment provided by the commissioner to lead agencies must be used to complete a comprehensive, person-centered assessment. The assessment must include the health, psychological, functional, environmental, and social needs of the individual necessary to develop a community support plan that meets the individual's needs and preferences.

(d) The assessment must be conducted in a face-to-face interview with the person being assessed and the person's legal representative. At the request of the person, other individuals

may participate in the assessment to provide information on the needs, strengths, and preferences of the person necessary to develop a community support plan that ensures the person's health and safety. Except for legal representatives or family members invited by the person, persons participating in the assessment may not be a provider of service or have any financial interest in the provision of services. For persons who are to be assessed for elderly waiver customized living or adult day services under section 256B.0915, with the permission of the person being assessed or the person's designated or legal representative, the client's current or proposed provider of services may submit a copy of the provider's nursing assessment or written report outlining its recommendations regarding the client's care needs. The person conducting the assessment must notify the provider of the date by which this information is to be submitted. This information shall be provided to the person conducting the assessment prior to the assessment. For a person who is to be assessed for waiver services under section 256B.092 or 256B.49, with the permission of the person being assessed or the person's designated legal representative, the person's current provider of services may submit a written report outlining recommendations regarding the person's care needs prepared by a direct service employee with at least 20 hours of service to that client. The person conducting the assessment or reassessment must notify the provider of the date by which this information is to be submitted. This information shall be provided to the person conducting the assessment and the person or the person's legal representative, and must be considered prior to the finalization of the assessment or reassessment.

(e) The person or the person's legal representative must be provided with a written community support plan within 40 calendar days of the assessment visit, regardless of whether the individual is eligible for Minnesota health care programs.

(f) For a person being assessed for elderly waiver services under section 256B.0915, a provider who submitted information under paragraph (d) shall receive a copy of the assessment, the final written community support plan when available, the case mix level, and the Residential Services Workbook.

(g) The written community support plan must include:

(1) a summary of assessed needs as defined in paragraphs (c) and (d);

(2) the individual's options and choices to meet identified needs, including all available options for case management services and providers;

(3) identification of health and safety risks and how those risks will be addressed, including personal risk management strategies;

(4) referral information; and

(5) informal caregiver supports, if applicable.

For a person determined eligible for state plan home care under subdivision 1a, paragraph (b), clause (1), the person or person's representative must also receive a copy of the home care service plan developed by the certified assessor.

~~(f)~~ (h) A person may request assistance in identifying community supports without participating in a complete assessment. Upon a request for assistance identifying community support, the person must be transferred or referred to long-term care options counseling services available under sections 256.975, subdivision 7, and 256.01, subdivision 24, for telephone assistance and follow up.

~~(g)~~ (i) The person has the right to make the final decision between institutional placement and community placement after the recommendations have been provided, except as provided in section 256.975, subdivision 7a, paragraph (d).

~~(h)~~ (j) The lead agency must give the person receiving assessment or support planning, or the person's legal representative, materials, and forms supplied by the commissioner containing the following information:

(1) written recommendations for community-based services and consumer-directed options;

(2) documentation that the most cost-effective alternatives available were offered to the individual. For purposes of this clause, "cost-effective" means community services and living arrangements that cost the same as or less than institutional care. For an individual found to meet eligibility criteria for home and community-based service programs under section 256B.0915 or 256B.49, "cost-effectiveness" has the meaning found in the federally approved waiver plan for each program;

(3) the need for and purpose of preadmission screening conducted by long-term care options counselors according to section 256.975, subdivisions 7a to 7c, if the person selects nursing facility placement. If the individual selects nursing facility placement, the lead agency shall forward information needed to complete the level of care determinations and screening for developmental disability and mental illness collected during the assessment to the long-term care options counselor using forms provided by the commissioner;

(4) the role of long-term care consultation assessment and support planning in eligibility determination for waiver and alternative care programs, and state plan home care, case management, and other services as defined in subdivision 1a, paragraphs (a), clause (6), and (b);

(5) information about Minnesota health care programs;

(6) the person's freedom to accept or reject the recommendations of the team;

(7) the person's right to confidentiality under the Minnesota Government Data Practices Act, chapter 13;

(8) the certified assessor's decision regarding the person's need for institutional level of care as determined under criteria established in subdivision 4e and the certified assessor's decision regarding eligibility for all services and programs as defined in subdivision 1a, paragraphs (a), clause (6), and (b); and

(9) the person's right to appeal the certified assessor's decision regarding eligibility for all services and programs as defined in subdivision 1a, paragraphs (a), clauses (6), (7), and (8), and (b), and incorporating the decision regarding the need for institutional level of care or the lead agency's final decisions regarding public programs eligibility according to section 256.045, subdivision 3.

~~(i)~~ (k) Face-to-face assessment completed as part of eligibility determination for the alternative care, elderly waiver, community access for disability inclusion, community alternative care, and brain injury waiver programs under sections 256B.0913, 256B.0915, and 256B.49 is valid to establish service eligibility for no more than 60 calendar days after the date of assessment.

~~(j)~~ (l) The effective eligibility start date for programs in paragraph ~~(i)~~(k) can never be prior to the date of assessment. If an assessment was completed more than 60 days before the effective waiver or alternative care program eligibility start date, assessment and support plan information must be updated and documented in the department's Medicaid Management Information System (MMIS). Notwithstanding retroactive medical assistance coverage of state plan services, the effective date of eligibility for programs included in paragraph ~~(i)~~ (k) cannot be prior to the date the most recent updated assessment is completed.

(m) If an eligibility update is completed within 90 days of the previous face-to-face assessment and documented in the department's Medicaid Management Information System (MMIS), the effective date of eligibility for programs included in paragraph (k) is the date of the previous face-to-face assessment when all other eligibility requirements are met.

Sec. 7. Minnesota Statutes 2016, section 256B.0915, subdivision 3a, is amended to read:

Subd. 3a. **Elderly waiver cost limits.** (a) Effective on the first day of the state fiscal year in which the resident assessment system as described in section ~~256B.438~~ 256R.17 for nursing home rate determination is implemented and the first day of each subsequent state

fiscal year, the monthly limit for the cost of waivered services to an individual elderly waiver client shall be the monthly limit of the case mix resident class to which the waiver client would be assigned under Minnesota Rules, parts 9549.0051 to 9549.0059, in effect on the last day of the previous state fiscal year, adjusted by any legislatively adopted home and community-based services percentage rate adjustment. If a legislatively authorized increase is service-specific, the monthly cost limit shall be adjusted based on the overall average increase to the elderly waiver program.

(b) The monthly limit for the cost of waivered services under paragraph (a) to an individual elderly waiver client assigned to a case mix classification A with:

(1) no dependencies in activities of daily living; or

(2) up to two dependencies in bathing, dressing, grooming, walking, and eating when the dependency score in eating is three or greater as determined by an assessment performed under section 256B.0911 shall be $1,750 per month effective on July 1, 2011, for all new participants enrolled in the program on or after July 1, 2011. This monthly limit shall be applied to all other participants who meet this criteria at reassessment. This monthly limit shall be increased annually as described in paragraphs (a) and (e).

(c) If extended medical supplies and equipment or environmental modifications are or will be purchased for an elderly waiver client, the costs may be prorated for up to 12 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's waivered services exceeds the monthly limit established in paragraph (a), (b), (d), or (e), the annual cost of all waivered services shall be determined. In this event, the annual cost of all waivered services shall not exceed 12 times the monthly limit of waivered services as described in paragraph (a), (b), (d), or (e).

(d) Effective July 1, 2013, the monthly cost limit of waiver services, including any necessary home care services described in section 256B.0651, subdivision 2, for individuals who meet the criteria as ventilator-dependent given in section 256B.0651, subdivision 1, paragraph (g), shall be the average of the monthly medical assistance amount established for home care services as described in section 256B.0652, subdivision 7, and the annual average contracted amount established by the commissioner for nursing facility services for ventilator-dependent individuals. This monthly limit shall be increased annually as described in paragraphs (a) and (e).

(e) Effective ~~July 1, 2016~~ January 1, 2018, and each ~~July~~ January 1 thereafter, the monthly cost limits for elderly waiver services in effect on the previous ~~June 30~~ December 31 shall be increased by the difference between any legislatively adopted home and community-based

provider rate increases effective on ~~July~~ January 1 or since the previous ~~July~~ January 1 and the average statewide percentage increase in nursing facility operating payment rates under ~~sections 256B.431, 256B.434, and 256B.441~~ chapter 256R, effective the previous January 1. This paragraph shall only apply if the average statewide percentage increase in nursing facility operating payment rates is greater than any legislatively adopted home and community-based provider rate increases effective on ~~July~~ January 1, or occurring since the previous ~~July~~ January 1.

Sec. 8. Minnesota Statutes 2016, section 256B.0915, subdivision 3e, is amended to read:

Subd. 3e. **Customized living service rate.** (a) Payment for customized living services shall be a monthly rate authorized by the lead agency within the parameters established by the commissioner. The payment agreement must delineate the amount of each component service included in the recipient's customized living service plan. The lead agency, with input from the provider of customized living services, shall ensure that there is a documented need within the parameters established by the commissioner for all component customized living services authorized.

(b) The payment rate must be based on the amount of component services to be provided utilizing component rates established by the commissioner. Counties and tribes shall use tools issued by the commissioner to develop and document customized living service plans and rates.

(c) Component service rates must not exceed payment rates for comparable elderly waiver or medical assistance services and must reflect economies of scale. Customized living services must not include rent or raw food costs.

(d) With the exception of individuals described in subdivision 3a, paragraph (b), the individualized monthly authorized payment for the customized living service plan shall not exceed 50 percent of the ~~greater of either the~~ statewide ~~or any of the geographic groups'~~ weighted average monthly nursing facility rate of the case mix resident class to which the elderly waiver eligible client would be assigned under Minnesota Rules, parts 9549.0051 to 9549.0059, less the maintenance needs allowance as described in subdivision 1d, paragraph (a). ~~Effective~~ On July 1 of ~~the state fiscal~~ each year ~~in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented and July 1 of each subsequent state fiscal year~~, the individualized monthly authorized payment for the services described in this clause shall not exceed the limit which was in effect on June 30 of the previous state fiscal year updated annually based on legislatively adopted changes to all service rate maximums for home and community-based service providers.

(e) For rates effective on or after January 1, 2022, the elderly waiver payment for customized living services includes a cognitive and behavioral needs factor equal to an additional 15 percent applied to the component service rates for a client:

(1) for whom the total monthly hours for customized living services divided by 30.4 is less than 3.62; and

(2) is determined, based on responses to questions 45 and 51 of the Minnesota long-term care consultation assessment form, to have either:

(i) wandering or orientation issues; or

(ii) anxiety, verbal aggression, physical aggression, repetitive behavior, agitation, self-injurious behavior, or behavior related to property destruction.

~~(e) Effective July 1, 2011,~~ (f) The individualized monthly payment for the customized living service plan for individuals described in subdivision 3a, paragraph (b), must be the monthly authorized payment limit for customized living for individuals classified as case mix A, reduced by 25 percent. This rate limit must be applied to all new participants enrolled in the program on or after July 1, 2011, who meet the criteria described in subdivision 3a, paragraph (b). This monthly limit also applies to all other participants who meet the criteria described in subdivision 3a, paragraph (b), at reassessment.

~~(f)~~ (g) Customized living services are delivered by a provider licensed by the Department of Health as a class A or class F home care provider and provided in a building that is registered as a housing with services establishment under chapter 144D. Licensed home care providers are subject to section 256B.0651, subdivision 14.

~~(g)~~ (h) A provider may not bill or otherwise charge an elderly waiver participant or their family for additional units of any allowable component service beyond those available under the service rate limits described in paragraph ~~(d)~~ (e), nor for additional units of any allowable component service beyond those approved in the service plan by the lead agency.

~~(h)~~ (i) Effective ~~July 1, 2016~~ January 1, 2018, and each ~~July~~ January 1 thereafter, individualized service rate limits for customized living services under this subdivision shall be increased by the difference between any legislatively adopted home and community-based provider rate increases effective on ~~July~~ January 1 or since the previous ~~July~~ January 1 and the average statewide percentage increase in nursing facility operating payment rates under sections 256B.431~~,~~ and 256B.434~~,~~ and ~~256B.441~~ chapter 256R, effective the previous January 1. This paragraph shall only apply if the average statewide percentage increase in nursing facility operating payment rates is greater than any legislatively adopted home and

community-based provider rate increases effective on ~~July~~ January 1, or occurring since the previous ~~July~~ January 1.

Sec. 9. Minnesota Statutes 2016, section 256B.0915, subdivision 3h, is amended to read:

Subd. 3h. **Service rate limits; 24-hour customized living services.** (a) The payment rate for 24-hour customized living services is a monthly rate authorized by the lead agency within the parameters established by the commissioner of human services. The payment agreement must delineate the amount of each component service included in each recipient's customized living service plan. The lead agency, with input from the provider of customized living services, shall ensure that there is a documented need within the parameters established by the commissioner for all component customized living services authorized. The lead agency shall not authorize 24-hour customized living services unless there is a documented need for 24-hour supervision.

(b) For purposes of this section, "24-hour supervision" means that the recipient requires assistance due to needs related to one or more of the following:

(1) intermittent assistance with toileting, positioning, or transferring;

(2) cognitive or behavioral issues;

(3) a medical condition that requires clinical monitoring; or

(4) for all new participants enrolled in the program on or after July 1, 2011, and all other participants at their first reassessment after July 1, 2011, dependency in at least three of the following activities of daily living as determined by assessment under section 256B.0911: bathing; dressing; grooming; walking; or eating when the dependency score in eating is three or greater; and needs medication management and at least 50 hours of service per month. The lead agency shall ensure that the frequency and mode of supervision of the recipient and the qualifications of staff providing supervision are described and meet the needs of the recipient.

(c) The payment rate for 24-hour customized living services must be based on the amount of component services to be provided utilizing component rates established by the commissioner. Counties and tribes will use tools issued by the commissioner to develop and document customized living plans and authorize rates.

(d) Component service rates must not exceed payment rates for comparable elderly waiver or medical assistance services and must reflect economies of scale.

(e) The individually authorized 24-hour customized living payments, in combination with the payment for other elderly waiver services, including case management, must not exceed the recipient's community budget cap specified in subdivision 3a. Customized living services must not include rent or raw food costs.

(f) The individually authorized 24-hour customized living payment rates shall not exceed the 95 percentile of statewide monthly authorizations for 24-hour customized living services in effect and in the Medicaid management information systems on March 31, 2009, for each case mix resident class under Minnesota Rules, parts 9549.0051 to 9549.0059, to which elderly waiver service clients are assigned. When there are fewer than 50 authorizations in effect in the case mix resident class, the commissioner shall multiply the calculated service payment rate maximum for the A classification by the standard weight for that classification under Minnesota Rules, parts 9549.0051 to 9549.0059, to determine the applicable payment rate maximum. Service payment rate maximums shall be updated annually based on legislatively adopted changes to all service rates for home and community-based service providers.

(g) Notwithstanding the requirements of paragraphs (d) and (f), the commissioner may establish alternative payment rate systems for 24-hour customized living services in housing with services establishments which are freestanding buildings with a capacity of 16 or fewer, by applying a single hourly rate for covered component services provided in either:

(1) licensed corporate adult foster homes; or

(2) specialized dementia care units which meet the requirements of section 144D.065 and in which:

(i) each resident is offered the option of having their own apartment; or

(ii) the units are licensed as board and lodge establishments with maximum capacity of eight residents, and which meet the requirements of Minnesota Rules, part 9555.6205, subparts 1, 2, 3, and 4, item A.

(h) Twenty-four-hour customized living services are delivered by a provider licensed by the Department of Health as a class A or class F home care provider and provided in a building that is registered as a housing with services establishment under chapter 144D. Licensed home care providers are subject to section 256B.0651, subdivision 14.

(i) A provider may not bill or otherwise charge an elderly waiver participant or their family for additional units of any allowable component service beyond those available under

the service rate limits described in paragraph (e), nor for additional units of any allowable component service beyond those approved in the service plan by the lead agency.

(j) Effective ~~July 1, 2016~~ January 1, 2018, and each ~~July~~ January 1 thereafter, individualized service rate limits for 24-hour customized living services under this subdivision shall be increased by the difference between any legislatively adopted home and community-based provider rate increases effective on ~~July~~ January 1 or since the previous ~~July~~ January 1 and the average statewide percentage increase in nursing facility operating payment rates under ~~sections 256B.431, 256B.434, and 256B.441~~ chapter 256R, effective the previous January 1. This paragraph shall only apply if the average statewide percentage increase in nursing facility operating payment rates is greater than any legislatively adopted home and community-based provider rate increases effective on ~~July~~ January 1, or occurring since the previous ~~July~~ January 1.

Sec. 10. Minnesota Statutes 2016, section 256B.0915, subdivision 5, is amended to read:

Subd. 5. **Assessments and reassessments for waiver clients.** (a) Each client shall receive an initial assessment of strengths, informal supports, and need for services in accordance with section 256B.0911, subdivisions 3, 3a, and 3b. A reassessment of a client served under the elderly waiver must be conducted at least every 12 months ~~and at other times when the case manager determines that there has been significant change in the client's functioning. This may include instances where the client is discharged from the hospital~~. There must be a determination that the client requires nursing facility level of care as defined in section 256B.0911, subdivision 4e, at initial and subsequent assessments to initiate and maintain participation in the waiver program.

(b) Regardless of other assessments identified in section 144.0724, subdivision 4, as appropriate to determine nursing facility level of care for purposes of medical assistance payment for nursing facility services, only face-to-face assessments conducted according to section 256B.0911, subdivisions 3a and 3b, that result in a nursing facility level of care determination will be accepted for purposes of initial and ongoing access to waiver service payment.

(c) The lead agency shall conduct a change-in-condition reassessment before the annual reassessment in cases where a client's condition changed due to a major health event, an emerging need or risk, worsening health condition, or cases where the current services do not meet the client's needs. A change-in-condition reassessment may be initiated by the lead agency, or it may be requested by the client or requested on the client's behalf by another party, such as a provider of services. The lead agency shall complete a change-in-condition

reassessment no later than 20 calendar days from the request. The lead agency shall conduct these assessments in a timely manner and expedite urgent requests. The lead agency shall evaluate urgent requests based on the client's needs and risk to the client if a reassessment is not completed.

Sec. 11. Minnesota Statutes 2016, section 256B.0915, is amended by adding a subdivision to read:

Subd. 11. **Payment rates; application.** The payment methodologies in subdivisions 12 to 16 apply to elderly waiver and elderly waiver customized living under this section, alternative care under section 256B.0913, essential community supports under section 256B.0922, and community access for disability inclusion customized living, brain injury customized living, and elderly waiver foster care and residential care.

Sec. 12. Minnesota Statutes 2016, section 256B.0915, is amended by adding a subdivision to read:

Subd. 12. **Payment rates; phase-in.** (a) Effective January 1, 2019, through December 31, 2020, all rates and rate components for services under subdivision 11 shall be the sum of 12 percent of the rates calculated under subdivisions 13 to 16 and 88 percent of the rates calculated using the rate methodology in effect as of June 30, 2017.

(b) Effective January 1, 2021, all rates and rate components for services under subdivision 11 shall be the sum of 20 percent of the rates calculated under subdivisions 13 to 16 and 80 percent of the rates calculated using the rate methodology in effect as of June 30, 2017.

Sec. 13. Minnesota Statutes 2016, section 256B.0915, is amended by adding a subdivision to read:

Subd. 13. **Payment rates; establishment.** (a) The commissioner shall use standard occupational classification (SOC) codes from the Bureau of Labor Statistics as defined in the most recent edition of the Occupational Handbook and data from the most recent and available nursing facility cost report, to establish rates and component rates every January 1 using Minnesota-specific wages taken from job descriptions.

(b) In creating the rates and component rates, the commissioner shall establish a base wage calculation for each component service and value, and add the following factors:

(1) payroll taxes and benefits;

(2) general and administrative;

(3) program plan support;

(4) registered nurse management and supervision; and

(5) social worker supervision.

Sec. 14. Minnesota Statutes 2016, section 256B.0915, is amended by adding a subdivision to read:

Subd. 14. **Payment rates; base wage index.** (a) Base wages are calculated for customized living, foster care, and residential care component services as follows:

(1) the home management and support services base wage equals 33.33 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for personal and home care aide (SOC code 39-9021); 33.33 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for food preparation workers (SOC code 35-2021); and 33.34 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for maids and housekeeping cleaners (SOC code 37-2012);

(2) the home care aide base wage equals 50 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for home health aides (SOC code 31-1011); and 50 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code 31-1014);

(3) the home health aide base wage equals 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for licensed practical and licensed vocational nurses (SOC code 29-2061); and 80 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code 31-1014); and

(4) the medication setups by licensed practical nurse base wage equals ten percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for licensed practical and licensed vocational nurses (SOC code 29-2061); and 90 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for registered nurses (SOC code 29-1141).

(b) Base wages are calculated for the following services as follows:

(1) the chore services base wage equals 100 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for landscaping and groundskeeping workers (SOC code 37-3011);

(2) the companion services base wage equals 50 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for personal and home care aides (SOC code 39-9021); and 50 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for maids and housekeeping cleaners (SOC code 37-2012);

(3) the homemaker services and assistance with personal care base wage equals 60 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for personal and home care aide (SOC code 39-9021); 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code 31-1014); and 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for maids and housekeeping cleaners (SOC code 37-2012);

(4) the homemaker services and cleaning base wage equals 60 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for personal and home care aide (SOC code 39-9021); 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code 31-1014); and 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for maids and housekeeping cleaners (SOC code 37-2012);

(5) the homemaker services and home management base wage equals 60 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for personal and home care aide (SOC code 39-9021); 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code 31-1014); and 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for maids and housekeeping cleaners (SOC code 37-2012);

(6) the in-home respite care services base wage equals five percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for registered nurses (SOC code 29-1141); 75 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code 31-1014); and 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for licensed practical and licensed vocational nurses (SOC code 29-2061);

(7) the out-of-home respite care services base wage equals five percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for registered nurses (SOC code 29-1141); 75 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code 31-1014); and 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for licensed practical and licensed vocational nurses (SOC code 29-2061); and

(8) the individual community living support base wage equals 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for licensed practical and licensed vocational nurses (SOC code 29-2061); and 80 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code 31-1014).

(c) Base wages are calculated for the following values as follows:

(1) the registered nurse base wage equals 100 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for registered nurses (SOC code 29-1141); and

(2) the social worker base wage equals 100 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for medical and public health social workers (SOC code 21-1022).

(d) If any of the SOC codes and positions are no longer available, the commissioner shall, in consultation with stakeholders, select a new SOC code and position that is the closest match to the previously used SOC position.

Sec. 15. Minnesota Statutes 2016, section 256B.0915, is amended by adding a subdivision to read:

Subd. 15. **Payment rates; factors.** The commissioner shall use the following factors:

(1) the payroll taxes and benefits factor is the sum of net payroll taxes and benefits divided by the sum of all salaries for all nursing facilities on the most recent and available cost report;

(2) the general and administrative factor is the sum of net general and administrative expenses minus administrative salaries divided by total operating expenses for all nursing facilities on the most recent and available cost report;

(3) the program plan support factor is defined as the direct service staff needed to provide support for the home and community-based service when not engaged in direct contact with clients. Based on the 2016 Non-Wage Provider Costs in Home and Community-Based Disability Waiver Services Report, this factor equals 12.8 percent;

(4) the registered nurse management and supervision factor equals 15 percent of the product of the position's base wage and the sum of the factors in clauses (1) to (3); and

(5) the social worker supervision factor equals 15 percent of the product of the position's base wage and the sum of the factors in clauses (1) to (3).

Sec. 16. Minnesota Statutes 2016, section 256B.0915, is amended by adding a subdivision to read:

Subd. 16. **Payment rates; component rates.** (a) For the purposes of this subdivision, the "adjusted base wage" for a position equals the position's base wage plus:

(1) the position's base wage multiplied by the payroll taxes and benefits factor;

(2) the position's base wage multiplied by the general and administrative factor; and

(3) the position's base wage multiplied by the program plan support factor.

(b) For medication setups by licensed nurse, registered nurse, and social worker services, the component rate for each service equals the respective position's adjusted base wage.

(c) For home management and support services, home care aide, and home health aide services, the component rate for each service equals the respective position's adjusted base wage plus the registered nurse management and supervision factor.

(d) The home management and support services component rate shall be used for payment for socialization and transportation component rates under elderly waiver customized living.

(e) The 15-minute unit rates for chore services and companion services are calculated as follows:

(1) sum the adjusted base wage for the respective position and the social worker factor; and

(2) divide the result of clause (1) by four.

(f) The 15-minute unit rates for homemaker services and assistance with personal care, homemaker services and cleaning, and homemaker services and home management are calculated as follows:

(1) sum the adjusted base wage for the respective position and the registered nurse management and supervision factor; and

(2) divide the result of clause (1) by four.

(g) The 15-minute unit rate for in-home respite care services is calculated as follows:

(1) sum the adjusted base wage for in-home respite care services and the registered nurse management and supervision factor; and

(2) divide the result of clause (1) by four.

(h) The in-home respite care services daily rate equals the in-home respite care services 15-minute unit rate multiplied by 18.

(i) The 15-minute unit rate for out-of-home respite care is calculated as follows:

(1) sum the out-of-home respite care services adjusted base wage and the registered nurse management and supervision factor; and

(2) divide the result of clause (1) by four.

(j) The out-of-home respite care services daily rate equals the out-of-home respite care services 15-minute unit rate multiplied by 18.

(k) The individual community living support rate is calculated as follows:

(1) sum the adjusted base wage for the home care aide rate in subdivision 14, paragraph (a), clause (2), and the social worker factor; and

(2) divide the result of clause (1) by four.

(l) The home delivered meals rate equals $9.30. Beginning July 1, 2018, the commissioner shall increase the home delivered meals rate every July 1 by the percent increase in the nursing facility dietary per diem using the two most recent nursing facility cost reports.

(m) The adult day services rate is based on the home care aide rate in subdivision 14, paragraph (a), clause (2), plus the additional factors from subdivision 15, except that the general and administrative factor used shall be 20 percent. The nonregistered nurse portion of the rate shall be multiplied by 0.25, to reflect an assumed-ratio staffing of one caregiver to four clients, and divided by four to determine the 15-minute unit rate. The registered nurse portion is divided by four to determine the 15-minute unit rate and $0.63 per 15-minute unit is added to cover the cost of meals.

(n) The adult day services bath 15-minute unit rate is the same as the calculation of the adult day services 15-minute unit rate without the adjustment for staffing ratio.

(o) If a bath is authorized for an adult day services client, at least two 15-minute units must be authorized to allow for adequate time to meet client needs. Adult day services may be authorized for up to 48 units, or 12 hours, per day based on client and family caregiver needs.

Sec. 17. Minnesota Statutes 2016, section 256B.0915, is amended by adding a subdivision to read:

Subd. 17. **Evaluation of rate methodology.** The commissioner, in consultation with stakeholders, shall conduct a study to evaluate the following:

(1) base wages in subdivision 14, to determine if the standard occupational classification codes for each rate and component rate are an appropriate representation of staff who deliver the services; and

(2) factors in subdivision 15, and adjusted base wage calculation in subdivision 16, to determine if the factors and calculations appropriately address nonwage provider costs.

By January 1, 2019, the commissioner shall submit a report to the legislature on the changes to the rate methodology in this statute, based on the results of the evaluation. Where feasible, the report shall address the impact of the new rates on the workforce situation and client access to services. The report should include any changes to the rate calculations methods that the commissioner recommends.

Sec. 18. Minnesota Statutes 2016, section 256B.0922, subdivision 1, is amended to read:

Subdivision 1. **Essential community supports.** (a) The purpose of the essential community supports program is to provide targeted services to persons age 65 and older who need essential community support, but whose needs do not meet the level of care required for nursing facility placement under section 144.0724, subdivision 11.

(b) Essential community supports are available not to exceed ~~$400~~ $600 per person per month. Essential community supports may be used as authorized within an authorization period not to exceed 12 months. Services must be available to a person who:

(1) is age 65 or older;

(2) is not eligible for medical assistance;

(3) has received a community assessment under section 256B.0911, subdivision 3a or 3b, and does not require the level of care provided in a nursing facility;

(4) meets the financial eligibility criteria for the alternative care program under section 256B.0913, subdivision 4;

(5) has a community support plan; and

(6) has been determined by a community assessment under section 256B.0911, subdivision 3a or 3b, to be a person who would require provision of at least one of the

following services, as defined in the approved elderly waiver plan, in order to maintain their community residence:

(i) adult day services;

(ii) family caregiver ~~support~~ services;

(iii) respite care;

~~(iii)~~ (iv) homemaker support;

(v) companion services;

~~(iv)~~ (vi) chores;

~~(v)~~ (vii) a personal emergency response device or system;

~~(vi)~~ (viii) home-delivered meals; or

~~(vii)~~ (ix) community living assistance as defined by the commissioner.

(c) The person receiving any of the essential community supports in this subdivision must also receive service coordination, not to exceed $600 in a 12-month authorization period, as part of their community support plan.

(d) A person who has been determined to be eligible for essential community supports must be reassessed at least annually and continue to meet the criteria in paragraph (b) to remain eligible for essential community supports.

(e) The commissioner is authorized to use federal matching funds for essential community supports as necessary and to meet demand for essential community supports as outlined in subdivision 2, and that amount of federal funds is appropriated to the commissioner for this purpose.

Sec. 19. Minnesota Statutes 2016, section 256B.431, subdivision 10, is amended to read:

Subd. 10. **Property rate adjustments and construction projects.** A nursing facility completing a construction project that is eligible for a rate adjustment under section 256B.434, subdivision 4f, and that was not approved through the moratorium exception process in section 144A.073 must request from the commissioner a property-related payment rate adjustment. ~~If the request is made within 60 days after the construction project's completion date,~~ The effective date of the rate adjustment is the first of the month of January or July, whichever occurs first following both the construction project's completion date and submission of the provider's rate adjustment request. ~~If the request is made more than 60 days after the completion date, the rate adjustment is effective on the first of the month~~

~~following the request.~~ The commissioner shall provide a rate notice reflecting the allowable costs within 60 days after receiving all the necessary information to compute the rate adjustment. No sooner than the effective date of the rate adjustment for the construction project, a nursing facility may adjust its rates by the amount anticipated to be allowed. Any amounts collected from private pay residents in excess of the allowable rate must be repaid to private pay residents with interest at the rate used by the commissioner of revenue for the late payment of taxes and in effect on the date the rate increase is effective. Construction projects with completion dates within one year of the completion date associated with the property rate adjustment request and phased projects with project completion dates within three years of the last phase of the phased project must be aggregated for purposes of the minimum thresholds in subdivisions 16 and 17, and the maximum threshold in section 144A.071, subdivision 2. "Construction project" and "project construction costs" have the meanings given them in Minnesota Statutes, section 144A.071, subdivision 1a.

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

Sec. 20. Minnesota Statutes 2016, section 256B.431, subdivision 16, is amended to read:

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

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

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

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

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

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

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

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

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

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

Sec. 21. Minnesota Statutes 2016, section 256B.431, subdivision 30, is amended to read:

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

effective the first day of the month of January or July, whichever occurs first following the ~~month in~~ 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, a nursing facility reimbursed under that section ~~which~~ 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 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 ~~month in~~ 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, a nursing facility reimbursed under that section~~,~~ ~~which~~ that has delicensed beds after July 1, 2000, by giving notice of the delicensure to the commissioner of health according to the notice requirements in section 144A.071, subdivision 4b, shall be allowed to:

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

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

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

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

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

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

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

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

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

Sec. 22. Minnesota Statutes 2016, section 256B.434, subdivision 4, is amended to read:

Subd. 4. **Alternate rates for nursing facilities.** Effective for the rate years beginning on and after January 1, 2019, a nursing facility's ~~case mix~~ property payment ~~rates~~ rate for the second and subsequent years of a facility's contract under this section are the previous

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

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

Sec. 23. Minnesota Statutes 2016, section 256B.434, subdivision 4f, is amended to read:

Subd. 4f. **Construction project rate adjustments effective October 1, 2006.** (a) Effective October 1, 2006, facilities reimbursed under this section may receive a property rate adjustment for construction projects exceeding the threshold in section 256B.431, subdivision 16, and below the threshold in section 144A.071, subdivision 2, clause (a). For these projects, capital assets purchased shall be counted as construction project costs for a rate adjustment request made by a facility if they are: (1) purchased within 24 months of the completion of the construction project; (2) purchased after the completion date of any prior construction project; and (3) are not purchased prior to July 14, 2005. Except as otherwise provided in this subdivision, the definitions, rate calculation methods, and principles in sections 144A.071 and 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080, shall be used to calculate rate adjustments for allowable construction projects under this subdivision and section 144A.073. Facilities completing construction projects between October 1, 2005, and October 1, 2006, are eligible to have a property rate adjustment effective October 1, 2006. Facilities completing projects after October 1, 2006, are eligible

for a property rate adjustment effective on the first day of the month following the completion date. Facilities completing projects after January 1, 2018, are eligible for a property rate adjustment effective on the first day of the month of January or July, whichever occurs immediately following the completion date.

(b) Notwithstanding subdivision 18, as of July 14, 2005, facilities with rates set under section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080, that commenced a construction project on or after October 1, 2004, and do not have a contract under subdivision 3 by September 30, 2006, are eligible to request a rate adjustment under section 256B.431, subdivision 10, through September 30, 2006. If the request results in the commissioner determining a rate adjustment is allowable, the rate adjustment is effective on the first of the month following project completion. These facilities shall be allowed to accumulate construction project costs for the period October 1, 2004, to September 30, 2006.

(c) Facilities shall be allowed construction project rate adjustments no sooner than 12 months after completing a previous construction project. Facilities must request the rate adjustment according to section 256B.431, subdivision 10.

(d) Capacity days shall be computed according to Minnesota Rules, part 9549.0060, subpart 11. For rate calculations under this section, the number of licensed beds in the nursing facility shall be the number existing after the construction project is completed and the number of days in the nursing facility's reporting period shall be 365.

(e) The value of assets to be recognized for a total replacement project as defined in section 256B.431, subdivision 17d, shall be computed as described in clause (1). The value of assets to be recognized for all other projects shall be computed as described in clause (2).

(1) Replacement-cost-new limits under section 256B.431, subdivision 17e, and the number of beds allowed under subdivision 3a, paragraph (c), shall be used to compute the maximum amount of assets allowable in a facility's property rate calculation. If a facility's current request for a rate adjustment results from the completion of a construction project that was previously approved under section 144A.073, the assets to be used in the rate calculation cannot exceed the lesser of the amount determined under sections 144A.071, subdivision 2, and 144A.073, subdivision 3b, or the actual allowable costs of the construction project. A current request that is not the result of a project under section 144A.073 cannot exceed the limit under section 144A.071, subdivision 2, paragraph (a). Applicable credits must be deducted from the cost of the construction project.

(2)(i) Replacement-cost-new limits under section 256B.431, subdivision 17e, and the number of beds allowed under section 256B.431, subdivision 3a, paragraph (c), shall be used to compute the maximum amount of assets allowable in a facility's property rate calculation.

(ii) The value of a facility's assets to be compared to the amount in item (i) begins with the total appraised value from the last rate notice a facility received when its rates were set under section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080. This value shall be indexed by the factor in section 256B.431, subdivision 3f, paragraph (a), for each rate year the facility received an inflation factor on its property-related rate when its rates were set under this section. The value of assets listed as previous capital additions, capital additions, and special projects on the facility's base year rate notice and the value of assets related to a construction project for which the facility received a rate adjustment when its rates were determined under this section shall be added to the indexed appraised value.

(iii) The maximum amount of assets to be recognized in computing a facility's rate adjustment after a project is completed is the lesser of the aggregate replacement-cost-new limit computed in (i) minus the assets recognized in (ii) or the actual allowable costs of the construction project.

(iv) If a facility's current request for a rate adjustment results from the completion of a construction project that was previously approved under section 144A.073, the assets to be added to the rate calculation cannot exceed the lesser of the amount determined under sections 144A.071, subdivision 2, and 144A.073, subdivision 3b, or the actual allowable costs of the construction project. A current request that is not the result of a project under section 144A.073 cannot exceed the limit stated in section 144A.071, subdivision 2, paragraph (a). Assets disposed of as a result of a construction project and applicable credits must be deducted from the cost of the construction project.

(f) For construction projects approved under section 144A.073, allowable debt may never exceed the lesser of the cost of the assets purchased, the threshold limit in section 144A.071, subdivision 2, or the replacement-cost-new limit less previously existing capital debt.

(g) For construction projects that were not approved under section 144A.073, allowable debt is limited to the lesser of the threshold in section 144A.071, subdivision 2, for such construction projects or the applicable limit in paragraph (e), clause (1) or (2), less previously existing capital debt. Amounts of debt taken out that exceed the costs of a construction project shall not be allowed regardless of the use of the funds.

For all construction projects being recognized, interest expense and average debt shall be computed based on the first 12 months following project completion. "Previously existing capital debt" means capital debt recognized on the last rate determined under section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080, and the amount of debt recognized for a construction project for which the facility received a rate adjustment when its rates were determined under this section.

For a total replacement project as defined in section 256B.431, subdivision 17d, the value of previously existing capital debt shall be zero.

(h) In addition to the interest expense allowed from the application of paragraph (f), the amounts allowed under section 256B.431, subdivision 17a, paragraph (a), clauses (2) and (3), will be added to interest expense.

(i) The equity portion of the construction project shall be computed as the allowable assets in paragraph (e), less the average debt in paragraph (f). The equity portion must be multiplied by 5.66 percent and the allowable interest expense in paragraph (f) must be added. This sum must be divided by 95 percent of capacity days to compute the construction project rate adjustment.

(j) For projects that are not a total replacement of a nursing facility, the amount in paragraph (i) is adjusted for nonreimbursable areas and then added to the current property payment rate of the facility.

(k) For projects that are a total replacement of a nursing facility, the amount in paragraph (i) becomes the new property payment rate after being adjusted for nonreimbursable areas. Any amounts existing in a facility's rate before the effective date of the construction project for equity incentives under section 256B.431, subdivision 16; capital repairs and replacements under section 256B.431, subdivision 15; or refinancing incentives under section 256B.431, subdivision 19, shall be removed from the facility's rates.

(l) No additional equipment allowance is allowed under Minnesota Rules, part 9549.0060, subpart 10, as the result of construction projects under this section. Allowable equipment shall be included in the construction project costs.

(m) Capital assets purchased after the completion date of a construction project shall be counted as construction project costs for any future rate adjustment request made by a facility under section 144A.071, subdivision 2, clause (a), if they are purchased within 24 months of the completion of the future construction project.

(n) In subsequent rate years, the property payment rate for a facility that results from the application of this subdivision shall be the amount inflated in subdivision 4.

(o) Construction projects are eligible for an equity incentive under section 256B.431, subdivision 16. When computing the equity incentive for a construction project under this subdivision, only the allowable costs and allowable debt related to the construction project shall be used. The equity incentive shall not be a part of the property payment rate and not inflated under subdivision 4. Effective October 1, 2006, all equity incentives for nursing facilities reimbursed under this section shall be allowed for a duration determined under section 256B.431, subdivision 16, paragraph (c).

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

Sec. 24. Minnesota Statutes 2016, section 256B.50, subdivision 1b, is amended to read:

Subd. 1b. **Filing an appeal.** To appeal, the provider shall file with the commissioner a written notice of appeal; the appeal must be postmarked or received by the commissioner within 60 days of the publication date ~~the determination of the payment rate was mailed or personally received by a provider, whichever is earlier~~ printed on the rate notice. The notice of appeal must specify each disputed item; the reason for the dispute; the total dollar amount in dispute for each separate disallowance, allocation, or adjustment of each cost item or part of a cost item; the computation that the provider believes is correct; the authority in statute or rule upon which the provider relies for each disputed item; the name and address of the person or firm with whom contacts may be made regarding the appeal; and other information required by the commissioner.

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

Sec. 25. Minnesota Statutes 2016, section 256B.5012, is amended by adding a subdivision to read:

Subd. 3a. **Therapeutic leave days.** Notwithstanding Minnesota Rules, part 9505.0415, subpart 7, a vacant bed in an intermediate care facility for persons with developmental disabilities shall be counted as a reserved bed when determining occupancy rates and eligibility for payment of a therapeutic leave day.

Sec. 26. Minnesota Statutes 2016, section 256R.02, subdivision 4, is amended to read:

Subd. 4. **Administrative costs.** "Administrative costs" means the identifiable costs for administering the overall activities of the nursing home. These costs include salaries and wages of the administrator, assistant administrator, business office employees, security

guards, and associated fringe benefits and payroll taxes, fees, contracts, or purchases related to business office functions, licenses, ~~and~~ permits except as provided in the external fixed costs category, employee recognition, travel including meals and lodging, all training except as specified in subdivision 17, voice and data communication or transmission, office supplies, property and liability insurance and other forms of insurance ~~not designated to other areas~~ except insurance that is a fringe benefit under subdivision 22, personnel recruitment, legal services, accounting services, management or business consultants, data processing, information technology, Web site, central or home office costs, business meetings and seminars, postage, fees for professional organizations, subscriptions, security services, advertising, board of directors fees, working capital interest expense, ~~and~~ bad debts, and bad debt collection fees.

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

Sec. 27. Minnesota Statutes 2016, section 256R.02, subdivision 18, is amended to read:

Subd. 18. **Employer health insurance costs.** "Employer health insurance costs" means premium expenses for group coverage ~~and reinsurance,~~; actual expenses incurred for self-insured plans, including reinsurance; and employer contributions to employee health reimbursement and health savings accounts. Premium and expense costs and contributions are allowable for (1) all employees and (2) the spouse and dependents of those employees who ~~meet the definition of full-time employees under the federal Affordable Care Act, Public Law 111-148~~ are employed on average at least 30 hours per week.

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

Sec. 28. Minnesota Statutes 2016, section 256R.07, is amended by adding a subdivision to read:

Subd. 6. **Electronic signature.** For documentation requiring a signature under this chapter or section 256B.431 or 256B.434, use of an electronic signature as defined under section 325L.02, paragraph (h), is allowed.

Sec. 29. Minnesota Statutes 2016, section 256R.10, is amended by adding a subdivision to read:

Subd. 7. **Not specified allowed costs.** When the cost category for allowed cost items or services is not specified in this chapter or the provider reimbursement manual, the commissioner, in consultation with stakeholders, shall determine the cost category for the allowed cost item or service.

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

Sec. 30. **[256R.18] REPORT BY COMMISSIONER OF HUMAN SERVICES.**

Beginning January 1, 2019, the commissioner shall provide to the house of representatives and senate committees with jurisdiction over nursing facility payment rates a biennial report on the effectiveness of the reimbursement system in improving quality, restraining costs, and any other features of the system as determined by the commissioner.

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

Sec. 31. Minnesota Statutes 2016, section 256R.37, is amended to read:

256R.37 SCHOLARSHIPS.

(a) For the 27-month period beginning October 1, 2015, through December 31, 2017, the commissioner shall allow a scholarship per diem of up to 25 cents for each nursing facility with no scholarship per diem that is requesting a scholarship per diem to be added to the external fixed payment rate to be used:

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

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

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

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

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

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

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

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

Sec. 32. Minnesota Statutes 2016, section 256R.40, subdivision 5, is amended to read:

Subd. 5. **Planned closure rate adjustment.** (a) The commissioner shall calculate the amount of the planned closure rate adjustment available under subdivision 6 according to clauses (1) to (4):

(1) the amount available is the net reduction of nursing facility beds multiplied by $2,080;

(2) the total number of beds in the nursing facility or facilities receiving the planned closure rate adjustment must be identified;

(3) capacity days are determined by multiplying the number determined under clause (2) by 365; and

(4) the planned closure rate adjustment is the amount available in clause (1), divided by capacity days determined under clause (3).

(b) A planned closure rate adjustment under this section is effective on the first day of the month <u>of January or July, whichever occurs immediately</u> following completion of closure of the facility designated for closure in the application and becomes part of the nursing facility's external fixed payment rate.

(c) Upon the request of a closing facility, the commissioner must allow the facility a closure rate adjustment as provided under section 144A.161, subdivision 10.

(d) A facility that has received a planned closure rate adjustment may reassign it to another facility that is under the same ownership at any time within three years of its effective date. The amount of the adjustment is computed according to paragraph (a).

(e) If the per bed dollar amount specified in paragraph (a), clause (1), is increased, the commissioner shall recalculate planned closure rate adjustments for facilities that delicense beds under this section on or after July 1, 2001, to reflect the increase in the per bed dollar amount. The recalculated planned closure rate adjustment is effective from the date the per bed dollar amount is increased.

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

Sec. 33. Minnesota Statutes 2016, section 256R.41, is amended to read:

256R.41 SINGLE-BED ROOM INCENTIVE.

(a) Beginning July 1, 2005, the operating payment rate for nursing facilities reimbursed under this chapter shall be increased by 20 percent multiplied by the ratio of the number of new single-bed rooms created divided by the number of active beds on July 1, 2005, for each bed closure that results in the creation of a single-bed room after July 1, 2005. The commissioner may implement rate adjustments for up to 3,000 new single-bed rooms each year. For eligible bed closures for which the commissioner receives a notice from a facility ~~during a calendar quarter~~ that a bed has been delicensed and a new single-bed room has been established, the rate adjustment in this paragraph shall be effective on either the first day of the ~~second~~ month ~~following that calendar quarter~~ of January or July, whichever occurs immediately following the date of the bed delicensure.

(b) A nursing facility is prohibited from discharging residents for purposes of establishing single-bed rooms. A nursing facility must submit documentation to the commissioner in a form prescribed by the commissioner, certifying the occupancy status of beds closed to create single-bed rooms. In the event that the commissioner determines that a facility has discharged a resident for purposes of establishing a single-bed room, the commissioner shall not provide a rate adjustment under paragraph (a).

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

Sec. 34. Minnesota Statutes 2016, section 256R.47, is amended to read:

256R.47 RATE ADJUSTMENT FOR CRITICAL ACCESS NURSING FACILITIES.

(a) The commissioner, in consultation with the commissioner of health, may designate certain nursing facilities as critical access nursing facilities. The designation shall be granted on a competitive basis, within the limits of funds appropriated for this purpose.

(b) The commissioner shall request proposals from nursing facilities every two years. Proposals must be submitted in the form and according to the timelines established by the commissioner. In selecting applicants to designate, the commissioner, in consultation with the commissioner of health, and with input from stakeholders, shall develop criteria designed to preserve access to nursing facility services in isolated areas, rebalance long-term care,

and improve quality. To the extent practicable, the commissioner shall ensure an even distribution of designations across the state.

(c) The commissioner shall allow the benefits in clauses (1) to (5) for nursing facilities designated as critical access nursing facilities:

(1) partial rebasing, with the commissioner allowing a designated facility operating payment rates being the sum of up to 60 percent of the operating payment rate determined in accordance with section 256R.21, subdivision 3, and at least 40 percent, with the sum of the two portions being equal to 100 percent, of the operating payment rate that would have been allowed had the facility not been designated. The commissioner may adjust these percentages by up to 20 percent and may approve a request for less than the amount allowed;

(2) enhanced payments for leave days. Notwithstanding section 256R.43, upon designation as a critical access nursing facility, the commissioner shall limit payment for leave days to 60 percent of that nursing facility's total payment rate for the involved resident, and shall allow this payment only when the occupancy of the nursing facility, inclusive of bed hold days, is equal to or greater than 90 percent;

(3) two designated critical access nursing facilities, with up to 100 beds in active service, may jointly apply to the commissioner of health for a waiver of Minnesota Rules, part 4658.0500, subpart 2, in order to jointly employ a director of nursing. The commissioner of health shall consider each waiver request independently based on the criteria under Minnesota Rules, part 4658.0040;

(4) the minimum threshold under section 256B.431, subdivision 15, paragraph (e), shall be 40 percent of the amount that would otherwise apply; and

(5) the quality-based rate limits under section 256R.23, subdivisions 5 to 7, apply to designated critical access nursing facilities.

(d) Designation of a critical access nursing facility is for a period of two years, after which the benefits allowed under paragraph (c) shall be removed. Designated facilities may apply for continued designation.

(e) This section is suspended and no state or federal funding shall be appropriated or allocated for the purposes of this section from January 1, 2016, to December 31, ~~2017~~ 2019.

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

Sec. 35. Minnesota Statutes 2016, section 256R.49, subdivision 1, is amended to read:

Subdivision 1. **Rate adjustments for compensation-related costs.** (a) ~~Operating payment rates of all nursing facilities that are reimbursed under this chapter shall be increased effective for rate years beginning on and after October 1, 2014, to address changes in compensation costs for nursing facility employees paid less than $14 per hour in accordance with this section.~~ Rate increases provided under this section before October 1, 2016, expire effective January 1, 2018, and rate increases provided on or after October 1, 2016, expire effective January 1, 2019.

(b) Nursing facilities that receive approval of the applications in subdivision 2 must receive rate adjustments according to subdivision 4. The rate adjustments must be used to pay compensation costs for nursing facility employees paid less than $14 per hour.

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

Sec. 36. **DIRECTION TO COMMISSIONER; ADULT DAY SERVICES STAFFING RATIOS.**

The commissioner of human services shall study the staffing ratio for adult day services clients and shall provide the chairs and ranking minority members of the house of representatives and senate committees with jurisdiction over adult day services with recommendations to adjust staffing ratios based on client needs by January 1, 2018.

Sec. 37. **REVISOR'S INSTRUCTION.**

The revisor of statutes, in consultation with the House Research Department, Office of Senate Counsel, Research, and Fiscal Analysis, and Department of Human Services shall prepare legislation for the 2018 legislative session to recodify laws governing the elderly waiver program in Minnesota Statutes, chapter 256B.

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

ARTICLE 4

HEALTH CARE

Section 1. Minnesota Statutes 2016, section 3.972, is amended by adding a subdivision to read:

Subd. 2b. **Audits of managed care organizations.** (a) The legislative auditor shall audit each managed care organization that contracts with the commissioner of human services to provide health care services under sections 256B.69, 256B.692, and 256L.12. The legislative

auditor shall design the audits to determine if a managed care organization used the public money in compliance with federal and state laws, rules, and in accordance with provisions in the managed care organization's contract with the commissioner of human services. The legislative auditor shall determine the schedule and scope of the audit work and may contract with vendors to assist with the audits. The managed care organization must cooperate with the legislative auditor and must provide the legislative auditor with all data, documents, and other information, regardless of classification, that the legislative auditor requests to conduct an audit. The legislative auditor shall periodically report audit results and recommendations to the Legislative Audit Commission and the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance.

(b) For purposes of this subdivision, a "managed care organization" means a demonstration provider as defined under section 256B.69, subdivision 2.

Sec. 2. Minnesota Statutes 2016, section 13.69, subdivision 1, is amended to read:

Subdivision 1. **Classifications.** (a) The following government data of the Department of Public Safety are private data:

(1) medical data on driving instructors, licensed drivers, and applicants for parking certificates and special license plates issued to physically disabled persons;

(2) other data on holders of a disability certificate under section 169.345, except that (i) data that are not medical data may be released to law enforcement agencies, and (ii) data necessary for enforcement of sections 169.345 and 169.346 may be released to parking enforcement employees or parking enforcement agents of statutory or home rule charter cities and towns;

(3) Social Security numbers in driver's license and motor vehicle registration records, except that Social Security numbers must be provided to the Department of Revenue for purposes of tax administration, the Department of Labor and Industry for purposes of workers' compensation administration and enforcement, the Department of Human Services for purposes of recovery of Minnesota health care program benefits paid, and the Department of Natural Resources for purposes of license application administration; and

(4) data on persons listed as standby or temporary custodians under section 171.07, subdivision 11, except that the data must be released to:

(i) law enforcement agencies for the purpose of verifying that an individual is a designated caregiver; or

(ii) law enforcement agencies who state that the license holder is unable to communicate at that time and that the information is necessary for notifying the designated caregiver of the need to care for a child of the license holder.

The department may release the Social Security number only as provided in clause (3) and must not sell or otherwise provide individual Social Security numbers or lists of Social Security numbers for any other purpose.

(b) The following government data of the Department of Public Safety are confidential data: data concerning an individual's driving ability when that data is received from a member of the individual's family.

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

Sec. 3. Minnesota Statutes 2016, section 62U.02, is amended to read:

62U.02 PAYMENT RESTRUCTURING; QUALITY INCENTIVE PAYMENTS.

Subdivision 1. **Development.** (a) The commissioner of health shall develop a standardized set of measures for use by health plan companies as specified in subdivision 5. As part of the standardized set of measures, the commissioner shall establish statewide measures by which to assess the quality of health care services offered by health care providers, including health care providers certified as health care homes under section 256B.0751. ~~Quality measures must be based on medical evidence and be developed through a process in which providers participate.~~ The statewide measures shall be used for the quality incentive payment system developed in subdivision 2 and the quality transparency requirements in subdivision 3. The statewide measures must:

(1) for purposes of assessing the quality of care provided at physician clinics, including clinics certified as health care homes under section 256B.0751, be selected from the available measures as defined in Code of Federal Regulations, title 42, part 414 or 495, as amended, unless the stakeholders identified under paragraph (b) determine that a particular diagnosis, condition, service, or procedure is not reflected in any of the available measures in a way that meets identified needs;

(2) be based on medical evidence;

(3) be developed through a process in which providers participate and consumer and community input and perspectives are obtained;

~~(1)~~ (4) include uniform definitions, measures, and forms for submission of data, to the greatest extent possible;

~~(2)~~ (5) seek to avoid increasing the administrative burden on health care providers; and

~~(3) be initially based on existing quality indicators for physician and hospital services, which are measured and reported publicly by quality measurement organizations, including, but not limited to, Minnesota Community Measurement and specialty societies;~~

~~(4)~~ (6) place a priority on measures of health care outcomes, rather than process measures, wherever possible~~; and~~

~~(5) incorporate measures for primary care, including preventive services, coronary artery and heart disease, diabetes, asthma, depression, and other measures as determined by the commissioner~~.

The measures may also include measures of care infrastructure and patient satisfaction.

(b) By June 30, 2018, the commissioner shall develop a measurement framework that identifies the most important elements for assessing the quality of care, articulates statewide quality improvement goals, ensures clinical relevance, fosters alignment with other measurement efforts, and defines the roles of stakeholders. By December 15, 2018, the commissioner shall use the framework to update the statewide measures used to assess the quality of health care services offered by health care providers, including health care providers certified as health care homes under section 256B.0751. No more than six statewide measures shall be required for single-specialty physician practices and no more than ten statewide measures shall be required for multispecialty physician practices. Measures in addition to the six statewide measures for single-specialty practices and the ten statewide measures for multispecialty practices may be included for a physician practice if derived from administrative claims data. Care infrastructure measures collected according to section 62J.495 shall not be counted toward the maximum number of measures specified in this paragraph. The commissioner shall develop the framework in consultation with stakeholders that include consumer, community, and advocacy organizations representing diverse communities and patients; health plan companies; health care providers whose quality is assessed, including providers who serve primarily socioeconomically complex patient populations; health care purchasers; community health boards; and quality improvement and measurement organizations. The commissioner, in consultation with stakeholders, shall review the framework at least once every three years. The commissioner shall also submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by September 30, 2018, summarizing the development of the measurement framework and making recommendations

on the type and appropriate maximum number of measures in the statewide measures set for implementation on January 1, 2020.

~~(b)~~ (c) Effective July 1, 2016, the commissioner shall stratify quality measures by race, ethnicity, preferred language, and country of origin beginning with five measures, and stratifying additional measures to the extent resources are available. On or after January 1, 2018, the commissioner may require measures to be stratified by other sociodemographic factors or composite indices of multiple factors that according to reliable data are correlated with health disparities and have an impact on performance on quality or cost indicators. New methods of stratifying data under this paragraph must be tested and evaluated through pilot projects prior to adding them to the statewide system. In determining whether to add additional sociodemographic factors and developing the methodology to be used, the commissioner shall consider the reporting burden on providers and determine whether there are alternative sources of data that could be used. The commissioner shall ensure that categories and data collection methods are developed in consultation with those communities impacted by health disparities using culturally appropriate community engagement principles and methods. The commissioner shall implement this paragraph in coordination with the contracting entity retained under subdivision 4, in order to build upon the data stratification methodology that has been developed and tested by the entity. Nothing in this paragraph expands or changes the commissioner's authority to collect, analyze, or report health care data. Any data collected to implement this paragraph must be data that is available or is authorized to be collected under other laws. Nothing in this paragraph grants authority to the commissioner to collect or analyze patient-level or patient-specific data of the patient characteristics identified under this paragraph.

~~(c)~~ (d) The statewide measures shall be reviewed at least annually by the commissioner.

Subd. 2. **Quality incentive payments.** (a) By July 1, 2009, the commissioner shall develop a system of quality incentive payments under which providers are eligible for quality-based payments that are in addition to existing payment levels, based upon a comparison of provider performance against specified targets, and improvement over time. The targets must be based upon and consistent with the quality measures established under subdivision 1.

(b) To the extent possible, the payment system must adjust for variations in patient population in order to reduce incentives to health care providers to avoid high-risk patients or populations, including those with risk factors related to race, ethnicity, language, country of origin, and sociodemographic factors.

(c) The requirements of section 62Q.101 do not apply under this incentive payment system.

Subd. 3. **Quality transparency.** (a) The commissioner shall establish standards for measuring health outcomes, establish a system for risk adjusting quality measures, and issue ~~annual~~ periodic public reports on trends in provider quality ~~beginning July 1, 2010~~ at the statewide, regional, or clinic levels.

(b) Effective July 1, 2017, the risk adjustment system established under this subdivision shall adjust for patient characteristics identified under subdivision 1, paragraph ~~(b)~~ (c), that are correlated with health disparities and have an impact on performance on cost and quality measures. The risk adjustment method may consist of reporting based on an actual-to-expected comparison that reflects the characteristics of the patient population served by the clinic or hospital. The commissioner shall implement this paragraph in coordination with any contracting entity retained under subdivision 4.

(c) ~~By January 1, 2010,~~ Physician clinics and hospitals shall submit standardized ~~electronic~~ information ~~on the outcomes and processes associated with patient care~~ for the identified statewide measures to the commissioner or the commissioner's designee in the formats specified by the commissioner, which must include alternative formats for clinics or hospitals experiencing technological or economic barriers to submission in standardized electronic form. ~~In addition to measures of care processes and outcomes, the report may include other measures designated by the commissioner, including, but not limited to, care infrastructure and patient satisfaction. The commissioner shall ensure that any quality data reporting requirements established under this subdivision are not duplicative of publicly reported, communitywide quality reporting activities currently under way in Minnesota.~~ The commissioner shall ensure that any quality data reporting requirements for physician clinics are aligned with the specifications and timelines for the selected measures as defined in subdivision 1, paragraph (a), clause (1). The commissioner may develop additional data on race, ethnicity, preferred language, country of origin, or other sociodemographic factors as identified under subdivision 1, paragraph (c), and as required for stratification or risk adjustment. None of the statewide measures selected shall require providers to use an external vendor to administer or collect data. ~~Nothing in this subdivision is intended to replace or duplicate current privately supported activities related to quality measurement and reporting in Minnesota.~~

Subd. 4. **Contracting.** The commissioner may contract with a private entity or consortium of private entities to complete the tasks in subdivisions 1 to 3. The private entity or consortium must be nonprofit and have governance that includes representatives from the

following stakeholder groups: health care providers, including providers serving high concentrations of patients and communities impacted by health disparities; health plan companies; consumers, including consumers representing groups who experience health disparities; employers or other health care purchasers; and state government. No one stakeholder group shall have a majority of the votes on any issue or hold extraordinary powers not granted to any other governance stakeholder.

Subd. 5. **Implementation.** ~~(a) By January 1, 2010,~~ Health plan companies shall use the standardized ~~quality~~ set of measures established under this section and shall not require providers to use and report health plan company-specific quality and outcome measures.

~~(b) By July 1, 2010, the commissioner of management and budget shall implement this incentive payment system for all participants in the state employee group insurance program.~~

Sec. 4. Minnesota Statutes 2016, section 62V.05, subdivision 12, is amended to read:

Subd. 12. **Reports on interagency agreements and intra-agency transfers.** The MNsure Board shall provide quarterly reports to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance on:

(1) interagency agreements or service-level agreements and any renewals or extensions of existing interagency or service-level agreements with a state department under section 15.01, state agency under section 15.012, or the Office of MN.IT Services, with a value of more than $100,000, or related agreements with the same department or agency with a cumulative value of more than $100,000; and

(2) transfers of appropriations of more than $100,000 between accounts within or between agencies.

The report must include the statutory citation authorizing the agreement, transfer or dollar amount, purpose, and effective date of the agreement, and the duration of the agreement~~, and a copy of the agreement~~.

Sec. 5. Minnesota Statutes 2016, section 256.01, is amended by adding a subdivision to read:

Subd. 18f. **Asset verification system.** The commissioner shall implement the Asset Verification System (AVS) according to Public Law 110-252, title VII, section 7001(d), to verify assets for an individual applying for or renewing health care benefits under section 256B.055, subdivision 7.

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

Sec. 6. Minnesota Statutes 2016, section 256.01, subdivision 41, is amended to read:

Subd. 41. **Reports on interagency agreements and intra-agency transfers.** The commissioner of human services shall provide quarterly reports to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance on:

(1) interagency agreements or service-level agreements and any renewals or extensions of existing interagency or service-level agreements with a state department under section 15.01, state agency under section 15.012, or the Office of MN.IT Services, with a value of more than $100,000, or related agreements with the same department or agency with a cumulative value of more than $100,000; and

(2) transfers of appropriations of more than $100,000 between accounts within or between agencies.

The report must include the statutory citation authorizing the agreement, transfer or dollar amount, purpose, and effective date of the agreement, and the duration of the agreement~~, and a copy of the agreement~~.

Sec. 7. Minnesota Statutes 2016, section 256.969, subdivision 2b, is amended to read:

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

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

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

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

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

(b) For the period beginning January 1, 2011, through October 31, 2014, rates shall not be rebased, except that a Minnesota long-term hospital shall be rebased effective January 1, 2011, based on its most recent Medicare cost report ending on or before September 1,

2008, with the provisions under subdivisions 9 and 23, based on the rates in effect on December 31, 2010. For rate setting periods after November 1, 2014, in which the base years are updated, a Minnesota long-term hospital's base year shall remain within the same period as other hospitals.

(c) Effective for discharges occurring on and after November 1, 2014, payment rates for hospital inpatient services provided by hospitals located in Minnesota or the local trade area, except for the hospitals paid under the methodologies described in paragraph (a), clauses (2) and (3), shall be rebased, incorporating cost and payment methodologies in a manner similar to Medicare. The base year for the rates effective November 1, 2014, shall be calendar year 2012. The rebasing under this paragraph shall be budget neutral, ensuring that the total aggregate payments under the rebased system are equal to the total aggregate payments that were made for the same number and types of services in the base year. Separate budget neutrality calculations shall be determined for payments made to critical access hospitals and payments made to hospitals paid under the DRG system. Only the rate increases or decreases under subdivision 3a or 3c that applied to the hospitals being rebased during the entire base period shall be incorporated into the budget neutrality calculation.

(d) For discharges occurring on or after November 1, 2014, through the next rebasing that occurs, the rebased rates under paragraph (c) that apply to hospitals under paragraph (a), clause (4), shall include adjustments to the projected rates that result in no greater than a five percent increase or decrease from the base year payments for any hospital. Any adjustments to the rates made by the commissioner under this paragraph and paragraph (e) shall maintain budget neutrality as described in paragraph (c).

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

(1) pediatric services;

(2) behavioral health services;

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

(4) transplant services;

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

(6) outlier admissions;

(7) low-volume providers; and

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

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

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

(2) for critical access hospitals, payment rates for discharges between November 1, 2014, and June 30, 2015, shall be set to the same rate of payment that applied for discharges on October 31, 2014;

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

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

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

(h) Effective for discharges occurring on or after July 1, ~~2017~~ 2021, and every two years thereafter, payment rates under this section shall be rebased to reflect only those changes in hospital costs between the existing base year and the next base year. The commissioner shall establish the base year for each rebasing period considering the most recent year for which filed Medicare cost reports are available. The estimated change in the average payment per hospital discharge resulting from a scheduled rebasing must be calculated and made available to the legislature by January 15 of each year in which rebasing is scheduled to occur, and must include by hospital the differential in payment rates compared to the individual hospital's costs.

(i) Effective for discharges occurring on or after July 1, 2015, payment rates for critical access hospitals located in Minnesota or the local trade area shall be determined using a new cost-based methodology. The commissioner shall establish within the methodology tiers of payment designed to promote efficiency and cost-effectiveness. Payment rates for

hospitals under this paragraph shall be set at a level that does not exceed the total cost for critical access hospitals as reflected in base year cost reports. Until the next rebasing that occurs, the new methodology shall result in no greater than a five percent decrease from the base year payments for any hospital, except a hospital that had payments that were greater than 100 percent of the hospital's costs in the base year shall have their rate set equal to 100 percent of costs in the base year. The rates paid for discharges on and after July 1, 2016, covered under this paragraph shall be increased by the inflation factor in subdivision 1, paragraph (a). The new cost-based rate shall be the final rate and shall not be settled to actual incurred costs. Hospitals shall be assigned a payment tier based on the following criteria:

(1) hospitals that had payments at or below 80 percent of their costs in the base year shall have a rate set that equals 85 percent of their base year costs;

(2) hospitals that had payments that were above 80 percent, up to and including 90 percent of their costs in the base year shall have a rate set that equals 95 percent of their base year costs; and

(3) hospitals that had payments that were above 90 percent of their costs in the base year shall have a rate set that equals 100 percent of their base year costs.

(j) The commissioner may refine the payment tiers and criteria for critical access hospitals to coincide with the next rebasing under paragraph (h). The factors used to develop the new methodology may include, but are not limited to:

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

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

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

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

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

(6) geographic location.

Sec. 8. Minnesota Statutes 2016, section 256.969, is amended by adding a subdivision to read:

Subd. 2e. **Alternate inpatient payment rate.** (a) If the days, costs, and revenues associated with patients who are eligible for medical assistance and also have private health insurance are required to be included in the calculation of the hospital-specific disproportionate share hospital payment limit for a rate year, then the commissioner, effective retroactively from rate years beginning on or after January 1, 2015, shall compute an alternate inpatient payment rate for a Minnesota hospital that is designated as a children's hospital and enumerated as such by Medicare. The commissioner shall reimburse the hospital for a rate year at the higher of the amount calculated under the alternate payment rate or the amount calculated under subdivision 9.

(b) The alternate payment rate must meet the criteria in clauses (1) to (4):

(1) the alternate payment rate shall be structured to target a total aggregate reimbursement amount equal to two percent less than each children's hospital's cost coverage percentage in the applicable base year for providing fee-for-service inpatient services under this section to patients enrolled in medical assistance;

(2) costs shall be determined using the most recently available medical assistance cost report provided under subdivision 4b, paragraph (a), clause (3), for the applicable base year. Costs shall be determined using standard Medicare cost finding and cost allocation methods and applied in the same manner as the costs were in the rebasing for the applicable base year. If the medical assistance cost report is not available, costs shall be determined in the interim using the Medicare cost report;

(3) in any rate year in which payment to a hospital is made using the alternate payment rate, no payments shall be made to the hospital under subdivision 9; and

(4) if the alternate payment amount increases payments at a rate that is higher than the inflation factor applied over the rebasing period, the commissioner shall take this into consideration when setting payment rates at the next rebasing.

Sec. 9. Minnesota Statutes 2016, section 256.969, subdivision 4b, is amended to read:

Subd. 4b. **Medical assistance cost reports for services.** (a) A hospital that meets one of the following criteria must annually submit to the commissioner medical assistance cost reports within six months of the end of the hospital's fiscal year:

(1) a hospital designated as a critical access hospital that receives medical assistance payments; ~~or~~

(2) a Minnesota hospital or out-of-state hospital located within a Minnesota local trade area that receives a disproportionate population adjustment under subdivision 9; or

(3) a Minnesota hospital that is designated as a children's hospital and enumerated as such by Medicare.

For purposes of this subdivision, local trade area has the meaning given in subdivision 17.

(b) The commissioner shall suspend payments to any hospital that fails to submit a report required under this subdivision. Payments must remain suspended until the report has been filed with and accepted by the commissioner.

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

Sec. 10. **[256B.0371] ADMINISTRATION OF DENTAL SERVICES.**

Subdivision 1. **Contract for dental administration services.** (a) The commissioner shall contract with up to two dental administrators to administer dental services for all recipients of medical assistance and MinnesotaCare.

(b) The dental administrator must provide administrative services, including, but not limited to:

(1) provider recruitment, contracting, and assistance;

(2) recipient outreach and assistance;

(3) utilization management and review for medical necessity of dental services;

(4) dental claims processing, including submission of encounter claims to the department;

(5) coordination with other services;

(6) management of fraud and abuse;

(7) monitoring of access to dental services;

(8) performance measurement;

(9) quality improvement and evaluation requirements; and

(10) management of third party liability requirements.

(c) A payment to a contracted dental provider shall be at the rates established under section 256B.76.

Subd. 2. **Requirements.** (a) Recipients shall be given a choice of dental provider, including any provider who agrees to the provider participation requirements and payment rates established under this section. The commissioner and dental services administrator shall comply with the network adequacy, geographic access, and essential community provider requirements that apply to managed care plans and county-based purchasing plans for nondental services.

(b) The commissioner shall implement this section in consultation with representatives of providers who provide dental services to patients enrolled in medical assistance or MinnesotaCare, including, but not limited to, providers who serve primarily low-income and socioeconomically complex patient populations.

(c) The commissioner shall consult with county-based purchasing plans on the development and review of a request for proposals, and development of metrics to evaluate the performance of a dental administrator. A contract between the commissioner and a dental administrator must ensure that the administrator coordinates and works with county-based purchasing plans to assist enrollees in accessing appropriate dental care within their geographic areas.

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

Sec. 11. Minnesota Statutes 2016, section 256B.04, subdivision 21, is amended to read:

Subd. 21. **Provider enrollment.** (a) The commissioner shall enroll providers and conduct screening activities as required by Code of Federal Regulations, title 42, section 455, subpart E, including database checks, unannounced pre- and post-enrollment site visits, fingerprinting, and criminal background studies. A provider providing services from multiple locations must enroll each location separately. The commissioner may deny a provider's incomplete application for enrollment if a provider fails to respond to the commissioner's request for additional information within 60 days of the request.

(b) The commissioner must revalidate each provider under this subdivision at least once every five years. The commissioner may revalidate a personal care assistance agency under this subdivision once every three years. The commissioner shall conduct revalidation as follows:

(1) provide 30-day notice of revalidation due date to include instructions for revalidation and a list of materials the provider must submit to revalidate;

(2) notify the provider that fails to completely respond within 30 days of any deficiencies and allow an additional 30 days to comply; and

(3) give 60-day notice of termination and immediately suspend a provider's ability to bill for failure to remedy any deficiencies within the 30-day time period. The provider shall have no right to appeal suspension of ability to bill.

(c) The commissioner may suspend a provider's ability to bill for a failure to comply with any individual provider requirements or conditions of participation until the provider comes into compliance. The commissioner's decision to suspend the provider is not subject to an administrative appeal.

(d) Notwithstanding any other provision to the contrary, all correspondence and notifications, including notifications of termination and other actions, shall be delivered electronically to a provider's MN-ITS mailbox. For a provider that does not have a MN-ITS account and mailbox, notice shall be sent by first class mail.

(e) If the commissioner or the Centers for Medicare and Medicaid Services determines that a provider is designated "high-risk," the commissioner may withhold payment from providers within that category upon initial enrollment for a 90-day period. The withholding for each provider must begin on the date of the first submission of a claim.

~~(b)~~ (f) An enrolled provider that is also licensed by the commissioner under chapter 245A, or is licensed as a home care provider by the Department of Health under chapter 144A and has a home and community-based services designation on the home care license under section 144A.484, must designate an individual as the entity's compliance officer. The compliance officer must:

(1) develop policies and procedures to assure adherence to medical assistance laws and regulations and to prevent inappropriate claims submissions;

(2) train the employees of the provider entity, and any agents or subcontractors of the provider entity including billers, on the policies and procedures under clause (1);

(3) respond to allegations of improper conduct related to the provision or billing of medical assistance services, and implement action to remediate any resulting problems;

(4) use evaluation techniques to monitor compliance with medical assistance laws and regulations;

(5) promptly report to the commissioner any identified violations of medical assistance laws or regulations; and

(6) within 60 days of discovery by the provider of a medical assistance reimbursement overpayment, report the overpayment to the commissioner and make arrangements with the commissioner for the commissioner's recovery of the overpayment.

The commissioner may require, as a condition of enrollment in medical assistance, that a provider within a particular industry sector or category establish a compliance program that contains the core elements established by the Centers for Medicare and Medicaid Services.

~~(c)~~ (g) The commissioner may revoke the enrollment of an ordering or rendering provider for a period of not more than one year, if the provider fails to maintain and, upon request from the commissioner, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by such provider, when the commissioner has identified a pattern of a lack of documentation. A pattern means a failure to maintain documentation or provide access to documentation on more than one occasion. Nothing in this paragraph limits the authority of the commissioner to sanction a provider under the provisions of section 256B.064.

~~(d)~~ (h) The commissioner shall terminate or deny the enrollment of any individual or entity if the individual or entity has been terminated from participation in Medicare or under the Medicaid program or Children's Health Insurance Program of any other state.

~~(e)~~ (i) As a condition of enrollment in medical assistance, the commissioner shall require that a provider designated "moderate" or "high-risk" by the Centers for Medicare and Medicaid Services or the commissioner permit the Centers for Medicare and Medicaid Services, its agents, or its designated contractors and the state agency, its agents, or its designated contractors to conduct unannounced on-site inspections of any provider location. The commissioner shall publish in the Minnesota Health Care Program Provider Manual a list of provider types designated "limited," "moderate," or "high-risk," based on the criteria and standards used to designate Medicare providers in Code of Federal Regulations, title 42, section 424.518. The list and criteria are not subject to the requirements of chapter 14. The commissioner's designations are not subject to administrative appeal.

~~(f)~~ (j) As a condition of enrollment in medical assistance, the commissioner shall require that a high-risk provider, or a person with a direct or indirect ownership interest in the provider of five percent or higher, consent to criminal background checks, including fingerprinting, when required to do so under state law or by a determination by the commissioner or the Centers for Medicare and Medicaid Services that a provider is designated high-risk for fraud, waste, or abuse.

~~(g)~~ (k)(1) Upon initial enrollment, reenrollment, and notification of revalidation, all durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) medical suppliers meeting the durable medical equipment provider and supplier definition in clause (3),

operating in Minnesota and receiving Medicaid funds must purchase a surety bond that is annually renewed and designates the Minnesota Department of Human Services as the obligee, and must be submitted in a form approved by the commissioner. For purposes of this clause, the following medical suppliers are not required to obtain a surety bond: a federally qualified health center, a home health agency, the Indian Health Service, a pharmacy, and a rural health clinic.

(2) At the time of initial enrollment or reenrollment, durable medical equipment providers and suppliers defined in clause (3) must purchase a surety bond of $50,000. If a revalidating provider's Medicaid revenue in the previous calendar year is up to and including $300,000, the provider agency must purchase a surety bond of $50,000. If a revalidating provider's Medicaid revenue in the previous calendar year is over $300,000, the provider agency must purchase a surety bond of $100,000. The surety bond must allow for recovery of costs and fees in pursuing a claim on the bond.

(3) "Durable medical equipment provider or supplier" means a medical supplier that can purchase medical equipment or supplies for sale or rental to the general public and is able to perform or arrange for necessary repairs to and maintenance of equipment offered for sale or rental.

~~(h)~~ (l) The Department of Human Services may require a provider to purchase a surety bond as a condition of initial enrollment, reenrollment, reinstatement, or continued enrollment if: (1) the provider fails to demonstrate financial viability, (2) the department determines there is significant evidence of or potential for fraud and abuse by the provider, or (3) the provider or category of providers is designated high-risk pursuant to paragraph ~~(a)~~ (e) and as per Code of Federal Regulations, title 42, section 455.450. The surety bond must be in an amount of $100,000 or ten percent of the provider's payments from Medicaid during the immediately preceding 12 months, whichever is greater. The surety bond must name the Department of Human Services as an obligee and must allow for recovery of costs and fees in pursuing a claim on the bond. This paragraph does not apply if the provider currently maintains a surety bond under the requirements in section 256B.0659 or 256B.85.

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

Sec. 12. Minnesota Statutes 2016, section 256B.04, subdivision 22, is amended to read:

Subd. 22. **Application fee.** (a) The commissioner must collect and retain federally required nonrefundable application fees to pay for provider screening activities in accordance with Code of Federal Regulations, title 42, section 455, subpart E. The enrollment application must be made under the procedures specified by the commissioner, in the form specified

by the commissioner, and accompanied by an application fee described in paragraph (b), or a request for a hardship exception as described in the specified procedures. Application fees must be deposited in the provider screening account in the special revenue fund. Amounts in the provider screening account are appropriated to the commissioner for costs associated with the provider screening activities required in Code of Federal Regulations, title 42, section 455, subpart E. The commissioner ~~shall conduct screening activities as required by Code of Federal Regulations, title 42, section 455, subpart E, and as otherwise provided by law, to include database checks, unannounced pre- and postenrollment site visits, fingerprinting, and criminal background studies. The commissioner must revalidate all providers under this subdivision at least once every five years~~ must revalidate all personal care assistance agencies under this subdivision at least once every three years.

(b) The application fee under this subdivision is $532 for the calendar year 2013. For calendar year 2014 and subsequent years, the fee:

(1) is adjusted by the percentage change to the Consumer Price Index for all urban consumers, United States city average, for the 12-month period ending with June of the previous year. The resulting fee must be announced in the Federal Register;

(2) is effective from January 1 to December 31 of a calendar year;

(3) is required on the submission of an initial application, an application to establish a new practice location, an application for reenrollment when the provider is not enrolled at the time of application of reenrollment, or at revalidation when required by federal regulation; and

(4) must be in the amount in effect for the calendar year during which the application for enrollment, new practice location, or reenrollment is being submitted.

(c) The application fee under this subdivision cannot be charged to:

(1) providers who are enrolled in Medicare or who provide documentation of payment of the fee to, and enrollment with, another state, unless the commissioner is required to rescreen the provider;

(2) providers who are enrolled but are required to submit new applications for purposes of reenrollment;

(3) a provider who enrolls as an individual; and

(4) group practices and clinics that bill on behalf of individually enrolled providers within the practice who have reassigned their billing privileges to the group practice or clinic.

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

Sec. 13. Minnesota Statutes 2016, section 256B.055, subdivision 2, is amended to read:

Subd. 2. **Subsidized foster children.** Medical assistance may be paid for a child eligible for or receiving foster care maintenance payments under Title IV-E of the Social Security Act, United States Code, title 42, sections 670 to 676, and to any child who is not title IV-E eligible but who is determined eligible for foster care or kinship assistance under chapter 256N.

EFFECTIVE DATE. This section is effective January 1, 2019, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 14. Minnesota Statutes 2016, section 256B.0621, subdivision 10, is amended to read:

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

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

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

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

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

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

EFFECTIVE DATE. This section is effective three months after federal approval.

Sec. 15. Minnesota Statutes 2016, section 256B.0625, subdivision 7, is amended to read:

Subd. 7. **Home care nursing.** Medical assistance covers home care nursing services in a recipient's home. Recipients who are authorized to receive home care nursing services in their home may use approved hours outside of the home during hours when normal life activities take them outside of their home. To use home care nursing services at school, the recipient or responsible party must provide written authorization in the care plan identifying

the chosen provider and the daily amount of services to be used at school. Medical assistance does not cover home care nursing services for residents of a hospital, nursing facility, intermediate care facility, or a health care facility licensed by the commissioner of health, ~~except as authorized in section 256B.64 for ventilator-dependent recipients in hospitals or~~ unless a resident who is otherwise eligible is on leave from the facility and the facility either pays for the home care nursing services or forgoes the facility per diem for the leave days that home care nursing services are used. Total hours of service and payment allowed for services outside the home cannot exceed that which is otherwise allowed in an in-home setting according to sections 256B.0651 and 256B.0654 . All home care nursing services must be provided according to the limits established under sections 256B.0651, 256B.0653, and 256B.0654. Home care nursing services may not be reimbursed if the nurse is the family foster care provider of a recipient who is under age 18, unless allowed under section 256B.0654, subdivision 4.

Sec. 16. Minnesota Statutes 2016, section 256B.0625, subdivision 20, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

(i) Notwithstanding any administrative rule to the contrary, prepaid medical assistance and MinnesotaCare include mental health case management. When the service is provided

through prepaid capitation, the nonfederal share is paid by the state and the county pays no share.

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

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

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

(2) programming the information systems.

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

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

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

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

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

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

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

EFFECTIVE DATE. This section is effective three months after federal approval.

Sec. 17. Minnesota Statutes 2016, section 256B.0625, is amended by adding a subdivision to read:

Subd. 20b. **Mental health targeted case management through interactive video.** (a) Subject to federal approval, contact made for targeted case management by interactive video shall be eligible for payment if:

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

(i) a hospital;

(ii) a nursing facility; or

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

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

(3) the use of interactive video is approved as part of the person's written personal service or case plan, taking into consideration the person's vulnerability and active personal relationships; and

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

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

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

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

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

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

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

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

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

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

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

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

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

EFFECTIVE DATE. This section is effective three months after federal approval.

Sec. 18. Minnesota Statutes 2016, section 256B.0625, is amended by adding a subdivision to read:

Subd. 56a. **Post-arrest community-based service coordination.** (a) Medical assistance covers post-arrest community-based service coordination for an individual who:

(1) has been identified as having a mental illness or substance use disorder using a screening tool approved by the commissioner;

(2) does not require the security of a public detention facility and is not considered an inmate of a public institution as defined in Code of Federal Regulations, title 42, section 435.1010;

(3) meets the eligibility requirements in section 256B.056; and

(4) has agreed to participate in post-arrest community-based service coordination through a diversion contract in lieu of incarceration.

(b) Post-arrest community-based service coordination means navigating services to address a client's mental health, chemical health, social, economic, and housing needs, or any other activity targeted at reducing the incidence of jail utilization and connecting individuals with existing covered services available to them, including, but not limited to, targeted case management, waiver case management, or care coordination.

(c) Post-arrest community-based service coordination must be provided by individuals who are qualified under one of the following criteria:

(1) a licensed mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6);

(2) a mental health practitioner as defined in section 245.462, subdivision 17, working under the clinical supervision of a mental health professional; or

(3) a certified peer specialist under section 256B.0615, working under the clinical supervision of a mental health professional.

(d) Reimbursement must be made in 15-minute increments and allowed for up to 60 days following the initial determination of eligibility.

(e) Providers of post-arrest community-based service coordination shall annually report to the commissioner on the number of individuals served, and number of the community-based services that were accessed by recipients. The commissioner shall ensure that services and payments provided under post-arrest community-based service coordination do not duplicate services or payments provided under section 256B.0625, subdivision 20, 256B.0753, 256B.0755, or 256B.0757.

(f) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of cost for post-arrest community-based service coordination services shall be provided by the recipient's county of residence, from sources other than federal funds or funds used to match other federal funds.

EFFECTIVE DATE. This section is effective three months after federal approval.

Sec. 19. Minnesota Statutes 2016, section 256B.0625, subdivision 57, is amended to read:

Subd. 57. **Payment for Part B Medicare crossover claims.** (a) Effective for services provided on or after January 1, 2012, medical assistance payment for an enrollee's cost-sharing associated with Medicare Part B is limited to an amount up to the medical assistance total allowed, when the medical assistance rate exceeds the amount paid by Medicare.

(b) Excluded from this limitation are payments for mental health services and payments for dialysis services provided to end-stage renal disease patients. The exclusion for mental health services does not apply to payments for physician services provided by psychiatrists and advanced practice nurses with a specialty in mental health.

(c) Excluded from this limitation are payments to federally qualified health centers, Indian Health Services, and rural health clinics.

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

Sec. 20. Minnesota Statutes 2016, section 256B.0625, subdivision 64, is amended to read:

Subd. 64. **Investigational drugs, biological products, and devices.** (a) Medical assistance and the early periodic screening, diagnosis, and treatment (EPSDT) program do not cover costs incidental to, associated with, or resulting from the use of investigational drugs, biological products, or devices as defined in section 151.375.

(b) Notwithstanding paragraph (a), stiripentol may be covered by the EPSDT program if all the following conditions are met:

(1) the use of stiripentol is determined to be medically necessary;

(2) the enrollee has a documented diagnosis of Dravet syndrome, regardless of whether an SCN1A genetic mutation is found, or the enrollee is a child with malignant migrating partial epilepsy in infancy due to an SCN2A genetic mutation;

(3) all other available covered prescription medications that are medically necessary for the enrollee have been tried without successful outcomes; and

(4) the United States Food and Drug Administration has approved the treating physician's individual patient investigational new drug application (IND) for the use of stiripentol for treatment.

This paragraph does not apply to MinnesotaCare coverage under chapter 256L.

Sec. 21. Minnesota Statutes 2016, section 256B.0659, subdivision 21, is amended to read:

Subd. 21. **Requirements for provider enrollment of personal care assistance provider agencies.** (a) All personal care assistance provider agencies must provide, at the time of enrollment, reenrollment, and revalidation as a personal care assistance provider agency in a format determined by the commissioner, information and documentation that includes, but is not limited to, the following:

(1) the personal care assistance provider agency's current contact information including address, telephone number, and e-mail address;

(2) proof of surety bond coverage for each location providing services. Upon new enrollment, or if the provider's Medicaid revenue in the previous calendar year is up to and including $300,000, the provider agency must purchase a surety bond of $50,000. If the

Medicaid revenue in the previous year is over $300,000, the provider agency must purchase a surety bond of $100,000. The surety bond must be in a form approved by the commissioner, must be renewed annually, and must allow for recovery of costs and fees in pursuing a claim on the bond;

(3) proof of fidelity bond coverage in the amount of $20,000 for each business location providing service;

(4) proof of workers' compensation insurance coverage identifying the business address where PCA services are provided from;

(5) proof of liability insurance coverage identifying the business address where PCA services are provided from and naming the department as a certificate holder;

~~(6) a description of the personal care assistance provider agency's organization identifying the names of all owners, managing employees, staff, board of directors, and the affiliations of the directors, owners, or staff to other service providers;~~

~~(7)~~ (6) a copy of the personal care assistance provider agency's written policies and procedures including: hiring of employees; training requirements; service delivery; and employee and consumer safety including process for notification and resolution of consumer grievances, identification and prevention of communicable diseases, and employee misconduct;

~~(8)~~ (7) copies of all other forms the personal care assistance provider agency uses in the course of daily business including, but not limited to:

(i) a copy of the personal care assistance provider agency's time sheet if the time sheet varies from the standard time sheet for personal care assistance services approved by the commissioner, and a letter requesting approval of the personal care assistance provider agency's nonstandard time sheet;

(ii) the personal care assistance provider agency's template for the personal care assistance care plan; and

(iii) the personal care assistance provider agency's template for the written agreement in subdivision 20 for recipients using the personal care assistance choice option, if applicable;

~~(9)~~ (8) a list of all training and classes that the personal care assistance provider agency requires of its staff providing personal care assistance services;

~~(10)~~ (9) documentation that the personal care assistance provider agency and staff have successfully completed all the training required by this section;

~~(11)~~ (10) documentation of the agency's marketing practices;

~~(12)~~ (11) disclosure of ownership, leasing, or management of all residential properties that is used or could be used for providing home care services;

~~(13)~~ (12) documentation that the agency will use the following percentages of revenue generated from the medical assistance rate paid for personal care assistance services for employee personal care assistant wages and benefits: 72.5 percent of revenue in the personal care assistance choice option and 72.5 percent of revenue from other personal care assistance providers. The revenue generated by the qualified professional and the reasonable costs associated with the qualified professional shall not be used in making this calculation; and

~~(14)~~ (13) effective May 15, 2010, documentation that the agency does not burden recipients' free exercise of their right to choose service providers by requiring personal care assistants to sign an agreement not to work with any particular personal care assistance recipient or for another personal care assistance provider agency after leaving the agency and that the agency is not taking action on any such agreements or requirements regardless of the date signed.

(b) Personal care assistance provider agencies shall provide the information specified in paragraph (a) to the commissioner at the time the personal care assistance provider agency enrolls as a vendor or upon request from the commissioner. The commissioner shall collect the information specified in paragraph (a) from all personal care assistance providers beginning July 1, 2009.

(c) All personal care assistance provider agencies shall require all employees in management and supervisory positions and owners of the agency who are active in the day-to-day management and operations of the agency to complete mandatory training as determined by the commissioner before submitting an application for enrollment of the agency as a provider. All personal care assistance provider agencies shall also require qualified professionals to complete the training required by subdivision 13 before submitting an application for enrollment of the agency as a provider. Employees in management and supervisory positions and owners who are active in the day-to-day operations of an agency who have completed the required training as an employee with a personal care assistance provider agency do not need to repeat the required training if they are hired by another agency, if they have completed the training within the past three years. By September 1, 2010, the required training must be available with meaningful access according to title VI of the Civil Rights Act and federal regulations adopted under that law or any guidance from the United States Health and Human Services Department. The required training must be

available online or by electronic remote connection. The required training must provide for competency testing. Personal care assistance provider agency billing staff shall complete training about personal care assistance program financial management. This training is effective July 1, 2009. Any personal care assistance provider agency enrolled before that date shall, if it has not already, complete the provider training within 18 months of July 1, 2009. Any new owners or employees in management and supervisory positions involved in the day-to-day operations are required to complete mandatory training as a requisite of working for the agency. Personal care assistance provider agencies certified for participation in Medicare as home health agencies are exempt from the training required in this subdivision. When available, Medicare-certified home health agency owners, supervisors, or managers must successfully complete the competency test.

(d) All surety bonds, fidelity bonds, workers' compensation insurance, and liability insurance required by this subdivision must be maintained continuously. After initial enrollment, a provider must submit proof of bonds and required coverages at any time at the request of the commissioner. Services provided while there are lapses in coverage are not eligible for payment. Lapses in coverage may result in sanctions, including termination. The commissioner shall send instructions and a due date to submit the requested information to the personal care assistance provider agency.

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

Sec. 22. Minnesota Statutes 2016, section 256B.072, is amended to read:

256B.072 PERFORMANCE REPORTING AND QUALITY IMPROVEMENT SYSTEM.

(a) The commissioner of human services shall establish a performance reporting system for health care providers who provide health care services to public program recipients covered under chapters 256B, 256D, and 256L, reporting separately for managed care and fee-for-service recipients.

(b) The measures used for the performance reporting system for medical groups ~~shall~~ may include measures of care for asthma, diabetes, hypertension, and coronary artery disease and measures of preventive care services. The measures used for the performance reporting system for inpatient hospitals shall include measures of care for acute myocardial infarction, heart failure, and pneumonia, and measures of care and prevention of surgical infections. In the case of a medical group, the measures used shall be consistent with ~~measures published by nonprofit Minnesota or national organizations that produce and disseminate health care quality measures or evidence-based health care guidelines~~ section 62U.02, subdivision 1,

paragraph (a), clause (1). In the case of inpatient hospital measures, the commissioner shall appoint the Minnesota Hospital Association and Stratis Health to advise on the development of the performance measures to be used for hospital reporting. To enable a consistent measurement process across the community, the commissioner may use measures of care provided for patients in addition to those identified in paragraph (a). The commissioner shall ensure collaboration with other health care reporting organizations so that the measures described in this section are consistent with those reported by those organizations and used by other purchasers in Minnesota.

(c) The commissioner may require providers to submit information in a required format to a health care reporting organization or to cooperate with the information collection procedures of that organization. The commissioner may collaborate with a reporting organization to collect information reported and to prevent duplication of reporting.

(d) By October 1, 2007, and annually thereafter, the commissioner shall report through a public Web site the results by medical groups and hospitals, where possible, of the measures under this section, and shall compare the results by medical groups and hospitals for patients enrolled in public programs to patients enrolled in private health plans. To achieve this reporting, the commissioner may collaborate with a health care reporting organization that operates a Web site suitable for this purpose.

(e) Performance measures must be stratified as provided under section 62U.02, subdivision 1, paragraph ~~(b)~~ (c), and risk-adjusted as specified in section 62U.02, subdivision 3, paragraph (b).

(f) Notwithstanding paragraph (b), by January 1, 2019, the commissioner shall consider and appropriately adjust quality metrics and benchmarks for providers who primarily serve socioeconomically complex patient populations and request to be scored on additional measures in this subdivision. This applies to all Minnesota health care programs, including for patient populations enrolled in health plans, county-based purchasing plans, or managed care organizations and for value-based purchasing arrangements, including, but not limited to, initiatives operating under sections 256B.0751, 256B.0753, 256B.0755, 256B.0756, and 256B.0757.

Sec. 23. Minnesota Statutes 2016, section 256B.0755, subdivision 1, is amended to read:

Subdivision 1. **Implementation.** (a) The commissioner shall ~~develop and authorize~~ continue and expand a demonstration project established under this section to test alternative and innovative integrated health ~~care delivery systems~~ partnerships, including accountable care organizations that provide services to a specified patient population for an agreed-upon

total cost of care or risk/gain sharing payment arrangement. The commissioner shall develop a request for proposals for participation in the demonstration project in consultation with hospitals, primary care providers, health plans, and other key stakeholders.

(b) In developing the request for proposals, the commissioner shall:

(1) establish uniform statewide methods of forecasting utilization and cost of care for the appropriate Minnesota public program populations, to be used by the commissioner for the ~~health care delivery system~~ integrated health partnership projects;

(2) identify key indicators of quality, access, patient satisfaction, and other performance indicators that will be measured, in addition to indicators for measuring cost savings;

(3) allow maximum flexibility to encourage innovation and variation so that a variety of provider collaborations are able to become ~~health care delivery systems~~ integrated health partnerships, and may be customized for the special needs and barriers of patient populations experiencing health disparities due to social, economic, racial, or ethnic factors,;

(4) encourage and authorize different levels and types of financial risk;

(5) encourage and authorize projects representing a wide variety of geographic locations, patient populations, provider relationships, and care coordination models;

(6) encourage projects that involve close partnerships between the ~~health care delivery system~~ integrated health partnership and counties and nonprofit agencies that provide services to patients enrolled with the ~~health care delivery system~~ integrated health partnership, including social services, public health, mental health, community-based services, and continuing care;

(7) encourage projects established by community hospitals, clinics, and other providers in rural communities;

(8) identify required covered services for a total cost of care model or services considered in whole or partially in an analysis of utilization for a risk/gain sharing model;

(9) establish a mechanism to monitor enrollment;

(10) establish quality standards for the ~~delivery system~~ integrated health partnership demonstrations that are appropriate for the particular patient population to be served; and

(11) encourage participation of privately insured population so as to create sufficient alignment in demonstration systems.

(c) To be eligible to participate in ~~the demonstration project~~ an integrated health partnership, a health care delivery system must:

(1) provide required covered services and care coordination to recipients enrolled in the ~~health care delivery system~~ integrated health partnership;

(2) establish a process to monitor enrollment and ensure the quality of care provided;

(3) in cooperation with counties and community social service agencies, coordinate the delivery of health care services with existing social services programs;

(4) provide a system for advocacy and consumer protection; and

(5) adopt innovative and cost-effective methods of care delivery and coordination, which may include the use of allied health professionals, telemedicine, patient educators, care coordinators, and community health workers.

(d) ~~A health care delivery system~~ An integrated health partnership demonstration may be formed by the following groups of providers of services and suppliers if they have established a mechanism for shared governance:

(1) professionals in group practice arrangements;

(2) networks of individual practices of professionals;

(3) partnerships or joint venture arrangements between hospitals and health care professionals;

(4) hospitals employing professionals; and

(5) other groups of providers of services and suppliers as the commissioner determines appropriate.

A managed care plan or county-based purchasing plan may participate in this demonstration in collaboration with one or more of the entities listed in clauses (1) to (5).

~~A health care delivery system~~ An integrated health partnership may contract with a managed care plan or a county-based purchasing plan to provide administrative services, including the administration of a payment system using the payment methods established by the commissioner for ~~health care delivery systems~~ integrated health partnerships.

(e) The commissioner may require ~~a health care delivery system~~ an integrated health partnership to enter into additional third-party contractual relationships for the assessment of risk and purchase of stop loss insurance or another form of insurance risk management related to the delivery of care described in paragraph (c).

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

Sec. 24. Minnesota Statutes 2016, section 256B.0755, subdivision 3, is amended to read:

Subd. 3. **Accountability.** (a) ~~Health care delivery systems~~ Integrated health partnerships must accept responsibility for the quality of care based on standards established under subdivision 1, paragraph (b), clause (10), and the cost of care or utilization of services provided to its enrollees under subdivision 1, paragraph (b), clause (1). Accountability standards must be appropriate to the particular population served.

(b) ~~A health care delivery system~~ An integrated health partnership may contract and coordinate with providers and clinics for the delivery of services and shall contract with community health clinics, federally qualified health centers, community mental health centers or programs, county agencies, and rural clinics to the extent practicable.

(c) ~~A health care delivery system~~ An integrated health partnership must indicate how it will coordinate with other services affecting its patients' health, quality of care, and cost of care that are provided by other providers, county agencies, and other organizations in the local service area. The ~~health care delivery system~~ integrated health partnership must indicate how it will engage other providers, counties, and organizations, including county-based purchasing plans, that provide services to patients of the ~~health care delivery system~~ integrated health partnership on issues related to local population health, including applicable local needs, priorities, and public health goals. The ~~health care delivery system~~ integrated health partnership must describe how local providers, counties, organizations, including county-based purchasing plans, and other relevant purchasers were consulted in developing the application to participate in the demonstration project.

Sec. 25. Minnesota Statutes 2016, section 256B.0755, subdivision 4, is amended to read:

Subd. 4. **Payment system.** (a) In developing a payment system for ~~health care delivery systems~~ integrated health partnerships, the commissioner shall establish a total cost of care benchmark or a risk/gain sharing payment model to be paid for services provided to the recipients enrolled in ~~a health care delivery system~~ an integrated health partnership.

(b) The payment system may include incentive payments to ~~health care delivery systems~~ integrated health partnerships that meet or exceed annual quality and performance targets realized through the coordination of care.

(c) An amount equal to the savings realized to the general fund as a result of the demonstration project shall be transferred each fiscal year to the health care access fund.

(d) The payment system shall include a population-based payment that supports care coordination services for all enrollees served by the integrated health partnerships, and is

risk-adjusted to reflect varying levels of care coordination intensiveness for enrollees with chronic conditions, limited English skills, cultural differences, or other barriers to health care. The population-based payment shall be a per member, per month payment paid at least on a quarterly basis. Integrated health partnerships receiving this payment must continue to meet cost and quality metrics under the program to maintain eligibility for the population-based payment. An integrated health partnership is eligible to receive a payment under this paragraph even if the partnership is not participating in a risk-based or gain-sharing payment model and regardless of the size of the patient population served by the integrated health partnership. Any integrated health partnership participant certified as a health care home under section 256B.0751 that agrees to a payment method that includes population-based payments for care coordination is not eligible to receive health care home payment or care coordination fee authorized under section 62U.03 or 256B.0753, subdivision 1, or in-reach care coordination under section 256B.0625, subdivision 56, for any medical assistance or MinnesotaCare recipients enrolled or attributed to the integrated health partnership under this demonstration.

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

Sec. 26. Minnesota Statutes 2016, section 256B.0755, is amended by adding a subdivision to read:

Subd. 9. **Patient incentives.** The commissioner may authorize an integrated health partnership to provide financial incentives for patients to:

(1) see a primary care provider for an initial health assessment;

(2) maintain a continuous relationship with the primary care provider; and

(3) participate in ongoing health improvement and coordination of care activities.

Sec. 27. Minnesota Statutes 2016, section 256B.0924, is amended by adding a subdivision to read:

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

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

(i) a hospital;

(ii) a nursing facility; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

EFFECTIVE DATE. This section is effective three months after federal approval.

Sec. 28. Minnesota Statutes 2016, section 256B.196, subdivision 2, is amended to read:

Subd. 2. **Commissioner's duties.** (a) For the purposes of this subdivision and subdivision 3, the commissioner shall determine the fee-for-service outpatient hospital services upper payment limit for nonstate government hospitals. The commissioner shall then determine the amount of a supplemental payment to Hennepin County Medical Center and Regions Hospital for these services that would increase medical assistance spending in this category to the aggregate upper payment limit for all nonstate government hospitals in Minnesota. In making this determination, the commissioner shall allot the available increases between Hennepin County Medical Center and Regions Hospital based on the ratio of medical assistance fee-for-service outpatient hospital payments to the two facilities. The commissioner shall adjust this allotment as necessary based on federal approvals, the amount of intergovernmental transfers received from Hennepin and Ramsey Counties, and other factors, in order to maximize the additional total payments. The commissioner shall inform Hennepin County and Ramsey County of the periodic intergovernmental transfers necessary to match federal Medicaid payments available under this subdivision in order to make supplementary medical assistance payments to Hennepin County Medical Center and Regions Hospital equal to an amount that when combined with existing medical assistance payments to nonstate governmental hospitals would increase total payments to hospitals in this category for outpatient services to the aggregate upper payment limit for all hospitals in this category in Minnesota. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to Hennepin County Medical Center and Regions Hospital.

(b) For the purposes of this subdivision and subdivision 3, the commissioner shall determine an upper payment limit for physicians and other billing professionals affiliated with Hennepin County Medical Center and with Regions Hospital. The upper payment limit shall be based on the average commercial rate or be determined using another method acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall inform Hennepin County and Ramsey County of the periodic intergovernmental transfers necessary to match the federal Medicaid payments available under this subdivision in order to make supplementary payments to physicians and other billing professionals affiliated with Hennepin County Medical Center and to make supplementary payments to physicians

and other billing professionals affiliated with Regions Hospital through HealthPartners Medical Group equal to the difference between the established medical assistance payment for physician and other billing professional services and the upper payment limit. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to physicians and other billing professionals affiliated with Hennepin County Medical Center and shall make supplementary payments to physicians and other billing professionals affiliated with Regions Hospital through HealthPartners Medical Group.

(c) Beginning January 1, 2010, Hennepin County and Ramsey County may make monthly voluntary intergovernmental transfers to the commissioner in amounts not to exceed $12,000,000 per year from Hennepin County and $6,000,000 per year from Ramsey County. The commissioner shall increase the medical assistance capitation payments to any licensed health plan under contract with the medical assistance program that agrees to make enhanced payments to Hennepin County Medical Center or Regions Hospital. The increase shall be in an amount equal to the annual value of the monthly transfers plus federal financial participation, with each health plan receiving its pro rata share of the increase based on the pro rata share of medical assistance admissions to Hennepin County Medical Center and Regions Hospital by those plans. For the purposes of this paragraph, "the base amount" means the total annual value of increased medical assistance capitation payments under this paragraph in state fiscal year 2018. For managed care contracts beginning on or after July 1, 2018, the commissioner shall reduce the total annual value of increased medical assistance capitation payments under this paragraph by an amount equal to ten percent of the base amount, and by an additional ten percent of the base amount for each subsequent contract year until June 30, 2025. Upon the request of the commissioner, health plans shall submit individual-level cost data for verification purposes. The commissioner may ratably reduce these payments on a pro rata basis in order to satisfy federal requirements for actuarial soundness. If payments are reduced, transfers shall be reduced accordingly. Any licensed health plan that receives increased medical assistance capitation payments under the intergovernmental transfer described in this paragraph shall increase its medical assistance payments to Hennepin County Medical Center and Regions Hospital by the same amount as the increased payments received in the capitation payment described in this paragraph. This paragraph expires on July 1, 2025.

(d) For the purposes of this subdivision and subdivision 3, the commissioner shall determine an upper payment limit for ambulance services affiliated with Hennepin County Medical Center and the city of St. Paul. The upper payment limit shall be based on the average commercial rate or be determined using another method acceptable to the Centers

for Medicare and Medicaid Services. The commissioner shall inform Hennepin County and the city of St. Paul of the periodic intergovernmental transfers necessary to match the federal Medicaid payments available under this subdivision in order to make supplementary payments to Hennepin County Medical Center and the city of St. Paul equal to the difference between the established medical assistance payment for ambulance services and the upper payment limit. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to Hennepin County Medical Center and the city of St. Paul.

(e) The commissioner shall inform the transferring governmental entities on an ongoing basis of the need for any changes needed in the intergovernmental transfers in order to continue the payments under paragraphs (a) to (d), at their maximum level, including increases in upper payment limits, changes in the federal Medicaid match, and other factors.

(f) The payments in paragraphs (a) to (d) shall be implemented independently of each other, subject to federal approval and to the receipt of transfers under subdivision 3.

Sec. 29. Minnesota Statutes 2016, section 256B.69, subdivision 9e, is amended to read:

Subd. 9e. **Financial audits.** ~~(a)~~ The legislative auditor shall ~~conduct or contract with vendors to conduct independent third-party financial audits of the information required to be provided by~~ audit managed care plans and county-based purchasing plans ~~under subdivision 9c, paragraph (b). The audits by the vendors shall be conducted as vendor resources permit and in accordance with generally accepted government auditing standards issued by the United States Government Accountability Office. The contract with the vendors shall be designed and administered so as to render the independent third-party audits eligible for a federal subsidy, if available. The contract shall require the audits to include a determination of compliance with the federal Medicaid rate certification process~~ to determine if a managed care plan or county-based purchasing plan used public money in compliance with federal and state laws, rules, and in accordance with provisions in the plan's contract with the commissioner. The legislative auditor shall conduct the audits in accordance with section 3.972, subdivision 2b.

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

Sec. 30. Minnesota Statutes 2016, section 256B.76, subdivision 1, is amended to read:

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

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

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

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

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

(c) Effective for services rendered on or after July 1, 2009, payment rates for physician and professional services shall be reduced by five percent, except that for the period July 1, 2009, through June 30, 2010, payment rates shall be reduced by 6.5 percent for the medical assistance and general assistance medical care programs, over the rates in effect on June 30, 2009. This reduction and the reductions in paragraph (d) do not apply to office or other outpatient visits, preventive medicine visits and family planning visits billed by physicians, advanced practice nurses, or physician assistants in a family planning agency or in one of the following primary care practices: general practice, general internal medicine, general pediatrics, general geriatrics, and family medicine. This reduction and the reductions in paragraph (d) do not apply to federally qualified health centers, rural health centers, and Indian health services. Effective October 1, 2009, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment reduction described in this paragraph.

(d) Effective for services rendered on or after July 1, 2010, payment rates for physician and professional services shall be reduced an additional seven percent over the five percent

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

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

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

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

(h) Effective for services provided on or after July 1, 2017, through June 30, 2019, payment rates for physician and professional services, shall be reduced by 2.3 percent, and effective for services provided on or after July 1, 2019, payments shall be reduced by three percent. Payments made to managed care plans and county-based purchasing plans shall be adjusted to reflect the rate reductions in this paragraph effective January 1, 2018. The services identified in paragraph (g) are not included in the rate reduction described in this paragraph.

Sec. 31. Minnesota Statutes 2016, section 256B.76, subdivision 2, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(j) Effective for services rendered on or after July 1, 2017, payment rates for dental services shall be increased by 25 percent. This increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, and Indian health services when an encounter rate is paid. Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect the payment increase described in this paragraph.

Sec. 32. **[256B.7635] REIMBURSEMENT FOR EVIDENCE-BASED PUBLIC HEALTH NURSE HOME VISITS.**

Effective for services provided on or after January 1, 2018, prenatal and postpartum follow-up home visits provided by public health nurses or registered nurses supervised by a public health nurse using evidence-based models shall be paid a minimum of $140 per visit. Evidence-based postpartum follow-up home visits must be administered by home visiting programs that meet the United States Department of Health and Human Services criteria for evidence-based models and are identified by the commissioner of health as eligible to be implemented under the Maternal, Infant, and Early Childhood Home Visiting program. Home visits must target mothers and their children beginning with prenatal visits through age three for the child.

Sec. 33. Minnesota Statutes 2016, section 256B.766, is amended to read:

256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.

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

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

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

(d) Effective for services provided on or after September 1, 2011, through June 30, 2013, total payments for ambulatory surgery centers facility fees, medical supplies and durable medical equipment not subject to a volume purchase contract, prosthetics and orthotics, renal dialysis services, laboratory services, public health nursing services, physical therapy

services, occupational therapy services, speech therapy services, eyeglasses not subject to a volume purchase contract, hearing aids not subject to a volume purchase contract, and anesthesia services shall be reduced by three percent from the rates in effect on August 31, 2011.

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

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

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

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

(i) Effective for services provided on or after July 1, 2015, the following categories of durable medical equipment shall be individually priced items: enteral nutrition and supplies, customized and other specialized tracheostomy tubes and supplies, electric patient lifts, and durable medical equipment repair and service. This paragraph does not apply to medical supplies and durable medical equipment subject to a volume purchase contract, products subject to the preferred diabetic testing supply program, and items provided to dually eligible

recipients when Medicare is the primary payer for the item. The commissioner shall not apply any medical assistance rate reductions to durable medical equipment as a result of Medicare competitive bidding.

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

(1) payment rates for durable medical equipment, prosthetics, orthotics, or supplies that were subject to the Medicare competitive bid that took effect in January of 2009 shall be increased by 9.5 percent; and

(2) payment rates for durable medical equipment, prosthetics, orthotics, or supplies on the medical assistance fee schedule, whether or not subject to the Medicare competitive bid that took effect in January of 2009, shall be increased by 2.94 percent, with this increase being applied after calculation of any increased payment rate under clause (1).

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

(k) Effective for services provided on or after July 1, 2017, through June 30, 2019, payments for basic care services, including physical therapy services; occupational therapy services; speech language pathology and related services; ambulatory surgical center facility fees; medical supplies and durable medical equipment, not subject to a volume purchase contract; prosthetics; orthotics; renal dialysis services; laboratory services; public health nursing services; eyeglasses, not subject to a volume purchase contract; hearing aids, not subject to a volume purchase contract; and anesthesia services shall be reduced by 2.3 percent and effective for services provided on or after July 1, 2019, payments shall be reduced by three percent. Payments made to managed care plans and county-based purchasing plans shall be adjusted to reflect the rate reduction in this paragraph effective January 1, 2018. The services identified in paragraph (g) are not included in the rate reduction described in this paragraph.

EFFECTIVE DATE. The amendment in paragraph (g) is effective the day following final enactment.

Sec. 34. Minnesota Statutes 2016, section 256L.03, subdivision 1, is amended to read:

Subdivision 1. **Covered health services.** (a) "Covered health services" means the health services reimbursed under chapter 256B, with the exception of special education services, home care nursing services, adult dental care services other than services covered under section 256B.0625, subdivision 9, orthodontic services, nonemergency medical transportation services, personal care assistance and case management services, and nursing home or intermediate care facilities services.

(b) No public funds shall be used for coverage of abortion under MinnesotaCare except where the life of the female would be endangered or substantial and irreversible impairment of a major bodily function would result if the fetus were carried to term; or where the pregnancy is the result of rape or incest.

(c) Covered health services shall be expanded as provided in this section.

(d) For the purposes of covered health services under this section, "child" means an individual younger than 19 years of age.

Sec. 35. Minnesota Statutes 2016, section 256L.03, subdivision 1a, is amended to read:

Subd. 1a. **Children; MinnesotaCare health care reform waiver.** Children are eligible for coverage of all services that are eligible for reimbursement under the medical assistance program according to chapter 256B, except special education services and that abortion services under MinnesotaCare shall be limited as provided under subdivision 1. Children are exempt from the provisions of subdivision 5, regarding co-payments. Children who are lawfully residing in the United States but who are not "qualified noncitizens" under title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Public Law 104-193, Statutes at Large, volume 110, page 2105, are eligible for coverage of all services provided under the medical assistance program according to chapter 256B.

Sec. 36. Minnesota Statutes 2016, section 256L.03, subdivision 5, is amended to read:

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

~~(1) $3 per prescription for adult enrollees;~~

~~(2) $25 for eyeglasses for adult enrollees;~~

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

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

~~(5) a family deductible equal to $2.75 per month per family and adjusted annually by the percentage increase in the medical care component of the CPI-U for the period of September to September of the preceding calendar year, rounded to the next-higher five cent increment.~~

~~(b) Paragraph (a) does~~ (a) Co-payments, coinsurance, and deductibles do not apply to children under the age of 21 and to American Indians as defined in Code of Federal Regulations, title 42, section ~~447.51~~ 600.5.

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

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

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

~~(f)~~ (b) The commissioner shall ~~increase~~ adjust co-payments, coinsurance, and deductibles for covered services in a manner sufficient to ~~reduce~~ maintain the actuarial value of the benefit to 94 percent. The cost-sharing changes described in this paragraph do not apply to eligible recipients or services exempt from cost-sharing under state law. The cost-sharing changes described in this paragraph shall not be implemented prior to January 1, 2016.

~~(g)~~ (c) The cost-sharing changes authorized under paragraph ~~(f)~~ (b) must satisfy the requirements for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations, title 42, sections 600.510 and 600.520.

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

Sec. 37. Minnesota Statutes 2016, section 256L.15, subdivision 2, is amended to read:

Subd. 2. **Sliding fee scale; monthly individual or family income.** (a) The commissioner shall establish a sliding fee scale to determine the percentage of monthly individual or family income that households at different income levels must pay to obtain coverage through the MinnesotaCare program. The sliding fee scale must be based on the enrollee's monthly individual or family income.

(b) Beginning January 1, 2014, MinnesotaCare enrollees shall pay premiums according to the premium scale specified in paragraph (d).

(c) Paragraph (b) does not apply to:

(1) children 20 years of age or younger; and

(2) individuals with household incomes below 35 percent of the federal poverty guidelines.

(d) The following premium scale is established for each individual in the household who is 21 years of age or older and enrolled in MinnesotaCare:

Federal Poverty Guideline Greater than or Equal to	**Less than**	**Individual Premium Amount**
35%	55%	$4
55%	80%	$6
80%	90%	$8
90%	100%	$10
100%	110%	$12
110%	120%	$14
120%	130%	$15
130%	140%	$16
140%	150%	$25
150%	160%	~~$29~~ $37
160%	170%	~~$33~~ $44
170%	180%	~~$38~~ $52
180%	190%	~~$43~~ $61
190%	200%	~~$50~~ $71
200%		$80

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

Sec. 38. **CAPITATION PAYMENT DELAY.**

(a) The commissioner of human services shall delay $54,654,000 of the medical assistance capitation payment to managed care plans and county-based purchasing plans due in April 2019 and all of the payment due in May 2019 and the payment due in April 2019 for special needs basic care until July 1, 2019. The payment shall be made no earlier than July 1, 2019, and no later than July 31, 2019.

(b) The commissioner of human services shall delay the medical assistance capitation payment to managed care plans and county-based purchasing plans due in April 2021 and May 2021 and the payment due in April 2021 for special needs basic care until July 1, 2021. The payment shall be made no earlier than July 1, 2021, and no later than July 31, 2021.

Sec. 39. **COMMISSIONER DUTY TO SEEK FEDERAL APPROVAL.**

The commissioner of human services shall seek federal approval that is necessary to implement Minnesota Statutes, sections 256B.0621, subdivision 10; 256B.0924, subdivision 4a; and 256B.0625, subdivision 20b, for interactive video contact.

Sec. 40. **LEGISLATIVE COMMISSION ON MANAGED CARE.**

Subdivision 1. **Establishment.** (a) A legislative commission is created to study and make recommendations to the legislature on issues relating to the competitive bidding program and procurement process for the medical assistance and MinnesotaCare contracts with managed care organizations for nonelderly, nondisabled adults and children enrollees.

(b) For purposes of this section, "managed care organization" means a demonstration provider as defined under Minnesota Statutes, section 256B.69, subdivision 2.

Subd. 2. **Membership.** (a) The commission consists of:

(1) four members of the senate, two members appointed by the senate majority leader and two members appointed by the senate minority leader;

(2) four members of the house of representatives, two members appointed by the speaker of the house and two members appointed by the minority leader; and

(3) the commissioner of human services or the commissioner's designee.

(b) The appointing authorities must make their appointments by July 1, 2017.

(c) The ranking senator from the majority party appointed to the commission shall convene the first meeting no later than September 1, 2017.

(d) The commission shall elect a chair among its members at the first meeting.

(e) Members serve without compensation or reimbursement for expenses, except that legislative members may receive per diem and be reimbursed for expenses as provided in the rules governing their respective bodies.

Subd. 3. **Staff.** The commissioner of human services shall provide staff and administrative and research services, as needed, to the commission.

Subd. 4. **Duties.** (a) The commission shall study, review, and make recommendations on the competitive bidding process for the managed care contracts that provide services to the nonelderly, nondisabled adults and children enrolled in medical assistance and MinnesotaCare. When reviewing the competitive bidding process, the commission shall consider and make recommendations on the following:

(1) the number of geographic regions to be established for competitive bidding and each procurement cycle and the criteria to be used in determining the minimum number of managed care organizations to serve each region or statistical area;

(2) the specifications of the request for proposals, including whether managed care organizations must address in their proposals priority areas identified by counties;

(3) the criteria to be used to determine whether managed care organizations will be requested to provide a best and final offer;

(4) the evaluation process that the commissioner must consider when evaluating each proposal, including the scoring weight to be given when there is a county board resolution identifying a managed care organization preference, and whether consideration shall be given to network adequacy for such services as dental, mental health, and primary care;

(5) the notification process to inform managed care organizations about the award determinations, but before the contracts are signed;

(6) process for appealing the commissioner's decision on the selection of a managed care plan or county-based purchasing plan in a county or counties; and

(7) whether an independent evaluation of the competitive bidding process is necessary, and if so, what the evaluation should entail.

(b) The commissioner shall consider the frequency of the procurement process in terms of how often the commissioner should conduct the procurement of managed care contracts and whether procurement should be conducted on a statewide basis or at staggered times for a limited number of counties within a specified region.

(c) The commission shall review proposed legislation that incorporates new federal regulations into managed care statutes, including the recodification of the managed care requirements in Minnesota Statutes, sections 256B.69 and 256B.692.

(d) The commission shall study, review, and make recommendations on a process that meets federal regulations for ensuring that provider rate increases passed by the legislature and incorporated into the capitated rates paid to managed care organizations are recognized in the rates paid by the managed care organizations to the providers while still providing managed care organizations the flexibility in negotiating rates paid to their provider networks.

(e) The commission shall consult with interested stakeholders and may solicit public testimony, as deemed necessary.

Subd. 5. **Report.** (a) The commission shall report its recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by February 15, 2018. The report shall include any draft legislation necessary to implement the recommendations.

(b) The commission shall provide preliminary recommendations to the commissioner of human services to be used by the commissioner if the commissioner decides to conduct a procurement for managed care contracts for the 2019 contract year.

Subd. 6. **Open meetings.** The commission is subject to Minnesota Statutes, section 3.055.

Subd. 7. **Expiration.** This section expires June 30, 2018.

Sec. 41. **REVISOR'S INSTRUCTION.**

The revisor of statutes, in the next edition of Minnesota Statutes, shall change the term "health care delivery system" and similar terms to "integrated health partnership" and similar terms, wherever it appears in Minnesota Statutes, section 256B.0755.

Sec. 42. **REPEALER.**

Minnesota Statutes 2016, sections 256B.0659, subdivision 22; 256B.19, subdivision 1c; and 256B.64, are repealed.

ARTICLE 5

HEALTH INSURANCE

Section 1. Minnesota Statutes 2016, section 62A.04, subdivision 1, is amended to read:

Subdivision 1. **Reference.** Any reference to "standard provisions" which may appear in other sections and which refer to accident and sickness or accident and health insurance shall hereinafter be construed as referring to accident and sickness policy provisions. The provisions of subdivision 2, clauses (4), (5), (6), (7), (8), (9), (10), and (12); subdivision 3, clauses (1), (3), (4), (5), (6), and (7); subdivision 6; and subdivision 10 do not apply to accident and sickness or accident and health insurance that are health plans defined in section 62A.011, subdivision 3.

EFFECTIVE DATE. This section is effective for policies offered, sold, issued, or renewed on or after January 1, 2018.

Sec. 2. Minnesota Statutes 2016, section 62A.21, subdivision 2a, is amended to read:

Subd. 2a. **Continuation privilege.** Every policy described in subdivision 1 shall contain a provision which permits continuation of coverage under the policy for the insured's ~~former spouse and~~ dependent children ~~upon~~ as defined in section 62Q.01, subdivision 2a, and former spouse, who was covered on the day before entry of a valid decree of dissolution of marriage. The coverage shall be continued until the earlier of the following dates:

(a) the date the insured's former spouse becomes covered under any other group health plan; or

(b) the date coverage would otherwise terminate under the policy.

If the coverage is provided under a group policy, any required premium contributions for the coverage shall be paid by the insured on a monthly basis to the group policyholder for remittance to the insurer. The policy must require the group policyholder to, upon request, provide the insured with written verification from the insurer of the cost of this coverage promptly at the time of eligibility for this coverage and at any time during the continuation period. In no event shall the amount of premium charged exceed 102 percent of the cost to the plan for such period of coverage for other similarly situated spouses and dependent children with respect to whom the marital relationship has not dissolved, without regard to whether such cost is paid by the employer or employee.

Upon request by the insured's ~~former spouse or~~ dependent ~~child~~ children and former spouse, who was covered on the day before entry of a valid decree of dissolution, a health carrier must provide the instructions necessary to enable the child or former spouse to elect continuation of coverage.

EFFECTIVE DATE. This section is effective for policies offered, sold, issued, or renewed on or after January 1, 2018.

Sec. 3. Minnesota Statutes 2016, section 62A.3075, is amended to read:

62A.3075 CANCER CHEMOTHERAPY TREATMENT COVERAGE.

(a) A health plan company that provides coverage under a health plan for cancer chemotherapy treatment shall not require a higher co-payment, deductible, or coinsurance amount for a prescribed, orally administered anticancer medication that is used to kill or slow the growth of cancerous cells than what the health plan requires for an intravenously administered or injected cancer medication that is provided, regardless of formulation or benefit category determination by the health plan company.

(b) A health plan company must not achieve compliance with this section by imposing an increase in co-payment, deductible, or coinsurance amount for an intravenously administered or injected cancer chemotherapy agent covered under the health plan.

(c) Nothing in this section shall be interpreted to prohibit a health plan company from requiring prior authorization or imposing other appropriate utilization controls in approving coverage for any chemotherapy.

(d) A plan offered by the commissioner of management and budget under section 43A.23 is deemed to be at parity and in compliance with this section.

(e) A health plan company is in compliance with this section if it does not include orally administered anticancer medication in the fourth tier of its pharmacy benefit.

(f) A health plan company that provides coverage under a health plan for cancer chemotherapy treatment must indicate the level of coverage for orally administered anticancer medication within its pharmacy benefit filing with the commissioner.

EFFECTIVE DATE. This section is effective January 1, 2018, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 4. Minnesota Statutes 2016, section 62A.65, subdivision 2, is amended to read:

Subd. 2. **Guaranteed renewal.** (a) No individual health plan may be offered, sold, issued, or renewed to a Minnesota resident unless the health plan provides that the plan is guaranteed renewable at a premium rate that does not take into account the claims experience or any change in the health status of any covered person that occurred after the initial issuance of the health plan to the person. The premium rate upon renewal must also otherwise comply with this section. A health carrier must not refuse to renew an individual health plan, except for nonpayment of premiums, fraud, or intentional misrepresentation of a material fact.

(b) At the time of renewal, a health carrier may elect to discontinue health plan coverage of an individual in the individual market, only in one or more of the following situations:

(1) the health carrier is ceasing to offer individual health plan coverage in the individual market in accordance with sections 62A.65, subdivision 8, and 62E.11, subdivision 9, and federal law;

(2) for network plans, the individual no longer resides, lives, or works in the service area of the health carrier, or the area for which the health carrier is authorized to do business, but only if coverage is terminated uniformly without regard to any health status-related factor of covered individuals; or

(3) a decision by the health carrier to discontinue offering a particular type of individual health plan if the health carrier:

(i) provides notice in writing to each individual provided coverage of that type of health plan at least 90 days before the date the coverage will be discontinued;

(ii) provides notice to the commissioner of commerce at least 30 business days before the health carrier gives notice to the individuals;

(iii) offers to each covered individual, on a guaranteed issue basis, the option to purchase any other individual health plan currently being offered by the health carrier or a related health carrier for individuals in the individual market; and

(iv) acts uniformly without regard to any health status-related factor of covered individuals or dependents of covered individuals who may become eligible for coverage.

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

Sec. 5. Minnesota Statutes 2016, section 62A.65, is amended by adding a subdivision to read:

Subd. 2a. **Uniform modification of a health plan.** (a) A health carrier may modify the health plan for a product, as defined under Code of Federal Regulations, title 45, section 144.103, offered to an individual in the individual market, at the time of coverage renewal if the modification is effective uniformly for all individuals with that product.

(b) For purposes of paragraph (a), modifications made uniformly and solely pursuant to applicable federal or state requirements are considered a uniform modification of coverage if:

(1) the modification is made within a reasonable time period after the imposition or modification of the federal or state requirement; and

(2) the modification is directly related to the imposition or modification of the federal or state requirement.

(c) Other types of modifications made uniformly are considered a uniform modification of coverage if the health plan for the product in the individual market meets all of the following criteria:

(1) the product is offered by the same health carrier;

(2) the product is offered as the same product network type which includes, but is not limited to, a health maintenance organization, preferred provider organization, exclusive provider organization, point of service, or indemnity;

(3) the product continues to cover at least a majority of the same service area;

(4) within the product, each health plan has the same cost-sharing structure as before the modification, except for any variation in cost sharing solely related to changes in cost and utilization of medical care, or to maintain the same metal level, as defined under section 62K.06, subdivision 4; and

(5) the product provides the same covered benefits, except for any changes in benefits that cumulatively impact the plan-adjusted index rate as defined under Code of Federal Regulations, title 45, section 156.80(d)(2), for any health plan within the product within an allowable variation of plus or minus two percentage points, not including changes pursuant to applicable federal or state requirements.

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

Sec. 6. Minnesota Statutes 2016, section 62A.65, subdivision 5, is amended to read:

Subd. 5. **Portability and conversion of coverage.** (a) For plan years beginning on or after January 1, 2014, no individual health plan may be offered, sold, issued, or renewed, to a Minnesota resident that contains a preexisting condition limitation, preexisting condition exclusion, or exclusionary rider. An individual age 19 or older may be subjected to an 18-month preexisting condition limitation during plan years beginning prior to January 1, 2014, unless the individual has maintained continuous coverage as defined in section 62L.02. The individual must not be subjected to an exclusionary rider. During plan years beginning prior to January 1, 2014, an individual who is age 19 or older and who has maintained continuous coverage may be subjected to a onetime preexisting condition limitation of up to 12 months, with credit for time covered under qualifying coverage as defined in section 62L.02, at the time that the individual first is covered under an individual health plan by any health carrier. Credit must be given for all qualifying coverage with respect to all

preexisting conditions, regardless of whether the conditions were preexisting with respect to any previous qualifying coverage. The individual must not be subjected to an exclusionary rider. Thereafter, the individual who is age 19 or older must not be subject to any preexisting condition limitation, preexisting condition exclusion, or exclusionary rider under an individual health plan by any health carrier, except an unexpired portion of a limitation under prior coverage, so long as the individual maintains continuous coverage as defined in section 62L.02. The prohibition on preexisting condition limitations for children age 18 or under does not apply to individual health plans that are grandfathered plans. The prohibition on preexisting condition limitations for adults age 19 and over beginning for plan years on or after January 1, 2014, does not apply to individual health plans that are grandfathered plans.

(b) A health carrier must offer an individual health plan to any individual previously covered under a group health plan issued by that health carrier, regardless of the size of the group, so long as the individual maintained continuous coverage as defined in section 62L.02. If the individual has available any continuation coverage provided under sections 62A.146; 62A.148; 62A.17, subdivisions 1 and 2; 62A.20; 62A.21; 62C.142; 62D.101; or 62D.105, or continuation coverage provided under federal law, the health carrier need not offer coverage under this paragraph until the individual has exhausted the continuation coverage. The offer must not be subject to underwriting, except as permitted under this paragraph. A health plan issued under this paragraph must be a qualified plan as defined in section 62E.02 and must not contain any preexisting condition limitation, preexisting condition exclusion, or exclusionary rider, except for any unexpired limitation or exclusion under the previous coverage. The individual health plan must cover pregnancy on the same basis as any other covered illness under the individual health plan. The offer of coverage by the health carrier must inform the individual that the coverage, including what is covered and the health care providers from whom covered care may be obtained, may not be the same as the individual's coverage under the group health plan. The offer of coverage by the health carrier must also inform the individual that the individual, if a Minnesota resident, may be eligible to obtain coverage from (i) other private sources of health coverage, or (ii) the Minnesota Comprehensive Health Association, without a preexisting condition limitation, and must provide the telephone number used by that association for enrollment purposes. The initial premium rate for the individual health plan must comply with subdivision 3. The premium rate upon renewal must comply with subdivision 2. In no event shall the premium rate exceed 100 percent of the premium charged for comparable individual coverage by the Minnesota Comprehensive Health Association, and the premium rate must be less than that amount if necessary to otherwise comply with this section. Coverage issued under this paragraph must provide that it cannot be canceled or nonrenewed as a result of the health

carrier's subsequent decision to leave the individual, small employer, or other group market. Section 72A.20, subdivision 28, applies to this paragraph. For plan years beginning on or after January 1, 2017, a health carrier is not required to offer coverage under this paragraph.

EFFECTIVE DATE. This section is effective for policies offered, sold, issued, or renewed on or after January 1, 2018.

Sec. 7. Minnesota Statutes 2016, section 62D.105, subdivision 1, is amended to read:

Subdivision 1. **Requirement.** Every health maintenance contract, which in addition to covering the enrollee also provides coverage to the ~~spouse and~~ dependent children to the limiting age as defined in section 62Q.01, subdivision 2a, of the enrollee and spouse who was covered on the day before entry of a valid decree of dissolution shall: (1) permit the spouse and dependent children to the limiting age as defined in section 62Q.01, subdivision 2a, to elect to continue coverage when the enrollee becomes enrolled for benefits under title XVIII of the Social Security Act (Medicare); and (2) permit the dependent children to continue coverage when they cease to be dependent children to the limiting age as defined in section 62Q.01, subdivision 2a, under the generally applicable requirement of the plan.

EFFECTIVE DATE. This section is effective for policies offered, sold, issued, or renewed on or after January 1, 2018.

Sec. 8. Minnesota Statutes 2016, section 62D.105, subdivision 2, is amended to read:

Subd. 2. **Continuation privilege.** The coverage described in subdivision 1 may be continued until the earlier of the following dates:

(1) the date coverage would otherwise terminate under the contract;

(2) 36 months after continuation by the spouse or dependent was elected; or

(3) the date the spouse or dependent children become covered under another group health plan or Medicare.

If coverage is provided under a group policy, any required fees for the coverage shall be paid by the enrollee on a monthly basis to the group contract holder for remittance to the health maintenance organization. In no event shall the fee charged exceed 102 percent of the cost to the plan for such coverage for other similarly situated spouse and dependent children to the limiting age as defined in section 62Q.01, subdivision 2a, to whom subdivision 1 is not applicable, without regard to whether such cost is paid by the employer or employee.

EFFECTIVE DATE. This section is effective for policies offered, sold, issued, or renewed on or after January 1, 2018.

Sec. 9. Minnesota Statutes 2016, section 62E.04, subdivision 11, is amended to read:

Subd. 11. ~~**Essential health benefits package**~~ **Affordable Care Act compliant plans.** For ~~individual or small group health plans that include the essential health benefits package and are~~ any policy of accident and health insurance subject to the requirements of the Affordable Care Act, as defined under section 62A.011, subdivision 1a, that is offered, sold, issued, or renewed on or after January 1, ~~2014~~ 2018, the requirements of this section do not apply.

EFFECTIVE DATE. This section is effective for policies offered, sold, issued, or renewed on or after January 1, 2018.

Sec. 10. Minnesota Statutes 2016, section 62E.05, subdivision 1, is amended to read:

Subdivision 1. **Certification.** Upon application by an insurer, fraternal, or employer for certification of a plan of health coverage as a qualified plan or a qualified Medicare supplement plan for the purposes of sections 62E.01 to 62E.19, the commissioner shall make a determination within 90 days as to whether the plan is qualified. All plans of health coverage, except Medicare supplement policies, shall be labeled as "qualified" or "nonqualified" on the front of the policy or contract, or on the schedule page. All qualified plans shall indicate whether they are number one, two, or three coverage plans. For any policy of accident and health insurance subject to the requirements of the Affordable Care Act, as defined under section 62A.011, subdivision 1a, that is offered, sold, issued, or renewed on or after January 1, 2018, the requirements of this section do not apply.

EFFECTIVE DATE. This section is effective for policies offered, sold, issued, or renewed on or after January 1, 2018.

Sec. 11. Minnesota Statutes 2016, section 62E.06, is amended by adding a subdivision to read:

Subd. 5. **Affordable Care Act compliant plans.** For any policy of accident and health insurance subject to the requirements of the Affordable Care Act, as defined under section 62A.011, subdivision 1a, that is offered, sold, issued, or renewed on or after January 1, 2018, the requirements of this section do not apply.

EFFECTIVE DATE. This section is effective for policies offered, sold, issued, or renewed on or after January 1, 2018.

Sec. 12. Minnesota Statutes 2016, section 62Q.18, subdivision 7, is amended to read:

Subd. 7. **Portability of coverage.** Effective July 1, 1994, no health plan company shall offer, sell, issue, or renew any group health plan that does not, with respect to individuals who maintain continuous coverage and who qualify under the group's eligibility requirements:

(1) make coverage available on a guaranteed issue basis;

(2) give full credit for previous continuous coverage against any applicable preexisting condition limitation or preexisting condition exclusion; and

(3) with respect to a group health plan offered, sold, issued, or renewed to a large employer, impose preexisting condition limitations or preexisting condition exclusions except to the extent that would be permitted under chapter 62L if the group sponsor were a small employer as defined in section 62L.02, subdivision 26.

To the extent that this subdivision conflicts with chapter 62L, chapter 62L governs, regardless of whether the group sponsor is a small employer as defined in section 62L.02, except that for group health plans issued to groups that are not small employers, this subdivision's requirement that the individual have maintained continuous coverage applies. An individual who has maintained continuous coverage, but would be considered a late entrant under chapter 62L, may be treated as a late entrant in the same manner under this subdivision as permitted under chapter 62L. For plan years beginning on or after January 1, 2017, a health plan company is no longer required to offer coverage under this subdivision.

EFFECTIVE DATE. This section is effective for policies offered, sold, issued, or renewed on or after January 1, 2018.

Sec. 13. **[62Q.575] ACCESS TO PRIMARY CARE PROVIDERS.**

Subdivision 1. **Provider network.** (a) No health plan company offering an individual health plan that is not a grandfathered plan shall deny a primary care provider the right to contract with the health plan company as an in-network provider if the primary care provider meets one of the following criteria:

(1) is certified as a health care home by the commissioner of health under section 256B.0751. To remain eligible for in-network status under this section, the primary care provider must maintain certification as a health care home; or

(2) is in the process of becoming certified as a health care home under section 256B.0751. To remain eligible for in-network status under this subdivision, the primary care provider must complete the certification process within six months to remain an in-network provider.

(b) A health plan company may require the primary care provider to meet reasonable data, utilization review, and quality assurance requirements on the same basis as other in-network providers.

(c) The primary care provider must agree to serve all enrollees of the health care company who select or designate the primary care provider, if designation is required.

(d) The primary care provider and health plan company may negotiate the payment rate for covered services provided by the primary care provider. The rate must not be less than the rate paid by the health plan company to the provider under a different category of coverage or health product, or other arrangement within a category of coverage.

Subd. 2. **Cost-sharing or other conditions.** No health plan company shall impose a co-payment, fee, or other cost-sharing requirement for selecting or designating a primary care provider of the enrollee's choosing or impose other conditions that limit the enrollee's ability to utilize a primary care provider of the enrollee's choosing, unless the health plan company imposes the same cost-sharing requirements, fees, conditions, or limits upon an enrollee's selection or designation of any of the health plan company's in-network primary care providers.

Subd. 3. **Care coordination.** (a) As part of the provider contract with primary care providers that are certified health care homes, the contract must include a care coordination payment for providing care coordination services. The care coordination payment under this subdivision must be a per enrollee, per month payment and must be in addition to the payment rate for the covered services provided by the primary care provider.

(b) The care coordination payment may vary based on care complexity, but must at least be equal to the payment amounts established under section 256B.0753.

(c) The health plan company shall not impose a co-payment, fee, or other cost-sharing requirement for care coordination services.

Subd. 4. **Notice.** The health plan company shall provide notice to enrollees of the provisions of this section.

Subd. 5. **Definition.** For purposes of this section, "primary care provider" means a physician licensed under chapter 147 or an advanced practice registered nurse licensed under chapter 148 who specializes in the practice of family medicine, general internal medicine, obstetrics and gynecology, or general pediatrics; or a health care clinic that specializes in the above-mentioned areas and utilizes a primary care team that includes physicians, physician assistants, or advanced practice registered nurses.

Subd. 6. **Limitations.** (a) This section does not apply to enrollees who are enrolled in a public health care program under chapter 256B or 256L, or the Minnesota restricted recipient program pursuant to Minnesota Rules, part 9505.2238.

(b) This section does not waive any exclusions of coverage under the terms and conditions of the enrollee's health plan.

(c) This section only applies to individual health plans.

Subd. 7. **Enforcement.** The commissioner of health shall enforce this section.

EFFECTIVE DATE. This section is effective January 1, 2018, and applies to any individual health plan offered, sold, issued, or renewed on or after that date.

Sec. 14. **[62Q.678] NETWORK OFFERINGS.**

(a) In counties where a health plan company actively markets an individual health plan, the health plan company must offer, in those counties, at least one individual health plan with a provider network that includes in-network access to more than a single health care provider system or a health plan that includes more than one primary care location in a county. This section is applicable only for the plan year in which the health plan company actively markets an individual health plan.

(b) The commissioner of health shall enforce this section.

EFFECTIVE DATE. This section is effective January 1, 2018, and applies to any health plan offered, sold, issued, or renewed on or after that date.

Sec. 15. Minnesota Statutes 2016, section 317A.811, subdivision 1, is amended to read:

Subdivision 1. **When required.** (a) Except as provided in subdivision 6, the following corporations shall notify the attorney general of their intent to dissolve, merge, or consolidate, or to transfer all or substantially all of their assets:

(1) a corporation that holds assets for a charitable purpose as defined in section 501B.35, subdivision 2; ~~or~~

(2) a health maintenance organization operating under chapter 62D;

(3) a service plan corporation operating under chapter 62C; or

~~(2)~~ (4) a corporation that is exempt under section 501(c)(3) of the Internal Revenue Code of 1986, or any successor section.

(b) The notice must include:

(1) the purpose of the corporation that is giving the notice;

(2) a list of assets owned or held by the corporation for charitable purposes;

(3) a description of restricted assets and purposes for which the assets were received;

(4) a description of debts, obligations, and liabilities of the corporation;

(5) a description of tangible assets being converted to cash and the manner in which they will be sold;

(6) anticipated expenses of the transaction, including attorney fees;

(7) a list of persons to whom assets will be transferred, if known;

(8) the purposes of persons receiving the assets; and

(9) the terms, conditions, or restrictions, if any, to be imposed on the transferred assets.

The notice must be signed on behalf of the corporation by an authorized person.

Sec. 16. Minnesota Statutes 2016, section 317A.811, is amended by adding a subdivision to read:

Subd. 1a. **Nonprofit health care entity; notice and approval required.** A corporation that is a health maintenance organization or a service plan corporation is subject to notice and approval requirements for certain transactions under section 317A.814.

Sec. 17. **[317A.814] NONPROFIT HEALTH CARE ENTITY CONVERSIONS.**

Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Commissioner" means the commissioner of commerce if the nonprofit health care entity at issue is a service plan corporation operating under chapter 62C, and the commissioner of health if the nonprofit health care entity at issue is a health maintenance organization operating under chapter 62D.

(c) "Conversion benefit entity" means a foundation, corporation, limited liability company, trust, partnership, or other entity that receives public benefit assets, or their value, in connection with a conversion transaction.

(d) "Conversion transaction" or "transaction" means a transaction in which a nonprofit health care entity merges, consolidates, converts, or transfers all or a substantial portion of its assets to an entity that is not a nonprofit corporation organized under this chapter that is also exempt under United States Code, title 26, section 501(c)(3). The substitution of a new

corporate member that transfers the control, responsibility for, or governance of a nonprofit health care entity is also considered a transaction for purposes of this section.

(e) "Family member" means a spouse, parent, or child or other legal dependent.

(f) "Nonprofit health care entity" means a service plan corporation operating under chapter 62C and a health maintenance organization operating under chapter 62D.

(g) "Public benefit assets" means the entirety of a nonprofit health care entity's assets, whether tangible or intangible.

(h) "Related organization" has the meaning given in section 317A.011.

Subd. 2. **Private inurement.** A nonprofit health care entity must not enter into a conversion transaction if a person who has been an officer, director, or other executive of the nonprofit health care entity, or of a related organization, or a family member of that person:

(1) has or will receive any compensation or other financial benefit, directly or indirectly, in connection with the conversion transaction;

(2) has held or will hold, regardless of whether guaranteed or contingent, an ownership stake, stock, securities, investment, or other financial interest in, or receive any type of compensation or other financial benefit from, any entity to which the nonprofit health care entity transfers public benefit assets in connection with a conversion transaction; or

(3) has held or will hold, regardless of whether guaranteed or contingent, an ownership stake, stock, securities, investment, or other financial interest in, or receive any type of compensation or other financial benefit from, any entity that has or will have a business relationship with any entity to which the nonprofit health care entity transfers public benefit assets in connection with a conversion transaction.

Subd. 3. **Attorney general notice and approval required.** (a) Before entering into a conversion transaction, the nonprofit health care entity must notify the attorney general as specified under section 317A.811, subdivision 1. The notice required by this subdivision also must include an itemization of the nonprofit health care entity's public benefit assets and the valuation that the entity attributes to those assets, a proposed plan for distribution of the value of those assets to a conversion benefit entity that meets the requirements of subdivision 5, and other information from the health maintenance organization or the proposed conversion benefit entity that the attorney general reasonably considers necessary for review of the proposed transaction.

(b) A copy of the notice and other information required under this subdivision must be given to the commissioner.

Subd. 4. **Review elements.** (a) The attorney general may approve, conditionally approve, or not approve a conversion transaction under this section. In making a decision whether to approve, conditionally approve, or not approve a proposed transaction, the attorney general, in consultation with the commissioner, shall consider any factors the attorney general considers relevant, including whether:

(1) the proposed transaction complies with this chapter and chapter 501B and other applicable laws;

(2) the proposed transaction involves or constitutes a breach of charitable trust;

(3) the nonprofit health care entity will receive full and fair value for its public benefit assets;

(4) the full and fair value of the public benefit assets to be transferred has been manipulated in a manner that causes or has caused the value of the assets to decrease;

(5) the proceeds of the proposed transaction will be used consistent with the public benefit for which the assets are held by the nonprofit health care entity;

(6) the proposed transaction will result in a breach of fiduciary duty, as determined by the attorney general, including whether:

(i) conflicts of interest exist related to payments to or benefits conferred upon officers, directors, board members, and executives of the nonprofit health care entity or a related organization;

(ii) the nonprofit health care entity's board of directors exercised reasonable care and due diligence in deciding to pursue the transaction, in selecting the entity with which to pursue the transaction, and in negotiating the terms and conditions of the transaction; and

(iii) the nonprofit health care entity's board of directors considered all reasonably viable alternatives, including any competing offers for its public benefit assets, or alternative transactions;

(7) the transaction will result in private inurement to any person, including owners, stakeholders, or directors, officers, or key staff of the nonprofit health care entity or entity to which the nonprofit health care entity proposes to transfer public benefit assets;

(8) the conversion benefit entity meets the requirements of subdivision 5; and

(9) the attorney general and the commissioner have been provided with sufficient information by the nonprofit health care entity to adequately evaluate the proposed transaction and the effects on the public, provided the attorney general or the commissioner has notified the nonprofit health care entity or the proposed conversion benefit entity of any inadequacy of the information and has provided a reasonable opportunity to remedy that inadequacy.

In addition, the attorney general shall consider the public comments received regarding the proposed conversion transaction and the proposed transaction's likely effect on the availability, accessibility, and affordability of health care services to the public.

(b) The attorney general must consult with the commissioner in making a decision whether to approve or disapprove a transaction.

Subd. 5. **Conversion benefit entity requirements.** (a) A conversion benefit entity must be an existing or new domestic nonprofit corporation organized under this chapter and also be exempt under United States Code, title 26, section 501(c)(3).

(b) The conversion benefit entity must be completely independent of any influence or control by the nonprofit health care entity and related organizations, all entities to which the nonprofit health care entity transfers any public benefit assets in connection with a conversion transaction, and the directors, officers, and other executives of those organizations or entities.

(c) The conversion benefit entity must have in place procedures and policies to prohibit conflicts of interest, including but not limited to prohibiting conflicts of interests relating to any grant-making activities that may benefit:

(1) the directors, officers, or other executives of the conversion benefit entity;

(2) any entity to which the nonprofit health care entity transfers any public benefit assets in connection with a conversion transaction; or

(3) any directors, officers, or other executives of any entity to which the nonprofit health care entity transfers any public benefit assets in connection with a conversion transaction.

(d) The charitable purpose and grant-making functions of the conversion benefit entity must be dedicated to meeting the health care needs of the people of this state.

Subd. 6. **Public comment.** Before issuing a decision under subdivision 7, the attorney general may solicit public comment regarding the proposed conversion transaction. The attorney general may hold one or more public meetings or solicit written or electronic correspondence. If a meeting is held, notice of the meeting must be published in a qualified newspaper of general circulation in this state at least seven days before the meeting.

Subd. 7. **Period for approval or disapproval; extension.** (a) Within 150 days of receiving notice of a proposed transaction, the attorney general shall notify the nonprofit health care entity in writing of its decision to approve, conditionally approve, or disapprove the transaction. If the transaction is not approved, the notice must include the reason for the decision. If the transaction is conditionally approved, the notice must specify the conditions that must be met. The attorney general may extend this period for an additional 90 days if necessary to obtain additional information.

(b) The time periods under this subdivision are suspended during the time when a request from the attorney general for additional information is outstanding.

Subd. 8. **Transfer of value of assets required.** If a proposed conversion transaction is approved or conditionally approved by the attorney general, the nonprofit health care entity shall transfer the entirety of the full and fair value of its public benefit assets to one or more conversion benefit entities as part of the transaction.

Subd. 9. **Assessment of costs.** The nonprofit health care entity or the conversion benefit entity must reimburse the attorney general or a state agency for all reasonable and actual costs incurred by the attorney general or a state agency in reviewing a proposed conversion transaction, including attorney fees at the billing rate used by the attorney general for state agencies and the costs for retention of actuarial, valuation, or other experts or consultants, and administrative costs.

Subd. 10. **Annual report by conversion benefit entity.** A conversion benefit entity must submit an annual report to the attorney general that contains a detailed description of its charitable activities related to the use of the public benefit assets received under a transaction that is approved under this section.

Subd. 11. **Penalties; remedies.** A conversion transaction entered into in violation of this section is null and void. The attorney general is authorized to bring an action to unwind a conversion transaction entered into in violation of this section and to recover the amount of any private inurement received or held in violation of subdivision 2. In addition to this recovery, the officers, directors, and other executives of each entity that is a party to and materially participated in a conversion transaction entered into in violation of this section may be subject to a civil penalty of up to the greater of either the entirety of any financial benefit each one derived from the transaction, or $1,000,000, as determined by the court. The attorney general is authorized to enforce this section pursuant to section 8.31.

Subd. 12. **Relation to other law.** (a) This section is in addition to, and does not affect or limit any power, remedy, or responsibility of a health maintenance organization, service

plan corporation, a conversion benefit entity, the attorney general, or the commissioner under this chapter, chapter 62C, 62D, 501B, or other law.

(b) Nothing in this section authorizes a nonprofit health care entity to enter into a conversion transaction not otherwise permitted under this chapter.

Sec. 18. Laws 2017, chapter 2, article 1, section 1, subdivision 3, is amended to read:

Subd. 3. **Eligible individual.** "Eligible individual" means a Minnesota resident who:

(1) is not receiving ~~a~~ an advanced premium tax credit under Code of Federal Regulations, title 26, section 1.36B-2, ~~as of the date their coverage is effectuated~~ in a month in which their coverage is effective;

(2) is not enrolled in public program coverage under Minnesota Statutes, section 256B.055, or 256L.04; and

(3) purchased an individual health plan from a health carrier in the individual market.

Sec. 19. Laws 2017, chapter 2, article 1, section 2, subdivision 4, is amended to read:

Subd. 4. **Data practices.** (a) The definitions in Minnesota Statutes, section 13.02, apply to this subdivision.

(b) Government data on an enrollee or health carrier under this section are private data on individuals or nonpublic data, except that the total reimbursement requested by a health carrier and the total state payment to the health carrier are public data.

(c) Notwithstanding Minnesota Statutes, section 138.17, not public government data on an enrollee or health carrier collected under this section must be destroyed by June 30, 2018, or upon completion by the legislative auditor of the audits required by section 3, whichever is later, except to the extent the legislative auditor maintains data for a longer period of time in order to comply with generally accepted government auditing standards.

Sec. 20. Laws 2017, chapter 2, article 1, section 2, is amended by adding a subdivision to read:

Subd. 5. **Data sharing.** (a) Notwithstanding any law to the contrary, the commissioner of human services and the executive director of MNsure must disclose to the commissioner of management and budget data on public program coverage enrollment under Minnesota Statutes, sections 256B.055 and 256L.04, data on an enrollee's receipt of an advanced premium tax credit under Code of Federal Regulations, title 26, section 1.36B-2.

(b) Notwithstanding any law to the contrary, the commissioner of management and budget must disclose data to health carriers on enrollees' enrollment in public program coverage under Minnesota Statutes, section 256B.055 or 256L.04, to the extent that the commissioner determines the disclosure is necessary for purposes of determining eligibility for the premium subsidy program authorized by this act.

(c) Data disclosed under this subdivision may be used only for the purpose of administration of the premium subsidy program under this act and may not be further disclosed to any other person, except as otherwise provided by law.

Sec. 21. Laws 2017, chapter 2, article 1, section 3, is amended to read:

Sec. 3. **AUDITS.**

(a) The legislative auditor shall conduct audits of the health carriers' supporting data, as prescribed by the commissioner, to determine whether payments align with criteria established in sections 1 and 2. The commissioner of human services shall provide data as necessary to the legislative auditor to complete the audit. The commissioner shall withhold or charge back payments to the health carriers to the extent they do not align with the criteria established in sections 1 and 2, as determined by the audit.

(b) The legislative auditor shall audit the extent to which health carriers provided premium subsidies to persons meeting the residency and other eligibility requirements specified in section 1, subdivision 3. The legislative auditor shall report to the commissioner the amount of premium subsidies provided by each health carrier to persons not eligible for a premium subsidy. The commissioner, in consultation with the commissioners of commerce ~~and~~, health, and human services shall develop and implement a process to recover from health carriers the amount of premium subsidies received for enrollees determined to be ineligible for premium subsidies by the legislative auditor. The legislative auditor, when conducting the required audit, and the commissioner, when determining the amount of premium subsidy to be recovered, may take into account the extent to which a health carrier makes use of the Minnesota eligibility system, as defined in Minnesota Statutes, section 62V.055, subdivision 1.

Sec. 22. Laws 2017, chapter 2, article 1, section 5, is amended to read:

Sec. 5. **SUNSET.**

This article ~~sunsets June 30~~, other than section 2, subdivision 5, and section 3, sunsets August 31, 2018.

Sec. 23. Laws 2017, chapter 2, article 1, section 7, is amended to read:

Sec. 7. **APPROPRIATIONS.**

(a) $311,788,000 in fiscal year 2017 is appropriated from the general fund to the commissioner of management and budget for premium assistance under section 2. This appropriation is onetime and is available through ~~June 30~~ August 31, 2018.

(b) $157,000 in fiscal year 2017 is appropriated from the general fund to the legislative auditor for purposes of section 3. This appropriation is onetime.

(c) Any unexpended amount from the appropriation in paragraph (a) after June 30, 2018, shall be transferred ~~on July 1~~ no later than August 31, 2018, from the general fund to the budget reserve account under Minnesota Statutes, section 16A.152, subdivision 1a.

Sec. 24. Laws 2017, chapter 2, article 2, section 13, is amended to read:

Sec. 13. **62Q.556 UNAUTHORIZED PROVIDER SERVICES.**

Subdivision 1. **Unauthorized provider services.** (a) Except as provided in paragraph (c), unauthorized provider services occur when an enrollee receives services:

(1) from a nonparticipating provider at a participating hospital or ambulatory surgical center, when the services are rendered:

(i) due to the unavailability of a participating provider;

(ii) by a nonparticipating provider without the enrollee's knowledge; or

(iii) due to the need for unforeseen services arising at the time the services are being rendered; or

(2) from a participating provider that sends a specimen taken from the enrollee in the participating provider's practice setting to a nonparticipating laboratory, pathologist, or other medical testing facility.

(b) Unauthorized provider services do not include emergency services as defined in section 62Q.55, subdivision 3.

(c) The services described in paragraph (a), clause (2), are not unauthorized provider services if the enrollee gives advance written consent to the provider acknowledging that the use of a provider, or the services to be rendered, may result in costs not covered by the health plan.

Subd. 2. **Prohibition.** (a) An enrollee's financial responsibility for the unauthorized provider services shall be the same cost-sharing requirements, including co-payments,

deductibles, coinsurance, coverage restrictions, and coverage limitations, as those applicable to services received by the enrollee from a participating provider. A health plan company must apply any enrollee cost sharing requirements, including co-payments, deductibles, and coinsurance, for unauthorized provider services to the enrollee's annual out-of-pocket limit to the same extent payments to a participating provider would be applied.

(b) A health plan company must attempt to negotiate the reimbursement, less any applicable enrollee cost sharing under paragraph (a), for the unauthorized provider services with the nonparticipating provider. If a health plan company's and nonparticipating provider's attempts to negotiate reimbursement for the health care services do not result in a resolution, the health plan company or provider may elect to refer the matter for binding arbitration, chosen in accordance with paragraph (c). A nondisclosure agreement must be executed by both parties prior to engaging an arbitrator in accordance with this section. The cost of arbitration must be shared equally between the parties.

(c) The commissioner of health, in consultation with the commissioner of the Bureau of Mediation Services, must develop a list of professionals qualified in arbitration, for the purpose of resolving disputes between a health plan company and nonparticipating provider arising from the payment for unauthorized provider services. The commissioner of health shall publish the list on the department of health's Web Site, and update the list as appropriate.

(d) The arbitrator must consider relevant information, including the health plan company's payments to other nonparticipating providers for the same services, the circumstances and complexity of the particular case, and the usual and customary rate for the service based on information available in a database in a national, independent, not-for-profit corporation, and similar fees received by the provider for the same services from other health plans in which the provider is nonparticipating, in reaching a decision.

Subd. 3. **Scope.** This section does not apply to services provided under chapter 256B or 256L.

Sec. 25. Laws 2017, chapter 2, article 2, section 13, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective ~~90 days following final enactment~~ January 1, 2019, and applies to provider services provided on or after that date.

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

ARTICLE 6

DIRECT CARE AND TREATMENT

Section 1. Minnesota Statutes 2016, section 253B.10, subdivision 1, is amended to read:

Subdivision 1. **Administrative requirements.** (a) When a person is committed, the court shall issue a warrant or an order committing the patient to the custody of the head of the treatment facility. The warrant or order shall state that the patient meets the statutory criteria for civil commitment.

(b) The commissioner shall prioritize patients being admitted from jail or a correctional institution who are:

(1) ordered confined in a state hospital for an examination under Minnesota Rules of Criminal Procedure, rules 20.01, subdivision 4, paragraph (a), and 20.02, subdivision 2;

(2) under civil commitment for competency treatment and continuing supervision under Minnesota Rules of Criminal Procedure, rule 20.01, subdivision 7;

(3) found not guilty by reason of mental illness under Minnesota Rules of Criminal Procedure, rule 20.02, subdivision 8, and under civil commitment or are ordered to be detained in a state hospital or other facility pending completion of the civil commitment proceedings; or

(4) committed under this chapter to the commissioner after dismissal of the patient's criminal charges.

Patients described in this paragraph must be admitted to a service operated by the commissioner within 48 hours. Regardless of when the 48-hour time period expires, a regional treatment center is not required to admit a patient after 12:00 p.m. on Friday and before 8:00 a.m. on Monday. The commitment must be ordered by the court as provided in section 253B.09, subdivision 1, paragraph (c).

(c) Upon the arrival of a patient at the designated treatment facility, the head of the facility shall retain the duplicate of the warrant and endorse receipt upon the original warrant or acknowledge receipt of the order. The endorsed receipt or acknowledgment must be filed in the court of commitment. After arrival, the patient shall be under the control and custody of the head of the treatment facility.

(d) Copies of the petition for commitment, the court's findings of fact and conclusions of law, the court order committing the patient, the report of the examiners, and the prepetition report shall be provided promptly to the treatment facility.

Sec. 2. Minnesota Statutes 2016, section 253B.22, subdivision 1, is amended to read:

Subdivision 1. **Establishment.** The commissioner shall establish a review board ~~of three or more persons for each regional center~~ to review the admission and retention of its patients receiving services under this chapter. The review board shall be comprised of two members and one chair. Each board member shall be selected and appointed by the commissioner. The appointed members shall be limited to one term of no more than three years and no board member can serve more than three consecutive three-year terms. One member shall be qualified in the diagnosis of mental illness, developmental disability, or chemical dependency, and one member shall be an attorney. The commissioner may, upon written request from the appropriate federal authority, establish a review panel for any federal treatment facility within the state to review the admission and retention of patients hospitalized under this chapter. For any review board established for a federal treatment facility, one of the persons appointed by the commissioner shall be the commissioner of veterans affairs or the commissioner's designee.

Sec. 3. **REVIEW OF ALTERNATIVES TO STATE-OPERATED GROUP HOMES HOUSING ONE PERSON.**

The commissioner of human services shall review the potential for, and the viability of, alternatives to state-operated group homes housing one person. The intent is to create housing options for individuals who do not belong in an institutionalized setting, but need additional support before transitioning to a more independent community placement. The review shall include an analysis of existing housing settings operated by counties and private providers, as well as the potential for new housing settings, and determine the viability for use by state-operated services. The commissioner shall seek input from interested stakeholders as part of the review. An update, including alternatives identified, will be provided by the commissioner to the members of the legislative committees having jurisdiction over human services issues no later than January 15, 2018.

ARTICLE 7

CHILDREN AND FAMILIES

Section 1. Minnesota Statutes 2016, section 13.32, is amended by adding a subdivision to read:

Subd. 12. **Access by welfare system.** County personnel in the welfare system may request access to education data in order to coordinate services for a student or family. The request must be submitted to the chief administrative officer of the school and must include

the basis for the request and a description of the information that is requested. The chief administrative officer must provide a copy of the request to the parent or legal guardian of the student who is the subject of the request, along with a form the parent or legal guardian may execute to consent to the release of specified information to the requester. Education data may be released under this subdivision only if the parent or legal guardian gives informed consent to the release.

Sec. 2. Minnesota Statutes 2016, section 13.46, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** As used in this section:

(a) "Individual" means an individual according to section 13.02, subdivision 8, but does not include a vendor of services.

(b) "Program" includes all programs for which authority is vested in a component of the welfare system according to statute or federal law, including, but not limited to, Native American tribe programs that provide a service component of the welfare system, the aid to families with dependent children program formerly codified in sections 256.72 to 256.87, Minnesota family investment program, temporary assistance for needy families program, medical assistance, general assistance, general assistance medical care formerly codified in chapter 256D, child care assistance program, and child support collections.

(c) "Welfare system" includes the Department of Human Services, local social services agencies, county welfare agencies, county public health agencies, county veteran services agencies, county housing agencies, private licensing agencies, the public authority responsible for child support enforcement, human services boards, community mental health center boards, state hospitals, state nursing homes, the ombudsman for mental health and developmental disabilities, Native American tribes to the extent a tribe provides a service component of the welfare system, and persons, agencies, institutions, organizations, and other entities under contract to any of the above agencies to the extent specified in the contract.

(d) "Mental health data" means data on individual clients and patients of community mental health centers, established under section 245.62, mental health divisions of counties and other providers under contract to deliver mental health services, or the ombudsman for mental health and developmental disabilities.

(e) "Fugitive felon" means a person who has been convicted of a felony and who has escaped from confinement or violated the terms of probation or parole for that offense.

(f) "Private licensing agency" means an agency licensed by the commissioner of human services under chapter 245A to perform the duties under section 245A.16.

Sec. 3. Minnesota Statutes 2016, section 13.46, subdivision 2, is amended to read:

Subd. 2. **General.** (a) Data on individuals collected, maintained, used, or disseminated by the welfare system are private data on individuals, and shall not be disclosed except:

(1) according to section 13.05;

(2) according to court order;

(3) according to a statute specifically authorizing access to the private data;

(4) to an agent of the welfare system and an investigator acting on behalf of a county, the state, or the federal government, including a law enforcement person or attorney in the investigation or prosecution of a criminal, civil, or administrative proceeding relating to the administration of a program;

(5) to personnel of the welfare system who require the data to verify an individual's identity; determine eligibility, amount of assistance, and the need to provide services to an individual or family across programs; coordinate services for an individual or family; evaluate the effectiveness of programs; assess parental contribution amounts; and investigate suspected fraud;

(6) to administer federal funds or programs;

(7) between personnel of the welfare system working in the same program;

(8) to the Department of Revenue to assess parental contribution amounts for purposes of section 252.27, subdivision 2a, administer and evaluate tax refund or tax credit programs and to identify individuals who may benefit from these programs. The following information may be disclosed under this paragraph: an individual's and their dependent's names, dates of birth, Social Security numbers, income, addresses, and other data as required, upon request by the Department of Revenue. Disclosures by the commissioner of revenue to the commissioner of human services for the purposes described in this clause are governed by section 270B.14, subdivision 1. Tax refund or tax credit programs include, but are not limited to, the dependent care credit under section 290.067, the Minnesota working family credit under section 290.0671, the property tax refund and rental credit under section 290A.04, and the Minnesota education credit under section 290.0674;

(9) between the Department of Human Services, the Department of Employment and Economic Development, and when applicable, the Department of Education, for the following purposes:

(i) to monitor the eligibility of the data subject for unemployment benefits, for any employment or training program administered, supervised, or certified by that agency;

(ii) to administer any rehabilitation program or child care assistance program, whether alone or in conjunction with the welfare system;

(iii) to monitor and evaluate the Minnesota family investment program or the child care assistance program by exchanging data on recipients and former recipients of food support, cash assistance under chapter 256, 256D, 256J, or 256K, child care assistance under chapter 119B, medical programs under chapter 256B or 256L, or a medical program formerly codified under chapter 256D; and

(iv) to analyze public assistance employment services and program utilization, cost, effectiveness, and outcomes as implemented under the authority established in Title II, Sections 201-204 of the Ticket to Work and Work Incentives Improvement Act of 1999. Health records governed by sections 144.291 to 144.298 and "protected health information" as defined in Code of Federal Regulations, title 45, section 160.103, and governed by Code of Federal Regulations, title 45, parts 160-164, including health care claims utilization information, must not be exchanged under this clause;

(10) to appropriate parties in connection with an emergency if knowledge of the information is necessary to protect the health or safety of the individual or other individuals or persons;

(11) data maintained by residential programs as defined in section 245A.02 may be disclosed to the protection and advocacy system established in this state according to Part C of Public Law 98-527 to protect the legal and human rights of persons with developmental disabilities or other related conditions who live in residential facilities for these persons if the protection and advocacy system receives a complaint by or on behalf of that person and the person does not have a legal guardian or the state or a designee of the state is the legal guardian of the person;

(12) to the county medical examiner or the county coroner for identifying or locating relatives or friends of a deceased person;

(13) data on a child support obligor who makes payments to the public agency may be disclosed to the Minnesota Office of Higher Education to the extent necessary to determine eligibility under section 136A.121, subdivision 2, clause (5);

(14) participant Social Security numbers and names collected by the telephone assistance program may be disclosed to the Department of Revenue to conduct an electronic data match with the property tax refund database to determine eligibility under section 237.70, subdivision 4a;

(15) the current address of a Minnesota family investment program participant may be disclosed to law enforcement officers who provide the name of the participant and notify the agency that:

(i) the participant:

(A) is a fugitive felon fleeing to avoid prosecution, or custody or confinement after conviction, for a crime or attempt to commit a crime that is a felony under the laws of the jurisdiction from which the individual is fleeing; or

(B) is violating a condition of probation or parole imposed under state or federal law;

(ii) the location or apprehension of the felon is within the law enforcement officer's official duties; and

(iii) the request is made in writing and in the proper exercise of those duties;

(16) the current address of a recipient of general assistance may be disclosed to probation officers and corrections agents who are supervising the recipient and to law enforcement officers who are investigating the recipient in connection with a felony level offense;

(17) information obtained from food support applicant or recipient households may be disclosed to local, state, or federal law enforcement officials, upon their written request, for the purpose of investigating an alleged violation of the Food Stamp Act, according to Code of Federal Regulations, title 7, section 272.1(c);

(18) the address, Social Security number, and, if available, photograph of any member of a household receiving food support shall be made available, on request, to a local, state, or federal law enforcement officer if the officer furnishes the agency with the name of the member and notifies the agency that:

(i) the member:

(A) is fleeing to avoid prosecution, or custody or confinement after conviction, for a crime or attempt to commit a crime that is a felony in the jurisdiction the member is fleeing;

(B) is violating a condition of probation or parole imposed under state or federal law; or

(C) has information that is necessary for the officer to conduct an official duty related to conduct described in subitem (A) or (B);

(ii) locating or apprehending the member is within the officer's official duties; and

(iii) the request is made in writing and in the proper exercise of the officer's official duty;

(19) the current address of a recipient of Minnesota family investment program, general assistance, or food support may be disclosed to law enforcement officers who, in writing, provide the name of the recipient and notify the agency that the recipient is a person required to register under section 243.166, but is not residing at the address at which the recipient is registered under section 243.166;

(20) certain information regarding child support obligors who are in arrears may be made public according to section 518A.74;

(21) data on child support payments made by a child support obligor and data on the distribution of those payments excluding identifying information on obligees may be disclosed to all obligees to whom the obligor owes support, and data on the enforcement actions undertaken by the public authority, the status of those actions, and data on the income of the obligor or obligee may be disclosed to the other party;

(22) data in the work reporting system may be disclosed under section 256.998, subdivision 7;

(23) to the Department of Education for the purpose of matching Department of Education student data with public assistance data to determine students eligible for free and reduced-price meals, meal supplements, and free milk according to United States Code, title 42, sections 1758, 1761, 1766, 1766a, 1772, and 1773; to allocate federal and state funds that are distributed based on income of the student's family; and to verify receipt of energy assistance for the telephone assistance plan;

(24) the current address and telephone number of program recipients and emergency contacts may be released to the commissioner of health or a community health board as defined in section 145A.02, subdivision 5, when the commissioner or community health board has reason to believe that a program recipient is a disease case, carrier, suspect case, or at risk of illness, and the data are necessary to locate the person;

(25) to other state agencies, statewide systems, and political subdivisions of this state, including the attorney general, and agencies of other states, interstate information networks,

federal agencies, and other entities as required by federal regulation or law for the administration of the child support enforcement program;

(26) to personnel of public assistance programs as defined in section 256.741, for access to the child support system database for the purpose of administration, including monitoring and evaluation of those public assistance programs;

(27) to monitor and evaluate the Minnesota family investment program by exchanging data between the Departments of Human Services and Education, on recipients and former recipients of food support, cash assistance under chapter 256, 256D, 256J, or 256K, child care assistance under chapter 119B, medical programs under chapter 256B or 256L, or a medical program formerly codified under chapter 256D;

(28) to evaluate child support program performance and to identify and prevent fraud in the child support program by exchanging data between the Department of Human Services, Department of Revenue under section 270B.14, subdivision 1, paragraphs (a) and (b), without regard to the limitation of use in paragraph (c), Department of Health, Department of Employment and Economic Development, and other state agencies as is reasonably necessary to perform these functions;

(29) counties operating child care assistance programs under chapter 119B may disseminate data on program participants, applicants, and providers to the commissioner of education;

(30) child support data on the child, the parents, and relatives of the child may be disclosed to agencies administering programs under titles IV-B and IV-E of the Social Security Act, as authorized by federal law; ~~or~~

(31) to a health care provider governed by sections 144.291 to 144.298, to the extent necessary to coordinate services;

(32) to the chief administrative officer of a school to coordinate services for a student and family; data that may be disclosed under this clause are limited to name, date of birth, gender, and address; or

(33) to county correctional agencies to the extent necessary to coordinate services and diversion programs; data that may be disclosed under this clause are limited to name, client demographics, program, case status, and county worker information.

(b) Information on persons who have been treated for drug or alcohol abuse may only be disclosed according to the requirements of Code of Federal Regulations, title 42, sections 2.1 to 2.67.

(c) Data provided to law enforcement agencies under paragraph (a), clause (15), (16), (17), or (18), or paragraph (b), are investigative data and are confidential or protected nonpublic while the investigation is active. The data are private after the investigation becomes inactive under section 13.82, subdivision 5, paragraph (a) or (b).

(d) Mental health data shall be treated as provided in subdivisions 7, 8, and 9, but are not subject to the access provisions of subdivision 10, paragraph (b).

For the purposes of this subdivision, a request will be deemed to be made in writing if made through a computer interface system.

Sec. 4. Minnesota Statutes 2016, section 13.84, subdivision 5, is amended to read:

Subd. 5. **Disclosure.** Private or confidential court services data shall not be disclosed except:

(a) pursuant to section 13.05;

(b) pursuant to a statute specifically authorizing disclosure of court services data;

(c) with the written permission of the source of confidential data;

(d) to the court services department, parole or probation authority or state or local correctional agency or facility having statutorily granted supervision over the individual subject of the data, or to county personnel within the welfare system;

(e) pursuant to subdivision 6;

(f) pursuant to a valid court order; or

(g) pursuant to section 611A.06, subdivision 3a.

Sec. 5. Minnesota Statutes 2016, section 119B.011, is amended by adding a subdivision to read:

Subd. 15b. **Law enforcement authority.** "Law enforcement authority" means a government agency or department within or outside Minnesota with jurisdiction to investigate or bring a civil or criminal action against a child care provider, including a county, city, or district attorney's office, the Attorney General's Office, a human services agency, a United States attorney's office, or a law enforcement agency.

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

Sec. 6. Minnesota Statutes 2016, section 119B.011, is amended by adding a subdivision to read:

Subd. 19c. **Stop payment.** "Stop payment" means canceling a payment that was already issued to a provider.

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

Sec. 7. Minnesota Statutes 2016, section 119B.02, subdivision 5, is amended to read:

Subd. 5. **Program integrity.** For child care assistance programs under this chapter, the commissioner shall enforce the requirements for program integrity and fraud prevention investigations under sections 256.046, 256.98, and 256.983 and chapter 245E.

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

Sec. 8. Minnesota Statutes 2016, section 119B.09, subdivision 9a, is amended to read:

Subd. 9a. **Child care centers; assistance.** (a) ~~For the purposes of this subdivision, "qualifying child" means a child who is not a child or dependent of an employee of the child care provider.~~ A child care center may receive authorizations for 25 or fewer children who are dependents of the center's employees. If a child care center is authorized for more than 25 children who are dependents of center employees, the county cannot authorize additional dependents of an employee until the number of children falls below 25.

~~(b) Funds distributed under this chapter must not be paid for child care services that are provided for a child or dependent of an employee under paragraph (a) unless at all times at least 50 percent of the children for whom the child care provider is providing care are qualifying children under paragraph (a).~~

~~(c) If a child care provider satisfies the requirements for payment under paragraph (b), but the percentage of qualifying children under paragraph (a) for whom the provider is providing care falls below 50 percent, the provider shall have four weeks to raise the percentage of qualifying children for whom the provider is providing care to at least 50 percent before payments to the provider are discontinued for child care services provided for a child who is not a qualifying child.~~

~~(d) This subdivision shall be implemented as follows:~~

~~(1) no later than August 1, 2014, the commissioner shall issue a notice to providers who have been identified as ineligible for funds distributed under this chapter as described in paragraph (b); and~~

~~(2) no later than January 5, 2015, payments to providers who do not comply with paragraph (c) will be discontinued for child care services provided for children who are not qualifying children.~~

~~(e) If a child's authorization for child care assistance is terminated under this subdivision, the county shall send a notice of adverse action to the provider and to the child's parent or guardian, including information on the right to appeal, under Minnesota Rules, part 3400.0185.~~

~~(f)~~ (b) Funds paid to providers during the period of time ~~between the issuance of a notice under paragraph (d), clause (1), and discontinuation of payments under paragraph (d), clause (2),~~ when a center is authorized for more than 25 children who are dependents of center employees must not be treated as overpayments under section 119B.11, subdivision 2a, due to noncompliance with this subdivision.

~~(g)~~ (c) Nothing in this subdivision precludes the commissioner from conducting fraud investigations relating to child care assistance, imposing sanctions, and obtaining monetary recovery as otherwise provided by law.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 9. **[119B.097] AUTHORIZATION WITH A SECONDARY PROVIDER.**

(a) If a child uses any combination of the following providers paid by child care assistance, a parent must choose one primary provider and one secondary provider per child that can be paid by child care assistance:

(1) an individual or child care center licensed under chapter 245A;

(2) an individual or child care center or facility holding a valid child care license issued by another state or tribe; or

(3) a child care center exempt from licensing under section 245A.03.

(b) The amount of child care authorized with the secondary provider cannot exceed 20 hours per two-week service period, per child, and the amount of care paid to a child's secondary provider is limited under section 119B.13, subdivision 1. The total amount of child care authorized with both the primary and secondary provider cannot exceed the amount of child care allowed based on the parents' eligible activity schedule, the child's school schedule, and any other factors relevant to the family's child care needs.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 10. Minnesota Statutes 2016, section 119B.125, subdivision 4, is amended to read:

Subd. 4. **Unsafe care.** A county may deny authorization as a child care provider to any applicant or ~~rescind~~ revoke the authorization of any provider when the county knows or has reason to believe that the provider is unsafe or that the circumstances of the chosen child care arrangement are unsafe. The county must include the conditions under which a provider or care arrangement will be determined to be unsafe in the county's child care fund plan under section 119B.08, subdivision 3.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 11. Minnesota Statutes 2016, section 119B.125, subdivision 6, is amended to read:

Subd. 6. **Record-keeping requirement.** (a) As a condition of payment, all providers receiving child care assistance payments must keep accurate and legible daily attendance records at the site where services are delivered for children receiving child care assistance and must make those records available immediately to the county or the commissioner upon request. The attendance records must be completed daily and include the date, the first and last name of each child in attendance, and the times when each child is dropped off and picked up. To the extent possible, the times that the child was dropped off to and picked up from the child care provider must be entered by the person dropping off or picking up the child. The daily attendance records must be retained at the site where services are delivered for six years after the date of service.

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

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

(d) The commissioner shall develop criteria to direct a county when the county must establish an attendance overpayment under this subdivision.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 12. Minnesota Statutes 2016, section 119B.13, subdivision 1, is amended to read:

Subdivision 1. **Subsidy restrictions.** (a) Beginning February 3, 2014, the maximum rate paid for child care assistance in any county or county price cluster under the child care fund shall be the greater of the 25th percentile of the 2011 child care provider rate survey or the maximum rate effective November 28, 2011. The commissioner may: (1) assign a county with no reported provider prices to a similar price cluster; and (2) consider county level access when determining final price clusters.

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

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

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

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

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

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

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

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

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

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

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

EFFECTIVE DATE. Paragraphs (d) to (i) are effective April 23, 2018.

Sec. 13. Minnesota Statutes 2016, section 119B.13, subdivision 6, is amended to read:

Subd. 6. **Provider payments.** (a) A provider must bill only for services documented according to section 119B.125, subdivision 6. The provider shall bill for services provided within ten days of the end of the service period. ~~If bills are submitted within ten days of the end of the service period,~~ Payments under the child care fund shall be made within ~~30~~ 21 days of receiving a complete bill from the provider. Counties or the state may establish policies that make payments on a more frequent basis.

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

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

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

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

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

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

(4) the provider is operating after:

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

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

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

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

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

(7) the provider fails to grant access to a county or the commissioner during regular business hours to examine all records necessary to determine the extent of services provided to a child care assistance recipient and the appropriateness of a claim for payment.

(e) If a county or the commissioner finds that a provider violated paragraph (d), clause (1) or (2), a county or the commissioner must deny or revoke the provider's authorization and either pursue a fraud disqualification under section 256.98, subdivision 8, paragraph (c), or refer the case to a law enforcement authority. A provider's rights related to an authorization denial or revocation under this paragraph are established in section 119B.161. If a provider's authorization is revoked or denied under this paragraph, the denial or revocation lasts until either:

(1) all criminal, civil, and administrative proceedings related to the provider's alleged misconduct conclude and any appeal rights are exhausted; or

(2) the commissioner decides, based on written evidence or argument submitted under section 119B.161, to authorize the provider.

(f) If a county or the commissioner denies or revokes a provider's authorization under paragraph (d), clause (4), the provider shall not be authorized until the order of suspension or order of revocation against the provider is lifted.

~~(e) For purposes of~~ (g) If a county or the commissioner finds that a provider violated paragraph (d), clauses (3), (5), ~~and~~ or (6), the county or the commissioner may ~~withhold~~ revoke or deny the provider's authorization ~~or payment for a period of time not to exceed three months beyond the time the condition has been corrected~~. If a provider's authorization

is revoked or denied under this paragraph, the denial or revocation may last up to 90 days from the date a county or the commissioner denies or revokes the provider's authorization.

(h) If a county or the commissioner determines a provider violated paragraph (d), clause (7), a county or the commissioner must deny or revoke the provider's authorization until a county or the commissioner determines whether the records sought comply with this chapter and chapter 245E. The provider's rights related to an authorization denial or revocation under this paragraph are established in section 119B.161.

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

EFFECTIVE DATE. Paragraph (a) is effective September 25, 2017. Paragraphs (d) to (i) are effective April 23, 2018.

Sec. 14. Minnesota Statutes 2016, section 119B.16, subdivision 1, is amended to read:

Subdivision 1. **Fair hearing allowed for applicants and recipients.** (a) An applicant or recipient adversely affected by an action of a county agency ~~action~~ or the commissioner may request and receive a fair hearing in accordance with this subdivision and section 256.045.

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

(c) An applicant or recipient does not have a right to a fair hearing if a county agency or the commissioner takes action against a provider.

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

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 15. Minnesota Statutes 2016, section 119B.16, subdivision 1a, is amended to read:

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

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

(b) A provider may request a fair hearing only as specified in this subdivision.

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

(1) denies or revokes a provider's authorization, unless the action entitles the provider to a consolidated contested case hearing under section 119B.16, subdivision 3, or an administrative review under section 119B.161;

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

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

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

(5) initiates an administrative fraud disqualification hearing; or

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

(d) A provider may request a fair hearing by submitting a written request to the Department of Human Services, Appeals Division. A provider's request must be received by the appeals division no later than 30 days after the date a county or the commissioner mails the notice. The provider's appeal request must contain the following:

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

(2) the computation the provider believes to be correct, if appropriate;

(3) the statute or rule relied on for each disputed item; and

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

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 16. Minnesota Statutes 2016, section 119B.16, subdivision 1b, is amended to read:

Subd. 1b. **Joint fair hearings.** ~~When a provider requests a fair hearing under subdivision 1a, the family in whose case the overpayment was created must be made a party to the fair hearing. All other issues raised by the family must be resolved in the same proceeding. When a family requests a fair hearing and claims that the county should have assigned responsibility for an overpayment to a provider, the provider must be made a party to the fair hearing.~~ The human services judge assigned to a fair hearing may join a family or a provider as a party to the fair hearing whenever joinder of that party is necessary to fully and fairly resolve ~~overpayment~~ issues raised in the appeal.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 17. Minnesota Statutes 2016, section 119B.16, is amended by adding a subdivision to read:

Subd. 1c. **Notice to providers.** (a) Before taking an action appealable under subdivision 1a, paragraph (c), a county agency or the commissioner must mail written notice to the provider against whom the action is being taken.

(b) The notice shall state:

(1) the factual basis for the department's determination;

(2) the action the department intends to take;

(3) the dollar amount of the monetary recovery or recoupment, if known; and

(4) the right to appeal the department's proposed action.

(c) A county agency or the commissioner must mail the written notice at least 15 calendar days before the adverse action's effective date.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 18. Minnesota Statutes 2016, section 119B.16, is amended by adding a subdivision to read:

Subd. 3. **Consolidated contested case hearing.** If a county agency or the commissioner denies or revokes a provider's authorization based on a licensing action, the provider may only appeal the denial or revocation in the same contested case proceeding that the provider appeals the licensing action.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 19. Minnesota Statutes 2016, section 119B.16, is amended by adding a subdivision to read:

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

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 20. **[119B.161] ADMINISTRATIVE REVIEW.**

Subdivision 1. **Temporary denial or revocation of authorization.** (a) A provider has the rights listed under this section if:

(1) the provider's authorization was denied or revoked under section 119B.13, subdivision 6, paragraph (d), clause (1), (2), or (7);

(2) the provider's authorization was temporarily suspended under paragraph (b); or

(3) a payment was suspended under chapter 245E.

(b) Unless the commissioner receives a timely and proper request for an appeal, a county's or the commissioner's action is a final department action.

(c) The commissioner may temporarily suspend a provider's authorization without prior notice and opportunity for hearing if the commissioner determines either that there is a credible allegation of fraud for which an investigation is pending under the child care assistance program, or that the suspension is necessary for public safety and the best interests of the child care assistance program. An allegation is considered credible if the allegation has indications of reliability. The commissioner may determine that an allegation is credible, if the commissioner reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.

Subd. 2. **Notice.** (a) A county or the commissioner must mail a provider notice within five days of suspending, revoking, or denying a provider's authorization under subdivision 1.

(b) The notice must:

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

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

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

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

(c) Notwithstanding Minnesota Rules, part 3400.0185, if a county or the commissioner denies or revokes a provider's authorization under section 119B.13, subdivision 6, paragraph (d), clause (1), (2), or (7); suspends a payment to a provider under chapter 245E; or temporarily suspends a payment to a provider under section 119B.161, subdivision 1, a county or the commissioner must send notice of termination to an affected family. The termination sent to an affected family is effective on the date the notice is created.

Subd. 3. **Duration.** If a provider's authorization is denied or revoked under section 119B.13, subdivision 6, paragraph (d), clause (1), (2), or (7); authorization is temporarily suspended under section 119B.161; or payment is suspended under chapter 245E, the provider's denial, revocation, temporary suspension, or payment suspension remains in effect until:

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

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

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

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

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

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

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 21. Minnesota Statutes 2016, section 245A.50, subdivision 5, is amended to read:

Subd. 5. **Sudden unexpected infant death and abusive head trauma training.** (a) License holders must document that before staff persons, caregivers, and helpers assist in the care of infants, they are instructed on the standards in section 245A.1435 and receive training on reducing the risk of sudden unexpected infant death. In addition, license holders must document that before staff persons, caregivers, and helpers assist in the care of infants and children under school age, they receive training on reducing the risk of abusive head trauma from shaking infants and young children. The training in this subdivision may be provided as initial training under subdivision 1 or ongoing annual training under subdivision 7.

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

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

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

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

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

Sec. 22. Minnesota Statutes 2016, section 245E.01, is amended by adding a subdivision to read:

Subd. 6a. **Credible allegation of fraud.** "Credible allegation of fraud" has the meaning given in section 256B.064, subdivision 2, paragraph (b), clause (2).

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

Sec. 23. Minnesota Statutes 2016, section 245E.02, subdivision 1, is amended to read:

Subdivision 1. **Investigating provider or recipient financial misconduct.** The department shall investigate alleged or suspected financial misconduct by providers and errors related to payments issued by the child care assistance program under this chapter. Recipients, employees, agents and consultants, and staff may be investigated when the evidence shows that their conduct is related to the financial misconduct of a provider, license holder, or controlling individual. When the alleged or suspected financial misconduct relates to acting as a recruiter offering conditional employment on behalf of a provider that has received funds from the child care assistance program, the department may investigate the provider, center owner, director, manager, license holder, or other controlling individual or agent, who is alleged to have acted as a recruiter offering conditional employment.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 24. Minnesota Statutes 2016, section 245E.02, subdivision 3, is amended to read:

Subd. 3. **Determination of investigation.** After completing its investigation, the department shall ~~issue one of the following determinations~~ determine that:

(1) no violation of child care assistance requirements occurred;

(2) there is insufficient evidence to show that a violation of child care assistance requirements occurred;

(3) a preponderance of evidence shows a violation of child care assistance program law, rule, or policy; or

(4) there exists a credible allegation of fraud involving the child care assistance program.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 25. Minnesota Statutes 2016, section 245E.02, subdivision 4, is amended to read:

Subd. 4. ~~**Actions**~~ **Referrals or administrative ~~sanctions~~ actions.** (a) After completing the determination under subdivision 3, the department may take one or more of the actions or sanctions specified in this subdivision.

(b) The department may take any of the following actions:

(1) refer the investigation to law enforcement or a county attorney for possible criminal prosecution;

(2) refer relevant information to the department's licensing division, the background studies division, the child care assistance program, the Department of Education, the federal child and adult care food program, or appropriate child or adult protection agency;

(3) enter into a settlement agreement with a provider, license holder, owner, agent, controlling individual, or recipient; or

(4) refer the matter for review by a prosecutorial agency with appropriate jurisdiction for possible civil action under the Minnesota False Claims Act, chapter 15C.

(c) In addition to section 256.98, the department may impose sanctions by:

(1) pursuing administrative disqualification through hearings or waivers;

(2) establishing and seeking monetary recovery or recoupment;

(3) issuing an order of corrective action that states the practices that are violations of child care assistance program policies, laws, or regulations, and that they must be corrected; ~~or~~

(4) suspending~~, denying, or terminating~~ payments to a provider~~.~~; or

(5) taking an action under section 119B.13, subdivision 6, paragraph (d).

(d) ~~Upon a finding by~~ If the commissioner determines that any child care provider, center owner, director, manager, license holder, or other controlling individual of a child care center has employed, used, or acted as a recruiter offering conditional employment for a child care center that has received child care assistance program funding, the commissioner shall:

(1) immediately suspend all program payments to all child care centers in which the person employing, using, or acting as a recruiter offering conditional employment is an owner, director, manager, license holder, or other controlling individual. The commissioner

shall suspend program payments under this clause even if services have already been provided; and

(2) immediately and permanently revoke the licenses of all child care centers of which the person employing, using, or acting as a recruiter offering conditional employment is an owner, director, manager, license holder, or other controlling individual.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 26. Minnesota Statutes 2016, section 245E.03, subdivision 2, is amended to read:

Subd. 2. **Failure to provide access.** ~~Failure to provide access may result in denial or termination of authorizations for or payments to a recipient, provider, license holder, or controlling individual in the child care assistance program.~~ If a provider fails to grant the department immediate access to records, the department may immediately suspend payments under section 119B.161, or the department may deny or revoke the provider's authorization. A provider, license holder, controlling individual, employee, or staff member must grant the department access during any hours that the program is open to examine the provider's program or the records listed in section 245E.05. A provider shall make records immediately available at the provider's place of business at the time the department requests access, unless the provider and the department both agree otherwise.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 27. Minnesota Statutes 2016, section 245E.03, subdivision 4, is amended to read:

Subd. 4. **Continued or repeated failure to provide access.** If the provider continues to fail to provide access at the expiration of the 15-day notice period, child care assistance program payments to the provider must be ~~denied~~ suspended beginning the 16th day following notice of the initial failure or refusal to provide access. ~~The department may rescind the denial based upon good cause if the provider submits in writing a good cause basis for having failed or refused to provide access. The writing must be postmarked no later than the 15th day following the provider's notice of initial failure to provide access.~~ A provider's, license holder's, controlling individual's, employee's, staff member's, or recipient's duty to provide access in this section continues after the provider's authorization is denied, revoked, or suspended. Additionally, the provider, license holder, or controlling individual must immediately provide complete, ongoing access to the department. Repeated failures to provide access must, after the initial failure or for any subsequent failure, result in termination from participation in the child care assistance program.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 28. Minnesota Statutes 2016, section 245E.04, is amended to read:

245E.04 HONEST AND TRUTHFUL STATEMENTS.

It shall be unlawful for a provider, license holder, controlling individual, or recipient to:

(1) falsify, conceal, or cover up by any ~~trick, scheme, or device a material fact~~ means;

(2) make any materially false, fictitious, or fraudulent statement or representation; or

(3) make or use any false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry related to any child care assistance program services that the provider, license holder, or controlling individual supplies or in relation to any child care assistance payments received by a provider, license holder, or controlling individual or to any fraud investigator or law enforcement officer conducting a financial misconduct investigation.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 29. Minnesota Statutes 2016, section 245E.05, subdivision 1, is amended to read:

Subdivision 1. **Records required to be retained.** The following records must be maintained, controlled, and made immediately accessible to license holders, providers, and controlling individuals. The records must be organized and labeled to correspond to categories that make them easy to identify so that they can be made available immediately upon request to an investigator acting on behalf of the commissioner at the provider's place of business:

(1) payroll ledgers, canceled checks, bank deposit slips, and any other accounting records;

(2) daily attendance records required by and that comply with section 119B.125, subdivision 6;

(3) billing transmittal forms requesting payments from the child care assistance program and billing adjustments related to child care assistance program payments;

(4) records identifying all persons, corporations, partnerships, and entities with an ownership or controlling interest in the provider's child care business;

(5) employee or contractor records identifying those persons currently employed by the provider's child care business or who have been employed by the business at any time within the previous five years. The records must include each employee's name, hourly and annual salary, qualifications, position description, job title, and dates of employment. In addition,

employee records that must be made available include the employee's time sheets, current home address of the employee or last known address of any former employee, and documentation of background studies required under chapter 119B or 245C;

(6) records related to transportation of children in care, including but not limited to:

(i) the dates and times that transportation is provided to children for transportation to and from the provider's business location for any purpose. For transportation related to field trips or locations away from the provider's business location, the names and addresses of those field trips and locations must also be provided;

(ii) the name, business address, phone number, and Web site address, if any, of the transportation service utilized; and

(iii) all billing or transportation records related to the transportation.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 30. Minnesota Statutes 2016, section 245E.06, subdivision 1, is amended to read:

Subdivision 1. **Factors regarding imposition of administrative ~~sanctions~~ actions.** (a) The department shall consider the following factors in determining the administrative ~~sanctions~~ actions to be imposed:

(1) nature and extent of financial misconduct;

(2) history of financial misconduct;

(3) actions taken or recommended by other state agencies, other divisions of the department, and court and administrative decisions;

(4) prior ~~imposition of sanctions~~ actions;

(5) size and type of provider;

(6) information obtained through an investigation from any source;

(7) convictions or pending criminal charges; and

(8) any other information relevant to the acts or omissions related to the financial misconduct.

(b) Any single factor under paragraph (a) may be determinative of the department's decision of whether and what ~~sanctions are imposed~~ actions to take.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 31. Minnesota Statutes 2016, section 245E.06, subdivision 2, is amended to read:

Subd. 2. **Written notice of department ~~sanction~~ action; ~~sanction~~ action effective date; ~~informal meeting~~.** ~~(a) The department shall give notice in writing to a person of an administrative sanction that is to be imposed. The notice shall be sent by mail as defined in section 245E.01, subdivision 11.~~

~~(b) The notice shall state:~~

~~(1) the factual basis for the department's determination;~~

~~(2) the sanction the department intends to take;~~

~~(3) the dollar amount of the monetary recovery or recoupment, if any;~~

~~(4) how the dollar amount was computed;~~

~~(5) the right to dispute the department's determination and to provide evidence;~~

~~(6) the right to appeal the department's proposed sanction; and~~

~~(7) the option to meet informally with department staff, and to bring additional documentation or information, to resolve the issues.~~

~~(c) In cases of determinations resulting in denial or termination of payments, in addition to the requirements of paragraph (b), the notice must state:~~

~~(1) the length of the denial or termination;~~

~~(2) the requirements and procedures for reinstatement; and~~

~~(3) the provider's right to submit documents and written arguments against the denial or termination of payments for review by the department before the effective date of denial or termination.~~

~~(d) The submission of documents and written argument for review by the department under paragraph (b), clause (5) or (7), or paragraph (c), clause (3), does not stay the deadline for filing an appeal.~~

(a) When taking an action against a provider, the department must give notice to:

(1) the provider as specified in section 119B.16 or 119B.161; and

(2) a family as specified under Minnesota Rules, part 3400.0185, or section 119B.161.

~~(c)~~ (b) Notwithstanding section 245E.03, subdivision 4, and except for a payment suspension or action under section 119B.161, subdivision 1, the effective date of the proposed ~~sanction~~ action under this chapter shall be 30 days after the license holder's, provider's,

controlling individual's, or recipient's receipt of the notice, unless timely appealed. If a timely appeal is made, the proposed ~~sanction~~ action shall be delayed pending the final outcome of the appeal. Implementation of a proposed ~~sanction~~ action following the resolution of a timely appeal may be postponed if, in the opinion of the department, the delay of ~~sanction~~ action is necessary to protect the health or safety of children in care. ~~The department may consider the economic hardship of a person in implementing the proposed sanction, but economic hardship shall not be a determinative factor in implementing the proposed sanction.~~

~~(f) Requests for an informal meeting to attempt to resolve issues and requests for appeals must be sent or delivered to the department's Office of Inspector General, Financial Fraud and Abuse Division.~~

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 32. Minnesota Statutes 2016, section 245E.06, subdivision 3, is amended to read:

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

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

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

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

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

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

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

A provider's rights related to an action taken under this chapter are established in sections 119B.16 and 119B.161.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 33. Minnesota Statutes 2016, section 245E.07, subdivision 1, is amended to read:

Subdivision 1. **Grounds for and methods of monetary recovery.** (a) The department may obtain monetary recovery from a provider who has been improperly paid by the child care assistance program, regardless of whether the error was on the part of the provider, the department, or the county and regardless of whether the error was intentional ~~or county error~~. The department does not need to establish a pattern ~~as a precondition of monetary recovery~~ of erroneous or false billing claims, duplicate billing claims, or billing claims based on false statements or financial misconduct.

(b) The department shall obtain monetary recovery from providers by the following means:

(1) permitting voluntary repayment of money, either in lump-sum payment or installment payments;

(2) using any legal collection process;

(3) deducting or withholding program payments; or

(4) utilizing the means set forth in chapter 16D.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 34. Minnesota Statutes 2016, section 252.27, subdivision 2a, is amended to read:

Subd. 2a. **Contribution amount.** (a) The natural or adoptive parents of a minor child, including a child determined eligible for medical assistance without consideration of parental income, must contribute to the cost of services used by making monthly payments on a sliding scale based on income, unless the child is married or has been married, parental rights have been terminated, or the child's adoption is subsidized according to chapter 259A or through title IV-E of the Social Security Act. The parental contribution is a partial or full payment for medical services provided for diagnostic, therapeutic, curing, treating, mitigating, rehabilitation, maintenance, and personal care services as defined in United States Code, title 26, section 213, needed by the child with a chronic illness or disability.

(b) For households with adjusted gross income equal to or greater than 275 percent of federal poverty guidelines, the parental contribution shall be computed by applying the following schedule of rates to the adjusted gross income of the natural or adoptive parents:

(1) if the adjusted gross income is equal to or greater than 275 percent of federal poverty guidelines and less than or equal to 545 percent of federal poverty guidelines, the parental contribution shall be determined using a sliding fee scale established by the commissioner of human services which begins at ~~2.23~~ 1.94 percent of adjusted gross income at 275 percent of federal poverty guidelines and increases to ~~6.08~~ 5.29 percent of adjusted gross income for those with adjusted gross income up to 545 percent of federal poverty guidelines;

(2) if the adjusted gross income is greater than 545 percent of federal poverty guidelines and less than 675 percent of federal poverty guidelines, the parental contribution shall be ~~6.08~~ 5.29 percent of adjusted gross income;

(3) if the adjusted gross income is equal to or greater than 675 percent of federal poverty guidelines and less than 975 percent of federal poverty guidelines, the parental contribution shall be determined using a sliding fee scale established by the commissioner of human services which begins at ~~6.08~~ 5.29 percent of adjusted gross income at 675 percent of federal poverty guidelines and increases to ~~8.1~~ 7.05 percent of adjusted gross income for those with adjusted gross income up to 975 percent of federal poverty guidelines; and

(4) if the adjusted gross income is equal to or greater than 975 percent of federal poverty guidelines, the parental contribution shall be ~~10.13~~ 8.81 percent of adjusted gross income.

If the child lives with the parent, the annual adjusted gross income is reduced by $2,400 prior to calculating the parental contribution. If the child resides in an institution specified in section 256B.35, the parent is responsible for the personal needs allowance specified under that section in addition to the parental contribution determined under this section. The parental contribution is reduced by any amount required to be paid directly to the child pursuant to a court order, but only if actually paid.

(c) The household size to be used in determining the amount of contribution under paragraph (b) includes natural and adoptive parents and their dependents, including the child receiving services. Adjustments in the contribution amount due to annual changes in the federal poverty guidelines shall be implemented on the first day of July following publication of the changes.

(d) For purposes of paragraph (b), "income" means the adjusted gross income of the natural or adoptive parents determined according to the previous year's federal tax form,

except, effective retroactive to July 1, 2003, taxable capital gains to the extent the funds have been used to purchase a home shall not be counted as income.

(e) The contribution shall be explained in writing to the parents at the time eligibility for services is being determined. The contribution shall be made on a monthly basis effective with the first month in which the child receives services. Annually upon redetermination or at termination of eligibility, if the contribution exceeded the cost of services provided, the local agency or the state shall reimburse that excess amount to the parents, either by direct reimbursement if the parent is no longer required to pay a contribution, or by a reduction in or waiver of parental fees until the excess amount is exhausted. All reimbursements must include a notice that the amount reimbursed may be taxable income if the parent paid for the parent's fees through an employer's health care flexible spending account under the Internal Revenue Code, section 125, and that the parent is responsible for paying the taxes owed on the amount reimbursed.

(f) The monthly contribution amount must be reviewed at least every 12 months; when there is a change in household size; and when there is a loss of or gain in income from one month to another in excess of ten percent. The local agency shall mail a written notice 30 days in advance of the effective date of a change in the contribution amount. A decrease in the contribution amount is effective in the month that the parent verifies a reduction in income or change in household size.

(g) Parents of a minor child who do not live with each other shall each pay the contribution required under paragraph (a). An amount equal to the annual court-ordered child support payment actually paid on behalf of the child receiving services shall be deducted from the adjusted gross income of the parent making the payment prior to calculating the parental contribution under paragraph (b).

(h) The contribution under paragraph (b) shall be increased by an additional five percent if the local agency determines that insurance coverage is available but not obtained for the child. For purposes of this section, "available" means the insurance is a benefit of employment for a family member at an annual cost of no more than five percent of the family's annual income. For purposes of this section, "insurance" means health and accident insurance coverage, enrollment in a nonprofit health service plan, health maintenance organization, self-insured plan, or preferred provider organization.

Parents who have more than one child receiving services shall not be required to pay more than the amount for the child with the highest expenditures. There shall be no resource contribution from the parents. The parent shall not be required to pay a contribution in

excess of the cost of the services provided to the child, not counting payments made to school districts for education-related services. Notice of an increase in fee payment must be given at least 30 days before the increased fee is due.

(i) The contribution under paragraph (b) shall be reduced by $300 per fiscal year if, in the 12 months prior to July 1:

(1) the parent applied for insurance for the child;

(2) the insurer denied insurance;

(3) the parents submitted a complaint or appeal, in writing to the insurer, submitted a complaint or appeal, in writing, to the commissioner of health or the commissioner of commerce, or litigated the complaint or appeal; and

(4) as a result of the dispute, the insurer reversed its decision and granted insurance.

For purposes of this section, "insurance" has the meaning given in paragraph (h).

A parent who has requested a reduction in the contribution amount under this paragraph shall submit proof in the form and manner prescribed by the commissioner or county agency, including, but not limited to, the insurer's denial of insurance, the written letter or complaint of the parents, court documents, and the written response of the insurer approving insurance. The determinations of the commissioner or county agency under this paragraph are not rules subject to chapter 14.

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

Sec. 35. Minnesota Statutes 2016, section 256.98, subdivision 8, is amended to read:

Subd. 8. **Disqualification from program.** (a) Any person found to be guilty of wrongfully obtaining assistance by a federal or state court or by an administrative hearing determination, or waiver thereof, through a disqualification consent agreement, or as part of any approved diversion plan under section 401.065, or any court-ordered stay which carries with it any probationary or other conditions, in the Minnesota family investment program and any affiliated program to include the diversionary work program and the work participation cash benefit program, the food stamp or food support program, the general assistance program, the group residential housing program, or the Minnesota supplemental aid program shall be disqualified from that program. In addition, any person disqualified from the Minnesota family investment program shall also be disqualified from the food stamp or food support program. The needs of that individual shall not be taken into consideration in determining the grant level for that assistance unit:

(1) for one year after the first offense;

(2) for two years after the second offense; and

(3) permanently after the third or subsequent offense.

The period of program disqualification shall begin on the date stipulated on the advance notice of disqualification without possibility of postponement for administrative stay or administrative hearing and shall continue through completion unless and until the findings upon which the sanctions were imposed are reversed by a court of competent jurisdiction. The period for which sanctions are imposed is not subject to review. The sanctions provided under this subdivision are in addition to, and not in substitution for, any other sanctions that may be provided for by law for the offense involved. A disqualification established through hearing or waiver shall result in the disqualification period beginning immediately unless the person has become otherwise ineligible for assistance. If the person is ineligible for assistance, the disqualification period begins when the person again meets the eligibility criteria of the program from which they were disqualified and makes application for that program.

(b) A family receiving assistance through child care assistance programs under chapter 119B with a family member who is found to be guilty of wrongfully obtaining child care assistance by a federal court, state court, or an administrative hearing determination or waiver, through a disqualification consent agreement, as part of an approved diversion plan under section 401.065, or a court-ordered stay with probationary or other conditions, is disqualified from child care assistance programs. The disqualifications must be for periods of one year and two years for the first and second offenses, respectively. Subsequent violations must result in permanent disqualification. During the disqualification period, disqualification from any child care program must extend to all child care programs and must be immediately applied.

(c) A provider caring for children receiving assistance through child care assistance programs under chapter 119B is disqualified from receiving payment for child care services from the child care assistance program under chapter 119B when the provider is found to have wrongfully obtained child care assistance by a federal court, state court, or an administrative hearing determination or waiver under section 256.046, through a disqualification consent agreement, as part of an approved diversion plan under section 401.065, or a court-ordered stay with probationary or other conditions. The disqualification must be for a period of ~~one year~~ two years for the first offense ~~and two years for the second offense~~. Any subsequent violation must result in permanent disqualification. The

disqualification period must be imposed immediately after a determination is made under this paragraph. During the disqualification period, the provider is disqualified from receiving payment from any child care program under chapter 119B.

(d) Any person found to be guilty of wrongfully obtaining MinnesotaCare for adults without children and upon federal approval, all categories of medical assistance and remaining categories of MinnesotaCare, except for children through age 18, by a federal or state court or by an administrative hearing determination, or waiver thereof, through a disqualification consent agreement, or as part of any approved diversion plan under section 401.065, or any court-ordered stay which carries with it any probationary or other conditions, is disqualified from that program. The period of disqualification is one year after the first offense, two years after the second offense, and permanently after the third or subsequent offense. The period of program disqualification shall begin on the date stipulated on the advance notice of disqualification without possibility of postponement for administrative stay or administrative hearing and shall continue through completion unless and until the findings upon which the sanctions were imposed are reversed by a court of competent jurisdiction. The period for which sanctions are imposed is not subject to review. The sanctions provided under this subdivision are in addition to, and not in substitution for, any other sanctions that may be provided for by law for the offense involved.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 36. Minnesota Statutes 2016, section 256E.30, subdivision 2, is amended to read:

Subd. 2. **Allocation of money.** (a) State money appropriated and community service block grant money allotted to the state and all money transferred to the community service block grant from other block grants shall be allocated annually to community action agencies and Indian reservation governments under clauses (b) and (c), and to migrant and seasonal farmworker organizations under clause (d).

(b) The available annual money will provide base funding to all community action agencies and the Indian reservations. Base funding amounts per agency are as follows: for agencies with low income populations up to ~~3,999~~ 1,999, $25,000; ~~4,000~~ 2,000 to 23,999, $50,000; and 24,000 or more, $100,000.

(c) All remaining money of the annual money available after the base funding has been determined must be allocated to each agency and reservation in proportion to the size of the poverty level population in the agency's service area compared to the size of the poverty level population in the state.

(d) Allocation of money to migrant and seasonal farmworker organizations must not exceed three percent of the total annual money available. Base funding allocations must be made for all community action agencies and Indian reservations that received money under this subdivision, in fiscal year 1984, and for community action agencies designated under this section with a service area population of 35,000 or greater.

Sec. 37. Minnesota Statutes 2016, section 256J.24, subdivision 5, is amended to read:

Subd. 5. **MFIP transitional standard.** The MFIP transitional standard is based on the number of persons in the assistance unit eligible for both food and cash assistance. The amount of the transitional standard is published annually by the Department of Human Services. The following table represents the cash portion of the transitional standard effective March 1, 2018.

Number of eligible people	Cash portion
1	$263
2	$450
3	$545
4	$634
5	$710
6	$786
7	$863
8	$929
9	$993
10	$1,048
Over 10	add $56 for each additional eligible person

Sec. 38. Minnesota Statutes 2016, section 256J.45, subdivision 2, is amended to read:

Subd. 2. **General information.** The MFIP orientation must consist of a presentation that informs caregivers of:

(1) the necessity to obtain immediate employment;

(2) the work incentives under MFIP, including the availability of the federal earned income tax credit and the Minnesota working family tax credit;

(3) the requirement to comply with the employment plan and other requirements of the employment and training services component of MFIP, including a description of the range of work and training activities that are allowable under MFIP to meet the individual needs of participants;

(4) the consequences for failing to comply with the employment plan and other program requirements, and that the county agency may not impose a sanction when failure to comply is due to the unavailability of child care or other circumstances where the participant has good cause under subdivision 3;

(5) the rights, responsibilities, and obligations of participants;

(6) the types and locations of child care services available through the county agency;

(7) the availability and the benefits of the early childhood health and developmental screening under sections 121A.16 to 121A.19; 123B.02, subdivision 16; and 123B.10;

(8) the caregiver's eligibility for transition year child care assistance under section 119B.05;

(9) the availability of all health care programs, including transitional medical assistance;

(10) the caregiver's option to choose an employment and training provider and information about each provider, including but not limited to, services offered, program components, job placement rates, job placement wages, and job retention rates;

(11) the caregiver's option to request approval of an education and training plan according to section 256J.53;

(12) the work study programs available under the higher education system; ~~and~~

(13) information about the 60-month time limit exemptions under the family violence waiver and referral information about shelters and programs for victims of family violence; and

(14) information about the income exclusions in section 256P.06, subdivision 2b.

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

Sec. 39. **[256N.261] SUPPORT FOR ADOPTIVE, FOSTER, AND KINSHIP FAMILIES.**

Subdivision 1. **Program established.** The commissioner shall design and implement a coordinated program to reduce the need for placement changes or out-of-home placements of children and youth in foster care, adoptive placements, and permanent physical and legal custody kinship placements, and to improve the functioning and stability of these families. To the extent federal funds are available, the commissioner shall provide the following adoption and foster care-competent services and ensure that placements are trauma-informed and child and family-centered:

(1) a program providing information, referrals, a parent-to-parent support network, peer support for youth, family activities, respite care, crisis services, educational support, and mental health services for children and youth in adoption, foster care, and kinship placements and adoptive, foster, and kinship families in Minnesota;

(2) training offered statewide in Minnesota for adoptive and kinship families, and training for foster families, and the professionals who serve the families, on the effects of trauma, common disabilities of adopted children and children in foster care, and kinship placements, and challenges in adoption, foster care, and kinship placements; and

(3) periodic evaluation of these services to ensure program effectiveness in preserving and improving the success of adoptive, foster, and kinship placements.

Subd. 2. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Child and family-centered" means individualized services that respond to a child's or youth's strengths, interests, and current developmental stage, including social, cognitive, emotional, physical, cultural, racial, and spiritual needs, and offer support to the entire adoptive, foster, or kinship family.

(c) "Trauma-informed" means care that acknowledges the effect trauma has on children and the children's families; modifies services to respond to the effects of trauma; emphasizes skill and strength-building rather than symptom management; and focuses on the physical and psychological safety of the child and family.

Sec. 40. Minnesota Statutes 2016, section 256P.06, subdivision 2, is amended to read:

Subd. 2. **Exempted individuals.** (a) The following members of an assistance unit under chapters 119B and 256J are exempt from having their earned income count towards the income of an assistance unit:

(1) children under six years old;

(2) caregivers under 20 years of age enrolled at least half-time in school; and

(3) minors enrolled in school full time.

(b) The following members of an assistance unit are exempt from having their earned and unearned income count towards the income of an assistance unit for 12 consecutive calendar months, beginning the month following the marriage date, for benefits under chapter 256J if the household income does not exceed 275 percent of the federal poverty guideline:

(1) a new spouse to a caretaker in an existing assistance unit; and

(2) the spouse designated by a newly married couple, both of whom were already members of an assistance unit under chapter 256J.

(c) If members identified in paragraph (b) also receive assistance under section 119B.05, they are exempt from having their earned and unearned income count towards the income of the assistance unit if the household income prior to the exemption does not exceed 67 percent of the state median income for recipients for 26 consecutive biweekly periods beginning the second biweekly period after the marriage date.

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

Sec. 41. Minnesota Statutes 2016, section 260C.451, subdivision 6, is amended to read:

Subd. 6. **Reentering foster care and accessing services after 18 years of age and up to 21 years of age.** (a) Upon request of an individual who had been under the guardianship of the commissioner and who has left foster care without being adopted, the responsible social services agency which had been the commissioner's agent for purposes of the guardianship shall develop with the individual a plan to increase the individual's ability to live safely and independently using the plan requirements of section 260C.212, subdivision 1, paragraph (c), clause (12), and to assist the individual to meet one or more of the eligibility criteria in subdivision 4 if the individual wants to reenter foster care. The responsible social services agency shall provide foster care as required to implement the plan. The responsible social services agency shall enter into a voluntary placement agreement under section 260C.229 with the individual if the plan includes foster care.

(b) Individuals who had not been under the guardianship of the commissioner of human services prior to 18 years of age may ask to reenter foster care after age 18 and~~, to the extent funds are available,~~ the responsible social services agency that had responsibility for planning for the individual before discharge from foster care ~~may~~ shall provide foster care or other services to the individual for the purpose of increasing the individual's ability to live safely and independently and to meet the eligibility criteria in subdivision 3a, if the individual:

(1) was in foster care for the six consecutive months prior to the person's 18th birthday, or left foster care within six months prior to the person's 18th birthday, and was not discharged home, adopted, or received into a relative's home under a transfer of permanent legal and physical custody under section 260C.515, subdivision 4; or

(2) was discharged from foster care while on runaway status after age 15.

(c) In conjunction with a qualifying and eligible individual under paragraph (b) and other appropriate persons, the responsible social services agency shall develop a specific

plan related to that individual's vocational, educational, social, or maturational needs and~~,~~ ~~to the extent funds are available,~~ provide foster care as required to implement the plan. The responsible social services agency shall enter into a voluntary placement agreement with the individual if the plan includes foster care.

(d) A child who left foster care while under guardianship of the commissioner of human services retains eligibility for foster care for placement at any time prior to 21 years of age.

Sec. 42. Minnesota Statutes 2016, section 626.556, subdivision 10j, is amended to read:

Subd. 10j. **Release of data to mandated reporters.** (a) A local social services or child protection agency, or the agency responsible for assessing or investigating the report of maltreatment or for providing child protective services, shall provide relevant private data on individuals obtained under this section to a mandated reporter who made the report and who has an ongoing responsibility for the health, education, or welfare of a child affected by the data, unless the agency determines that providing the data would not be in the best interests of the child. The agency may provide the data to other mandated reporters with ongoing responsibility for the health, education, or welfare of the child. Mandated reporters with ongoing responsibility for the health, education, or welfare of a child affected by the data include the child's teachers or other appropriate school personnel, foster parents, health care providers, respite care workers, therapists, social workers, child care providers, residential care staff, crisis nursery staff, probation officers, and court services personnel. Under this section, a mandated reporter need not have made the report to be considered a person with ongoing responsibility for the health, education, or welfare of a child affected by the data. Data provided under this section must be limited to data pertinent to the individual's responsibility for caring for the child.

(b) A reporter who receives private data on individuals under this subdivision must treat the data according to that classification, regardless of whether the reporter is an employee of a government entity. The remedies and penalties under sections 13.08 and 13.09 apply if a reporter releases data in violation of this section or other law.

Sec. 43. **MINNESOTA BIRTH TO EIGHT PILOT PROJECT.**

Subdivision 1. **Authorization.** The commissioner of human services shall award a grant to Dakota County to develop and implement pilots that will evaluate the impact of a coordinated systems and service delivery approach on key developmental milestones and outcomes that ultimately lead to reading proficiency by age eight within the target population. The pilot program is from July 1, 2017, to June 30, 2021.

Subd. 2. **Pilot design and goals.** The pilot will establish five key developmental milestone markers from birth to age eight. Enrollees in the pilot will be developmentally assessed and tracked by a technology solution that tracks developmental milestones along the established developmental continuum. If a child's progress falls below established milestones and the weighted scoring, the coordinated service system will focus on identified areas of concern, mobilize appropriate supportive services, and offer services to identified children and their families.

Subd. 3. **Program participants in phase 1 target population.** Pilot program participants must:

(1) be enrolled in a Women's Infant & Children (WIC) program;

(2) be participating in a family home visiting program, or nurse family practice, or Healthy Families America (HFA);

(3) be children and families qualifying for and participating in early language learners (ELL) in the school district in which they reside; and

(4) be voluntarily willing to participate in the pilot.

Subd. 4. **Evaluation and report.** The county or counties shall work with a third-party evaluator to evaluate the effectiveness of the pilot and report back to the legislature each year by February 1 with an update on the progress of the pilot. The final report on the pilot is due January 1, 2022.

Sec. 44. **MINNESOTA PATHWAYS TO PROSPERITY PILOT PROJECT.**

Subdivision 1. **Authorization.** The commissioner of human services may develop a pilot that will test an alternative financing model for the distribution of publicly funded benefits. The commissioner may work with interested counties to develop the pilot and determine the waivers that are necessary to implement the pilot program based on the pilot design in subdivisions 2 and 3, and outcome measures in subdivision 4.

Subd. 2. **Pilot program design and goals.** The pilot program must reduce the historical separation between the state funds and systems affecting families who are receiving public assistance. The pilot program shall eliminate, where possible, funding restrictions to allow a more comprehensive approach to the needs of the families in the pilot program, and focus on upstream, prevention-oriented supports and interventions.

Subd. 3. **Program participants.** Pilot program participants must:

(1) be 26 years of age or younger with a minimum of one child;

(2) voluntarily agree to participate in the pilot program;

(3) be eligible for, applying for, or receiving public benefits including but not limited to housing assistance, education supports, employment supports, child care, transportation supports, medical assistance, earned income tax credit, or the child care tax credit; and

(4) be enrolled in an education program that is focused on obtaining a career that will likely result in a livable wage.

Subd. 4. **Outcomes.** The outcomes measures for the pathways to prosperity include:

(1) improvement in the affordability, safety, and permanence of suitable housing;

(2) improvement in family functioning and stability, including in the areas of behavioral health, incarceration, involvement with the child welfare system, or equivalent indicators;

(3) secure educational gains for parent and specifically for children from early childhood through high school, including absentee reduction, preschool readiness scores, third grade reading competency, graduation, GPA, and standardized test improvement;

(4) improvement in attachment to the workforce of one or both adults, including enhanced job stability; wage gains; career advancement; progress in career preparation; or an equivalent combination of these or related measures; and

(5) improvement in health access and health outcomes for parents and children.

Sec. 45. **REPEALER.**

Minnesota Statutes 2016, sections 13.468; and 256J.626, subdivision 5, are repealed.

ARTICLE 8

CHEMICAL AND MENTAL HEALTH SERVICES

Section 1. **[245.4662] GRANT PROGRAM; MENTAL HEALTH INNOVATION.**

Subdivision 1. **Definitions.** (a) For the purposes of this section, the following terms have the meaning given them:

(b) "Community partnership" means a project involving the collaboration of two or more eligible applicants.

(c) "Eligible applicant" means an eligible county, Indian tribe, mental health service provider, hospital, or community partnership. Eligible applicant does not include a state-operated direct care and treatment facility or program under chapter 246.

(d) "Intensive residential treatment services" has the meaning given in section 256B.0622, subdivision 2.

(e) "Metropolitan area" means the seven-county metropolitan area, as defined in section 473.121, subdivision 2.

Subd. 2. **Grants authorized.** The commissioner of human services shall award grants to eligible applicants to plan, establish, or operate programs to improve accessibility and quality of community-based, outpatient mental health services and reduce the number of clients admitted to regional treatment centers and community behavioral health hospitals. The commissioner shall award half of all grant funds to eligible applicants in the metropolitan area and half of all grant funds to eligible applicants outside the metropolitan area. The commissioner shall publish criteria for grant awards no later than September 1, 2017.

Subd. 3. **Allocation of grants.** (a) To receive a grant under this section, an applicant must submit an application to the commissioner of human services by October 31, 2017, and by October 31 each year thereafter. A grant may be awarded upon the signing of a grant contract. An applicant may apply for and the commissioner may award grants for one-year or two-year periods.

(b) An application must be on a form and contain information as specified by the commissioner but at a minimum must contain:

(1) a description of the purpose or project for which grant funds will be used;

(2) a description of the specific problem the grant funds will address;

(3) a description of achievable objectives, a work plan, and a timeline for implementation and completion of processes or projects enabled by the grant; and

(4) a process for documenting and evaluating results of the grant.

(c) The commissioner shall review each application to determine whether the application is complete and whether the applicant and the project are eligible for a grant. In evaluating applications according to paragraph (d), the commissioner shall establish criteria including, but not limited to: the eligibility of the project; the applicant's thoroughness and clarity in describing the problem grant funds are intended to address; a description of the applicant's proposed project; a description of the population demographics and service area of the proposed project; the manner in which the applicant will demonstrate the effectiveness of any projects undertaken; and evidence of efficiencies and effectiveness gained through collaborative efforts. The commissioner may also consider other relevant factors, including, but not limited to, the proposed project's longevity and financial sustainability. In evaluating

applications, the commissioner may request additional information regarding a proposed project, including information on project cost. An applicant's failure to provide the information requested disqualifies an applicant. The commissioner shall determine the number of grants awarded.

(d) In determining whether eligible applicants receive grants under this section, the commissioner shall give preference to the following:

(1) intensive residential treatment services, providing time-limited mental health services in a residential setting;

(2) the creation of stand-alone urgent care centers for mental health and psychiatric consultation services, crisis residential services or collaboration between crisis teams and critical access hospitals;

(3) establishing new community mental health services or expanding the capacity of existing services; and

(4) other innovative projects that improve options for mental health services in community settings and reduce the number of clients who remain in regional treatment centers and community behavioral health hospitals beyond when discharge is determined to be clinically appropriate.

Subd. 4. **Awarding of grants.** The commissioner must notify grantees of awards by December 15, 2017, and grant funds must be disbursed by January 1, 2018, and by December 15 and January 1, respectively, each year thereafter.

Sec. 2. Minnesota Statutes 2016, section 245.4889, subdivision 1, is amended to read:

Subdivision 1. **Establishment and authority.** (a) The commissioner is authorized to make grants from available appropriations to assist:

(1) counties;

(2) Indian tribes;

(3) children's collaboratives under section 124D.23 or 245.493; or

(4) mental health service providers.

(b) The following services are eligible for grants under this section:

(1) services to children with emotional disturbances as defined in section 245.4871, subdivision 15, and their families;

(2) transition services under section 245.4875, subdivision 8, for young adults under age 21 and their families;

(3) respite care services for children with severe emotional disturbances who are at risk of out-of-home placement;

(4) children's mental health crisis services;

(5) mental health services for people from cultural and ethnic minorities;

(6) children's mental health screening and follow-up diagnostic assessment and treatment;

(7) services to promote and develop the capacity of providers to use evidence-based practices in providing children's mental health services;

(8) school-linked mental health services;

(9) building evidence-based mental health intervention capacity for children birth to age five;

(10) suicide prevention and counseling services that use text messaging statewide;

(11) mental health first aid training;

(12) training for parents, collaborative partners, and mental health providers on the impact of adverse childhood experiences and trauma and development of an interactive Web site to share information and strategies to promote resilience and prevent trauma;

(13) transition age services to develop or expand mental health treatment and supports for adolescents and young adults 26 years of age or younger;

(14) early childhood mental health consultation;

(15) evidence-based interventions for youth at risk of developing or experiencing a first episode of psychosis, and a public awareness campaign on the signs and symptoms of psychosis; ~~and~~

(16) psychiatric consultation for primary care practitioners~~.~~;

(17) providers to begin operations and meet program requirements when establishing a new children's mental health program. These may be start-up grants; and

(18) transportation for children to school-linked mental health services.

(c) Services under paragraph (b) must be designed to help each child to function and remain with the child's family in the community and delivered consistent with the child's

treatment plan. Transition services to eligible young adults under this paragraph ~~(b)~~ must be designed to foster independent living in the community.

EFFECTIVE DATE. Clause (17) is effective the day following final enactment.

Sec. 3. Minnesota Statutes 2016, section 245.91, subdivision 4, is amended to read:

Subd. 4. **Facility or program.** "Facility" or "program" means a nonresidential or residential program as defined in section 245A.02, subdivisions 10 and 14, ~~that is required to be licensed by the commissioner of human services,~~ and any agency, facility, or program that provides services or treatment for mental illness, developmental disabilities, chemical dependency, or emotional disturbance that is required to be licensed, certified, or registered by the commissioner of human services, health, or education; and an acute care inpatient facility that provides services or treatment for mental illness, developmental disabilities, chemical dependency, or emotional disturbance.

Sec. 4. Minnesota Statutes 2016, section 245.91, subdivision 6, is amended to read:

Subd. 6. **Serious injury.** "Serious injury" means:

(1) fractures;

(2) dislocations;

(3) evidence of internal injuries;

(4) head injuries with loss of consciousness or potential for a closed head injury or concussion without loss of consciousness requiring a medical assessment by a health care professional, whether or not further medical attention was sought;

(5) lacerations involving injuries to tendons or organs, and those for which complications are present;

(6) extensive second-degree or third-degree burns, and other burns for which complications are present;

(7) extensive second-degree or third-degree frostbite, and others for which complications are present;

(8) irreversible mobility or avulsion of teeth;

(9) injuries to the eyeball;

(10) ingestion of foreign substances and objects that are harmful;

(11) near drowning;

(12) heat exhaustion or sunstroke; ~~and~~

(13) attempted suicide; and

~~(13)~~ (14) all other injuries and incidents considered serious after an assessment by a ~~physician.~~ health care professional, including but not limited to self-injurious behavior, a medication error requiring medical treatment, a suspected delay of medical treatment, a complication of a previous injury, or a complication of medical treatment for an injury.

Sec. 5. Minnesota Statutes 2016, section 245.97, subdivision 6, is amended to read:

Subd. 6. **Terms, compensation, and removal.** The membership terms, compensation, and removal of members of the committee and the filling of membership vacancies are governed by section ~~15.0575~~ 15.0597.

Sec. 6. Minnesota Statutes 2016, section 245A.03, subdivision 2, is amended to read:

Subd. 2. **Exclusion from licensure.** (a) This chapter does not apply to:

(1) residential or nonresidential programs that are provided to a person by an individual who is related unless the residential program is a child foster care placement made by a local social services agency or a licensed child-placing agency, except as provided in subdivision 2a;

(2) nonresidential programs that are provided by an unrelated individual to persons from a single related family;

(3) residential or nonresidential programs that are provided to adults who do not ~~abuse chemicals or who do not have a chemical dependency~~ misuse substances or have a substance use disorder, a mental illness, a developmental disability, a functional impairment, or a physical disability;

(4) sheltered workshops or work activity programs that are certified by the commissioner of employment and economic development;

(5) programs operated by a public school for children 33 months or older;

(6) nonresidential programs primarily for children that provide care or supervision for periods of less than three hours a day while the child's parent or legal guardian is in the same building as the nonresidential program or present within another building that is directly contiguous to the building in which the nonresidential program is located;

(7) nursing homes or hospitals licensed by the commissioner of health except as specified under section 245A.02;

(8) board and lodge facilities licensed by the commissioner of health that do not provide children's residential services under Minnesota Rules, chapter 2960, mental health or chemical dependency treatment;

(9) homes providing programs for persons placed by a county or a licensed agency for legal adoption, unless the adoption is not completed within two years;

(10) programs licensed by the commissioner of corrections;

(11) recreation programs for children or adults that are operated or approved by a park and recreation board whose primary purpose is to provide social and recreational activities;

(12) programs operated by a school as defined in section 120A.22, subdivision 4; YMCA as defined in section 315.44; YWCA as defined in section 315.44; or JCC as defined in section 315.51, whose primary purpose is to provide child care or services to school-age children;

(13) Head Start nonresidential programs which operate for less than 45 days in each calendar year;

(14) noncertified boarding care homes unless they provide services for five or more persons whose primary diagnosis is mental illness or a developmental disability;

(15) programs for children such as scouting, boys clubs, girls clubs, and sports and art programs, and nonresidential programs for children provided for a cumulative total of less than 30 days in any 12-month period;

(16) residential programs for persons with mental illness, that are located in hospitals;

(17) the religious instruction of school-age children; Sabbath or Sunday schools; or the congregate care of children by a church, congregation, or religious society during the period used by the church, congregation, or religious society for its regular worship;

(18) camps licensed by the commissioner of health under Minnesota Rules, chapter 4630;

(19) mental health outpatient services for adults with mental illness or children with emotional disturbance;

(20) residential programs serving school-age children whose sole purpose is cultural or educational exchange, until the commissioner adopts appropriate rules;

(21) community support services programs as defined in section 245.462, subdivision 6, and family community support services as defined in section 245.4871, subdivision 17;

(22) the placement of a child by a birth parent or legal guardian in a preadoptive home for purposes of adoption as authorized by section 259.47;

(23) settings registered under chapter 144D which provide home care services licensed by the commissioner of health to fewer than seven adults;

(24) ~~chemical dependency or~~ substance ~~abuse~~ use disorder treatment activities of licensed professionals in private practice as defined in ~~Minnesota Rules, part 9530.6405, subpart 15, when the treatment activities are not paid for by the consolidated chemical dependency treatment fund~~ section 245G.01, subdivision 17;

(25) consumer-directed community support service funded under the Medicaid waiver for persons with developmental disabilities when the individual who provided the service is:

(i) the same individual who is the direct payee of these specific waiver funds or paid by a fiscal agent, fiscal intermediary, or employer of record; and

(ii) not otherwise under the control of a residential or nonresidential program that is required to be licensed under this chapter when providing the service;

(26) a program serving only children who are age 33 months or older, that is operated by a nonpublic school, for no more than four hours per day per child, with no more than 20 children at any one time, and that is accredited by:

(i) an accrediting agency that is formally recognized by the commissioner of education as a nonpublic school accrediting organization; or

(ii) an accrediting agency that requires background studies and that receives and investigates complaints about the services provided.

A program that asserts its exemption from licensure under item (ii) shall, upon request from the commissioner, provide the commissioner with documentation from the accrediting agency that verifies: that the accreditation is current; that the accrediting agency investigates complaints about services; and that the accrediting agency's standards require background studies on all people providing direct contact services; or

(27) a program operated by a nonprofit organization incorporated in Minnesota or another state that serves youth in kindergarten through grade 12; provides structured, supervised youth development activities; and has learning opportunities take place before or after school, on weekends, or during the summer or other seasonal breaks in the school calendar. A program exempt under this clause is not eligible for child care assistance under chapter 119B. A program exempt under this clause must:

(i) have a director or supervisor on site who is responsible for overseeing written policies relating to the management and control of the daily activities of the program, ensuring the health and safety of program participants, and supervising staff and volunteers;

(ii) have obtained written consent from a parent or legal guardian for each youth participating in activities at the site; and

(iii) have provided written notice to a parent or legal guardian for each youth at the site that the program is not licensed or supervised by the state of Minnesota and is not eligible to receive child care assistance payments.

(b) For purposes of paragraph (a), clause (6), a building is directly contiguous to a building in which a nonresidential program is located if it shares a common wall with the building in which the nonresidential program is located or is attached to that building by skyway, tunnel, atrium, or common roof.

(c) Except for the home and community-based services identified in section 245D.03, subdivision 1, nothing in this chapter shall be construed to require licensure for any services provided and funded according to an approved federal waiver plan where licensure is specifically identified as not being a condition for the services and funding.

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

Sec. 7. Minnesota Statutes 2016, section 245A.191, is amended to read:

245A.191 PROVIDER ELIGIBILITY FOR PAYMENTS FROM THE CHEMICAL DEPENDENCY CONSOLIDATED TREATMENT FUND.

(a) When a ~~chemical dependency~~ substance use disorder treatment provider licensed under chapter 245G or Minnesota Rules, parts 2960.0430 to 2960.0490 ~~or 9530.6405 to 9530.6505~~, agrees to meet the applicable requirements under section 254B.05, subdivision 5, ~~paragraphs (b), clauses (1) to (4) and (6), (c), and (e),~~ to be eligible for enhanced funding from the chemical dependency consolidated treatment fund, the applicable requirements under section 254B.05 are also licensing requirements that may be monitored for compliance through licensing investigations and licensing inspections.

(b) Noncompliance with the requirements identified under paragraph (a) may result in:

(1) a correction order or a conditional license under section 245A.06, or sanctions under section 245A.07;

(2) nonpayment of claims submitted by the license holder for public program reimbursement;

(3) recovery of payments made for the service;

(4) disenrollment in the public payment program; or

(5) other administrative, civil, or criminal penalties as provided by law.

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

Sec. 8. **[245G.01] DEFINITIONS.**

Subdivision 1. **Scope.** The terms used in this chapter have the meanings given them.

Subd. 2. **Administration of medication.** "Administration of medication" means providing a medication to a client, and includes the following tasks, performed in the following order:

(1) checking the client's medication record;

(2) preparing the medication for administration;

(3) administering the medication to the client;

(4) documenting the administration of the medication, or the reason for not administering a medication as prescribed; and

(5) reporting information to a licensed practitioner or a nurse regarding a problem with the administration of medication or the client's refusal to take the medication, if applicable.

Subd. 3. **Adolescent.** "Adolescent" means an individual under 18 years of age.

Subd. 4. **Alcohol and drug counselor.** "Alcohol and drug counselor" has the meaning given in section 148F.01, subdivision 5.

Subd. 5. **Applicant.** "Applicant" means an individual, corporation, partnership, voluntary association, controlling individual, or other organization that applied for a license under this chapter.

Subd. 6. **Capacity management system.** "Capacity management system" means a database maintained by the department to compile and make information available to the public about the waiting list status and current admission capability of each opioid treatment program.

Subd. 7. **Central registry.** "Central registry" means a database maintained by the department to collect identifying information from two or more programs about an individual applying for maintenance treatment or detoxification treatment for opioid addiction to prevent an individual's concurrent enrollment in more than one program.

Subd. 8. **Client.** "Client" means an individual accepted by a license holder for assessment or treatment of a substance use disorder. An individual remains a client until the license holder no longer provides or intends to provide the individual with treatment service.

Subd. 9. **Commissioner.** "Commissioner" means the commissioner of human services.

Subd. 10. **Co-occurring disorders.** "Co-occurring disorders" means a diagnosis of both a substance use disorder and a mental health disorder.

Subd. 11. **Department.** "Department" means the Department of Human Services.

Subd. 12. **Direct contact.** "Direct contact" has the meaning given for "direct contact" in section 245C.02, subdivision 11.

Subd. 13. **Face-to-face.** "Face-to-face" means two-way, real-time, interactive and visual communication between a client and a treatment service provider and includes services delivered in person or via telemedicine.

Subd. 14. **License.** "License" means a certificate issued by the commissioner authorizing the license holder to provide a specific program for a specified period of time according to the terms of the license and the rules of the commissioner.

Subd. 15. **License holder.** "License holder" means an individual, corporation, partnership, voluntary organization, or other organization that is legally responsible for the operation of the program, was granted a license by the commissioner under this chapter, and is a controlling individual.

Subd. 16. **Licensed practitioner.** "Licensed practitioner" means an individual who is authorized to prescribe medication as defined in section 151.01, subdivision 23.

Subd. 17. **Licensed professional in private practice.** "Licensed professional in private practice" means an individual who:

(1) is licensed under chapter 148F, or is exempt from licensure under that chapter but is otherwise licensed to provide alcohol and drug counseling services;

(2) practices solely within the permissible scope of the individual's license as defined in the law authorizing licensure; and

(3) does not affiliate with other licensed or unlicensed professionals to provide alcohol and drug counseling services. Affiliation does not include conferring with another professional or making a client referral.

Subd. 18. **Nurse.** "Nurse" means an individual licensed and currently registered to practice professional or practical nursing as defined in section 148.171, subdivisions 14 and 15.

Subd. 19. **Opioid treatment program or OTP.** "Opioid treatment program" or "OTP" means a program or practitioner engaged in opioid treatment of an individual that provides dispensing of an opioid agonist treatment medication, along with a comprehensive range of medical and rehabilitative services, when clinically necessary, to an individual to alleviate the adverse medical, psychological, or physical effects of an opioid addiction. OTP includes detoxification treatment, short-term detoxification treatment, long-term detoxification treatment, maintenance treatment, comprehensive maintenance treatment, and interim maintenance treatment.

Subd. 20. **Paraprofessional.** "Paraprofessional" means an employee, agent, or independent contractor of the license holder who performs tasks to support treatment service. A paraprofessional may be referred to by a variety of titles including but not limited to technician, case aide, or counselor assistant. If currently a client of the license holder, the client cannot be a paraprofessional for the license holder.

Subd. 21. **Student intern.** "Student intern" means an individual who is authorized by a licensing board to provide services under supervision of a licensed professional.

Subd. 22. **Substance.** "Substance" means alcohol, solvents, controlled substances as defined in section 152.01, subdivision 4, and other mood-altering substances.

Subd. 23. **Substance use disorder.** "Substance use disorder" has the meaning given in the current Diagnostic and Statistical Manual of Mental Disorders.

Subd. 24. **Substance use disorder treatment.** "Substance use disorder treatment" means treatment of a substance use disorder, including the process of assessment of a client's needs, development of planned methods, including interventions or services to address a client's needs, provision of services, facilitation of services provided by other service providers, and ongoing reassessment by a qualified professional when indicated. The goal of substance use disorder treatment is to assist or support the client's efforts to recover from a substance use disorder.

Subd. 25. **Target population.** "Target population" means individuals with a substance use disorder and the specified characteristics that a license holder proposes to serve.

Subd. 26. **Telemedicine.** "Telemedicine" means the delivery of a substance use disorder treatment service while the client is at an originating site and the licensed health care provider is at a distant site as specified in section 254B.05, subdivision 5, paragraph (f).

Subd. 27. **Treatment director.** "Treatment director" means an individual who meets the qualifications specified in section 245G.11, subdivisions 1 and 3, and is designated by the license holder to be responsible for all aspects of the delivery of treatment service.

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

Sec. 9. **[245G.02] APPLICABILITY.**

Subdivision 1. **Applicability.** Except as provided in subdivisions 2 and 3, no person, corporation, partnership, voluntary association, controlling individual, or other organization may provide a substance use disorder treatment service to an individual with a substance use disorder unless licensed by the commissioner.

Subd. 2. **Exemption from license requirement.** This chapter does not apply to a county or recovery community organization that is providing a service for which the county or recovery community organization is an eligible vendor under section 254B.05. This chapter does not apply to an organization whose primary functions are information, referral, diagnosis, case management, and assessment for the purposes of client placement, education, support group services, or self-help programs. This chapter does not apply to the activities of a licensed professional in private practice.

Subd. 3. **Excluded hospitals.** This chapter does not apply to substance use disorder treatment provided by a hospital licensed under chapter 62J, or under sections 144.50 to 144.56, unless the hospital accepts funds for substance use disorder treatment from the consolidated chemical dependency treatment fund under chapter 254B, medical assistance under chapter 256B, or MinnesotaCare or health care cost containment under chapter 256L, or general assistance medical care formerly codified in chapter 256D.

Subd. 4. **Applicability of Minnesota Rules, chapter 2960.** A residential adolescent substance use disorder treatment program serving an individual younger than 16 years of age must be licensed according to Minnesota Rules, chapter 2960.

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

Sec. 10. **[245G.03] LICENSING REQUIREMENTS.**

Subdivision 1. **License requirements.** (a) An applicant for a license to provide substance use disorder treatment must comply with the general requirements in chapters 245A and 245C, sections 626.556 and 626.557, and Minnesota Rules, chapter 9544.

(b) The commissioner may grant variances to the requirements in this chapter that do not affect the client's health or safety if the conditions in section 245A.04, subdivision 9, are met.

Subd. 2. **Application.** Before the commissioner issues a license, an applicant must submit, on forms provided by the commissioner, any documents the commissioner requires to demonstrate the following:

(1) compliance with this chapter;

(2) compliance with applicable building, fire and safety codes, health rules, zoning ordinances, and other applicable rules and regulations or documentation that a waiver was granted. An applicant's receipt of a waiver does not constitute modification of any requirement in this chapter; and

(3) insurance coverage, including bonding, sufficient to cover all client funds, property, and interests.

Subd. 3. **Change in license terms.** (a) The commissioner must determine whether a new license is needed when a change in clauses (1) to (4) occurs. A license holder must notify the commissioner before a change in one of the following occurs:

(1) the Department of Health's licensure of the program;

(2) whether the license holder provides services specified in sections 245G.18 to 245G.22;

(3) location; or

(4) capacity if the license holder meets the requirements of section 245G.21.

(b) A license holder must notify the commissioner and must apply for a new license if there is a change in program ownership.

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

Sec. 11. **[245G.04] INITIAL SERVICES PLAN.**

(a) The license holder must complete an initial services plan on the day of service initiation. The plan must address the client's immediate health and safety concerns, identify

the needs to be addressed in the first treatment session, and make treatment suggestions for the client during the time between intake and completion of the individual treatment plan.

(b) The initial services plan must include a determination of whether a client is a vulnerable adult as defined in section 626.5572, subdivision 21. An adult client of a residential program is a vulnerable adult. An individual abuse prevention plan, according to sections 245A.65, subdivision 2, paragraph (b), and 626.557, subdivision 14, paragraph (b), is required for a client who meets the definition of vulnerable adult.

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

Sec. 12. **[245G.05] COMPREHENSIVE ASSESSMENT AND ASSESSMENT SUMMARY.**

Subdivision 1. **Comprehensive assessment.** (a) A comprehensive assessment of the client's substance use disorder must be administered face-to-face by an alcohol and drug counselor within three calendar days after service initiation for a residential program or during the initial session for all other programs. If the comprehensive assessment is not completed during the initial session, the client-centered reason for the delay must be documented in the client's file and the planned completion date. If the client received a comprehensive assessment that authorized the treatment service, an alcohol and drug counselor must review the assessment to determine compliance with this subdivision, including applicable timelines. If available, the alcohol and drug counselor may use current information provided by a referring agency or other source as a supplement. Information gathered more than 45 days before the date of admission is not considered current. If the comprehensive assessment cannot be completed in the time specified, the treatment plan must indicate a person-centered reason for the delay, and how and when the comprehensive assessment will be completed. The comprehensive assessment must include sufficient information to complete the assessment summary according to subdivision 2 and the individual treatment plan according to section 245G.06. The comprehensive assessment must include information about the client's needs that relate to substance use and personal strengths that support recovery, including:

(1) age, sex, cultural background, sexual orientation, living situation, economic status, and level of education;

(2) circumstances of service initiation;

(3) previous attempts at treatment for substance misuse or substance use disorder, compulsive gambling, or mental illness;

(4) substance use history including amounts and types of substances used, frequency and duration of use, periods of abstinence, and circumstances of relapse, if any. For each substance used within the previous 30 days, the information must include the date of the most recent use and previous withdrawal symptoms;

(5) specific problem behaviors exhibited by the client when under the influence of substances;

(6) family status, family history, including history or presence of physical or sexual abuse, level of family support, and substance misuse or substance use disorder of a family member or significant other;

(7) physical concerns or diagnoses, the severity of the concerns, and whether the concerns are being addressed by a health care professional;

(8) mental health history and psychiatric status, including symptoms, disability, current treatment supports, and psychotropic medication needed to maintain stability; the assessment must utilize screening tools approved by the commissioner pursuant to section 245.4863 to identify whether the client screens positive for co-occurring disorders;

(9) arrests and legal interventions related to substance use;

(10) ability to function appropriately in work and educational settings;

(11) ability to understand written treatment materials, including rules and the client's rights;

(12) risk-taking behavior, including behavior that puts the client at risk of exposure to blood-borne or sexually transmitted diseases;

(13) social network in relation to expected support for recovery and leisure time activities that are associated with substance use;

(14) whether the client is pregnant and, if so, the health of the unborn child and the client's current involvement in prenatal care;

(15) whether the client recognizes problems related to substance use and is willing to follow treatment recommendations; and

(16) collateral information. If the assessor gathered sufficient information from the referral source or the client to apply the criteria in parts 9530.6620 and 9530.6622, a collateral contact is not required.

(b) If the client is identified as having opioid use disorder or seeking treatment for opioid use disorder, the program must provide educational information to the client concerning:

(1) risks for opioid use disorder and dependence;

(2) treatment options, including the use of a medication for opioid use disorder;

(3) the risk of and recognizing opioid overdose; and

(4) the use, availability, and administration of naloxone to respond to opioid overdose.

(c) The commissioner shall develop educational materials that are supported by research and updated periodically. The license holder must use the educational materials that are approved by the commissioner to comply with this requirement.

(d) If the comprehensive assessment is completed to authorize treatment service for the client, at the earliest opportunity during the assessment interview the assessor shall determine if:

(1) the client is in severe withdrawal and likely to be a danger to self or others;

(2) the client has severe medical problems that require immediate attention; or

(3) the client has severe emotional or behavioral symptoms that place the client or others at risk of harm.

If one or more of the conditions in clauses (1) to (3) are present, the assessor must end the assessment interview and follow the procedures in the program's medical services plan under section 245G.08, subdivision 2, to help the client obtain the appropriate services. The assessment interview may resume when the condition is resolved.

Subd. 2. **Assessment summary.** (a) An alcohol and drug counselor must complete an assessment summary within three calendar days after service initiation for a residential program and within three sessions for all other programs. If the comprehensive assessment is used to authorize the treatment service, the alcohol and drug counselor must prepare an assessment summary on the same date the comprehensive assessment is completed. If the comprehensive assessment and assessment summary are to authorize treatment services, the assessor must determine appropriate services for the client using the dimensions in Minnesota Rules, part 9530.6622, and document the recommendations.

(b) An assessment summary must include:

(1) a risk description according to section 245G.05 for each dimension listed in paragraph (c);

(2) a narrative summary supporting the risk descriptions; and

(3) a determination of whether the client has a substance use disorder.

(c) An assessment summary must contain information relevant to treatment service planning and recorded in the dimensions in clauses (1) to (6). The license holder must consider:

(1) Dimension 1, acute intoxication/withdrawal potential; the client's ability to cope with withdrawal symptoms and current state of intoxication;

(2) Dimension 2, biomedical conditions and complications; the degree to which any physical disorder of the client would interfere with treatment for substance use, and the client's ability to tolerate any related discomfort. The license holder must determine the impact of continued chemical use on the unborn child, if the client is pregnant;

(3) Dimension 3, emotional, behavioral, and cognitive conditions and complications; the degree to which any condition or complication is likely to interfere with treatment for substance use or with functioning in significant life areas and the likelihood of harm to self or others;

(4) Dimension 4, readiness for change; the support necessary to keep the client involved in treatment service;

(5) Dimension 5, relapse, continued use, and continued problem potential; the degree to which the client recognizes relapse issues and has the skills to prevent relapse of either substance use or mental health problems; and

(6) Dimension 6, recovery environment; whether the areas of the client's life are supportive of or antagonistic to treatment participation and recovery.

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

Sec. 13. **[245G.06] INDIVIDUAL TREATMENT PLAN.**

Subdivision 1. **General.** Each client must have an individual treatment plan developed by an alcohol and drug counselor within seven days of service initiation for a residential program and within three sessions for all other programs. The client must have active, direct involvement in selecting the anticipated outcomes of the treatment process and developing the treatment plan. The individual treatment plan must be signed by the client and the alcohol and drug counselor and document the client's involvement in the development of the plan. The plan may be a continuation of the initial services plan required in section 245G.04. Treatment planning must include ongoing assessment of client needs. An individual treatment plan must be updated based on new information gathered about the client's condition and on whether methods identified have the intended effect. A change to the plan must be signed by the client and the alcohol and drug counselor. The plan must provide for the involvement

of the client's family and people selected by the client as important to the success of treatment at the earliest opportunity, consistent with the client's treatment needs and written consent.

Subd. 2. **Plan contents.** An individual treatment plan must be recorded in the six dimensions listed in section 245G.05, subdivision 2, paragraph (c), must address each issue identified in the assessment summary, prioritized according to the client's needs and focus, and must include:

(1) specific methods to address each identified need, including amount, frequency, and anticipated duration of treatment service. The methods must be appropriate to the client's language, reading skills, cultural background, and strengths;

(2) resources to refer the client to when the client's needs are to be addressed concurrently by another provider; and

(3) goals the client must reach to complete treatment and terminate services.

Subd. 3. **Documentation of treatment services; treatment plan review.** (a) A review of all treatment services must be documented weekly and include a review of:

(1) care coordination activities;

(2) medical and other appointments the client attended;

(3) issues related to medications that are not documented in the medication administration record; and

(4) issues related to attendance for treatment services, including the reason for any client absence from a treatment service.

(b) A note must be entered immediately following any significant event. A significant event is an event that impacts the client's relationship with other clients, staff, the client's family, or the client's treatment plan.

(c) A treatment plan review must be entered in a client's file weekly or after each treatment service, whichever is less frequent, by the staff member providing the service. The review must indicate the span of time covered by the review and each of the six dimensions listed in section 245G.05, subdivision 2, paragraph (c). The review must:

(1) indicate the date, type, and amount of each treatment service provided and the client's response to each service;

(2) address each goal in the treatment plan and whether the methods to address the goals are effective;

(3) include monitoring of any physical and mental health problems;

(4) document the participation of others;

(5) document staff recommendations for changes in the methods identified in the treatment plan and whether the client agrees with the change; and

(6) include a review and evaluation of the individual abuse prevention plan according to section 245A.65.

(d) Each entry in a client's record must be accurate, legible, signed, and dated. A late entry must be clearly labeled "late entry." A correction to an entry must be made in a way in which the original entry can still be read.

Subd. 4. **Service discharge summary.** (a) An alcohol and drug counselor must write a discharge summary for each client. The summary must be completed within five days of the client's service termination or within five days from the client's or program's decision to terminate services, whichever is earlier.

(b) The service discharge summary must be recorded in the six dimensions listed in section 245G.05, subdivision 2, paragraph (c), and include the following information:

(1) the client's issues, strengths, and needs while participating in treatment, including services provided;

(2) the client's progress toward achieving each goal identified in the individual treatment plan;

(3) a risk description according to section 245G.05; and

(4) the reasons for and circumstances of service termination. If a program discharges a client at staff request, the reason for discharge and the procedure followed for the decision to discharge must be documented and comply with the program's policies on staff-initiated client discharge. If a client is discharged at staff request, the program must give the client crisis and other referrals appropriate for the client's needs and offer assistance to the client to access the services.

(c) For a client who successfully completes treatment, the summary must also include:

(1) the client's living arrangements at service termination;

(2) continuing care recommendations, including transitions between more or less intense services, or more frequent to less frequent services, and referrals made with specific attention to continuity of care for mental health, as needed;

(3) service termination diagnosis; and

(4) the client's prognosis.

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

Sec. 14. **[245G.07] TREATMENT SERVICE.**

Subdivision 1. **Treatment service.** (a) A license holder must offer the following treatment services, unless clinically inappropriate and the justifying clinical rationale is documented:

(1) individual and group counseling to help the client identify and address needs related to substance use and develop strategies to avoid harmful substance use after discharge and to help the client obtain the services necessary to establish a lifestyle free of the harmful effects of substance use disorder;

(2) client education strategies to avoid inappropriate substance use and health problems related to substance use and the necessary lifestyle changes to regain and maintain health. Client education must include information on tuberculosis education on a form approved by the commissioner, the human immunodeficiency virus according to section 245A.19, other sexually transmitted diseases, drug and alcohol use during pregnancy, and hepatitis. A licensed alcohol and drug counselor must be present during an educational group;

(3) a service to help the client integrate gains made during treatment into daily living and to reduce the client's reliance on a staff member for support;

(4) a service to address issues related to co-occurring disorders, including client education on symptoms of mental illness, the possibility of comorbidity, and the need for continued medication compliance while recovering from substance use disorder. A group must address co-occurring disorders, as needed. When treatment for mental health problems is indicated, the treatment must be integrated into the client's individual treatment plan;

(5) on July 1, 2018, or upon federal approval, whichever is later, peer recovery support services provided one-to-one by an individual in recovery. Peer support services include education, advocacy, mentoring through self-disclosure of personal recovery experiences, attending recovery and other support groups with a client, accompanying the client to appointments that support recovery, assistance accessing resources to obtain housing, employment, education, and advocacy services, and nonclinical recovery support to assist the transition from treatment into the recovery community; and

(6) on July 1, 2018, or upon federal approval, whichever is later, care coordination provided by an individual who meets the staff qualifications in section 245G.11, subdivision 7. Care coordination services include:

(i) assistance in coordination with significant others to help in the treatment planning process whenever possible;

(ii) assistance in coordination with and follow up for medical services as identified in the treatment plan;

(iii) facilitation of referrals to substance use disorder services as indicated by a client's medical provider, comprehensive assessment, or treatment plan;

(iv) facilitation of referrals to mental health services as identified by a client's comprehensive assessment or treatment plan;

(v) assistance with referrals to economic assistance, social services, housing resources, and prenatal care according to the client's needs;

(vi) life skills advocacy and support accessing treatment follow-up, disease management, and education services, including referral and linkages to long-term services and supports as needed; and

(vii) documentation of the provision of care coordination services in the client's file.

(b) A treatment service provided to a client must be provided according to the individual treatment plan and must consider cultural differences and special needs of a client.

Subd. 2. **Additional treatment service.** A license holder may provide or arrange the following additional treatment service as a part of the client's individual treatment plan:

(1) relationship counseling provided by a qualified professional to help the client identify the impact of the client's substance use disorder on others and to help the client and persons in the client's support structure identify and change behaviors that contribute to the client's substance use disorder;

(2) therapeutic recreation to allow the client to participate in recreational activities without the use of mood-altering chemicals and to plan and select leisure activities that do not involve the inappropriate use of chemicals;

(3) stress management and physical well-being to help the client reach and maintain an appropriate level of health, physical fitness, and well-being;

(4) living skills development to help the client learn basic skills necessary for independent living;

(5) employment or educational services to help the client become financially independent;

(6) socialization skills development to help the client live and interact with others in a positive and productive manner; and

(7) room, board, and supervision at the treatment site to provide the client with a safe and appropriate environment to gain and practice new skills.

Subd. 3. **Counselors.** A treatment service, including therapeutic recreation, must be provided by an alcohol and drug counselor according to section 245G.11, unless the individual providing the service is specifically qualified according to the accepted credential required to provide the service. Therapeutic recreation does not include planned leisure activities.

Subd. 4. **Location of service provision.** The license holder may provide services at any of the license holder's licensed locations or at another suitable location including a school, government building, medical or behavioral health facility, or social service organization. If services are provided off site from the licensed site, the reason for the provision of services remotely must be documented.

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

Sec. 15. **[245G.08] MEDICAL SERVICES.**

Subdivision 1. **Health care services.** An applicant or license holder must maintain a complete description of the health care services, nursing services, dietary services, and emergency physician services offered by the applicant or license holder.

Subd. 2. **Procedures.** The applicant or license holder must have written procedures for obtaining a medical intervention for a client, that are approved in writing by a physician who is licensed under chapter 147, unless:

(1) the license holder does not provide a service under section 245G.21; and

(2) a medical intervention is referred to 911, the emergency telephone number, or the client's physician.

Subd. 3. **Standing order protocol.** A license holder that maintains a supply of naloxone available for emergency treatment of opioid overdose must have a written standing order protocol by a physician who is licensed under chapter 147, that permits the license holder to maintain a supply of naloxone on site, and must require staff to undergo specific training in administration of naloxone.

Subd. 4. **Consultation services.** The license holder must have access to and document the availability of a licensed mental health professional to provide diagnostic assessment and treatment planning assistance.

Subd. 5. **Administration of medication and assistance with self-medication.** (a) A license holder must meet the requirements in this subdivision if a service provided includes the administration of medication.

(b) A staff member, other than a licensed practitioner or nurse, who is delegated by a licensed practitioner or a registered nurse the task of administration of medication or assisting with self-medication, must:

(1) successfully complete a medication administration training program for unlicensed personnel through an accredited Minnesota postsecondary educational institution. A staff member's completion of the course must be documented in writing and placed in the staff member's personnel file;

(2) be trained according to a formalized training program that is taught by a registered nurse and offered by the license holder. The training must include the process for administration of naloxone, if naloxone is kept on site. A staff member's completion of the training must be documented in writing and placed in the staff member's personnel records; or

(3) demonstrate to a registered nurse competency to perform the delegated activity. A registered nurse must be employed or contracted to develop the policies and procedures for administration of medication or assisting with self-administration of medication, or both.

(c) A registered nurse must provide supervision as defined in section 148.171, subdivision 23. The registered nurse's supervision must include, at a minimum, monthly on-site supervision or more often if warranted by a client's health needs. The policies and procedures must include:

(1) a provision that a delegation of administration of medication is limited to the administration of a medication that is administered orally, topically, or as a suppository, an eye drop, an ear drop, or an inhalant;

(2) a provision that each client's file must include documentation indicating whether staff must conduct the administration of medication or the client must self-administer medication, or both;

(3) a provision that a client may carry emergency medication such as nitroglycerin as instructed by the client's physician;

(4) a provision for the client to self-administer medication when a client is scheduled to be away from the facility;

(5) a provision that if a client self-administers medication when the client is present in the facility, the client must self-administer medication under the observation of a trained staff member;

(6) a provision that when a license holder serves a client who is a parent with a child, the parent may only administer medication to the child under a staff member's supervision;

(7) requirements for recording the client's use of medication, including staff signatures with date and time;

(8) guidelines for when to inform a nurse of problems with self-administration of medication, including a client's failure to administer, refusal of a medication, adverse reaction, or error; and

(9) procedures for acceptance, documentation, and implementation of a prescription, whether written, verbal, telephonic, or electronic.

Subd. 6. **Control of drugs.** A license holder must have and implement written policies and procedures developed by a registered nurse that contain:

(1) a requirement that each drug must be stored in a locked compartment. A Schedule II drug, as defined by section 152.02, subdivision 3, must be stored in a separately locked compartment, permanently affixed to the physical plant or medication cart;

(2) a system which accounts for all scheduled drugs each shift;

(3) a procedure for recording the client's use of medication, including the signature of the staff member who completed the administration of the medication with the time and date;

(4) a procedure to destroy a discontinued, outdated, or deteriorated medication;

(5) a statement that only authorized personnel are permitted access to the keys to a locked compartment;

(6) a statement that no legend drug supply for one client shall be given to another client; and

(7) a procedure for monitoring the available supply of naloxone on site, replenishing the naloxone supply when needed, and destroying naloxone according to clause (4).

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

Sec. 16. **[245G.09] CLIENT RECORDS.**

Subdivision 1. **Client records required.** (a) A license holder must maintain a file of current and accurate client records on the premises where the treatment service is provided or coordinated. For services provided off site, client records must be available at the program and adhere to the same clinical and administrative policies and procedures as services provided on site. A program using an electronic health record must maintain virtual access to client records on the premises where the treatment service is delivered. The content and format of client records must be uniform and entries in each record must be signed and dated by the staff member making the entry. Client records must be protected against loss, tampering, or unauthorized disclosure according to section 254A.09, chapter 13, and Code of Federal Regulations, title 42, chapter 1, part 2, subpart B, sections 2.1 to 2.67, and title 45, parts 160 to 164.

(b) The program must have a policy and procedure that identifies how the program will track and record client attendance at treatment activities, including the date, duration, and nature of each treatment service provided to the client.

Subd. 2. **Record retention.** The client records of a discharged client must be retained by a license holder for seven years. A license holder that ceases to provide treatment service must retain client records for seven years from the date of facility closure and must notify the commissioner of the location of the client records and the name of the individual responsible for maintaining the client's records.

Subd. 3. **Contents.** Client records must contain the following:

(1) documentation that the client was given information on client rights and responsibilities, grievance procedures, tuberculosis, and HIV, and that the client was provided an orientation to the program abuse prevention plan required under section 245A.65, subdivision 2, paragraph (a), clause (4). If the client has an opioid use disorder, the record must contain documentation that the client was provided educational information according to section 245G.05, subdivision 1, paragraph (b);

(2) an initial services plan completed according to section 245G.04;

(3) a comprehensive assessment completed according to section 245G.05;

(4) an assessment summary completed according to section 245G.05, subdivision 2;

(5) an individual abuse prevention plan according to sections 245A.65, subdivision 2, and 626.557, subdivision 14, when applicable;

(6) an individual treatment plan according to section 245G.06, subdivisions 1 and 2;

(7) documentation of treatment services and treatment plan review according to section 245G.06, subdivision 3; and

(8) a summary at the time of service termination according to section 245G.06, subdivision 4.

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

Sec. 17. **[245G.10] STAFF REQUIREMENTS.**

Subdivision 1. **Treatment director.** A license holder must have a treatment director.

Subd. 2. **Alcohol and drug counselor supervisor.** A license holder must employ an alcohol and drug counselor supervisor who meets the requirements of section 245G.11, subdivision 4. An individual may be simultaneously employed as a treatment director, alcohol and drug counselor supervisor, and an alcohol and drug counselor if the individual meets the qualifications for each position. If an alcohol and drug counselor is simultaneously employed as an alcohol and drug counselor supervisor or treatment director, that individual must be considered a 0.5 full-time equivalent alcohol and drug counselor for staff requirements under subdivision 4.

Subd. 3. **Responsible staff member.** A treatment director must designate a staff member who, when present in the facility, is responsible for the delivery of treatment service. A license holder must have a designated staff member during all hours of operation. A license holder providing room and board and treatment at the same site must have a responsible staff member on duty 24 hours a day. The designated staff member must know and understand the implications of this chapter and sections 245A.65, 626.556, 626.557, and 626.5572.

Subd. 4. **Staff requirement.** It is the responsibility of the license holder to determine an acceptable group size based on each client's needs except that treatment services provided in a group shall not exceed 16 clients. A counselor in an opioid treatment program must not supervise more than 50 clients. The license holder must maintain a record that documents compliance with this subdivision.

Subd. 5. **Medical emergency.** When a client is present, a license holder must have at least one staff member on the premises who has a current American Red Cross standard first aid certificate or an equivalent certificate and at least one staff member on the premises who has a current American Red Cross community, American Heart Association, or equivalent CPR certificate. A single staff member with both certifications satisfies this requirement.

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

Sec. 18. **[245G.11] STAFF QUALIFICATIONS.**

Subdivision 1. **General qualifications.** (a) All staff members who have direct contact must be 18 years of age or older. At the time of employment, each staff member must meet the qualifications in this subdivision. For purposes of this subdivision, "problematic substance use" means a behavior or incident listed by the license holder in the personnel policies and procedures according to section 245G.13, subdivision 1, clause (5).

(b) A treatment director, supervisor, nurse, counselor, student intern, or other professional must be free of problematic substance use for at least the two years immediately preceding employment and must sign a statement attesting to that fact.

(c) A paraprofessional, recovery peer, or any other staff member with direct contact must be free of problematic substance use for at least one year immediately preceding employment and must sign a statement attesting to that fact.

Subd. 2. **Employment; prohibition on problematic substance use.** A staff member with direct contact must be free from problematic substance use as a condition of employment, but is not required to sign additional statements. A staff member with direct contact who is not free from problematic substance use must be removed from any responsibilities that include direct contact for the time period specified in subdivision 1. The time period begins to run on the date of the last incident of problematic substance use as described in the facility's policies and procedures according to section 245G.13, subdivision 1, clause (5).

Subd. 3. **Treatment directors.** A treatment director must:

(1) have at least one year of work experience in direct service to an individual with substance use disorder or one year of work experience in the management or administration of direct service to an individual with substance use disorder;

(2) have a baccalaureate degree or three years of work experience in administration or personnel supervision in human services; and

(3) know and understand the implications of this chapter, chapter 245A, and sections 626.556, 626.557, and 626.5572. Demonstration of the treatment director's knowledge must be documented in the personnel record.

Subd. 4. **Alcohol and drug counselor supervisors.** An alcohol and drug counselor supervisor must:

(1) meet the qualification requirements in subdivision 5;

(2) have three or more years of experience providing individual and group counseling to individuals with substance use disorder; and

(3) know and understand the implications of this chapter and sections 245A.65, 626.556, 626.557, and 626.5572.

Subd. 5. **Alcohol and drug counselor qualifications.** (a) An alcohol and drug counselor must either be licensed or exempt from licensure under chapter 148F.

(b) An individual who is exempt from licensure under chapter 148F, must meet one of the following additional requirements:

(1) completion of at least a baccalaureate degree with a major or concentration in social work, nursing, sociology, human services, or psychology, or licensure as a registered nurse; successful completion of a minimum of 120 hours of classroom instruction in which each of the core functions listed in chapter 148F is covered; and successful completion of 440 hours of supervised experience as an alcohol and drug counselor, either as a student or a staff member;

(2) completion of at least 270 hours of drug counselor training in which each of the core functions listed in chapter 148F is covered, and successful completion of 880 hours of supervised experience as an alcohol and drug counselor, either as a student or as a staff member;

(3) current certification as an alcohol and drug counselor or alcohol and drug counselor reciprocal, through the evaluation process established by the International Certification and Reciprocity Consortium Alcohol and Other Drug Abuse, Inc.;

(4) completion of a bachelor's degree including 480 hours of alcohol and drug counseling education from an accredited school or educational program and 880 hours of alcohol and drug counseling practicum; or

(5) employment in a program formerly licensed under Minnesota Rules, parts 9530.5000 to 9530.6400, and successful completion of 6,000 hours of supervised work experience in a licensed program as an alcohol and drug counselor prior to January 1, 2005.

(c) An alcohol and drug counselor may not provide a treatment service that requires professional licensure unless the individual possesses the necessary license. For the purposes of enforcing this section, the commissioner has the authority to monitor a service provider's compliance with the relevant standards of the service provider's profession and may issue

licensing actions against the license holder according to sections 245A.05, 245A.06, and 245A.07, based on the commissioner's determination of noncompliance.

Subd. 6. **Paraprofessionals.** A paraprofessional must have knowledge of client rights, according to section 148F.165, and staff member responsibilities. A paraprofessional may not admit, transfer, or discharge a client but may be responsible for the delivery of treatment service according to section 245G.10, subdivision 3.

Subd. 7. **Care coordination provider qualifications.** (a) Care coordination must be provided by qualified staff. An individual is qualified to provide care coordination if the individual:

(1) is skilled in the process of identifying and assessing a wide range of client needs;

(2) is knowledgeable about local community resources and how to use those resources for the benefit of the client;

(3) has successfully completed 30 hours of classroom instruction on care coordination for an individual with substance use disorder;

(4) has either:

(i) a bachelor's degree in one of the behavioral sciences or related fields; or

(ii) current certification as an alcohol and drug counselor, level I, by the Upper Midwest Indian Council on Addictive Disorders; and

(5) has at least 2,000 hours of supervised experience working with individuals with substance use disorder.

(b) A care coordinator must receive at least one hour of supervision regarding individual service delivery from an alcohol and drug counselor weekly.

Subd. 8. **Recovery peer qualifications.** A recovery peer must:

(1) be at least 21 years of age and have a high school diploma or its equivalent;

(2) have a minimum of one year in recovery from substance use disorder;

(3) hold a current credential from a certification body approved by the commissioner that demonstrates skills and training in the domains of ethics and boundaries, advocacy, mentoring and education, and recovery and wellness support; and

(4) receive ongoing supervision in areas specific to the domains of the recovery peer's role by an alcohol and drug counselor or an individual with a certification approved by the commissioner.

Subd. 9. **Volunteers.** A volunteer may provide treatment service when the volunteer is supervised and can be seen or heard by a staff member meeting the criteria in subdivision 4 or 5, but may not practice alcohol and drug counseling unless qualified under subdivision 5.

Subd. 10. **Student interns.** A qualified staff member must supervise and be responsible for a treatment service performed by a student intern and must review and sign each assessment, progress note, and individual treatment plan prepared by a student intern. A student intern must receive the orientation and training required in section 245G.13, subdivisions 1, clause (7), and 2. No more than 50 percent of the treatment staff may be students or licensing candidates with time documented to be directly related to the provision of treatment services for which the staff are authorized.

Subd. 11. **Individuals with temporary permit.** (a) An individual with a temporary permit from the Board of Behavioral Health and Therapy may provide chemical dependency treatment service according to this subdivision.

(b) An individual with a temporary permit must be supervised by a licensed alcohol and drug counselor assigned by the license holder. The supervising licensed alcohol and drug counselor must document the amount and type of supervision provided at least on a weekly basis. The supervision must relate to the clinical practice.

(c) An individual with a temporary permit must be supervised by a clinical supervisor approved by the Board of Behavioral Health and Therapy. The supervision must be documented and meet the requirements of section 148F.04, subdivision 4.

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

Sec. 19. **[245G.12] PROVIDER POLICIES AND PROCEDURES.**

A license holder must develop a written policies and procedures manual, indexed according to section 245A.04, subdivision 14, paragraph (c), that provides staff members immediate access to all policies and procedures and provides a client and other authorized parties access to all policies and procedures. The manual must contain the following materials:

(1) assessment and treatment planning policies, including screening for mental health concerns and treatment objectives related to the client's identified mental health concerns in the client's treatment plan;

(2) policies and procedures regarding HIV according to section 245A.19;

(3) the license holder's methods and resources to provide information on tuberculosis and tuberculosis screening to each client and to report a known tuberculosis infection according to section 144.4804;

(4) personnel policies according to section 245G.13;

(5) policies and procedures that protect a client's rights according to section 245G.15;

(6) a medical services plan according to section 245G.08;

(7) emergency procedures according to section 245G.16;

(8) policies and procedures for maintaining client records according to section 245G.09;

(9) procedures for reporting the maltreatment of minors according to section 626.556, and vulnerable adults according to sections 245A.65, 626.557, and 626.5572;

(10) a description of treatment services, including the amount and type of services provided;

(11) the methods used to achieve desired client outcomes;

(12) the hours of operation; and

(13) the target population served.

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

Sec. 20. **[245G.13] PROVIDER PERSONNEL POLICIES.**

Subdivision 1. **Personnel policy requirements.** A license holder must have written personnel policies that are available to each staff member. The personnel policies must:

(1) ensure that staff member retention, promotion, job assignment, or pay are not affected by a good faith communication between a staff member and the department, the Department of Health, the ombudsman for mental health and developmental disabilities, law enforcement, or a local agency for the investigation of a complaint regarding a client's rights, health, or safety;

(2) contain a job description for each staff member position specifying responsibilities, degree of authority to execute job responsibilities, and qualification requirements;

(3) provide for a job performance evaluation based on standards of job performance conducted on a regular and continuing basis, including a written annual review;

(4) describe behavior that constitutes grounds for disciplinary action, suspension, or dismissal, including policies that address staff member problematic substance use and the

requirements of section 245G.11, subdivision 1, policies prohibiting personal involvement with a client in violation of chapter 604, and policies prohibiting client abuse described in sections 245A.65, 626.556, 626.557, and 626.5572;

(5) identify how the program will identify whether behaviors or incidents are problematic substance use, including a description of how the facility must address:

(i) receiving treatment for substance use within the period specified for the position in the staff qualification requirements, including medication-assisted treatment;

(ii) substance use that negatively impacts the staff member's job performance;

(iii) chemical use that affects the credibility of treatment services with a client, referral source, or other member of the community;

(iv) symptoms of intoxication or withdrawal on the job; and

(v) the circumstances under which an individual who participates in monitoring by the health professional services program for a substance use or mental health disorder is able to provide services to the program's clients;

(6) include a chart or description of the organizational structure indicating lines of authority and responsibilities;

(7) include orientation within 24 working hours of starting for each new staff member based on a written plan that, at a minimum, must provide training related to the staff member's specific job responsibilities, policies and procedures, client confidentiality, HIV minimum standards, and client needs; and

(8) include policies outlining the license holder's response to a staff member with a behavior problem that interferes with the provision of treatment service.

Subd. 2. **Staff development.** (a) A license holder must ensure that each staff member has the training described in this subdivision.

(b) Each staff member must be trained every two years in:

(1) client confidentiality rules and regulations and client ethical boundaries; and

(2) emergency procedures and client rights as specified in sections 144.651, 148F.165, and 253B.03.

(c) Annually each staff member with direct contact must be trained on mandatory reporting as specified in sections 245A.65, 626.556, 626.5561, 626.557, and 626.5572,

including specific training covering the license holder's policies for obtaining a release of client information.

(d) Upon employment and annually thereafter, each staff member with direct contact must receive training on HIV minimum standards according to section 245A.19.

(e) A treatment director, supervisor, nurse, or counselor must have a minimum of 12 hours of training in co-occurring disorders that includes competencies related to philosophy, trauma-informed care, screening, assessment, diagnosis and person-centered treatment planning, documentation, programming, medication, collaboration, mental health consultation, and discharge planning. A new staff member who has not obtained the training must complete the training within six months of employment. A staff member may request, and the license holder may grant, credit for relevant training obtained before employment, which must be documented in the staff member's personnel file.

Subd. 3. **Personnel files.** The license holder must maintain a separate personnel file for each staff member. At a minimum, the personnel file must conform to the requirements of this chapter. A personnel file must contain the following:

(1) a completed application for employment signed by the staff member and containing the staff member's qualifications for employment;

(2) documentation related to the staff member's background study data, according to chapter 245C;

(3) for a staff member who provides psychotherapy services, employer names and addresses for the past five years for which the staff member provided psychotherapy services, and documentation of an inquiry required by sections 604.20 to 604.205 made to the staff member's former employer regarding substantiated sexual contact with a client;

(4) documentation that the staff member completed orientation and training;

(5) documentation that the staff member meets the requirements in section 245G.11;

(6) documentation demonstrating the staff member's compliance with section 245G.08, subdivision 3, for a staff member who conducts administration of medication; and

(7) documentation demonstrating the staff member's compliance with section 245G.18, subdivision 2, for a staff member that treats an adolescent client.

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

Sec. 21. **[245G.14] SERVICE INITIATION AND TERMINATION POLICIES.**

Subdivision 1. **Service initiation policy.** A license holder must have a written service initiation policy containing service initiation preferences that comply with this section and Code of Federal Regulations, title 45, part 96.131, and specific service initiation criteria. The license holder must not initiate services for an individual who does not meet the service initiation criteria. The service initiation criteria must be either posted in the area of the facility where services for a client are initiated, or given to each interested person upon request. Titles of each staff member authorized to initiate services for a client must be listed in the services initiation and termination policies.

Subd. 2. **License holder responsibilities.** (a) The license holder must have and comply with a written protocol for (1) assisting a client in need of care not provided by the license holder, and (2) a client who poses a substantial likelihood of harm to the client or others, if the behavior is beyond the behavior management capabilities of the staff members.

(b) A service termination and denial of service initiation that poses an immediate threat to the health of any individual or requires immediate medical intervention must be referred to a medical facility capable of admitting the client.

(c) A service termination policy and a denial of service initiation that involves the commission of a crime against a license holder's staff member or on a license holder's premises, as provided under Code of Federal Regulations, title 42, section 2.12(c)(5), and title 45, parts 160 to 164, must be reported to a law enforcement agency with jurisdiction.

Subd. 3. **Service termination policies.** A license holder must have a written policy specifying the conditions when a client must be terminated from service. The service termination policy must include:

(1) procedures for a client whose services were terminated under subdivision 2;

(2) a description of client behavior that constitutes reason for a staff-requested service termination and a process for providing this information to a client;

(3) a requirement that before discharging a client from a residential setting, for not reaching treatment plan goals, the license holder must confer with other interested persons to review the issues involved in the decision. The documentation requirements for a staff-requested service termination must describe why the decision to discharge is warranted, the reasons for the discharge, and the alternatives considered or attempted before discharging the client;

(4) procedures consistent with section 253B.16, subdivision 2, that staff members must follow when a client admitted under chapter 253B is to have services terminated;

(5) procedures a staff member must follow when a client leaves against staff or medical advice and when the client may be dangerous to the client or others, including a policy that requires a staff member to assist the client with assessing needs of care or other resources;

(6) procedures for communicating staff-approved service termination criteria to a client, including the expectations in the client's individual treatment plan according to section 245G.06; and

(7) titles of each staff member authorized to terminate a client's service must be listed in the service initiation and service termination policies.

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

Sec. 22. **[245G.15] CLIENT RIGHTS PROTECTION.**

Subdivision 1. **Explanation.** A client has the rights identified in sections 144.651, 148F.165, 253B.03, and 254B.02, subdivision 2, as applicable. The license holder must give each client at service initiation a written statement of the client's rights and responsibilities. A staff member must review the statement with a client at that time.

Subd. 2. **Grievance procedure.** At service initiation, the license holder must explain the grievance procedure to the client or the client's representative. The grievance procedure must be posted in a place visible to clients, and made available upon a client's or former client's request. The grievance procedure must require that:

(1) a staff member helps the client develop and process a grievance;

(2) current telephone numbers and addresses of the Department of Human Services, Licensing Division; the Office of Ombudsman for Mental Health and Developmental Disabilities; the Department of Health Office of Health Facilities Complaints; and the Board of Behavioral Health and Therapy, when applicable, be made available to a client; and

(3) a license holder responds to the client's grievance within three days of a staff member's receipt of the grievance, and the client may bring the grievance to the highest level of authority in the program if not resolved by another staff member.

Subd. 3. **Photographs of client.** (a) A photograph, video, or motion picture of a client taken in the provision of treatment service is considered client records. A photograph for identification and a recording by video or audio technology to enhance either therapy or staff member supervision may be required of a client, but may only be available for use as

communications within a program. A client must be informed when the client's actions are being recorded by camera or other technology, and the client must have the right to refuse any recording or photography, except as authorized by this subdivision.

(b) A license holder must have a written policy regarding the use of any personal electronic device that can record, transmit, or make images of another client. A license holder must inform each client of this policy and the client's right to refuse being photographed or recorded.

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

Sec. 23. **[245G.16] BEHAVIORAL EMERGENCY PROCEDURES.**

(a) A license holder or applicant must have written behavioral emergency procedures that staff must follow when responding to a client who exhibits behavior that is threatening to the safety of the client or others. Programs must incorporate person-centered planning and trauma-informed care in the program's behavioral emergency procedure policies. The procedures must include:

(1) a plan designed to prevent a client from hurting themselves or others;

(2) contact information for emergency resources that staff must consult when a client's behavior cannot be controlled by the behavioral emergency procedures;

(3) types of procedures that may be used;

(4) circumstances under which behavioral emergency procedures may be used; and

(5) staff members authorized to implement behavioral emergency procedures.

(b) Behavioral emergency procedures must not be used to enforce facility rules or for the convenience of staff. Behavioral emergency procedures must not be part of any client's treatment plan, or used at any time for any reason except in response to specific current behavior that threatens the safety of the client or others. Behavioral emergency procedures may not include the use of seclusion or restraint.

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

Sec. 24. **[245G.17] EVALUATION.**

A license holder must participate in the drug and alcohol abuse normative evaluation system by submitting information about each client to the commissioner in a manner prescribed by the commissioner. A license holder must submit additional information

requested by the commissioner that is necessary to meet statutory or federal funding requirements.

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

Sec. 25. **[245G.18] LICENSE HOLDERS SERVING ADOLESCENTS.**

Subdivision 1. **License.** A residential treatment program that serves an adolescent younger than 16 years of age must be licensed as a residential program for a child in out-of-home placement by the department unless the license holder is exempt under section 245A.03, subdivision 2.

Subd. 2. **Alcohol and drug counselor qualifications.** In addition to the requirements specified in section 245G.11, subdivisions 1 and 5, an alcohol and drug counselor providing treatment service to an adolescent must have:

(1) an additional 30 hours of classroom instruction or one three-credit semester college course in adolescent development. This training need only be completed one time; and

(2) at least 150 hours of supervised experience as an adolescent counselor, either as a student or as a staff member.

Subd. 3. **Staff ratios.** At least 25 percent of a counselor's scheduled work hours must be allocated to indirect services, including documentation of client services, coordination of services with others, treatment team meetings, and other duties. A counseling group consisting entirely of adolescents must not exceed 16 adolescents. It is the responsibility of the license holder to determine an acceptable group size based on the needs of the clients.

Subd. 4. **Academic program requirements.** A client who is required to attend school must be enrolled and attending an educational program that was approved by the Department of Education.

Subd. 5. **Program requirements.** In addition to the requirements specified in the client's treatment plan under section 245G.06, programs serving an adolescent must include:

(1) coordination with the school system to address the client's academic needs;

(2) when appropriate, a plan that addresses the client's leisure activities without chemical use; and

(3) a plan that addresses family involvement in the adolescent's treatment.

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

Sec. 26. **[245G.19] LICENSE HOLDERS SERVING CLIENTS WITH CHILDREN.**

Subdivision 1. **Health license requirements.** In addition to the requirements of sections 245G.01 to 245G.17, a license holder that offers supervision of a child of a client is subject to the requirements of this section. A license holder providing room and board for a client and the client's child must have an appropriate facility license from the Department of Health.

Subd. 2. **Supervision of a child.** "Supervision of a child" means a caregiver is within sight or hearing of an infant, toddler, or preschooler at all times so that the caregiver can intervene to protect the child's health and safety. For a school-age child it means a caregiver is available to help and care for the child to protect the child's health and safety.

Subd. 3. **Policy and schedule required.** A license holder must meet the following requirements:

(1) have a policy and schedule delineating the times and circumstances when the license holder is responsible for supervision of a child in the program and when the child's parents are responsible for supervision of a child. The policy must explain how the program will communicate its policy about supervision of a child responsibility to the parent; and

(2) have written procedures addressing the actions a staff member must take if a child is neglected or abused, including while the child is under the supervision of the child's parent.

Subd. 4. **Additional licensing requirements.** During the times the license holder is responsible for the supervision of a child, the license holder must meet the following standards:

(1) child and adult ratios in Minnesota Rules, part 9502.0367;

(2) day care training in section 245A.50;

(3) behavior guidance in Minnesota Rules, part 9502.0395;

(4) activities and equipment in Minnesota Rules, part 9502.0415;

(5) physical environment in Minnesota Rules, part 9502.0425; and

(6) water, food, and nutrition in Minnesota Rules, part 9502.0445, unless the license holder has a license from the Department of Health.

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

Sec. 27. **[245G.20] LICENSE HOLDERS SERVING PERSONS WITH CO-OCCURRING DISORDERS.**

A license holder specializing in the treatment of a person with co-occurring disorders must:

(1) demonstrate that staff levels are appropriate for treating a client with a co-occurring disorder, and that there are adequate staff members with mental health training;

(2) have continuing access to a medical provider with appropriate expertise in prescribing psychotropic medication;

(3) have a mental health professional available for staff member supervision and consultation;

(4) determine group size, structure, and content considering the special needs of a client with a co-occurring disorder;

(5) have documentation of active interventions to stabilize mental health symptoms present in the individual treatment plans and progress notes;

(6) have continuing documentation of collaboration with continuing care mental health providers, and involvement of the providers in treatment planning meetings;

(7) have available program materials adapted to a client with a mental health problem;

(8) have policies that provide flexibility for a client who may lapse in treatment or may have difficulty adhering to established treatment rules as a result of a mental illness, with the goal of helping a client successfully complete treatment; and

(9) have individual psychotherapy and case management available during treatment service.

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

Sec. 28. **[245G.21] REQUIREMENTS FOR LICENSED RESIDENTIAL TREATMENT.**

Subdivision 1. **Applicability.** A license holder who provides supervised room and board at the licensed program site as a treatment component is defined as a residential program according to section 245A.02, subdivision 14, and is subject to this section.

Subd. 2. **Visitors.** A client must be allowed to receive visitors at times prescribed by the license holder. The license holder must set and post a notice of visiting rules and hours, including both day and evening times. A client's right to receive visitors other than a personal

physician, religious adviser, county case manager, parole or probation officer, or attorney may be subject to visiting hours established by the license holder for all clients. The treatment director or designee may impose limitations as necessary for the welfare of a client provided the limitation and the reasons for the limitation are documented in the client's file. A client must be allowed to receive visits at all reasonable times from the client's personal physician, religious adviser, county case manager, parole or probation officer, and attorney.

Subd. 3. **Client property management.** A license holder who provides room and board and treatment services to a client in the same facility, and any license holder that accepts client property must meet the requirements for handling client funds and property in section 245A.04, subdivision 13. License holders:

(1) may establish policies regarding the use of personal property to ensure that treatment activities and the rights of other clients are not infringed upon;

(2) may take temporary custody of a client's property for violation of a facility policy;

(3) must retain the client's property for a minimum of seven days after the client's service termination if the client does not reclaim property upon service termination, or for a minimum of 30 days if the client does not reclaim property upon service termination and has received room and board services from the license holder; and

(4) must return all property held in trust to the client at service termination regardless of the client's service termination status, except that:

(i) a drug, drug paraphernalia, or drug container that is subject to forfeiture under section 609.5316, must be given to the custody of a local law enforcement agency. If giving the property to the custody of a local law enforcement agency violates Code of Federal Regulations, title 42, sections 2.1 to 2.67, or title 45, parts 160 to 164, a drug, drug paraphernalia, or drug container must be destroyed by a staff member designated by the program director; and

(ii) a weapon, explosive, and other property that can cause serious harm to the client or others must be given to the custody of a local law enforcement agency, and the client must be notified of the transfer and of the client's right to reclaim any lawful property transferred; and

(iii) a medication that was determined by a physician to be harmful after examining the client must be destroyed, except when the client's personal physician approves the medication for continued use.

Subd. 4. **Health facility license.** A license holder who provides room and board and treatment services in the same facility must have the appropriate license from the Department of Health.

Subd. 5. **Facility abuse prevention plan.** A license holder must establish and enforce an ongoing facility abuse prevention plan consistent with sections 245A.65 and 626.557, subdivision 14.

Subd. 6. **Individual abuse prevention plan.** A license holder must prepare an individual abuse prevention plan for each client as specified under sections 245A.65, subdivision 2, and 626.557, subdivision 14.

Subd. 7. **Health services.** A license holder must have written procedures for assessing and monitoring a client's health, including a standardized data collection tool for collecting health-related information about each client. The policies and procedures must be approved and signed by a registered nurse.

Subd. 8. **Administration of medication.** A license holder must meet the administration of medications requirements of section 245G.08, subdivision 5, if services include medication administration.

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

Sec. 29. **[245G.22] OPIOID TREATMENT PROGRAMS.**

Subdivision 1. **Additional requirements.** (a) An opioid treatment program licensed under this chapter must also comply with the requirements of this section and Code of Federal Regulations, title 42, part 8. When federal guidance or interpretations are issued on federal standards or requirements also required under this section, the federal guidance or interpretations shall apply.

(b) Where a standard in this section differs from a standard in an otherwise applicable administrative rule or statute, the standard of this section applies.

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

(b) "Diversion" means the use of a medication for the treatment of opioid addiction being diverted from intended use of the medication.

(c) "Guest dose" means administration of a medication used for the treatment of opioid addiction to a person who is not a client of the program that is administering or dispensing the medication.

(d) "Medical director" means a physician licensed to practice medicine in the jurisdiction that the opioid treatment program is located who assumes responsibility for administering all medical services performed by the program, either by performing the services directly or by delegating specific responsibility to authorized program physicians and health care professionals functioning under the medical director's direct supervision.

(e) "Medication used for the treatment of opioid use disorder" means a medication approved by the Food and Drug Administration for the treatment of opioid use disorder.

(f) "Minnesota health care programs" has the meaning given in section 256B.0636.

(g) "Opioid treatment program" has the meaning given in Code of Federal Regulations, title 42, section 8.12, and includes programs licensed under this chapter.

(h) "Placing authority" has the meaning given in Minnesota Rules, part 9530.6605, subpart 21a.

(i) "Unsupervised use" means the use of a medication for the treatment of opioid use disorder dispensed for use by a client outside of the program setting.

Subd. 3. **Medication orders.** Before the program may administer or dispense a medication used for the treatment of opioid use disorder:

(1) a client-specific order must be received from an appropriately credentialed physician who is enrolled as a Minnesota health care programs provider and meets all applicable provider standards;

(2) the signed order must be documented in the client's record; and

(3) if the physician that issued the order is not able to sign the order when issued, the unsigned order must be entered in the client record at the time it was received, and the physician must review the documentation and sign the order in the client's record within 72 hours of the medication being ordered. The license holder must report to the commissioner any medication error that endangers a client's health, as determined by the medical director.

Subd. 4. **High dose requirements.** A client being administered or dispensed a dose beyond that set forth in subdivision 6, paragraph (a), clause (1), that exceeds 150 milligrams of methadone or 24 milligrams of buprenorphine daily, and for each subsequent increase, must meet face-to-face with a prescribing physician. The meeting must occur before the administration or dispensing of the increased medication dose.

Subd. 5. **Drug testing.** Each client enrolled in the program must receive a minimum of eight random drug abuse tests per 12 months of treatment. Drug abuse tests must be

reasonably disbursed over the 12-month period. A license holder may elect to conduct more drug abuse tests.

Subd. 6. **Criteria for unsupervised use.** (a) To limit the potential for diversion of medication used for the treatment of opioid use disorder to the illicit market, medication dispensed to a client for unsupervised use shall be subject to the following requirements:

(1) any client in an opioid treatment program may receive a single unsupervised use dose for a day that the clinic is closed for business, including Sundays and state and federal holidays; and

(2) other treatment program decisions on dispensing medications used for the treatment of opioid use disorder to a client for unsupervised use shall be determined by the medical director.

(b) In determining whether a client may be permitted unsupervised use of medications, a physician with authority to prescribe must consider the criteria in this paragraph. The criteria in this paragraph must also be considered when determining whether dispensing medication for a client's unsupervised use is appropriate to increase or to extend the amount of time between visits to the program. The criteria are:

(1) absence of recent abuse of drugs including but not limited to opioids, non-narcotics, and alcohol;

(2) regularity of program attendance;

(3) absence of serious behavioral problems at the program;

(4) absence of known recent criminal activity such as drug dealing;

(5) stability of the client's home environment and social relationships;

(6) length of time in comprehensive maintenance treatment;

(7) reasonable assurance that unsupervised use medication will be safely stored within the client's home; and

(8) whether the rehabilitative benefit the client derived from decreasing the frequency of program attendance outweighs the potential risks of diversion or unsupervised use.

(c) The determination, including the basis of the determination must be documented in the client's medical record.

Subd. 7. **Restrictions for unsupervised use of methadone hydrochloride.** (a) If a physician with authority to prescribe determines that a client meets the criteria in subdivision

6 and may be dispensed a medication used for the treatment of opioid addiction, the restrictions in this subdivision must be followed when the medication to be dispensed is methadone hydrochloride.

(b) During the first 90 days of treatment, the unsupervised use medication supply must be limited to a maximum of a single dose each week and the client shall ingest all other doses under direct supervision.

(c) In the second 90 days of treatment, the unsupervised use medication supply must be limited to two doses per week.

(d) In the third 90 days of treatment, the unsupervised use medication supply must not exceed three doses per week.

(e) In the remaining months of the first year, a client may be given a maximum six-day unsupervised use medication supply.

(f) After one year of continuous treatment, a client may be given a maximum two-week unsupervised use medication supply.

(g) After two years of continuous treatment, a client may be given a maximum one-month unsupervised use medication supply, but must make monthly visits to the program.

Subd. 8. **Restriction exceptions.** When a license holder has reason to accelerate the number of unsupervised use doses of methadone hydrochloride, the license holder must comply with the requirements of Code of Federal Regulations, title 42, section 8.12, the criteria for unsupervised use and must use the exception process provided by the federal Center for Substance Abuse Treatment Division of Pharmacologic Therapies. For the purposes of enforcement of this subdivision, the commissioner has the authority to monitor a program for compliance with federal regulations and may issue licensing actions according to sections 245A.05, 245A.06, and 245A.07 based on the commissioner's determination of noncompliance.

Subd. 9. **Guest dose.** To receive a guest dose, the client must be enrolled in an opioid treatment program elsewhere in the state or country and be receiving the medication on a temporary basis because the client is not able to receive the medication at the program in which the client is enrolled. Such arrangements shall not exceed 30 consecutive days in any one program and must not be for the convenience or benefit of either program. A guest dose may also occur when the client's primary clinic is not open and the client is not receiving unsupervised use doses.

Subd. 10. **Capacity management and waiting list system compliance.** An opioid treatment program must notify the department within seven days of the program reaching both 90 and 100 percent of the program's capacity to care for clients. Each week, the program must report its capacity, currently enrolled dosing clients, and any waiting list. A program reporting 90 percent of capacity must also notify the department when the program's census increases or decreases from the 90 percent level.

Subd. 11. **Waiting list.** An opioid treatment program must have a waiting list system. If the person seeking admission cannot be admitted within 14 days of the date of application, each person seeking admission must be placed on the waiting list, unless the person seeking admission is assessed by the program and found ineligible for admission according to this chapter and Code of Federal Regulations, title 42, part 1, subchapter A, section 8.12(e), and title 45, parts 160 to 164. The waiting list must assign a unique client identifier for each person seeking treatment while awaiting admission. A person seeking admission on a waiting list who receives no services under section 245G.07, subdivision 1, must not be considered a client as defined in section 245G.01, subdivision 9.

Subd. 12. **Client referral.** An opioid treatment program must consult the capacity management system to ensure that a person on a waiting list is admitted at the earliest time to a program providing appropriate treatment within a reasonable geographic area. If the client was referred through a public payment system and if the program is not able to serve the client within 14 days of the date of application for admission, the program must contact and inform the referring agency of any available treatment capacity listed in the state capacity management system.

Subd. 13. **Outreach.** An opioid treatment program must carry out activities to encourage an individual in need of treatment to undergo treatment. The program's outreach model must:

(1) select, train, and supervise outreach workers;

(2) contact, communicate, and follow up with individuals with high-risk substance misuse, individuals with high-risk substance misuse associates, and neighborhood residents within the constraints of federal and state confidentiality requirements;

(3) promote awareness among individuals who engage in substance misuse by injection about the relationship between injecting substances and communicable diseases such as HIV; and

(4) recommend steps to prevent HIV transmission.

Subd. 14. **Central registry.** (a) A license holder must comply with requirements to submit information and necessary consents to the state central registry for each client admitted, as specified by the commissioner. The license holder must submit data concerning medication used for the treatment of opioid use disorder. The data must be submitted in a method determined by the commissioner and the original information must be kept in the client's record. The information must be submitted for each client at admission and discharge. The program must document the date the information was submitted. The client's failure to provide the information shall prohibit participation in an opioid treatment program. The information submitted must include the client's:

(1) full name and all aliases;

(2) date of admission;

(3) date of birth;

(4) Social Security number or Alien Registration Number, if any;

(5) current or previous enrollment status in another opioid treatment program;

(6) government-issued photo identification card number; and

(7) driver's license number, if any.

(b) The requirements in paragraph (a) are effective upon the commissioner's implementation of changes to the drug and alcohol abuse normative evaluation system or development of an electronic system by which to submit the data.

Subd. 15. **Nonmedication treatment services; documentation.** (a) The program must offer at least 50 consecutive minutes of individual or group therapy treatment services as defined in section 245G.07, subdivision 1, paragraph (a), clause (1), per week, for the first ten weeks following admission, and at least 50 consecutive minutes per month thereafter. As clinically appropriate, the program may offer these services cumulatively and not consecutively in increments of no less than 15 minutes over the required time period, and for a total of 60 minutes of treatment services over the time period, and must document the reason for providing services cumulatively in the client's record. The program may offer additional levels of service when deemed clinically necessary.

(b) Notwithstanding the requirements of comprehensive assessments in section 245G.05, the assessment must be completed within 21 days of service initiation.

(c) Notwithstanding the requirements of individual treatment plans set forth in section 245G.06:

(1) treatment plan contents for a maintenance client are not required to include goals the client must reach to complete treatment and have services terminated;

(2) treatment plans for a client in a taper or detox status must include goals the client must reach to complete treatment and have services terminated;

(3) for the initial ten weeks after admission for all new admissions, readmissions, and transfers, progress notes must be entered in a client's file at least weekly and be recorded in each of the six dimensions upon the development of the treatment plan and thereafter. Subsequently, the counselor must document progress in the six dimensions at least once monthly or, when clinical need warrants, more frequently; and

(4) upon the development of the treatment plan and thereafter, treatment plan reviews must occur weekly, or after each treatment service, whichever is less frequent, for the first ten weeks after the treatment plan is developed. Following the first ten weeks of treatment plan reviews, reviews may occur monthly, unless the client's needs warrant more frequent revisions or documentation.

Subd. 16. **Prescription monitoring program.** (a) The program must develop and maintain a policy and procedure that requires the ongoing monitoring of the data from the prescription monitoring program (PMP) for each client. The policy and procedure must include how the program meets the requirements in paragraph (b).

(b) If a medication used for the treatment of substance use disorder is administered or dispensed to a client, the license holder shall be subject to the following requirements:

(1) upon admission to a methadone clinic outpatient treatment program, a client must be notified in writing that the commissioner of human services and the medical director must monitor the PMP to review the prescribed controlled drugs a client received;

(2) the medical director or the medical director's delegate must review the data from the PMP described in section 152.126 before the client is ordered any controlled substance, as defined under section 152.126, subdivision 1, paragraph (c), including medications used for the treatment of opioid addiction, and the medical director's or the medical director's delegate's subsequent reviews of the PMP data must occur at least every 90 days;

(3) a copy of the PMP data reviewed must be maintained in the client's file;

(4) when the PMP data contains a recent history of multiple prescribers or multiple prescriptions for controlled substances, the physician's review of the data and subsequent actions must be documented in the client's file within 72 hours and must contain the medical director's determination of whether or not the prescriptions place the client at risk of harm

and the actions to be taken in response to the PMP findings. The provider must conduct subsequent reviews of the PMP on a monthly basis; and

(5) if at any time the medical director believes the use of the controlled substances places the client at risk of harm, the program must seek the client's consent to discuss the client's opioid treatment with other prescribers and must seek the client's consent for the other prescriber to disclose to the opioid treatment program's medical director the client's condition that formed the basis of the other prescriptions. If the information is not obtained within seven days, the medical director must document whether or not changes to the client's medication dose or number of unsupervised use doses are necessary until the information is obtained.

(c) The commissioner shall collaborate with the Minnesota Board of Pharmacy to develop and implement an electronic system for the commissioner to routinely access the PMP data to determine whether any client enrolled in an opioid addiction treatment program licensed according to this section was prescribed or dispensed a controlled substance in addition to that administered or dispensed by the opioid addiction treatment program. When the commissioner determines there have been multiple prescribers or multiple prescriptions of controlled substances for a client, the commissioner shall:

(1) inform the medical director of the opioid treatment program only that the commissioner determined the existence of multiple prescribers or multiple prescriptions of controlled substances; and

(2) direct the medical director of the opioid treatment program to access the data directly, review the effect of the multiple prescribers or multiple prescriptions, and document the review.

(d) If determined necessary, the commissioner shall seek a federal waiver of, or exception to, any applicable provision of Code of Federal Regulations, title 42, section 2.34(c), before implementing this subdivision.

Subd. 17. **Policies and procedures.** (a) A license holder must develop and maintain the policies and procedures required in this subdivision.

(b) For a program that is not open every day of the year, the license holder must maintain a policy and procedure that permits a client to receive a single unsupervised use of medication used for the treatment of opioid use disorder for days that the program is closed for business, including, but not limited to, Sundays and state and federal holidays as required under subdivision 6, paragraph (a), clause (1).

(c) The license holder must maintain a policy and procedure that includes specific measures to reduce the possibility of diversion. The policy and procedure must:

(1) specifically identify and define the responsibilities of the medical and administrative staff for performing diversion control measures; and

(2) include a process for contacting no less than five percent of clients who have unsupervised use of medication, excluding clients approved solely under subdivision 6, paragraph (a), clause (1), to require clients to physically return to the program each month. The system must require clients to return to the program within a stipulated time frame and turn in all unused medication containers related to opioid use disorder treatment. The license holder must document all related contacts on a central log and the outcome of the contact for each client in the client's record.

(d) Medication used for the treatment of opioid use disorder must be ordered, administered, and dispensed according to applicable state and federal regulations and the standards set by applicable accreditation entities. If a medication order requires assessment by the person administering or dispensing the medication to determine the amount to be administered or dispensed, the assessment must be completed by an individual whose professional scope of practice permits an assessment. For the purposes of enforcement of this paragraph, the commissioner has the authority to monitor the person administering or dispensing the medication for compliance with state and federal regulations and the relevant standards of the license holder's accreditation agency and may issue licensing actions according to sections 245A.05, 245A.06, and 245A.07, based on the commissioner's determination of noncompliance.

Subd. 18. **Quality improvement plan.** The license holder must develop and maintain a quality improvement plan that:

(1) includes evaluation of the services provided to clients to identify issues that may improve service delivery and client outcomes;

(2) includes goals for the program to accomplish based on the evaluation;

(3) is reviewed annually by the management of the program to determine whether the goals were met and, if not, whether additional action is required;

(4) is updated at least annually to include new or continued goals based on an updated evaluation of services; and

(5) identifies two specific goal areas, in addition to others identified by the program, including:

(i) a goal concerning oversight and monitoring of the premises around and near the exterior of the program to reduce the possibility of medication used for the treatment of opioid use disorder being inappropriately used by a client, including but not limited to the sale or transfer of the medication to others; and

(ii) a goal concerning community outreach, including but not limited to communications with local law enforcement and county human services agencies, to increase coordination of services and identification of areas of concern to be addressed in the plan.

Subd. 19. **Placing authorities.** A program must provide certain notification and client-specific updates to placing authorities for a client who is enrolled in Minnesota health care programs. At the request of the placing authority, the program must provide client-specific updates, including but not limited to informing the placing authority of positive drug screenings and changes in medications used for the treatment of opioid use disorder ordered for the client.

Subd. 20. **Duty to report suspected drug diversion.** (a) To the fullest extent permitted under Code of Federal Regulations, title 42, sections 2.1 to 2.67, a program shall report to law enforcement any credible evidence that the program or its personnel knows, or reasonably should know, that is directly related to a diversion crime on the premises of the program, or a threat to commit a diversion crime.

(b) "Diversion crime," for the purposes of this section, means diverting, attempting to divert, or conspiring to divert Schedule I, II, III, or IV drugs, as defined in section 152.02, on the program's premises.

(c) The program must document the program's compliance with the requirement in paragraph (a) in either a client's record or an incident report. A program's failure to comply with paragraph (a) may result in sanctions as provided in sections 245A.06 and 245A.07.

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

Sec. 30. Minnesota Statutes 2016, section 254A.01, is amended to read:

254A.01 PUBLIC POLICY.

It is hereby declared to be the public policy of this state that scientific evidence shows that addiction to alcohol or other drugs is a chronic brain disorder with potential for recurrence, and as with many other chronic conditions, people with substance use disorders can be effectively treated and can enter recovery. The interests of society are best served by reducing the stigma of substance use disorder and providing persons who are dependent upon alcohol or other drugs with a comprehensive range of rehabilitative and social services

that span intensity levels and are not restricted to a particular point in time. Further, it is declared that treatment under these services shall be voluntary when possible: treatment shall not be denied on the basis of prior treatment; treatment shall be based on an individual treatment plan for each person undergoing treatment; treatment shall include a continuum of services available for a person leaving a program of treatment; treatment shall include all family members at the earliest possible phase of the treatment process.

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

Sec. 31. Minnesota Statutes 2016, section 254A.02, subdivision 2, is amended to read:

Subd. 2. **Approved treatment program.** "Approved treatment program" means care and treatment services provided by any individual, organization or association to ~~drug dependent~~ persons with a substance use disorder, which meets the standards established by the commissioner of human services.

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

Sec. 32. Minnesota Statutes 2016, section 254A.02, subdivision 3, is amended to read:

Subd. 3. **Comprehensive program.** "Comprehensive program" means the range of services which are to be made available for the purpose of prevention, care and treatment of ~~alcohol and drug abuse~~ substance misuse and substance use disorder.

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

Sec. 33. Minnesota Statutes 2016, section 254A.02, subdivision 5, is amended to read:

Subd. 5. **Drug dependent person.** "Drug dependent person" means any ~~inebriate person or any~~ person incapable of self-management or management of personal affairs or unable to function physically or mentally in an effective manner because of the abuse of a drug, including alcohol.

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

Sec. 34. Minnesota Statutes 2016, section 254A.02, subdivision 6, is amended to read:

Subd. 6. **Facility.** "Facility" means any treatment facility administered under an approved treatment program ~~established under Laws 1973, chapter 572~~.

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

Sec. 35. Minnesota Statutes 2016, section 254A.02, is amended by adding a subdivision to read:

Subd. 6a. **Substance misuse.** "Substance misuse" means the use of any psychoactive or mood-altering substance, without compelling medical reason, in a manner that results in mental, emotional, or physical impairment and causes socially dysfunctional or socially disordering behavior and that results in psychological dependence or physiological addiction as a function of continued use. Substance misuse has the same meaning as drug abuse or abuse of drugs.

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

Sec. 36. Minnesota Statutes 2016, section 254A.02, subdivision 8, is amended to read:

Subd. 8. **Other drugs.** "Other drugs" means any psychoactive ~~chemical~~ substance other than alcohol.

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

Sec. 37. Minnesota Statutes 2016, section 254A.02, subdivision 10, is amended to read:

Subd. 10. **State authority.** "State authority" is a division established within the Department of Human Services for the purpose of relating the authority of state government in the area of ~~alcohol and drug abuse~~ substance misuse and substance use disorder to the ~~alcohol and drug abuse~~ substance misuse and substance use disorder-related activities within the state.

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

Sec. 38. Minnesota Statutes 2016, section 254A.02, is amended by adding a subdivision to read:

Subd. 10a. **Substance use disorder.** "Substance use disorder" has the meaning given in the current Diagnostic and Statistical Manual of Mental Disorders.

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

Sec. 39. Minnesota Statutes 2016, section 254A.03, is amended to read:

254A.03 STATE AUTHORITY ON ALCOHOL AND DRUG ABUSE.

Subdivision 1. **Alcohol and Other Drug Abuse Section.** There is hereby created an Alcohol and Other Drug Abuse Section in the Department of Human Services. This section

shall be headed by a director. The commissioner may place the director's position in the unclassified service if the position meets the criteria established in section 43A.08, subdivision 1a. The section shall:

(1) conduct and foster basic research relating to the cause, prevention and methods of diagnosis, treatment and rehabilitation of ~~alcoholic and other drug dependent~~ persons with substance misuse and substance use disorder;

(2) coordinate and review all activities and programs of all the various state departments as they relate to ~~alcohol and other drug dependency and abuse~~ problems associated with substance misuse and substance use disorder;

(3) develop, demonstrate, and disseminate new methods and techniques for ~~the~~ prevention, early intervention, treatment and ~~rehabilitation of alcohol and other drug abuse and dependency problems~~ recovery support for substance misuse and substance use disorder;

(4) gather facts and information about ~~alcoholism and other drug dependency and abuse~~ substance misuse and substance use disorder, and about the efficiency and effectiveness of prevention, treatment, and ~~rehabilitation~~ recovery support services from all comprehensive programs, including programs approved or licensed by the commissioner of human services or the commissioner of health or accredited by the Joint Commission on Accreditation of Hospitals. The state authority is authorized to require information from comprehensive programs which is reasonable and necessary to fulfill these duties. When required information has been previously furnished to a state or local governmental agency, the state authority shall collect the information from the governmental agency. The state authority shall disseminate facts and summary information about ~~alcohol and other drug abuse dependency~~ problems associated with substance misuse and substance use disorder to public and private agencies, local governments, local and regional planning agencies, and the courts for guidance to and assistance in prevention, treatment and ~~rehabilitation~~ recovery support;

(5) inform and educate the general public on ~~alcohol and other drug dependency and abuse problems~~ substance misuse and substance use disorder;

(6) serve as the state authority concerning ~~alcohol and other drug dependency and abuse~~ substance misuse and substance use disorder by monitoring the conduct of diagnosis and referral services, research and comprehensive programs. The state authority shall submit a biennial report to the governor and the legislature containing a description of public services delivery and recommendations concerning increase of coordination and quality of services, and decrease of service duplication and cost;

(7) establish a state plan which shall set forth goals and priorities for a comprehensive ~~alcohol and other drug dependency and abuse program~~ continuum of care for substance misuse and substance use disorder for Minnesota. All state agencies operating ~~alcohol and other drug abuse or dependency~~ substance misuse or substance use disorder programs or administering state or federal funds for such programs shall annually set their program goals and priorities in accordance with the state plan. Each state agency shall annually submit its plans and budgets to the state authority for review. The state authority shall certify whether proposed services comply with the comprehensive state plan and advise each state agency of review findings;

(8) make contracts with and grants to public and private agencies and organizations, both profit and nonprofit, and individuals, using federal funds, and state funds as authorized to pay for costs of state administration, including evaluation, statewide programs and services, research and demonstration projects, and American Indian programs;

(9) receive and administer ~~monies~~ money available for ~~alcohol and drug abuse~~ substance misuse and substance use disorder programs under the alcohol, drug abuse, and mental health services block grant, United States Code, title 42, sections 300X to 300X-9;

(10) solicit and accept any gift of money or property for purposes of Laws 1973, chapter 572, and any grant of money, services, or property from the federal government, the state, any political subdivision thereof, or any private source;

(11) with respect to ~~alcohol and other drug abuse~~ substance misuse and substance use disorder programs serving the American Indian community, establish guidelines for the employment of personnel with considerable practical experience in ~~alcohol and other drug abuse problems~~ substance misuse and substance use disorder, and understanding of social and cultural problems related to ~~alcohol and other drug abuse~~ substance misuse and substance use disorder, in the American Indian community.

Subd. 2. **American Indian programs.** There is hereby created a section of American Indian programs, within the Alcohol and Drug Abuse Section of the Department of Human Services, to be headed by a special assistant for American Indian programs on ~~alcoholism and drug abuse~~ substance misuse and substance use disorder and two assistants to that position. The section shall be staffed with all personnel necessary to fully administer programming for ~~alcohol and drug abuse~~ substance misuse and substance use disorder services for American Indians in the state. The special assistant position shall be filled by a person with considerable practical experience in and understanding of ~~alcohol and other drug abuse problems~~ substance misuse and substance use disorder in the American Indian

community, who shall be responsible to the director of the Alcohol and Drug Abuse Section created in subdivision 1 and shall be in the unclassified service. The special assistant shall meet and consult with the American Indian Advisory Council as described in section 254A.035 and serve as a liaison to the Minnesota Indian Affairs Council and tribes to report on the status of ~~alcohol and other drug abuse~~ substance misuse and substance use disorder among American Indians in the state of Minnesota. The special assistant with the approval of the director shall:

(1) administer funds appropriated for American Indian groups, organizations and reservations within the state for American Indian ~~alcoholism and drug abuse~~ substance misuse and substance use disorder programs;

(2) establish policies and procedures for such American Indian programs with the assistance of the American Indian Advisory Board; and

(3) hire and supervise staff to assist in the administration of the American Indian program section within the Alcohol and Drug Abuse Section of the Department of Human Services.

Subd. 3. **Rules for ~~chemical dependency~~ substance use disorder care.** (a) The commissioner of human services shall establish by rule criteria to be used in determining the appropriate level of chemical dependency care for each recipient of public assistance seeking treatment for ~~alcohol or other drug dependency and abuse problems.~~ substance misuse or substance use disorder. Upon federal approval of a comprehensive assessment as a Medicaid benefit, or on July 1, 2018, whichever is later, and notwithstanding the criteria in Minnesota Rules, parts 9530.6600 to 9530.6655, an eligible vendor of comprehensive assessments under section 254B.05 may determine and approve the appropriate level of substance use disorder treatment for a recipient of public assistance. The process for determining an individual's financial eligibility for the consolidated chemical dependency treatment fund or determining an individual's enrollment in or eligibility for a publicly subsidized health plan is not affected by the individual's choice to access a comprehensive assessment for placement.

(b) The commissioner shall develop and implement a utilization review process for publicly funded treatment placements to monitor and review the clinical appropriateness and timeliness of all publicly funded placements in treatment.

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

Sec. 40. Minnesota Statutes 2016, section 254A.035, subdivision 1, is amended to read:

Subdivision 1. **Establishment.** There is created an American Indian Advisory Council to assist the state authority on ~~alcohol and drug abuse~~ substance misuse and substance use disorder in proposal review and formulating policies and procedures relating to ~~chemical dependency and the abuse of alcohol and other drugs~~ substance misuse and substance use disorder by American Indians.

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

Sec. 41. Minnesota Statutes 2016, section 254A.04, is amended to read:

254A.04 CITIZENS ADVISORY COUNCIL.

There is hereby created an Alcohol and Other Drug Abuse Advisory Council to advise the Department of Human Services concerning the problems of ~~alcohol and other drug dependency and abuse~~ substance misuse and substance use disorder, composed of ten members. Five members shall be individuals whose interests or training are in the field of ~~alcohol dependency~~ alcohol-specific substance use disorder and ~~abuse~~ alcohol misuse; and five members whose interests or training are in the field of ~~dependency~~ substance use disorder and ~~abuse of drugs~~ misuse of substances other than alcohol. The terms, compensation and removal of members shall be as provided in section 15.059. The council expires June 30, 2018. The commissioner of human services shall appoint members whose terms end in even-numbered years. The commissioner of health shall appoint members whose terms end in odd-numbered years.

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

Sec. 42. Minnesota Statutes 2016, section 254A.08, is amended to read:

254A.08 DETOXIFICATION CENTERS.

Subdivision 1. **Detoxification services.** Every county board shall provide detoxification services for ~~drug dependent persons~~ any person incapable of self-management or management of personal affairs or unable to function physically or mentally in an effective manner because of the use of a drug, including alcohol. The board may utilize existing treatment programs and other agencies to meet this responsibility.

Subd. 2. **Program requirements.** For the purpose of this section, a detoxification program means a social rehabilitation program licensed by the Department of Human Services under Minnesota Rules, parts 9530.6510 to 9530.6590, and established for the purpose of facilitating access into care and treatment by detoxifying and evaluating the

person and providing entrance into a comprehensive program. Evaluation of the person shall include verification by a professional, after preliminary examination, that the person is intoxicated or has symptoms of ~~chemical dependency~~ substance misuse or substance use disorder and appears to be in imminent danger of harming self or others. A detoxification program shall have available the services of a licensed physician for medical emergencies and routine medical surveillance. A detoxification program licensed by the Department of Human Services to serve both adults and minors at the same site must provide for separate sleeping areas for adults and minors.

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

Sec. 43. Minnesota Statutes 2016, section 254A.09, is amended to read:

254A.09 CONFIDENTIALITY OF RECORDS.

The Department of Human Services shall assure confidentiality to individuals who are the subject of research by the state authority or are recipients of ~~alcohol or drug abuse~~ substance misuse or substance use disorder information, assessment, or treatment from a licensed or approved program. The commissioner shall withhold from all persons not connected with the conduct of the research the names or other identifying characteristics of a subject of research unless the individual gives written permission that information relative to treatment and recovery may be released. Persons authorized to protect the privacy of subjects of research may not be compelled in any federal, state or local, civil, criminal, administrative or other proceeding to identify or disclose other confidential information about the individuals. Identifying information and other confidential information related to ~~alcohol or drug abuse~~ substance misuse or substance use disorder information, assessment, treatment, or aftercare services may be ordered to be released by the court for the purpose of civil or criminal investigations or proceedings if, after review of the records considered for disclosure, the court determines that the information is relevant to the purpose for which disclosure is requested. The court shall order disclosure of only that information which is determined relevant. In determining whether to compel disclosure, the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the treatment relationship in the program affected and in other programs similarly situated, and the actual or potential harm to the ability of programs to attract and retain patients if disclosure occurs. This section does not exempt any person from the reporting obligations under section 626.556, nor limit the use of information reported in any proceeding arising out of the abuse or neglect of a child. Identifying information and other confidential information related to ~~alcohol or drug abuse information~~ substance misuse or substance use disorder, assessment,

treatment, or aftercare services may be ordered to be released by the court for the purpose of civil or criminal investigations or proceedings. No information may be released pursuant to this section that would not be released pursuant to section 595.02, subdivision 2.

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

Sec. 44. Minnesota Statutes 2016, section 254A.19, subdivision 3, is amended to read:

Subd. 3. **Financial conflicts of interest.** (a) Except as provided in paragraph (b) or (c), an assessor conducting a chemical use assessment under Minnesota Rules, parts 9530.6600 to 9530.6655, may not have any direct or shared financial interest or referral relationship resulting in shared financial gain with a treatment provider.

(b) A county may contract with an assessor having a conflict described in paragraph (a) if the county documents that:

(1) the assessor is employed by a culturally specific service provider or a service provider with a program designed to treat individuals of a specific age, sex, or sexual preference;

(2) the county does not employ a sufficient number of qualified assessors and the only qualified assessors available in the county have a direct or shared financial interest or a referral relationship resulting in shared financial gain with a treatment provider; or

(3) the county social service agency has an existing relationship with an assessor or service provider and elects to enter into a contract with that assessor to provide both assessment and treatment under circumstances specified in the county's contract, provided the county retains responsibility for making placement decisions.

(c) The county may contract with a hospital to conduct chemical assessments if the requirements in subdivision 1a are met.

An assessor under this paragraph may not place clients in treatment. The assessor shall gather required information and provide it to the county along with any required documentation. The county shall make all placement decisions for clients assessed by assessors under this paragraph.

(d) An eligible vendor under section 254B.05 conducting a comprehensive assessment for an individual seeking treatment shall approve the nature, intensity level, and duration of treatment service if a need for services is indicated, but the individual assessed can access any enrolled provider that is licensed to provide the level of service authorized, including the provider or program that completed the assessment. If an individual is enrolled in a

prepaid health plan, the individual must comply with any provider network requirements or limitations.

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

Sec. 45. Minnesota Statutes 2016, section 254B.01, subdivision 3, is amended to read:

Subd. 3. **~~Chemical dependency~~ Substance use disorder treatment services.** "~~Chemical dependency~~ Substance use disorder treatment services" means a planned program of care for the treatment of ~~chemical dependency~~ substance misuse or ~~chemical abuse~~ substance use disorder to minimize or prevent further ~~chemical abuse~~ substance misuse by the person. Diagnostic, evaluation, prevention, referral, detoxification, and aftercare services that are not part of a program of care licensable as a residential or nonresidential ~~chemical dependency~~ substance use disorder treatment program are not ~~chemical dependency~~ substance use disorder services for purposes of this section. For pregnant and postpartum women, ~~chemical dependency~~ substance use disorder services include halfway house services, aftercare services, psychological services, and case management.

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

Sec. 46. Minnesota Statutes 2016, section 254B.01, is amended by adding a subdivision to read:

Subd. 8. **Recovery community organization.** "Recovery community organization" means an independent organization led and governed by representatives of local communities of recovery. A recovery community organization mobilizes resources within and outside of the recovery community to increase the prevalence and quality of long-term recovery from alcohol and other drug addiction. Recovery community organizations provide peer-based recovery support activities such as training of recovery peers. Recovery community organizations provide mentorship and ongoing support to individuals dealing with a substance use disorder and connect them with the resources that can support each person's recovery. A recovery community organization also promotes a recovery-focused orientation in community education and outreach programming, and organize recovery-focused policy advocacy activities to foster healthy communities and reduce the stigma of substance use disorder.

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

Sec. 47. Minnesota Statutes 2016, section 254B.03, subdivision 2, is amended to read:

Subd. 2. **Chemical dependency fund payment.** (a) Payment from the chemical dependency fund is limited to payments for services other than detoxification licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, that, if located outside of federally recognized tribal lands, would be required to be licensed by the commissioner as a chemical dependency treatment or rehabilitation program under sections 245A.01 to 245A.16, and services other than detoxification provided in another state that would be required to be licensed as a chemical dependency program if the program were in the state. Out of state vendors must also provide the commissioner with assurances that the program complies substantially with state licensing requirements and possesses all licenses and certifications required by the host state to provide chemical dependency treatment. ~~Except for chemical dependency transitional rehabilitation programs,~~ Vendors receiving payments from the chemical dependency fund must not require co-payment from a recipient of benefits for services provided under this subdivision. The vendor is prohibited from using the client's public benefits to offset the cost of services paid under this section. The vendor shall not require the client to use public benefits for room or board costs. This includes but is not limited to cash assistance benefits under chapters 119B, 256D, and 256J, or SNAP benefits. Retention of SNAP benefits is a right of a client receiving services through the consolidated chemical dependency treatment fund or through state contracted managed care entities. Payment from the chemical dependency fund shall be made for necessary room and board costs provided by vendors certified according to section 254B.05, or in a community hospital licensed by the commissioner of health according to sections 144.50 to 144.56 to a client who is:

(1) determined to meet the criteria for placement in a residential chemical dependency treatment program according to rules adopted under section 254A.03, subdivision 3; and

(2) concurrently receiving a chemical dependency treatment service in a program licensed by the commissioner and reimbursed by the chemical dependency fund.

(b) A county may, from its own resources, provide chemical dependency services for which state payments are not made. A county may elect to use the same invoice procedures and obtain the same state payment services as are used for chemical dependency services for which state payments are made under this section if county payments are made to the state in advance of state payments to vendors. When a county uses the state system for payment, the commissioner shall make monthly billings to the county using the most recent available information to determine the anticipated services for which payments will be made in the coming month. Adjustment of any overestimate or underestimate based on actual

expenditures shall be made by the state agency by adjusting the estimate for any succeeding month.

(c) The commissioner shall coordinate chemical dependency services and determine whether there is a need for any proposed expansion of chemical dependency treatment services. The commissioner shall deny vendor certification to any provider that has not received prior approval from the commissioner for the creation of new programs or the expansion of existing program capacity. The commissioner shall consider the provider's capacity to obtain clients from outside the state based on plans, agreements, and previous utilization history, when determining the need for new treatment services.

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

Sec. 48. Minnesota Statutes 2016, section 254B.04, subdivision 1, is amended to read:

Subdivision 1. **Eligibility.** ~~(a)~~ Persons eligible for benefits under Code of Federal Regulations, title 25, part 20, and persons eligible for medical assistance benefits under sections 256B.055, 256B.056, and 256B.057, subdivisions 1, 5, and 6, or who meet the income standards of section 256B.056, subdivision 4, are entitled to chemical dependency fund services. State money appropriated for this paragraph must be placed in a separate account established for this purpose.

Persons with dependent children who are determined to be in need of chemical dependency treatment pursuant to an assessment under section 626.556, subdivision 10, or a case plan under section 260C.201, subdivision 6, or 260C.212, shall be assisted by the local agency to access needed treatment services. Treatment services must be appropriate for the individual or family, which may include long-term care treatment or treatment in a facility that allows the dependent children to stay in the treatment facility. The county shall pay for out-of-home placement costs, if applicable.

~~(b) A person not entitled to services under paragraph (a), but with family income that is less than 215 percent of the federal poverty guidelines for the applicable family size, shall be eligible to receive chemical dependency fund services within the limit of funds appropriated for this group for the fiscal year. If notified by the state agency of limited funds, a county must give preferential treatment to persons with dependent children who are in need of chemical dependency treatment pursuant to an assessment under section 626.556, subdivision 10, or a case plan under section 260C.201, subdivision 6, or 260C.212. A county may spend money from its own sources to serve persons under this paragraph. State money appropriated for this paragraph must be placed in a separate account established for this purpose.~~

~~(c) Persons whose income is between 215 percent and 412 percent of the federal poverty guidelines for the applicable family size shall be eligible for chemical dependency services on a sliding fee basis, within the limit of funds appropriated for this group for the fiscal year. Persons eligible under this paragraph must contribute to the cost of services according to the sliding fee scale established under subdivision 3. A county may spend money from its own sources to provide services to persons under this paragraph. State money appropriated for this paragraph must be placed in a separate account established for this purpose.~~

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

Sec. 49. Minnesota Statutes 2016, section 254B.04, subdivision 2b, is amended to read:

Subd. 2b. **Eligibility for placement in opioid treatment programs.** ~~(a) Notwithstanding provisions of Minnesota Rules, part 9530.6622, subpart 5, related to a placement authority's requirement to authorize services or service coordination in a program that complies with Minnesota Rules, part 9530.6500, or Code of Federal Regulations, title 42, part 8, and after taking into account an individual's preference for placement in an opioid treatment program, a placement authority may, but is not required to, authorize services or service coordination or otherwise place an individual in an opioid treatment program. Prior to making a determination of placement for an individual, the placing authority must consult with the current treatment provider, if any.~~

~~(b)~~ Prior to placement of an individual who is determined by the assessor to require treatment for opioid addiction, the assessor must provide educational information concerning treatment options for opioid addiction, including the use of a medication for the use of opioid addiction. The commissioner shall develop educational materials supported by research and updated periodically that must be used by assessors to comply with this requirement.

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

Sec. 50. Minnesota Statutes 2016, section 254B.05, subdivision 1, is amended to read:

Subdivision 1. **Licensure required.** (a) Programs licensed by the commissioner are eligible vendors. Hospitals may apply for and receive licenses to be eligible vendors, notwithstanding the provisions of section 245A.03. American Indian programs that provide ~~chemical dependency primary~~ substance use disorder treatment, extended care, transitional residence, or outpatient treatment services, and are licensed by tribal government are eligible vendors.

(b) On July 1, 2018, or upon federal approval, whichever is later, a licensed professional in private practice who meets the requirements of section 245G.11, subdivisions 1 and 4, is an eligible vendor of a comprehensive assessment and assessment summary provided according to section 245G.05, and treatment services provided according to sections 245G.06 and 245G.07, subdivision 1, paragraphs (a), clauses (1) to (5), and (b); and subdivision 2.

(c) On July 1, 2018, or upon federal approval, whichever is later, a county is an eligible vendor for a comprehensive assessment and assessment summary when provided by an individual who meets the staffing credentials of section 245G.11, subdivisions 1 and 4, and completed according to the requirements of section 245G.05. A county is an eligible vendor of care coordination services when provided by an individual who meets the staffing credentials of section 245G.11, subdivisions 1 and 7, and provided according to the requirements of section 245G.07, subdivision 1, clause (7).

(d) On July 1, 2018, or upon federal approval, whichever is later, a recovery community organization that meets certification requirements identified by the commissioner is an eligible vendor of peer support services.

(e) Detoxification programs licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, are not eligible vendors. Programs that are not licensed as a ~~chemical dependency~~ residential or nonresidential substance use disorder treatment or withdrawal management program by the commissioner or by tribal government or do not meet the requirements of subdivisions 1a and 1b are not eligible vendors.

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

Sec. 51. Minnesota Statutes 2016, section 254B.05, subdivision 1a, is amended to read:

Subd. 1a. **Room and board provider requirements.** (a) Effective January 1, 2000, vendors of room and board are eligible for chemical dependency fund payment if the vendor:

(1) has rules prohibiting residents bringing chemicals into the facility or using chemicals while residing in the facility and provide consequences for infractions of those rules;

(2) is determined to meet applicable health and safety requirements;

(3) is not a jail or prison;

(4) is not concurrently receiving funds under chapter 256I for the recipient;

(5) admits individuals who are 18 years of age or older;

(6) is registered as a board and lodging or lodging establishment according to section 157.17;

(7) has awake staff on site 24 hours per day;

(8) has staff who are at least 18 years of age and meet the requirements of ~~Minnesota Rules, part 9530.6450, subpart 1, item A~~ section 245G.11, subdivision 1, paragraph (a);

(9) has emergency behavioral procedures that meet the requirements of ~~Minnesota Rules, part 9530.6475~~ section 245G.16;

(10) meets the requirements of ~~Minnesota Rules, part 9530.6435, subparts 3 and 4, items A and B~~ section 245G.08, subdivision 5, if administering medications to clients;

(11) meets the abuse prevention requirements of section 245A.65, including a policy on fraternization and the mandatory reporting requirements of section 626.557;

(12) documents coordination with the treatment provider to ensure compliance with section 254B.03, subdivision 2;

(13) protects client funds and ensures freedom from exploitation by meeting the provisions of section 245A.04, subdivision 13;

(14) has a grievance procedure that meets the requirements of ~~Minnesota Rules, part 9530.6470, subpart 2~~ section 245G.15, subdivision 2; and

(15) has sleeping and bathroom facilities for men and women separated by a door that is locked, has an alarm, or is supervised by awake staff.

(b) Programs licensed according to Minnesota Rules, chapter 2960, are exempt from paragraph (a), clauses (5) to (15).

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

Sec. 52. Minnesota Statutes 2016, section 254B.05, subdivision 5, is amended to read:

Subd. 5. **Rate requirements.** (a) The commissioner shall establish rates for ~~chemical dependency~~ substance use disorder services and service enhancements funded under this chapter.

(b) Eligible ~~chemical dependency~~ substance use disorder treatment services include:

(1) outpatient treatment services that are licensed according to ~~Minnesota Rules, parts 9530.6405 to 9530.6480~~ sections 245G.01 to 245G.17, or applicable tribal license;

(2) on July 1, 2018, or upon federal approval, whichever is later, comprehensive assessments provided according to sections 245.4863, paragraph (a), and 245G.05, and Minnesota Rules, part 9530.6422;

(3) on July 1, 2018, or upon federal approval, whichever is later, care coordination services provided according to section 245G.07, subdivision 1, paragraph (a), clause (6);

(4) on July 1, 2018, or upon federal approval, whichever is later, peer recovery support services provided according to section 245G.07, subdivision 1, paragraph (a), clause (5);

(5) on July 1, 2018, or upon federal approval, whichever is later, withdrawal management services provided according to chapter 245F;

~~(2)~~ (6) medication-assisted therapy services that are licensed according to ~~Minnesota Rules, parts 9530.6405 to 9530.6480 and 9530.6500~~ section 245G.07, subdivision 1, or applicable tribal license;

~~(3)~~ (7) medication-assisted therapy plus enhanced treatment services that meet the requirements of clause ~~(2)~~ (6) and provide nine hours of clinical services each week;

~~(4)~~ (8) high, medium, and low intensity residential treatment services that are licensed according to ~~Minnesota Rules, parts 9530.6405 to 9530.6480 and 9530.6505,~~ sections 245G.01 to 245G.17 and 245G.22 or applicable tribal license which provide, respectively, 30, 15, and five hours of clinical services each week;

~~(5)~~ (9) hospital-based treatment services that are licensed according to ~~Minnesota Rules, parts 9530.6405 to 9530.6480,~~ sections 245G.01 to 245G.17 or applicable tribal license and licensed as a hospital under sections 144.50 to 144.56;

~~(6)~~ (10) adolescent treatment programs that are licensed as outpatient treatment programs according to ~~Minnesota Rules, parts 9530.6405 to 9530.6485,~~ sections 245G.01 to 245G.18 or as residential treatment programs according to Minnesota Rules, parts 2960.0010 to 2960.0220, and 2960.0430 to 2960.0490, or applicable tribal license;

~~(7)~~ (11) high-intensity residential treatment services that are licensed according to ~~Minnesota Rules, parts 9530.6405 to 9530.6480 and 9530.6505,~~ sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license, which provide 30 hours of clinical services each week provided by a state-operated vendor or to clients who have been civilly committed to the commissioner, present the most complex and difficult care needs, and are a potential threat to the community; and

~~(8)~~ (12) room and board facilities that meet the requirements of subdivision 1a.

(c) The commissioner shall establish higher rates for programs that meet the requirements of paragraph (b) and one of the following additional requirements:

(1) programs that serve parents with their children if the program:

(i) provides on-site child care during the hours of treatment activity that:

(A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter 9503; or

(B) meets the licensure exclusion criteria of section 245A.03, subdivision 2, paragraph (a), clause (6), and meets the requirements under ~~Minnesota Rules, part 9530.6490, subpart 4~~ section 245G.19, subdivision 4; or

(ii) arranges for off-site child care during hours of treatment activity at a facility that is licensed under chapter 245A as:

(A) a child care center under Minnesota Rules, chapter 9503; or

(B) a family child care home under Minnesota Rules, chapter 9502;

(2) culturally specific programs as defined in section 254B.01, subdivision 4a, or programs or subprograms serving special populations, if the program or subprogram meets the following requirements:

(i) is designed to address the unique needs of individuals who share a common language, racial, ethnic, or social background;

(ii) is governed with significant input from individuals of that specific background; and

(iii) employs individuals to provide individual or group therapy, at least 50 percent of whom are of that specific background, except when the common social background of the individuals served is a traumatic brain injury or cognitive disability and the program employs treatment staff who have the necessary professional training, as approved by the commissioner, to serve clients with the specific disabilities that the program is designed to serve;

(3) programs that offer medical services delivered by appropriately credentialed health care staff in an amount equal to two hours per client per week if the medical needs of the client and the nature and provision of any medical services provided are documented in the client file; and

(4) programs that offer services to individuals with co-occurring mental health and chemical dependency problems if:

(i) the program meets the co-occurring requirements in ~~Minnesota Rules, part 9530.6495~~ section 245G.20;

(ii) 25 percent of the counseling staff are licensed mental health professionals, as defined in section 245.462, subdivision 18, clauses (1) to (6), or are students or licensing candidates

under the supervision of a licensed alcohol and drug counselor supervisor and licensed mental health professional, except that no more than 50 percent of the mental health staff may be students or licensing candidates with time documented to be directly related to provisions of co-occurring services;

(iii) clients scoring positive on a standardized mental health screen receive a mental health diagnostic assessment within ten days of admission;

(iv) the program has standards for multidisciplinary case review that include a monthly review for each client that, at a minimum, includes a licensed mental health professional and licensed alcohol and drug counselor, and their involvement in the review is documented;

(v) family education is offered that addresses mental health and substance abuse disorders and the interaction between the two; and

(vi) co-occurring counseling staff shall receive eight hours of co-occurring disorder training annually.

(d) In order to be eligible for a higher rate under paragraph (c), clause (1), a program that provides arrangements for off-site child care must maintain current documentation at the chemical dependency facility of the child care provider's current licensure to provide child care services. Programs that provide child care according to paragraph (c), clause (1), must be deemed in compliance with the licensing requirements in ~~Minnesota Rules, part 9530.6490~~ section 245G.19.

(e) Adolescent residential programs that meet the requirements of Minnesota Rules, parts 2960.0430 to 2960.0490 and 2960.0580 to 2960.0690, are exempt from the requirements in paragraph (c), clause (4), items (i) to (iv).

(f) Subject to federal approval, chemical dependency services that are otherwise covered as direct face-to-face services may be provided via two-way interactive video. The use of two-way interactive video must be medically appropriate to the condition and needs of the person being served. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to direct face-to-face services. The interactive video equipment and connection must comply with Medicare standards in effect at the time the service is provided.

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

Sec. 53. Minnesota Statutes 2016, section 254B.051, is amended to read:

254B.051 SUBSTANCE ~~ABUSE~~ USE DISORDER TREATMENT EFFECTIVENESS.

In addition to the substance ~~abuse~~ use disorder treatment program performance outcome measures that the commissioner of human services collects annually from treatment providers, the commissioner shall request additional data from programs that receive appropriations from the consolidated chemical dependency treatment fund. This data shall include number of client readmissions six months after release from inpatient treatment, and the cost of treatment per person for each program receiving consolidated chemical dependency treatment funds. The commissioner may post this data on the department Web site.

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

Sec. 54. Minnesota Statutes 2016, section 254B.07, is amended to read:

254B.07 THIRD-PARTY LIABILITY.

The state agency provision and payment of, or liability for, ~~chemical dependency~~ substance use disorder medical care is the same as in section 256B.042.

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

Sec. 55. Minnesota Statutes 2016, section 254B.08, is amended to read:

254B.08 FEDERAL WAIVERS.

The commissioner shall apply for any federal waivers necessary to secure, to the extent allowed by law, federal financial participation for the provision of services to persons who need ~~chemical dependency~~ substance use disorder services. The commissioner may seek amendments to the waivers or apply for additional waivers to contain costs. The commissioner shall ensure that payment for the cost of providing ~~chemical dependency~~ substance use disorder services under the federal waiver plan does not exceed the cost of ~~chemical dependency~~ substance use disorder services that would have been provided without the waivered services.

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

Sec. 56. Minnesota Statutes 2016, section 254B.09, is amended to read:

254B.09 INDIAN RESERVATION ALLOCATION OF CHEMICAL DEPENDENCY FUND.

Subdivision 1. **Vendor payments.** The commissioner shall pay eligible vendors for ~~chemical dependency~~ substance use disorder services to American Indians on the same basis as other payments, except that no local match is required when an invoice is submitted by the governing authority of a federally recognized American Indian tribal body or a county if the tribal governing body has not entered into an agreement under subdivision 2 on behalf of a current resident of the reservation under this section.

Subd. 2. **American Indian agreements.** The commissioner may enter into agreements with federally recognized tribal units to pay for ~~chemical dependency~~ substance use disorder treatment services provided under Laws 1986, chapter 394, sections 8 to 20. The agreements must clarify how the governing body of the tribal unit fulfills local agency responsibilities regarding:

(1) the form and manner of invoicing; and

(2) provide that only invoices for eligible vendors according to section 254B.05 will be included in invoices sent to the commissioner for payment, to the extent that money allocated under subdivisions 4 and 5 is used.

Subd. 6. **American Indian tribal placements.** After entering into an agreement under subdivision 2, the governing authority of each reservation may submit invoices to the state for the cost of providing ~~chemical dependency~~ substance use disorder services to residents of the reservation according to the placement rules governing county placements, except that local match requirements are waived. The governing body may designate an agency to act on its behalf to provide placement services and manage invoices by written notice to the commissioner and evidence of agreement by the agency designated.

Subd. 8. **Payments to improve services to American Indians.** The commissioner may set rates for ~~chemical dependency~~ substance use disorder services to American Indians according to the American Indian Health Improvement Act, Public Law 94-437, for eligible vendors. These rates shall supersede rates set in county purchase of service agreements when payments are made on behalf of clients eligible according to Public Law 94-437.

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

Sec. 57. Minnesota Statutes 2016, section 254B.12, subdivision 2, is amended to read:

Subd. 2. **Payment methodology for highly specialized vendors.** Notwithstanding subdivision 1, the commissioner shall seek federal authority to develop separate payment methodologies for ~~chemical dependency~~ substance use disorder treatment services provided under the consolidated chemical dependency treatment fund: (1) by a state-operated vendor;

or (2) for persons who have been civilly committed to the commissioner, present the most complex and difficult care needs, and are a potential threat to the community. A payment methodology under this subdivision is effective for services provided on or after October 1, 2015, or on or after the receipt of federal approval, whichever is later.

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

Sec. 58. Minnesota Statutes 2016, section 254B.13, subdivision 2a, is amended to read:

Subd. 2a. **Eligibility for navigator pilot program.** (a) To be considered for participation in a navigator pilot program, an individual must:

(1) be a resident of a county with an approved navigator program;

(2) be eligible for consolidated chemical dependency treatment fund services;

(3) be a voluntary participant in the navigator program;

(4) satisfy one of the following items:

(i) have at least one severity rating of three or above in dimension four, five, or six in a comprehensive assessment under ~~Minnesota Rules, part 9530.6422~~ section 245G.05, paragraph (c), clauses (4) to (6); or

(ii) have at least one severity rating of two or above in dimension four, five, or six in a comprehensive assessment under ~~Minnesota Rules, part 9530.6422,~~ section 245G.05, paragraph (c), clauses (4) to (6), and be currently participating in a Rule 31 treatment program under ~~Minnesota Rules, parts 9530.6405 to 9530.6505,~~ chapter 245G or be within 60 days following discharge after participation in a Rule 31 treatment program; and

(5) have had at least two treatment episodes in the past two years, not limited to episodes reimbursed by the consolidated chemical dependency treatment funds. An admission to an emergency room, a detoxification program, or a hospital may be substituted for one treatment episode if it resulted from the individual's substance use disorder.

(b) New eligibility criteria may be added as mutually agreed upon by the commissioner and participating navigator programs.

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

Sec. 59. Minnesota Statutes 2016, section 256B.0625, subdivision 45a, is amended to read:

Subd. 45a. **Psychiatric residential treatment facility services for persons under 21 years of age.** (a) Medical assistance covers psychiatric residential treatment facility services, according to section 256B.0941, for persons ~~under~~ younger than 21 years of age. Individuals who reach age 21 at the time they are receiving services are eligible to continue receiving services until they no longer require services or until they reach age 22, whichever occurs first.

(b) For purposes of this subdivision, "psychiatric residential treatment facility" means a facility other than a hospital that provides psychiatric services, as described in Code of Federal Regulations, title 42, sections 441.151 to 441.182, to individuals under age 21 in an inpatient setting.

(c) ~~The commissioner shall develop admissions and discharge procedures and establish rates consistent with guidelines from the federal Centers for Medicare and Medicaid Services.~~

~~(d)~~ The commissioner shall enroll up to 150 certified psychiatric residential treatment facility services beds at up to six sites. The commissioner shall select psychiatric residential treatment facility services providers through a request for proposals process. Providers of state-operated services may respond to the request for proposals.

Sec. 60. **[256B.0941] PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY FOR PERSONS UNDER 21 YEARS OF AGE.**

Subdivision 1. **Eligibility.** (a) An individual who is eligible for mental health treatment services in a psychiatric residential treatment facility must meet all of the following criteria:

(1) before admission, services are determined to be medically necessary by the state's medical review agent according to Code of Federal Regulations, title 42, section 441.152;

(2) is younger than 21 years of age at the time of admission. Services may continue until the individual meets criteria for discharge or reaches 22 years of age, whichever occurs first;

(3) has a mental health diagnosis as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders, as well as clinical evidence of severe aggression, or a finding that the individual is a risk to self or others;

(4) has functional impairment and a history of difficulty in functioning safely and successfully in the community, school, home, or job; an inability to adequately care for

one's physical needs; or caregivers, guardians, or family members are unable to safely fulfill the individual's needs;

(5) requires psychiatric residential treatment under the direction of a physician to improve the individual's condition or prevent further regression so that services will no longer be needed;

(6) utilized and exhausted other community-based mental health services, or clinical evidence indicates that such services cannot provide the level of care needed; and

(7) was referred for treatment in a psychiatric residential treatment facility by a qualified mental health professional licensed as defined in section 245.4871, subdivision 27, clauses (1) to (6).

(b) A mental health professional making a referral shall submit documentation to the state's medical review agent containing all information necessary to determine medical necessity, including a standard diagnostic assessment completed within 180 days of the individual's admission. Documentation shall include evidence of family participation in the individual's treatment planning and signed consent for services.

Subd. 2. **Services.** Psychiatric residential treatment facility service providers must offer and have the capacity to provide the following services:

(1) development of the individual plan of care, review of the individual plan of care every 30 days, and discharge planning by required members of the treatment team according to Code of Federal Regulations, title 42, sections 441.155 to 441.156;

(2) any services provided by a psychiatrist or physician for development of an individual plan of care, conducting a review of the individual plan of care every 30 days, and discharge planning by required members of the treatment team according to Code of Federal Regulations, title 42, sections 441.155 to 441.156;

(3) active treatment seven days per week that may include individual, family, or group therapy as determined by the individual care plan;

(4) individual therapy, provided a minimum of twice per week;

(5) family engagement activities, provided a minimum of once per week;

(6) consultation with other professionals, including case managers, primary care professionals, community-based mental health providers, school staff, or other support planners;

(7) coordination of educational services between local and resident school districts and the facility;

(8) 24-hour nursing; and

(9) direct care and supervision, supportive services for daily living and safety, and positive behavior management.

Subd. 3. **Per diem rate.** (a) The commissioner shall establish a statewide per diem rate for psychiatric residential treatment facility services for individuals 21 years of age or younger. The rate for a provider must not exceed the rate charged by that provider for the same service to other payers. Payment must not be made to more than one entity for each individual for services provided under this section on a given day. The commissioner shall set rates prospectively for the annual rate period. The commissioner shall require providers to submit annual cost reports on a uniform cost reporting form and shall use submitted cost reports to inform the rate-setting process. The cost reporting shall be done according to federal requirements for Medicare cost reports.

(b) The following are included in the rate:

(1) costs necessary for licensure and accreditation, meeting all staffing standards for participation, meeting all service standards for participation, meeting all requirements for active treatment, maintaining medical records, conducting utilization review, meeting inspection of care, and discharge planning. The direct services costs must be determined using the actual cost of salaries, benefits, payroll taxes, and training of direct services staff and service-related transportation; and

(2) payment for room and board provided by facilities meeting all accreditation and licensing requirements for participation.

(c) A facility may submit a claim for payment outside of the per diem for professional services arranged by and provided at the facility by an appropriately licensed professional who is enrolled as a provider with Minnesota health care programs. Arranged services must be billed by the facility on a separate claim, and the facility shall be responsible for payment to the provider. These services must be included in the individual plan of care and are subject to prior authorization by the state's medical review agent.

(d) Medicaid shall reimburse for concurrent services as approved by the commissioner to support continuity of care and successful discharge from the facility. "Concurrent services" means services provided by another entity or provider while the individual is admitted to a psychiatric residential treatment facility. Payment for concurrent services may be limited

and these services are subject to prior authorization by the state's medical review agent. Concurrent services may include targeted case management, assertive community treatment, clinical care consultation, team consultation, and treatment planning.

(e) Payment rates under this subdivision shall not include the costs of providing the following services:

(1) educational services;

(2) acute medical care or specialty services for other medical conditions;

(3) dental services; and

(4) pharmacy drug costs.

(f) For purposes of this section, "actual cost" means costs that are allowable, allocable, reasonable, and consistent with federal reimbursement requirements in Code of Federal Regulations, title 48, chapter 1, part 31, relating to for-profit entities, and the Office of Management and Budget Circular Number A-122, relating to nonprofit entities.

Subd. 4. **Leave days.** (a) Medical assistance covers therapeutic and hospital leave days, provided the recipient was not discharged from the psychiatric residential treatment facility and is expected to return to the psychiatric residential treatment facility. A reserved bed must be held for a recipient on hospital leave or therapeutic leave.

(b) A therapeutic leave day to home shall be used to prepare for discharge and reintegration and shall be included in the individual plan of care. The state shall reimburse 75 percent of the per diem rate for a reserve bed day while the recipient is on therapeutic leave. A therapeutic leave visit may not exceed three days without prior authorization.

(c) A hospital leave day shall be a day for which a recipient has been admitted to a hospital for medical or acute psychiatric care and is temporarily absent from the psychiatric residential treatment facility. The state shall reimburse 50 percent of the per diem rate for a reserve bed day while the recipient is receiving medical or psychiatric care in a hospital.

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

Sec. 61. Minnesota Statutes 2016, section 256B.0943, subdivision 13, is amended to read:

Subd. 13. **Exception to excluded services.** Notwithstanding subdivision 12, up to 15 hours of children's therapeutic services and supports provided within a six-month period to a child with severe emotional disturbance who is residing in a hospital; ~~a group home as defined in Minnesota Rules, parts 2960.0130 to 2960.0220;~~ a residential treatment facility licensed under Minnesota Rules, parts 2960.0580 to 2960.0690; a psychiatric residential

treatment facility under section 256B.0625, subdivision 45a; a regional treatment center; or other institutional group setting or who is participating in a program of partial hospitalization are eligible for medical assistance payment if part of the discharge plan.

Sec. 62. Minnesota Statutes 2016, section 256B.0945, subdivision 2, is amended to read:

Subd. 2. **Covered services.** All services must be included in a child's individualized treatment or multiagency plan of care as defined in chapter 245.

For facilities that are not institutions for mental diseases according to federal statute and regulation, medical assistance covers mental health-related services that are required to be provided by a residential facility under section 245.4882 and administrative rules promulgated thereunder, except for room and board. For residential facilities determined by the federal Centers for Medicare and Medicaid Services to be an institution for mental diseases, medical assistance covers medically necessary mental health services provided by the facility according to section 256B.055, subdivision 13, except for room and board.

Sec. 63. Minnesota Statutes 2016, section 256B.0945, subdivision 4, is amended to read:

Subd. 4. **Payment rates.** (a) Notwithstanding sections 256B.19 and 256B.041, payments to counties for residential services provided under this section by a residential facility shall:

(1) for services provided by a residential facility that is not an institution for mental diseases, only be made of federal earnings for services provided ~~under this section~~, and the nonfederal share of costs for services provided under this section shall be paid by the county from sources other than federal funds or funds used to match other federal funds. Payment to counties for services provided according to this section shall be a proportion of the per day contract rate that relates to rehabilitative mental health services and shall not include payment for costs or services that are billed to the IV-E program as room and board~~.~~; and

(2) for services provided by a residential facility that is determined to be an institution for mental diseases, be equivalent to the federal share of the payment that would have been made if the residential facility were not an institution for mental diseases. The portion of the payment representing what would be the nonfederal shares shall be paid by the county. Payment to counties for services provided according to this section shall be a proportion of the per day contract rate that relates to rehabilitative mental health services and shall not include payment for costs or services that are billed to the IV-E program as room and board.

(b) Per diem rates paid to providers under this section by prepaid plans shall be the proportion of the per-day contract rate that relates to rehabilitative mental health services

and shall not include payment for group foster care costs or services that are billed to the county of financial responsibility. Services provided in facilities located in bordering states are eligible for reimbursement on a fee-for-service basis only as described in paragraph (a) and are not covered under prepaid health plans.

(c) Payment for mental health rehabilitative services provided under this section by or under contract with an American Indian tribe or tribal organization or by agencies operated by or under contract with an American Indian tribe or tribal organization must be made according to section 256B.0625, subdivision 34, or other relevant federally approved rate-setting methodology.

(d) The commissioner shall set aside a portion not to exceed five percent of the federal funds earned for county expenditures under this section to cover the state costs of administering this section. Any unexpended funds from the set-aside shall be distributed to the counties in proportion to their earnings under this section.

Sec. 64. **CHILDREN'S MENTAL HEALTH REPORT AND RECOMMENDATIONS.**

The commissioner of human services shall conduct a comprehensive analysis of Minnesota's continuum of intensive mental health services and shall develop recommendations for a sustainable and community-driven continuum of care for children with serious mental health needs, including children currently being served in residential treatment. The commissioner's analysis shall include, but not be limited to:

(1) data related to access, utilization, efficacy, and outcomes for Minnesota's current system of residential mental health treatment for a child with a severe emotional disturbance;

(2) potential expansion of the state's psychiatric residential treatment facility (PRTF) capacity, including increasing the number of PRTF beds and conversion of existing children's mental health residential treatment programs into PRTFs;

(3) the capacity need for PRTF and other group settings within the state if adequate community-based alternatives are accessible, equitable, and effective statewide;

(4) recommendations for expanding alternative community-based service models to meet the needs of a child with a serious mental health disorder who would otherwise require residential treatment and potential service models that could be utilized, including data related to access, utilization, efficacy, and outcomes;

(5) models of care used in other states; and

(6) analysis and specific recommendations for the design and implementation of new service models, including analysis to inform rate setting as necessary.

The analysis shall be supported and informed by extensive stakeholder engagement. Stakeholders include individuals who receive services, family members of individuals who receive services, providers, counties, health plans, advocates, and others. Stakeholder engagement shall include interviews with key stakeholders, intentional outreach to individuals who receive services and the individual's family members, and regional listening sessions.

The commissioner shall provide a report with specific recommendations and timelines for implementation to the legislative committees with jurisdiction over children's mental health policy and finance by November 15, 2018.

Sec. 65. **RESIDENTIAL TREATMENT AND PAYMENT RATE REFORM.**

The commissioner shall contract with an outside expert to identify recommendations for the development of a substance use disorder residential treatment program model and payment structure that is not subject to the federal institutions for mental diseases exclusion and that is financially sustainable for providers, while incentivizing best practices and improved treatment outcomes. The analysis and report must include recommendations and a timeline for supporting providers to transition to the new models of care delivery. No later than December 15, 2018, a report with recommendations must be delivered to members of the legislative committees in the house of representatives and senate with jurisdiction over health and human services policy and finance.

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

Sec. 66. **REVISOR'S INSTRUCTION.**

In Minnesota Statutes and Minnesota Rules, the revisor of statutes, in consultation with the with the Department of Human Services, shall make necessary cross-reference changes that are needed as a result of the enactment of sections 6 to 27 and 65. The revisor shall make any necessary technical and grammatical changes to preserve the meaning of the text.

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

Sec. 67. **REPEALER.**

(a) Minnesota Statutes 2016, sections 245A.1915; 245A.192; and 254A.02, subdivision 4, are repealed.

(b) Minnesota Rules, parts 9530.6405, subparts 1, 1a, 2, 3, 4, 5, 6, 7, 7a, 8, 9, 10, 11, 12, 13, 14, 14a, 15, 15a, 16, 17, 17a, 17b, 17c, 18, 20, and 21; 9530.6410; 9530.6415; 9530.6420; 9530.6422; 9530.6425; 9530.6430; 9530.6435; 9530.6440; 9530.6445; 9530.6450; 9530.6455; 9530.6460; 9530.6465; 9530.6470; 9530.6475; 9530.6480; 9530.6485; 9530.6490; 9530.6495; 9530.6500; and 9530.6505, are repealed.

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

ARTICLE 9

OPERATIONS

Section 1. Minnesota Statutes 2016, section 13.46, subdivision 4, is amended to read:

Subd. 4. **Licensing data.** (a) As used in this subdivision:

(1) "licensing data" are all data collected, maintained, used, or disseminated by the welfare system pertaining to persons licensed or registered or who apply for licensure or registration or who formerly were licensed or registered under the authority of the commissioner of human services;

(2) "client" means a person who is receiving services from a licensee or from an applicant for licensure; and

(3) "personal and personal financial data" are Social Security numbers, identity of and letters of reference, insurance information, reports from the Bureau of Criminal Apprehension, health examination reports, and social/home studies.

(b)(1)(i) Except as provided in paragraph (c), the following data on applicants, license holders, and former licensees are public: name, address, telephone number of licensees, date of receipt of a completed application, dates of licensure, licensed capacity, type of client preferred, variances granted, record of training and education in child care and child development, type of dwelling, name and relationship of other family members, previous license history, class of license, the existence and status of complaints, and the number of serious injuries to or deaths of individuals in the licensed program as reported to the commissioner of human services, the local social services agency, or any other county welfare agency. For purposes of this clause, a serious injury is one that ~~is treated~~ requires treatment by a physician.

(ii) when a correction order, an order to forfeit a fine, an order of license suspension, an order of temporary immediate suspension, an order of license revocation, an order of license denial, or an order of conditional license has been issued, or a complaint is resolved, the

following data on current and former licensees and applicants are public: the general nature of the complaint or allegations leading to the temporary immediate suspension; the substance and investigative findings of the licensing or maltreatment complaint, licensing violation, or substantiated maltreatment; the existence of settlement negotiations; the record of informal resolution of a licensing violation; orders of hearing; findings of fact; conclusions of law; specifications of the final correction order, fine, suspension, temporary immediate suspension, revocation, denial, or conditional license contained in the record of licensing action; whether a fine has been paid; and the status of any appeal of these actions.

(iii) When a license denial under section 245A.05 or a sanction under section 245A.07 is based on a determination that a license holder, applicant, or controlling individual is responsible for maltreatment under section 626.556 or 626.557, the identity of the applicant, license holder, or controlling individual as the individual responsible for maltreatment is public data at the time of the issuance of the license denial or sanction.

(iv) When a license denial under section 245A.05 or a sanction under section 245A.07 is based on a determination that a license holder, applicant, or controlling individual is disqualified under chapter 245C, the identity of the license holder, applicant, or controlling individual as the disqualified individual and the reason for the disqualification are public data at the time of the issuance of the licensing sanction or denial. If the applicant, license holder, or controlling individual requests reconsideration of the disqualification and the disqualification is affirmed, the reason for the disqualification and the reason to not set aside the disqualification are public data.

(2) For applicants who withdraw their application prior to licensure or denial of a license, the following data are public: the name of the applicant, the city and county in which the applicant was seeking licensure, the dates of the commissioner's receipt of the initial application and completed application, the type of license sought, and the date of withdrawal of the application.

(3) for applicants who are denied a license, the following data are public: the name and address of the applicant, the city and county in which the applicant was seeking licensure, the dates of the commissioner's receipt of the initial application and completed application, the type of license sought, the date of denial of the application, the nature of the basis for the denial, the existence of settlement negotiations, the record of informal resolution of a denial, orders of hearings, findings of fact, conclusions of law, specifications of the final order of denial, and the status of any appeal of the denial.

(4) When maltreatment is substantiated under section 626.556 or 626.557 and the victim and the substantiated perpetrator are affiliated with a program licensed under chapter 245A, the commissioner of human services, local social services agency, or county welfare agency may inform the license holder where the maltreatment occurred of the identity of the substantiated perpetrator and the victim.

(5) Notwithstanding clause (1), for child foster care, only the name of the license holder and the status of the license are public if the county attorney has requested that data otherwise classified as public data under clause (1) be considered private data based on the best interests of a child in placement in a licensed program.

(c) The following are private data on individuals under section 13.02, subdivision 12, or nonpublic data under section 13.02, subdivision 9: personal and personal financial data on family day care program and family foster care program applicants and licensees and their family members who provide services under the license.

(d) The following are private data on individuals: the identity of persons who have made reports concerning licensees or applicants that appear in inactive investigative data, and the records of clients or employees of the licensee or applicant for licensure whose records are received by the licensing agency for purposes of review or in anticipation of a contested matter. The names of reporters of complaints or alleged violations of licensing standards under chapters 245A, 245B, 245C, and 245D, and applicable rules and alleged maltreatment under sections 626.556 and 626.557, are confidential data and may be disclosed only as provided in section 626.556, subdivision 11, or 626.557, subdivision 12b.

(e) Data classified as private, confidential, nonpublic, or protected nonpublic under this subdivision become public data if submitted to a court or administrative law judge as part of a disciplinary proceeding in which there is a public hearing concerning a license which has been suspended, immediately suspended, revoked, or denied.

(f) Data generated in the course of licensing investigations that relate to an alleged violation of law are investigative data under subdivision 3.

(g) Data that are not public data collected, maintained, used, or disseminated under this subdivision that relate to or are derived from a report as defined in section 626.556, subdivision 2, or 626.5572, subdivision 18, are subject to the destruction provisions of sections 626.556, subdivision 11c, and 626.557, subdivision 12b.

(h) Upon request, not public data collected, maintained, used, or disseminated under this subdivision that relate to or are derived from a report of substantiated maltreatment as defined in section 626.556 or 626.557 may be exchanged with the Department of Health

for purposes of completing background studies pursuant to section 144.057 and with the Department of Corrections for purposes of completing background studies pursuant to section 241.021.

(i) Data on individuals collected according to licensing activities under chapters 245A and 245C, data on individuals collected by the commissioner of human services according to investigations under chapters 245A, 245B, 245C, and 245D, and sections 626.556 and 626.557 may be shared with the Department of Human Rights, the Department of Health, the Department of Corrections, the ombudsman for mental health and developmental disabilities, and the individual's professional regulatory board when there is reason to believe that laws or standards under the jurisdiction of those agencies may have been violated or the information may otherwise be relevant to the board's regulatory jurisdiction. Background study data on an individual who is the subject of a background study under chapter 245C for a licensed service for which the commissioner of human services is the license holder may be shared with the commissioner and the commissioner's delegate by the licensing division. Unless otherwise specified in this chapter, the identity of a reporter of alleged maltreatment or licensing violations may not be disclosed.

(j) In addition to the notice of determinations required under section 626.556, subdivision 10f, if the commissioner or the local social services agency has determined that an individual is a substantiated perpetrator of maltreatment of a child based on sexual abuse, as defined in section 626.556, subdivision 2, and the commissioner or local social services agency knows that the individual is a person responsible for a child's care in another facility, the commissioner or local social services agency shall notify the head of that facility of this determination. The notification must include an explanation of the individual's available appeal rights and the status of any appeal. If a notice is given under this paragraph, the government entity making the notification shall provide a copy of the notice to the individual who is the subject of the notice.

(k) All not public data collected, maintained, used, or disseminated under this subdivision and subdivision 3 may be exchanged between the Department of Human Services, Licensing Division, and the Department of Corrections for purposes of regulating services for which the Department of Human Services and the Department of Corrections have regulatory authority.

Sec. 2. Minnesota Statutes 2016, section 245A.02, subdivision 2b, is amended to read:

Subd. 2b. **Annual or annually.** With the exception of subdivision 2c, "annual" or "annually" means prior to or within the same month of the subsequent calendar year.

Sec. 3. Minnesota Statutes 2016, section 245A.02, is amended by adding a subdivision to read:

Subd. 2c. **Annual or annually; family child care training requirements.** For the purposes of section 245A.50, subdivisions 1 to 9, "annual" or "annually" means the 12-month period beginning on the license effective date or the annual anniversary of the effective date and ending on the day prior to the annual anniversary of the license effective date.

Sec. 4. **[245A.055] NOTIFICATION TO PROVIDER.**

(a) When the county agency responsible for family child care and group family child care licensing conducts an annual or biennial licensing inspection, the agency must provide, before departure from the residence or facility, a written or electronic notification to the licensee of potential licensing violations noted during the inspection and the condition that constitutes the violation.

(b) Providing this notification to the licensee does not relieve the county agency from notifying the license holder and the commissioner of the violation as required by statute or rule.

Sec. 5. Minnesota Statutes 2016, section 245A.06, subdivision 2, is amended to read:

Subd. 2. **Reconsideration of correction orders.** (a) If the applicant or license holder believes that the contents of the commissioner's correction order are in error, the applicant or license holder may ask the Department of Human Services to reconsider the parts of the correction order that are alleged to be in error. The request for reconsideration must be made in writing and must be postmarked and sent to the commissioner within 20 calendar days after receipt of the correction order by the applicant or license holder, and:

(1) specify the parts of the correction order that are alleged to be in error;

(2) explain why they are in error; and

(3) include documentation to support the allegation of error.

A request for reconsideration does not stay any provisions or requirements of the correction order. The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14.

(b) This paragraph applies only to licensed family child care providers. A licensed family child care provider who requests reconsideration of a correction order under paragraph (a)

may also request, on a form and in the manner prescribed by the commissioner, that the commissioner expedite the review if:

(1) the provider is challenging a violation and provides a description of how complying with the corrective action for that violation would require the substantial expenditure of funds or a significant change to their program; and

(2) describes what actions the provider will take in lieu of the corrective action ordered to ensure the health and safety of children in care pending the commissioner's review of the correction order.

(c) By January 1, 2018, and each year thereafter, the Department of Human Services must report data to the chairs and ranking minority members of the legislative committees with jurisdiction over human services policy from the previous year that includes:

(1) the number of licensed family child care provider appeals of correction orders to the Department of Human Services;

(2) the number of correction order appeals by family child care providers that the Department of Human Services grants; and

(3) the number of correction order appeals that the Department of Human Services denies.

Sec. 6. Minnesota Statutes 2016, section 245A.07, subdivision 3, is amended to read:

Subd. 3. **License suspension, revocation, or fine.** (a) The commissioner may suspend or revoke a license, or impose a fine if:

(1) a license holder fails to comply fully with applicable laws or rules;

(2) a license holder, a controlling individual, or an individual living in the household where the licensed services are provided or is otherwise subject to a background study has a disqualification which has not been set aside under section 245C.22;

(3) a license holder knowingly withholds relevant information from or gives false or misleading information to the commissioner in connection with an application for a license, in connection with the background study status of an individual, during an investigation, or regarding compliance with applicable laws or rules; or

(4) after July 1, 2012, and upon request by the commissioner, a license holder fails to submit the information required of an applicant under section 245A.04, subdivision 1, paragraph (f) or (g).

A license holder who has had a license suspended, revoked, or has been ordered to pay a fine must be given notice of the action by certified mail or personal service. If mailed, the notice must be mailed to the address shown on the application or the last known address of the license holder. The notice must state the reasons the license was suspended, revoked, or a fine was ordered.

(b) If the license was suspended or revoked, the notice must inform the license holder of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The license holder may appeal an order suspending or revoking a license. The appeal of an order suspending or revoking a license must be made in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within ten calendar days after the license holder receives notice that the license has been suspended or revoked. If a request is made by personal service, it must be received by the commissioner within ten calendar days after the license holder received the order. Except as provided in subdivision 2a, paragraph (c), if a license holder submits a timely appeal of an order suspending or revoking a license, the license holder may continue to operate the program as provided in section 245A.04, subdivision 7, paragraphs (g) and (h), until the commissioner issues a final order on the suspension or revocation.

(c)(1) If the license holder was ordered to pay a fine, the notice must inform the license holder of the responsibility for payment of fines and the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The appeal of an order to pay a fine must be made in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within ten calendar days after the license holder receives notice that the fine has been ordered. If a request is made by personal service, it must be received by the commissioner within ten calendar days after the license holder received the order.

(2) The license holder shall pay the fines assessed on or before the payment date specified. If the license holder fails to fully comply with the order, the commissioner may issue a second fine or suspend the license until the license holder complies. If the license holder receives state funds, the state, county, or municipal agencies or departments responsible for administering the funds shall withhold payments and recover any payments made while the license is suspended for failure to pay a fine. A timely appeal shall stay payment of the fine until the commissioner issues a final order.

(3) A license holder shall promptly notify the commissioner of human services, in writing, when a violation specified in the order to forfeit a fine is corrected. If upon reinspection the commissioner determines that a violation has not been corrected as indicated by the order

to forfeit a fine, the commissioner may issue a second fine. The commissioner shall notify the license holder by certified mail or personal service that a second fine has been assessed. The license holder may appeal the second fine as provided under this subdivision.

(4) Fines shall be assessed as follows:

(i) the license holder shall forfeit $1,000 for each determination of maltreatment of a child under section 626.556 or the maltreatment of a vulnerable adult under section 626.557 for which the license holder is determined responsible for the maltreatment under section 626.556, subdivision 10e, paragraph (i), or 626.557, subdivision 9c, paragraph (c);

(ii) if the commissioner determines that a determination of maltreatment for which the license holder is responsible is the result of maltreatment that meets the definition of serious maltreatment as defined in section 245C.02, subdivision 18, the license holder shall forfeit $5,000;

(iii) for a program that operates out of the license holder's home and a program licensed under Minnesota Rules, parts 9502.0300 to 9502.0495, the fine assessed against the license holder shall not exceed $1,000 for each determination of maltreatment;

(iv) the license holder shall forfeit $200 for each occurrence of a violation of law or rule governing matters of health, safety, or supervision, including but not limited to the provision of adequate staff-to-child or adult ratios, and failure to comply with background study requirements under chapter 245C; and

(v) the license holder shall forfeit $100 for each occurrence of a violation of law or rule other than those subject to a $5,000, $1,000, or $200 fine ~~above~~ in items (i) to (iv).

For purposes of this section, "occurrence" means each violation identified in the commissioner's fine order. Fines assessed against a license holder that holds a license to provide home and community-based services, as identified in section 245D.03, subdivision 1, and a community residential setting or day services facility license under chapter 245D where the services are provided, may be assessed against both licenses for the same occurrence, but the combined amount of the fines shall not exceed the amount specified in this clause for that occurrence.

(5) When a fine has been assessed, the license holder may not avoid payment by closing, selling, or otherwise transferring the licensed program to a third party. In such an event, the license holder will be personally liable for payment. In the case of a corporation, each controlling individual is personally and jointly liable for payment.

(d) Except for background study violations involving the failure to comply with an order to immediately remove an individual or an order to provide continuous, direct supervision, the commissioner shall not issue a fine under paragraph (c) relating to a background study violation to a license holder who self-corrects a background study violation before the commissioner discovers the violation. A license holder who has previously exercised the provisions of this paragraph to avoid a fine for a background study violation may not avoid a fine for a subsequent background study violation unless at least 365 days have passed since the license holder self-corrected the earlier background study violation.

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

Sec. 7. **[245A.1434] INFORMATION FOR CHILD CARE LICENSE HOLDERS.**

The commissioner shall inform family child care and child care center license holders on a timely basis of changes to state and federal statute, rule, regulation, and policy relating to the provision of licensed child care, the child care assistance program under chapter 119B, the quality rating and improvement system under section 124D.142, and child care licensing functions delegated to counties. Communications under this section shall include information to promote license holder compliance with identified changes. Communications under this section may be accomplished by electronic means and shall be made available to the public online.

Sec. 8. Minnesota Statutes 2016, section 626.556, subdivision 3c, is amended to read:

Subd. 3c. **Local welfare agency, Department of Human Services or Department of Health responsible for assessing or investigating reports of maltreatment.** (a) The ~~county~~ local welfare agency is the agency responsible for assessing or investigating allegations of maltreatment in child foster care, family child care, legally ~~unlicensed~~ nonlicensed child care, ~~juvenile correctional facilities licensed under section 241.021 located in the local welfare agency's county,~~ and reports involving children served by an unlicensed personal care provider organization under section 256B.0659. Copies of findings related to personal care provider organizations under section 256B.0659 must be forwarded to the Department of Human Services provider enrollment.

(b) The Department of Human Services is the agency responsible for assessing or investigating allegations of maltreatment in juvenile correctional facilities listed under section 241.021 located in the local welfare agency's county and in facilities licensed or certified under chapters 245A and 245D, except for child foster care and family child care.

(c) The Department of Health is the agency responsible for assessing or investigating allegations of child maltreatment in facilities licensed under sections 144.50 to 144.58 and 144A.43 to 144A.482.

ARTICLE 10

HEALTH DEPARTMENT

Section 1. Minnesota Statutes 2016, section 103I.101, subdivision 2, is amended to read:

Subd. 2. **Duties.** The commissioner shall:

(1) regulate the drilling, construction, modification, repair, and sealing of wells and borings;

(2) examine and license:

(i) well contractors;

(ii) persons constructing, repairing, and sealing bored geothermal heat exchangers;

(iii) persons modifying or repairing well casings, well screens, or well diameters;

(iv) persons constructing, repairing, and sealing drive point wells or dug wells;

(v) persons installing well pumps or pumping equipment;

(vi) persons constructing, repairing, and sealing dewatering wells;

(vii) persons sealing wells~~; persons installing well pumps or pumping equipment~~ or borings; and

(viii) persons excavating or drilling holes for the installation of elevator borings ~~or hydraulic cylinders~~;

(3) ~~register~~ license and examine monitoring well contractors;

(4) license explorers engaged in exploratory boring and examine individuals who supervise or oversee exploratory boring;

(5) after consultation with the commissioner of natural resources and the Pollution Control Agency, establish standards for the design, location, construction, repair, and sealing of wells and borings within the state; and

(6) issue permits for wells, groundwater thermal devices, bored geothermal heat exchangers, and elevator borings.

Sec. 2. Minnesota Statutes 2016, section 103I.101, subdivision 5, is amended to read:

Subd. 5. **Commissioner to adopt rules.** The commissioner shall adopt rules including:

(1) issuance of licenses for:

(i) qualified well contractors~~,~~;

(ii) persons modifying or repairing well casings, well screens, or well diameters;

~~(ii)~~ (iii) persons constructing, repairing, and sealing drive point wells or dug wells;

~~(iii)~~ (iv) persons constructing, repairing, and sealing dewatering wells;

~~(iv)~~ (v) persons sealing wells or borings;

~~(v)~~ (vi) persons installing well pumps or pumping equipment;

~~(vi)~~ (vii) persons constructing, repairing, and sealing bored geothermal heat exchangers; and

~~(vii)~~ (viii) persons constructing, repairing, and sealing elevator borings;

(2) issuance of ~~registration~~ licenses for monitoring well contractors;

(3) establishment of conditions for examination and review of applications for license and ~~registration~~ certification;

(4) establishment of conditions for revocation and suspension of license and ~~registration~~ certification;

(5) establishment of minimum standards for design, location, construction, repair, and sealing of wells and borings to implement the purpose and intent of this chapter;

(6) establishment of a system for reporting on wells and borings drilled and sealed;

(7) establishment of standards for the construction, maintenance, sealing, and water quality monitoring of wells in areas of known or suspected contamination;

(8) establishment of wellhead protection measures for wells serving public water supplies;

(9) establishment of procedures to coordinate collection of well and boring data with other state and local governmental agencies;

(10) establishment of criteria and procedures for submission of well and boring logs, formation samples or well or boring cuttings, water samples, or other special information required for and water resource mapping; and

(11) establishment of minimum standards for design, location, construction, maintenance, repair, sealing, safety, and resource conservation related to borings, including exploratory borings as defined in section 103I.005, subdivision 9.

Sec. 3. Minnesota Statutes 2016, section 103I.111, subdivision 6, is amended to read:

Subd. 6. **Unsealed wells and borings are public health nuisances.** A well or boring that is required to be sealed under section 103I.301 but is not sealed is a public health nuisance. A county may abate the unsealed well or boring with the same authority of a community health board to abate a public health nuisance under section 145A.04, subdivision 8.

Sec. 4. Minnesota Statutes 2016, section 103I.111, subdivision 7, is amended to read:

Subd. 7. **Local license ~~or registration~~ fees prohibited.** (a) A political subdivision may not require a licensed well contractor to pay a license ~~or registration~~ fee.

(b) The commissioner of health must provide a political subdivision with a list of licensed well contractors upon request.

Sec. 5. Minnesota Statutes 2016, section 103I.111, subdivision 8, is amended to read:

Subd. 8. **Municipal regulation of drilling.** A municipality may regulate all drilling, except well, elevator ~~shaft~~ boring, and exploratory drilling that is subject to the provisions of this chapter, above, in, through, and adjacent to subsurface areas designated for mined underground space development and existing mined underground space. The regulations may prohibit, restrict, control, and require permits for the drilling.

Sec. 6. Minnesota Statutes 2016, section 103I.205, is amended to read:

103I.205 WELL AND BORING CONSTRUCTION.

Subdivision 1. **Notification required.** (a) Except as provided in paragraphs (d) and (e), a person may not construct a well until a notification of the proposed well on a form prescribed by the commissioner is filed with the commissioner with the filing fee in section 103I.208, and, when applicable, the person has met the requirements of paragraph (f). If after filing the well notification an attempt to construct a well is unsuccessful, a new notification is not required unless the information relating to the successful well has substantially changed.

(b) The property owner, the property owner's agent, or the ~~well~~ licensed contractor where a well is to be located must file the well notification with the commissioner.

(c) The well notification under this subdivision preempts local permits and notifications, and counties or home rule charter or statutory cities may not require a permit or notification for wells unless the commissioner has delegated the permitting or notification authority under section 103I.111.

(d) A person who is an individual that constructs a drive point water-supply well on property owned or leased by the individual for farming or agricultural purposes or as the individual's place of abode must notify the commissioner of the installation and location of the well. The person must complete the notification form prescribed by the commissioner and mail it to the commissioner by ten days after the well is completed. A fee may not be charged for the notification. A person who sells drive point wells at retail must provide buyers with notification forms and informational materials including requirements regarding wells, their location, construction, and disclosure. The commissioner must provide the notification forms and informational materials to the sellers.

(e) A person may not construct a monitoring well until a permit is issued by the commissioner for the construction. If after obtaining a permit an attempt to construct a well is unsuccessful, a new permit is not required as long as the initial permit is modified to indicate the location of the successful well.

(f) When the operation of a well will require an appropriation permit from the commissioner of natural resources, a person may not begin construction of the well until the person submits the following information to the commissioner of natural resources:

(1) the location of the well;

(2) the formation or aquifer that will serve as the water source;

(3) the maximum daily, seasonal, and annual pumpage rates and volumes that will be requested in the appropriation permit; and

(4) other information requested by the commissioner of natural resources that is necessary to conduct the preliminary assessment required under section 103G.287, subdivision 1, paragraph (c).

The person may begin construction after receiving preliminary approval from the commissioner of natural resources.

Subd. 2. **Emergency permit and notification exemptions.** The commissioner may adopt rules that modify the procedures for filing a well or boring notification or well or boring permit if conditions occur that:

(1) endanger the public health and welfare or cause a need to protect the groundwater; or

(2) require the monitoring well contractor, limited well/boring contractor, or well contractor to begin constructing a well before obtaining a permit or notification.

Subd. 3. **Maintenance permit.** (a) Except as provided under paragraph (b), a well that is not in use must be sealed or have a maintenance permit.

(b) If a monitoring well or a dewatering well is not sealed by 14 months after completion of construction, the owner of the property on which the well is located must obtain and annually renew a maintenance permit from the commissioner.

Subd. 4. **License required.** (a) Except as provided in paragraph (b), (c), (d), or (e), section 103I.401, subdivision 2, or 103I.601, subdivision 2, a person may not drill, construct, repair, or seal a well or boring unless the person has a well contractor's license in possession.

(b) A person may construct, repair, and seal a monitoring well if the person:

(1) is a professional engineer licensed under sections 326.02 to 326.15 in the branches of civil or geological engineering;

(2) is a hydrologist or hydrogeologist certified by the American Institute of Hydrology;

(3) is a professional geoscientist licensed under sections 326.02 to 326.15;

(4) is a geologist certified by the American Institute of Professional Geologists; or

(5) meets the qualifications established by the commissioner in rule.

A person must ~~register with~~ be licensed by the commissioner as a monitoring well contractor on forms provided by the commissioner.

(c) A person may do the following work with a limited well/boring contractor's license in possession. A separate license is required for each of the six activities:

(1) installing or repairing well screens or pitless units or pitless adaptors and well casings from the pitless adaptor or pitless unit to the upper termination of the well casing;

(2) constructing, repairing, and sealing drive point wells or dug wells;

(3) installing well pumps or pumping equipment;

(4) sealing wells or borings;

(5) constructing, repairing, or sealing dewatering wells; or

(6) constructing, repairing, or sealing bored geothermal heat exchangers.

(d) A person may construct, repair, and seal an elevator boring with an elevator boring contractor's license.

(e) Notwithstanding other provisions of this chapter requiring a license ~~or registration~~, a license ~~or registration~~ is not required for a person who complies with the other provisions of this chapter if the person is:

(1) an individual who constructs a well on land that is owned or leased by the individual and is used by the individual for farming or agricultural purposes or as the individual's place of abode;

(2) an individual who performs labor or services for a contractor licensed ~~or registered~~ under the provisions of this chapter in connection with the construction, sealing, or repair of a well or boring at the direction and under the personal supervision of a contractor licensed ~~or registered~~ under the provisions of this chapter; or

(3) a licensed plumber who is repairing submersible pumps or water pipes associated with well water systems if: (i) the repair location is within an area where there is no licensed ~~or registered~~ well contractor within 50 miles, and (ii) the licensed plumber complies with all relevant sections of the plumbing code.

Subd. 5. **At-grade monitoring wells.** At-grade monitoring wells are authorized without variance and may be installed for the purpose of evaluating groundwater conditions or for use as a leak detection device. An at-grade monitoring well must be installed in accordance with the rules of the commissioner. The at-grade monitoring wells must be installed with an impermeable double locking cap approved by the commissioner and must be labeled monitoring wells.

Subd. 6. **Distance requirements for sources of contamination, buildings, gas pipes, liquid propane tanks, and electric lines.** (a) A person may not place, construct, or install an actual or potential source of contamination, building, gas pipe, liquid propane tank, or electric line any closer to a well or boring than the isolation distances prescribed by the commissioner by rule unless a variance has been prescribed by rule.

(b) The commissioner shall establish by rule reduced isolation distances for facilities which have safeguards in accordance with sections 18B.01, subdivision 26, and 18C.005, subdivision 29.

Subd. 7. **Well identification label required.** After a well has been constructed, the person constructing the well must attach a label to the well showing the unique well number.

Subd. 8. **Wells on property of another.** A person may not construct or have constructed a well for the person's own use on the property of another until the owner of the property on which the well is to be located and the intended well user sign a written agreement that identifies which party will be responsible for obtaining all permits or filing notification, paying applicable fees and for sealing the well. If the property owner refuses to sign the agreement, the intended well user may, in lieu of a written agreement, state in writing to the commissioner that the well user will be responsible for obtaining permits, filing notification, paying applicable fees, and sealing the well. Nothing in this subdivision eliminates the responsibilities of the property owner under this chapter, or allows a person to construct a well on the property of another without consent or other legal authority.

Subd. 9. **Report of work.** Within 30 days after completion or sealing of a well or boring, the person doing the work must submit a verified report to the commissioner containing the information specified by rules adopted under this chapter.

Within 30 days after receiving the report, the commissioner shall send or otherwise provide access to a copy of the report to the commissioner of natural resources, to the local soil and water conservation district where the well is located, and to the director of the Minnesota Geological Survey.

Sec. 7. Minnesota Statutes 2016, section 103I.301, is amended to read:

103I.301 WELL <u>AND BORING</u> SEALING REQUIREMENTS.

Subdivision 1. **Wells and borings.** (a) A property owner must have a well or boring sealed if:

(1) the well or boring is contaminated or may contribute to the spread of contamination;

(2) the well or boring was attempted to be sealed but was not sealed according to the provisions of this chapter; or

(3) the well or boring is located, constructed, or maintained in a manner that its continued use or existence endangers groundwater quality or is a safety or health hazard.

(b) A well <u>or boring</u> that is not in use must be sealed unless the property owner has a maintenance permit for the well.

(c) The property owner must have a well or boring sealed by a ~~registered or~~ licensed person authorized to seal the well or boring, consistent with provisions of this chapter.

Subd. 2. **Monitoring wells.** The owner of the property where a monitoring well is located must have the monitoring well sealed when the well is no longer in use. The owner must have a well contractor, limited well/boring sealing contractor, or a monitoring well contractor seal the monitoring well.

Subd. 3. **Dewatering wells.** (a) The owner of the property where a dewatering well is located must have the dewatering well sealed when the dewatering well is no longer in use.

(b) A well contractor, limited well/boring sealing contractor, or limited dewatering well contractor shall seal the dewatering well.

Subd. 4. **Sealing procedures.** Wells and borings must be sealed according to rules adopted by the commissioner.

Subd. 6. **Notification required.** A person may not seal a well until a notification of the proposed sealing is filed as prescribed by the commissioner.

Sec. 8. Minnesota Statutes 2016, section 103I.501, is amended to read:

103I.501 LICENSING AND REGULATION OF WELLS AND BORINGS.

(a) The commissioner shall regulate and license:

(1) drilling, constructing, and repair of wells;

(2) sealing of wells;

(3) installing of well pumps and pumping equipment;

(4) excavating, drilling, repairing, and sealing of elevator borings;

(5) construction, repair, and sealing of environmental bore holes; and

(6) construction, repair, and sealing of bored geothermal heat exchangers.

(b) The commissioner shall examine and license well contractors, limited well/boring contractors, ~~and~~ elevator boring contractors, and ~~examine and register~~ monitoring well contractors.

(c) The commissioner shall license explorers engaged in exploratory boring and shall examine persons who supervise or oversee exploratory boring.

Sec. 9. Minnesota Statutes 2016, section 103I.505, is amended to read:

103I.505 RECIPROCITY OF LICENSES AND ~~REGISTRATIONS~~ CERTIFICATIONS.

Subdivision 1. **Reciprocity authorized.** The commissioner may issue a license or ~~register~~ certify a person under this chapter, without giving an examination, if the person is licensed or ~~registered~~ certified in another state and:

(1) the requirements for licensing or ~~registration~~ certification under which the well or boring contractor was licensed or ~~registered~~ person was certified do not conflict with this chapter;

(2) the requirements are of a standard not lower than that specified by the rules adopted under this chapter; and

(3) equal reciprocal privileges are granted to licensees or ~~registrants~~ certified persons of this state.

Subd. 2. **Fees required.** A well or boring contractor or certified person must apply for the license or ~~registration~~ certification and pay the fees under the provisions of this chapter to receive a license or ~~registration~~ certification under this section.

Sec. 10. Minnesota Statutes 2016, section 103I.515, is amended to read:

103I.515 LICENSES NOT TRANSFERABLE.

A license or ~~registration~~ certification issued under this chapter is not transferable.

Sec. 11. Minnesota Statutes 2016, section 103I.535, subdivision 3, is amended to read:

Subd. 3. **Certification examination.** After the commissioner has approved the application, the applicant must take an examination given by the commissioner.

Sec. 12. Minnesota Statutes 2016, section 103I.535, is amended by adding a subdivision to read:

Subd. 3b. **Certification renewal.** (a) A representative must file an application and a renewal application fee to renew the certification by the date stated in the certification.

(b) The renewal application must include information that the certified representative has met continuing education requirements established by the commissioner by rule.

Sec. 13. Minnesota Statutes 2016, section 103I.535, subdivision 6, is amended to read:

Subd. 6. **License fee.** The fee for an elevator ~~shaft~~ boring contractor's license is $75.

Sec. 14. Minnesota Statutes 2016, section 103I.541, is amended to read:

103I.541 MONITORING WELL CONTRACTOR'S ~~REGISTRATION~~ LICENSE; REPRESENTATIVE'S CERTIFICATION.

Subdivision 1. ~~**Registration**~~ **Certification.** A person seeking ~~registration as~~ certification to represent a monitoring well contractor must meet examination and experience requirements adopted by the commissioner by rule.

Subd. 2. **Validity.** A monitoring well contractor's ~~registration~~ certification is valid until the date prescribed in the ~~registration~~ certification by the commissioner.

Subd. 2a. **Certification application.** (a) An individual must submit an application and application fee to the commissioner to apply for certification as a representative of a monitoring well contractor.

(b) The application must be on forms prescribed by the commissioner. The application must state the applicant's qualifications for the certification, and other information required by the commissioner.

~~Subd. 2b. **Issuance of registration.** If a person employs a certified representative, submits the bond under subdivision 3, and pays the registration fee of $75 for a monitoring well contractor registration, the commissioner shall issue a monitoring well contractor registration to the applicant. The fee for an individual registration is $75. The commissioner may not act on an application until the application fee is paid.~~

Subd. 2c. **Certification fee.** (a) The application fee for certification as a representative of a monitoring well contractor is $75. The commissioner may not act on an application until the application fee is paid.

(b) The renewal fee for certification as a representative of a monitoring well contractor is $75. The commissioner may not renew a certification until the renewal fee is paid.

Subd. 2d. **Examination.** After the commissioner has approved an application, the applicant must take an examination given by the commissioner.

Subd. 2e. **Issuance of certification.** If the applicant meets the experience requirements established by rule and passes the examination as determined by the commissioner, the commissioner shall issue the applicant a certification to represent a monitoring well contractor.

Subd. 2f. **Certification renewal.** (a) A representative must file an application and a renewal application fee to renew the certification by the date stated in the certification.

(b) The renewal application must include information that the certified representative has met continuing education requirements established by the commissioner by rule.

Subd. 2g. **Issuance of license.** (a) If a person employs a certified representative, submits the bond under subdivision 3, and pays the license fee of $75 for a monitoring well contractor license, the commissioner shall issue a monitoring well contractor license to the applicant.

(b) The commissioner may not act on an application until the application fee is paid.

Subd. 3. **Bond.** (a) As a condition of being issued a monitoring well contractor's ~~registration~~ license, the applicant must submit a corporate surety bond for $10,000 approved by the commissioner. The bond must be conditioned to pay the state on performance of work in this state that is not in compliance with this chapter or rules adopted under this chapter. The bond is in lieu of other license bonds required by a political subdivision of the state.

(b) From proceeds of the bond, the commissioner may compensate persons injured or suffering financial loss because of a failure of the applicant to perform work or duties in compliance with this chapter or rules adopted under this chapter.

Subd. 4. **License renewal.** (a) A person must file an application and a renewal application fee to renew the ~~registration~~ license by the date stated in the ~~registration~~ license.

(b) The renewal application fee for a monitoring well contractor's ~~registration~~ license is $75.

(c) The renewal application must include information that the certified representative of the applicant has met continuing education requirements established by the commissioner by rule.

(d) At the time of the renewal, the commissioner must have on file all well and boring construction reports, well and boring sealing reports, well permits, and notifications for work conducted by the ~~registered~~ licensed person since the last ~~registration~~ license renewal.

Subd. 5. **Incomplete or late renewal.** If a ~~registered~~ licensed person submits a renewal application after the required renewal date:

(1) the ~~registered~~ licensed person must include a late fee of $75; and

(2) the ~~registered~~ licensed person may not conduct activities authorized by the monitoring well contractor's ~~registration~~ license until the renewal application, renewal application fee, late fee, and all other information required in subdivision 4 are submitted.

Sec. 15. Minnesota Statutes 2016, section 103I.545, subdivision 1, is amended to read:

Subdivision 1. **Drilling machine.** (a) A person may not use a drilling machine such as a cable tool, rotary tool, hollow rod tool, or auger for a drilling activity requiring a license ~~or registration~~ under this chapter unless the drilling machine is registered with the commissioner.

(b) A person must apply for the registration on forms prescribed by the commissioner and submit a $75 registration fee.

(c) A registration is valid for one year.

Sec. 16. Minnesota Statutes 2016, section 103I.545, subdivision 2, is amended to read:

Subd. 2. **Hoist.** (a) A person may not use a machine such as a hoist for an activity requiring a license ~~or registration~~ under this chapter to repair wells or borings, seal wells or borings, or install pumps unless the machine is registered with the commissioner.

(b) A person must apply for the registration on forms prescribed by the commissioner and submit a $75 registration fee.

(c) A registration is valid for one year.

Sec. 17. Minnesota Statutes 2016, section 103I.711, subdivision 1, is amended to read:

Subdivision 1. **Impoundment.** The commissioner may apply to district court for a warrant authorizing seizure and impoundment of all drilling machines or hoists owned or used by a person. The court shall issue an impoundment order upon the commissioner's showing that a person is constructing, repairing, or sealing wells or borings or installing pumps or pumping equipment or excavating holes for installing elevator ~~shafts~~ borings without a license ~~or registration~~ as required under this chapter. A sheriff on receipt of the warrant must seize and impound all drilling machines and hoists owned or used by the person. A person from whom equipment is seized under this subdivision may file an action in district court for the purpose of establishing that the equipment was wrongfully seized.

Sec. 18. Minnesota Statutes 2016, section 103I.715, subdivision 2, is amended to read:

Subd. 2. **Gross misdemeanors.** A person is guilty of a gross misdemeanor who:

(1) willfully violates a provision of this chapter or order of the commissioner;

(2) engages in the business of drilling or making wells, sealing wells, installing pumps or pumping equipment, or constructing elevator ~~shafts~~ borings without a license required by this chapter; or

(3) engages in the business of exploratory boring without an exploratory borer's license under this chapter.

Sec. 19. Minnesota Statutes 2016, section 144.05, subdivision 6, is amended to read:

Subd. 6. **Reports on interagency agreements and intra-agency transfers.** The commissioner of health shall provide quarterly reports to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance on:

(1) interagency agreements or service-level agreements and any renewals or extensions of existing interagency or service-level agreements with a state department under section 15.01, state agency under section 15.012, or the Office of MN.IT Services, with a value of more than $100,000, or related agreements with the same department or agency with a cumulative value of more than $100,000; and

(2) transfers of appropriations of more than $100,000 between accounts within or between agencies.

The report must include the statutory citation authorizing the agreement, transfer or dollar amount, purpose, and effective date of the agreement, and the duration of the agreement~~, and a copy of the agreement~~.

Sec. 20. **[144.059] PALLIATIVE CARE ADVISORY COUNCIL.**

Subdivision 1. **Membership.** The Palliative Care Advisory Council shall consist of 18 public members.

Subd. 2. **Public members.** (a) The commissioner shall appoint, in the manner provided in section 15.0597, 18 public members, including the following:

(1) two physicians, of which one is certified by the American Board of Hospice and Palliative Medicine;

(2) two registered nurses or advanced practice registered nurses, of which one is certified by the National Board for Certification of Hospice and Palliative Nurses;

(3) one care coordinator experienced in working with people with serious or chronic illness and their families;

(4) one spiritual counselor experienced in working with people with serious or chronic illness and their families;

(5) three licensed health professionals, such as complementary and alternative health care practitioners, dieticians or nutritionists, pharmacists, or physical therapists, who are neither physicians nor nurses, but who have experience as members of a palliative care interdisciplinary team working with people with serious or chronic illness and their families;

(6) one licensed social worker experienced in working with people with serious or chronic illness and their families;

(7) four patients or personal caregivers experienced with serious or chronic illness;

(8) one representative of a health plan company;

(9) one physician assistant that is a member of the American Academy of Hospice and Palliative Medicine; and

(10) two members from any of the categories described in clauses (1) to (9).

(b) The commissioner must include, where possible, representation that is racially, culturally, linguistically, geographically, and economically diverse.

(c) The council must include at least six members who reside outside Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Mille Lacs, Ramsey, Scott, Sherburne, Sibley, Stearns, Washington, or Wright Counties.

(d) To the extent possible, council membership must include persons who have experience in palliative care research, palliative care instruction in a medical or nursing school setting, palliative care services for veterans as a provider or recipient, or pediatric care.

(e) Council membership must include health professionals who have palliative care work experience or expertise in palliative care delivery models in a variety of inpatient, outpatient, and community settings, including acute care, long-term care, or hospice, with a variety of populations, including pediatric, youth, and adult patients.

Subd. 3. **Term.** Members of the council shall serve for a term of three years and may be reappointed. Members shall serve until their successors have been appointed.

Subd. 4. **Administration.** The commissioner or the commissioner's designee shall provide meeting space and administrative services for the council.

Subd. 5. **Chairs.** At the council's first meeting, and biannually thereafter, the members shall elect a chair and a vice-chair whose duties shall be established by the council.

Subd. 6. **Meeting.** The council shall meet at least twice yearly.

Subd. 7. **No compensation.** Public members of the council serve without compensation.

Subd. 8. **Duties.** (a) The council shall consult with and advise the commissioner on matters related to the establishment, maintenance, operation, and outcomes evaluation of palliative care initiatives in the state.

(b) By February 15 of each year, the council shall submit to the chairs and ranking minority members of the committees of the senate and the house of representatives with primary jurisdiction over health care a report containing:

(1) the advisory council's assessment of the availability of palliative care in the state;

(2) the advisory council's analysis of barriers to greater access to palliative care; and

(3) recommendations for legislative action, with draft legislation to implement the recommendations.

(c) The Department of Health shall publish the report each year on the department's Web site.

Subd. 9. **Open meetings.** The council is subject to the requirements of chapter 13D.

Subd. 10. **Sunset.** The council shall sunset January 1, 2025.

Sec. 21. Minnesota Statutes 2016, section 144.122, is amended to read:

144.122 LICENSE, PERMIT, AND SURVEY FEES.

(a) The state commissioner of health, by rule, may prescribe procedures and fees for filing with the commissioner as prescribed by statute and for the issuance of original and renewal permits, licenses, registrations, and certifications issued under authority of the commissioner. The expiration dates of the various licenses, permits, registrations, and certifications as prescribed by the rules shall be plainly marked thereon. Fees may include application and examination fees and a penalty fee for renewal applications submitted after the expiration date of the previously issued permit, license, registration, and certification. The commissioner may also prescribe, by rule, reduced fees for permits, licenses, registrations, and certifications when the application therefor is submitted during the last three months of the permit, license, registration, or certification period. Fees proposed to be prescribed in the rules shall be first approved by the Department of Management and Budget. All fees proposed to be prescribed in rules shall be reasonable. The fees shall be in an amount so that the total fees collected by the commissioner will, where practical, approximate the cost to the commissioner in administering the program. All fees collected

shall be deposited in the state treasury and credited to the state government special revenue fund unless otherwise specifically appropriated by law for specific purposes.

(b) The commissioner may charge a fee for voluntary certification of medical laboratories and environmental laboratories, and for environmental and medical laboratory services provided by the department, without complying with paragraph (a) or chapter 14. Fees charged for environment and medical laboratory services provided by the department must be approximately equal to the costs of providing the services.

(c) The commissioner may develop a schedule of fees for diagnostic evaluations conducted at clinics held by the services for children with disabilities program. All receipts generated by the program are annually appropriated to the commissioner for use in the maternal and child health program.

(d) The commissioner shall set license fees for hospitals and nursing homes that are not boarding care homes at the following levels:

Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and American Osteopathic Association (AOA) hospitals	$7,655 plus $16 per bed
Non-JCAHO and non-AOA hospitals	$5,280 plus $250 per bed
Nursing home	$183 plus $91 per bed

The commissioner shall set license fees for outpatient surgical centers, boarding care homes, and supervised living facilities at the following levels:

Outpatient surgical centers	$3,712
Boarding care homes	$183 plus $91 per bed
Supervised living facilities	$183 plus $91 per bed.

Fees collected under this paragraph are nonrefundable. The fees are nonrefundable even if received before July 1, 2017, for licenses or registrations being issued effective July 1, 2017, or later.

(e) Unless prohibited by federal law, the commissioner of health shall charge applicants the following fees to cover the cost of any initial certification surveys required to determine a provider's eligibility to participate in the Medicare or Medicaid program:

Prospective payment surveys for hospitals	$	900
Swing bed surveys for nursing homes	$	1,200
Psychiatric hospitals	$	1,400
Rural health facilities	$	1,100
Portable x-ray providers	$	500

Home health agencies	$	1,800
Outpatient therapy agencies	$	800
End stage renal dialysis providers	$	2,100
Independent therapists	$	800
Comprehensive rehabilitation outpatient facilities	$	1,200
Hospice providers	$	1,700
Ambulatory surgical providers	$	1,800
Hospitals	$	4,200
Other provider categories or additional resurveys required to complete initial certification	Actual surveyor costs: average surveyor cost x number of hours for the survey process.	

These fees shall be submitted at the time of the application for federal certification and shall not be refunded. All fees collected after the date that the imposition of fees is not prohibited by federal law shall be deposited in the state treasury and credited to the state government special revenue fund.

Sec. 22. Minnesota Statutes 2016, section 144.1501, subdivision 2, is amended to read:

Subd. 2. **Creation of account.** (a) A health professional education loan forgiveness program account is established. The commissioner of health shall use money from the account to establish a loan forgiveness program:

(1) for medical residents and mental health professionals agreeing to practice in designated rural areas or underserved urban communities or specializing in the area of pediatric psychiatry;

(2) for midlevel practitioners agreeing to practice in designated rural areas or to teach at least 12 credit hours, or 720 hours per year in the nursing field in a postsecondary program at the undergraduate level or the equivalent at the graduate level;

(3) for nurses who agree to practice in a Minnesota nursing home; an intermediate care facility for persons with developmental disability; ~~or~~ a hospital if the hospital owns and operates a Minnesota nursing home and a minimum of 50 percent of the hours worked by the nurse is in the nursing home; a housing with services establishment as defined in section 144D.01, subdivision 4; or for a home care provider as defined in section 144A.43, subdivision 4; or agree to teach at least 12 credit hours, or 720 hours per year in the nursing field in a postsecondary program at the undergraduate level or the equivalent at the graduate level;

(4) for other health care technicians agreeing to teach at least 12 credit hours, or 720 hours per year in their designated field in a postsecondary program at the undergraduate level or the equivalent at the graduate level. The commissioner, in consultation with the Healthcare Education-Industry Partnership, shall determine the health care fields where the need is the greatest, including, but not limited to, respiratory therapy, clinical laboratory technology, radiologic technology, and surgical technology;

(5) for pharmacists, advanced dental therapists, dental therapists, and public health nurses who agree to practice in designated rural areas; and

(6) for dentists agreeing to deliver at least 25 percent of the dentist's yearly patient encounters to state public program enrollees or patients receiving sliding fee schedule discounts through a formal sliding fee schedule meeting the standards established by the United States Department of Health and Human Services under Code of Federal Regulations, title 42, section 51, chapter 303.

(b) Appropriations made to the account do not cancel and are available until expended, except that at the end of each biennium, any remaining balance in the account that is not committed by contract and not needed to fulfill existing commitments shall cancel to the fund.

Sec. 23. **[144.1505] PRIMARY CARE CLINICAL TRAINING EXPANSION GRANT PROGRAM.**

Subdivision 1. **Definitions.** For purposes of this section, the following definitions apply:

(1) "eligible advanced practice registered nurse program" means a program that is located in Minnesota and is currently accredited as a master's, doctoral, or postgraduate level advanced practice registered nurse program by the Commission on Collegiate Nursing Education or by the Accreditation Commission for Education in Nursing, or is a candidate for accreditation;

(2) "eligible physician assistant program" means a program that is located in Minnesota and is currently accredited as a physician assistant program by the Accreditation Review Commission on Education for the Physician Assistant, or is a candidate for accreditation; and

(3) "project" means a project to establish or expand clinical training for physician assistants or advanced practice registered nurses in Minnesota.

Subd. 2. **Program.** (a) The commissioner of health shall award health professional training site grants to eligible physician assistant and advanced practice registered nurse

programs to plan and implement expanded clinical training. A planning grant shall not exceed $75,000, and a training grant shall not exceed $150,000 for the first year, $100,000 for the second year, and $50,000 for the third year per program.

(b) Funds may be used for:

(1) establishing or expanding clinical training for physician assistants and advanced practice registered nurses in Minnesota;

(2) recruitment, training, and retention of students and faculty;

(3) connecting students with appropriate clinical training sites, internships, practicums, or externship activities;

(4) travel and lodging for students;

(5) faculty, student, and preceptor salaries, incentives, or other financial support;

(6) development and implementation of cultural competency training;

(7) evaluations;

(8) training site improvements, fees, equipment, and supplies required to establish, maintain, or expand a physician assistant or advanced practice registered nurse training program; and

(9) supporting clinical education in which trainees are part of a primary care team model.

Subd. 3. **Applications.** Eligible physician assistant and advanced practice registered nurse programs seeking a grant shall apply to the commissioner. Applications must include a description of the number of additional students who will be trained using grant funds; attestation that funding will be used to support an increase in the number of clinical training slots; a description of the problem that the proposed project will address; a description of the project, including all costs associated with the project, sources of funds for the project, detailed uses of all funds for the project, and the results expected; and a plan to maintain or operate any component included in the project after the grant period. The applicant must describe achievable objectives, a timetable, and roles and capabilities of responsible individuals in the organization.

Subd. 4. **Consideration of applications.** The commissioner shall review each application to determine whether or not the application is complete and whether the program and the project are eligible for a grant. In evaluating applications, the commissioner shall score each application based on factors including, but not limited to, the applicant's clarity and thoroughness in describing the project and the problems to be addressed, the extent to which

the applicant has demonstrated that the applicant has made adequate provisions to ensure proper and efficient operation of the training program once the grant project is completed, the extent to which the proposed project is consistent with the goal of increasing access to primary care and mental health services for rural and underserved urban communities, the extent to which the proposed project incorporates team-based primary care, and project costs and use of funds.

Subd. 5. **Program oversight.** The commissioner shall determine the amount of a grant to be given to an eligible program based on the relative score of each eligible program's application, other relevant factors discussed during the review, and the funds available to the commissioner. Appropriations made to the program do not cancel and are available until expended. During the grant period, the commissioner may require and collect from programs receiving grants any information necessary to evaluate the program.

Sec. 24. Minnesota Statutes 2016, section 144.551, subdivision 1, is amended to read:

Subdivision 1. **Restricted construction or modification.** (a) The following construction or modification may not be commenced:

(1) any erection, building, alteration, reconstruction, modernization, improvement, extension, lease, or other acquisition by or on behalf of a hospital that increases the bed capacity of a hospital, relocates hospital beds from one physical facility, complex, or site to another, or otherwise results in an increase or redistribution of hospital beds within the state; and

(2) the establishment of a new hospital.

(b) This section does not apply to:

(1) construction or relocation within a county by a hospital, clinic, or other health care facility that is a national referral center engaged in substantial programs of patient care, medical research, and medical education meeting state and national needs that receives more than 40 percent of its patients from outside the state of Minnesota;

(2) a project for construction or modification for which a health care facility held an approved certificate of need on May 1, 1984, regardless of the date of expiration of the certificate;

(3) a project for which a certificate of need was denied before July 1, 1990, if a timely appeal results in an order reversing the denial;

(4) a project exempted from certificate of need requirements by Laws 1981, chapter 200, section 2;

(5) a project involving consolidation of pediatric specialty hospital services within the Minneapolis-St. Paul metropolitan area that would not result in a net increase in the number of pediatric specialty hospital beds among the hospitals being consolidated;

(6) a project involving the temporary relocation of pediatric-orthopedic hospital beds to an existing licensed hospital that will allow for the reconstruction of a new philanthropic, pediatric-orthopedic hospital on an existing site and that will not result in a net increase in the number of hospital beds. Upon completion of the reconstruction, the licenses of both hospitals must be reinstated at the capacity that existed on each site before the relocation;

(7) the relocation or redistribution of hospital beds within a hospital building or identifiable complex of buildings provided the relocation or redistribution does not result in: (i) an increase in the overall bed capacity at that site; (ii) relocation of hospital beds from one physical site or complex to another; or (iii) redistribution of hospital beds within the state or a region of the state;

(8) relocation or redistribution of hospital beds within a hospital corporate system that involves the transfer of beds from a closed facility site or complex to an existing site or complex provided that: (i) no more than 50 percent of the capacity of the closed facility is transferred; (ii) the capacity of the site or complex to which the beds are transferred does not increase by more than 50 percent; (iii) the beds are not transferred outside of a federal health systems agency boundary in place on July 1, 1983; and (iv) the relocation or redistribution does not involve the construction of a new hospital building;

(9) a construction project involving up to 35 new beds in a psychiatric hospital in Rice County that primarily serves adolescents and that receives more than 70 percent of its patients from outside the state of Minnesota;

(10) a project to replace a hospital or hospitals with a combined licensed capacity of 130 beds or less if: (i) the new hospital site is located within five miles of the current site; and (ii) the total licensed capacity of the replacement hospital, either at the time of construction of the initial building or as the result of future expansion, will not exceed 70 licensed hospital beds, or the combined licensed capacity of the hospitals, whichever is less;

(11) the relocation of licensed hospital beds from an existing state facility operated by the commissioner of human services to a new or existing facility, building, or complex operated by the commissioner of human services; from one regional treatment center site

to another; or from one building or site to a new or existing building or site on the same campus;

(12) the construction or relocation of hospital beds operated by a hospital having a statutory obligation to provide hospital and medical services for the indigent that does not result in a net increase in the number of hospital beds, notwithstanding section 144.552, 27 beds, of which 12 serve mental health needs, may be transferred from Hennepin County Medical Center to Regions Hospital under this clause;

(13) a construction project involving the addition of up to 31 new beds in an existing nonfederal hospital in Beltrami County;

(14) a construction project involving the addition of up to eight new beds in an existing nonfederal hospital in Otter Tail County with 100 licensed acute care beds;

(15) a construction project involving the addition of 20 new hospital beds used for rehabilitation services in an existing hospital in Carver County serving the southwest suburban metropolitan area. Beds constructed under this clause shall not be eligible for reimbursement under medical assistance or MinnesotaCare;

(16) a project for the construction or relocation of up to 20 hospital beds for the operation of up to two psychiatric facilities or units for children provided that the operation of the facilities or units have received the approval of the commissioner of human services;

(17) a project involving the addition of 14 new hospital beds to be used for rehabilitation services in an existing hospital in Itasca County;

(18) a project to add 20 licensed beds in existing space at a hospital in Hennepin County that closed 20 rehabilitation beds in 2002, provided that the beds are used only for rehabilitation in the hospital's current rehabilitation building. If the beds are used for another purpose or moved to another location, the hospital's licensed capacity is reduced by 20 beds;

(19) a critical access hospital established under section 144.1483, clause (9), and section 1820 of the federal Social Security Act, United States Code, title 42, section 1395i-4, that delicensed beds since enactment of the Balanced Budget Act of 1997, Public Law 105-33, to the extent that the critical access hospital does not seek to exceed the maximum number of beds permitted such hospital under federal law;

(20) notwithstanding section 144.552, a project for the construction of a new hospital in the city of Maple Grove with a licensed capacity of up to 300 beds provided that:

(i) the project, including each hospital or health system that will own or control the entity that will hold the new hospital license, is approved by a resolution of the Maple Grove City Council as of March 1, 2006;

(ii) the entity that will hold the new hospital license will be owned or controlled by one or more not-for-profit hospitals or health systems that have previously submitted a plan or plans for a project in Maple Grove as required under section 144.552, and the plan or plans have been found to be in the public interest by the commissioner of health as of April 1, 2005;

(iii) the new hospital's initial inpatient services must include, but are not limited to, medical and surgical services, obstetrical and gynecological services, intensive care services, orthopedic services, pediatric services, noninvasive cardiac diagnostics, behavioral health services, and emergency room services;

(iv) the new hospital:

(A) will have the ability to provide and staff sufficient new beds to meet the growing needs of the Maple Grove service area and the surrounding communities currently being served by the hospital or health system that will own or control the entity that will hold the new hospital license;

(B) will provide uncompensated care;

(C) will provide mental health services, including inpatient beds;

(D) will be a site for workforce development for a broad spectrum of health-care-related occupations and have a commitment to providing clinical training programs for physicians and other health care providers;

(E) will demonstrate a commitment to quality care and patient safety;

(F) will have an electronic medical records system, including physician order entry;

(G) will provide a broad range of senior services;

(H) will provide emergency medical services that will coordinate care with regional providers of trauma services and licensed emergency ambulance services in order to enhance the continuity of care for emergency medical patients; and

(I) will be completed by December 31, 2009, unless delayed by circumstances beyond the control of the entity holding the new hospital license; and

(v) as of 30 days following submission of a written plan, the commissioner of health has not determined that the hospitals or health systems that will own or control the entity that will hold the new hospital license are unable to meet the criteria of this clause;

(21) a project approved under section 144.553;

(22) a project for the construction of a hospital with up to 25 beds in Cass County within a 20-mile radius of the state Ah-Gwah-Ching facility, provided the hospital's license holder is approved by the Cass County Board;

(23) a project for an acute care hospital in Fergus Falls that will increase the bed capacity from 108 to 110 beds by increasing the rehabilitation bed capacity from 14 to 16 and closing a separately licensed 13-bed skilled nursing facility;

(24) notwithstanding section 144.552, a project for the construction and expansion of a specialty psychiatric hospital in Hennepin County for up to 50 beds, exclusively for patients who are under 21 years of age on the date of admission. The commissioner conducted a public interest review of the mental health needs of Minnesota and the Twin Cities metropolitan area in 2008. No further public interest review shall be conducted for the construction or expansion project under this clause;

(25) a project for a 16-bed psychiatric hospital in the city of Thief River Falls, if the commissioner finds the project is in the public interest after the public interest review conducted under section 144.552 is complete; ~~or~~

(26)(i) a project for a 20-bed psychiatric hospital, within an existing facility in the city of Maple Grove, exclusively for patients who are under 21 years of age on the date of admission, if the commissioner finds the project is in the public interest after the public interest review conducted under section 144.552 is complete;

(ii) this project shall serve patients in the continuing care benefit program under section 256.9693. The project may also serve patients not in the continuing care benefit program; and

(iii) if the project ceases to participate in the continuing care benefit program, the commissioner must complete a subsequent public interest review under section 144.552. If the project is found not to be in the public interest, the license must be terminated six months from the date of that finding. If the commissioner of human services terminates the contract without cause or reduces per diem payment rates for patients under the continuing care benefit program below the rates in effect for services provided on December 31, 2015, the

project may cease to participate in the continuing care benefit program and continue to operate without a subsequent public interest review; or

(27) a project involving the addition of 21 new beds in an existing psychiatric hospital in Hennepin County that is exclusively for patients who are under 21 years of age on the date of admission.

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

Sec. 25. Minnesota Statutes 2016, section 144A.472, subdivision 7, is amended to read:

Subd. 7. **Fees; application, change of ownership, and renewal.** (a) An initial applicant seeking temporary home care licensure must submit the following application fee to the commissioner along with a completed application:

(1) for a basic home care provider, $2,100; or

(2) for a comprehensive home care provider, $4,200.

(b) A home care provider who is filing a change of ownership as required under subdivision 5 must submit the following application fee to the commissioner, along with the documentation required for the change of ownership:

(1) for a basic home care provider, $2,100; or

(2) for a comprehensive home care provider, $4,200.

(c) A home care provider who is seeking to renew the provider's license shall pay a fee to the commissioner based on revenues derived from the provision of home care services during the calendar year prior to the year in which the application is submitted, according to the following schedule:

License Renewal Fee

Provider Annual Revenue	Fee
greater than $1,500,000	$6,625
greater than $1,275,000 and no more than $1,500,000	$5,797
greater than $1,100,000 and no more than $1,275,000	$4,969
greater than $950,000 and no more than $1,100,000	$4,141
greater than $850,000 and no more than $950,000	$3,727
greater than $750,000 and no more than $850,000	$3,313
greater than $650,000 and no more than $750,000	$2,898

greater than $550,000 and no more than $650,000	$2,485
greater than $450,000 and no more than $550,000	$2,070
greater than $350,000 and no more than $450,000	$1,656
greater than $250,000 and no more than $350,000	$1,242
greater than $100,000 and no more than $250,000	$828
greater than $50,000 and no more than $100,000	$500
greater than $25,000 and no more than $50,000	$400
no more than $25,000	$200

(d) If requested, the home care provider shall provide the commissioner information to verify the provider's annual revenues or other information as needed, including copies of documents submitted to the Department of Revenue.

(e) At each annual renewal, a home care provider may elect to pay the highest renewal fee for its license category, and not provide annual revenue information to the commissioner.

(f) A temporary license or license applicant, or temporary licensee or licensee that knowingly provides the commissioner incorrect revenue amounts for the purpose of paying a lower license fee, shall be subject to a civil penalty in the amount of double the fee the provider should have paid.

(g) Fees and penalties collected under this section shall be deposited in the state treasury and credited to the state government special revenue fund. All fees are nonrefundable. Fees collected under paragraph (c) are nonrefundable even if received before July 1, 2017, for temporary licenses or licenses being issued effective July 1, 2017, or later.

(h) The license renewal fee schedule in this subdivision is effective July 1, 2016.

Sec. 26. Minnesota Statutes 2016, section 144A.474, subdivision 11, is amended to read:

Subd. 11. **Fines.** (a) Fines and enforcement actions under this subdivision may be assessed based on the level and scope of the violations described in paragraph (c) as follows:

(1) Level 1, no fines or enforcement;

(2) Level 2, fines ranging from $0 to $500, in addition to any of the enforcement mechanisms authorized in section 144A.475 for widespread violations;

(3) Level 3, fines ranging from $500 to $1,000, in addition to any of the enforcement mechanisms authorized in section 144A.475; and

(4) Level 4, fines ranging from $1,000 to $5,000, in addition to any of the enforcement mechanisms authorized in section 144A.475.

(b) Correction orders for violations are categorized by both level and scope and fines shall be assessed as follows:

(1) level of violation:

(i) Level 1 is a violation that has no potential to cause more than a minimal impact on the client and does not affect health or safety;

(ii) Level 2 is a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death;

(iii) Level 3 is a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death; and

(iv) Level 4 is a violation that results in serious injury, impairment, or death.

(2) scope of violation:

(i) isolated, when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally;

(ii) pattern, when more than a limited number of clients are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly but is not found to be pervasive; and

(iii) widespread, when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the clients.

(c) If the commissioner finds that the applicant or a home care provider required to be licensed under sections 144A.43 to 144A.482 has not corrected violations by the date specified in the correction order or conditional license resulting from a survey or complaint investigation, the commissioner may impose a fine. A notice of noncompliance with a correction order must be mailed to the applicant's or provider's last known address. The noncompliance notice must list the violations not corrected.

(d) The license holder must pay the fines assessed on or before the payment date specified. If the license holder fails to fully comply with the order, the commissioner may issue a second fine or suspend the license until the license holder complies by paying the fine. A timely appeal shall stay payment of the fine until the commissioner issues a final order.

(e) A license holder shall promptly notify the commissioner in writing when a violation specified in the order is corrected. If upon reinspection the commissioner determines that

a violation has not been corrected as indicated by the order, the commissioner may issue a second fine. The commissioner shall notify the license holder by mail to the last known address in the licensing record that a second fine has been assessed. The license holder may appeal the second fine as provided under this subdivision.

(f) A home care provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14.

(g) When a fine has been assessed, the license holder may not avoid payment by closing, selling, or otherwise transferring the licensed program to a third party. In such an event, the license holder shall be liable for payment of the fine.

(h) In addition to any fine imposed under this section, the commissioner may assess costs related to an investigation that results in a final order assessing a fine or other enforcement action authorized by this chapter.

(i) Fines collected under this subdivision shall be deposited in the state government special revenue fund and credited to an account separate from the revenue collected under section 144A.472. Subject to an appropriation by the legislature, the revenue from the fines collected ~~may~~ must be used by the commissioner for special projects to improve home care in Minnesota as recommended by the advisory council established in section 144A.4799.

Sec. 27. Minnesota Statutes 2016, section 144A.4799, subdivision 3, is amended to read:

Subd. 3. **Duties.** (a) At the commissioner's request, the advisory council shall provide advice regarding regulations of Department of Health licensed home care providers in this chapter, including advice on the following:

(1) community standards for home care practices;

(2) enforcement of licensing standards and whether certain disciplinary actions are appropriate;

(3) ways of distributing information to licensees and consumers of home care;

(4) training standards;

(5) identifying emerging issues and opportunities in the home care field, including the use of technology in home and telehealth capabilities;

(6) allowable home care licensing modifications and exemptions, including a method for an integrated license with an existing license for rural licensed nursing homes to provide limited home care services in an adjacent independent living apartment building owned by the licensed nursing home; and

(7) recommendations for studies using the data in section 62U.04, subdivision 4, including but not limited to studies concerning costs related to dementia and chronic disease among an elderly population over 60 and additional long-term care costs, as described in section 62U.10, subdivision 6.

(b) The advisory council shall perform other duties as directed by the commissioner.

(c) The advisory council shall annually review the balance of the account in the state government special revenue fund described in section 144A.474, subdivision 11, paragraph (i), and make annual recommendations by January 15 directly to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services regarding appropriations to the commissioner for the purposes in section 144A.474, subdivision 11, paragraph (i).

Sec. 28. Minnesota Statutes 2016, section 144A.70, is amended by adding a subdivision to read:

Subd. 4a. **Nurse.** "Nurse" means a licensed practical nurse as defined in section 148.171, subdivision 8, or a registered nurse as defined in section 148.171, subdivision 20.

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

Sec. 29. Minnesota Statutes 2016, section 144A.70, subdivision 6, is amended to read:

Subd. 6. **Supplemental nursing services agency.** "Supplemental nursing services agency" means a person, firm, corporation, partnership, or association engaged for hire in the business of providing or procuring temporary employment in health care facilities for nurses, nursing assistants, nurse aides, and orderlies~~, and other licensed health professionals~~. Supplemental nursing services agency does not include an individual who only engages in providing the individual's services on a temporary basis to health care facilities. Supplemental nursing services agency does not include a professional home care agency licensed under section 144A.471 that only provides staff to other home care providers.

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

Sec. 30. Minnesota Statutes 2016, section 144D.06, is amended to read:

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 ~~in addition to registration under this chapter~~. A housing with services establishment is ~~subject to the provisions of section 325F.72 and chapter 504B~~ not required to obtain a lodging license under chapter 157 and related rules.

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

Sec. 31. **[144D.071] CHANGE OF LIVING UNIT.**

Housing with services establishments must not require a resident to move from the resident's living unit to another living unit, to share a unit, or to move out of the building after a resident begins receiving services under section 256B.0915.

Sec. 32. **[144H.01] DEFINITIONS.**

Subdivision 1. **Application.** The terms defined in this section apply to this chapter.

Subd. 2. **Basic services.** "Basic services" includes but is not limited to:

(1) the development, implementation, and monitoring of a comprehensive protocol of care that is developed in conjunction with the parent or guardian of a medically complex or technologically dependent child and that specifies the medical, nursing, psychosocial, and developmental therapies required by the medically complex or technologically dependent child; and

(2) the caregiver training needs of the child's parent or guardian.

Subd. 3. **Commissioner.** "Commissioner" means the commissioner of health.

Subd. 4. **Licensee.** "Licensee" means an owner of a prescribed pediatric extended care (PPEC) center licensed under this chapter.

Subd. 5. **Medically complex or technologically dependent child.** "Medically complex or technologically dependent child" means a child who, because of a medical condition, requires continuous therapeutic interventions or skilled nursing supervision which must be prescribed by a licensed physician and administered by, or under the direct supervision of, a licensed registered nurse.

Subd. 6. **Owner.** "Owner" means an individual whose ownership interest provides sufficient authority or control to affect or change decisions regarding the operation of the PPEC center. An owner includes a sole proprietor, a general partner, or any other individual whose ownership interest has the ability to affect the management and direction of the PPEC center's policies.

Subd. 7. **Prescribed pediatric extended care center, PPEC center, or center.** "Prescribed pediatric extended care center," "PPEC center," or "center" means any facility operated on a for-profit or nonprofit basis to provide nonresidential basic services to three or more medically complex or technologically dependent children who require such services and who are not related to the owner by blood, marriage, or adoption.

Subd. 8. **Supportive services or contracted services.** "Supportive services or contracted services" include but are not limited to speech therapy, occupational therapy, physical therapy, social work services, developmental services, child life services, and psychology services.

Sec. 33. **[144H.02] LICENSURE REQUIRED.**

A person may not own or operate a prescribed pediatric extended care center in this state unless the person holds a temporary or current license issued under this chapter. A separate license must be obtained for each PPEC center maintained on separate premises, even if the same management operates the PPEC centers. Separate licenses are not required for separate buildings on the same grounds. A center shall not be operated on the same grounds as a child care center licensed under Minnesota Rules, chapter 9503.

Sec. 34. **[144H.03] EXEMPTIONS.**

This chapter does not apply to:

(1) a facility operated by the United States government or a federal agency; or

(2) a health care facility licensed under chapter 144 or 144A.

Sec. 35. **[144H.04] LICENSE APPLICATION AND RENEWAL.**

Subdivision 1. **Licenses.** A person seeking licensure for a PPEC center must submit a completed application for licensure to the commissioner, in a form and manner determined by the commissioner. The applicant must also submit the application fee, in the amount specified in section 144H.05, subdivision 1. Effective February 1, 2019, the commissioner shall issue a license for a PPEC center if the commissioner determines that the applicant and center meet the requirements of this chapter and rules adopted under this chapter. A license issued under this subdivision is valid for two years.

Subd. 2. **License renewal.** A license issued under subdivision 1 may be renewed for a period of two years if the licensee:

(1) submits an application for renewal in a form and manner determined by the commissioner, at least 30 days before the license expires. An application for renewal submitted after the renewal deadline date must be accompanied by a late fee in the amount specified in section 144H.05, subdivision 3;

(2) submits the renewal fee in the amount specified in section 144H.05, subdivision 2;

(3) demonstrates that the licensee has provided basic services at the PPEC center within the past two years;

(4) provides evidence that the applicant meets the requirements for licensure; and

(5) provides other information required by the commissioner.

Subd. 3. **License not transferable.** A PPEC center license issued under this section is not transferable to another party. Before acquiring ownership of a PPEC center, a prospective applicant must apply to the commissioner for a new license.

Sec. 36. **[144H.05] FEES.**

Subdivision 1. **Initial application fee.** The initial application fee for PPEC center licensure is $11,000.

Subd. 2. **License renewal.** The fee for renewal of a PPEC center license is $4,720.

Subd. 3. **Late fee.** The fee for late submission of an application to renew a PPEC center license is $25.

Subd. 4. **Nonrefundable; state government special revenue fund.** All fees collected under this chapter are nonrefundable and must be deposited in the state treasury and credited to the state government special revenue fund.

Sec. 37. **[144H.06] RULEMAKING.**

The commissioner shall adopt rules necessary to implement the technical implementation for sections 144H.01, 144H.02, 144H.03, 144H.04, and 144H.05. Rules adopted under this section shall include requirements for:

(1) applying for, issuing, and renewing PPEC center licenses;

(2) a center's physical plant, including standards for plumbing, electrical, ventilation, heating and cooling, adequate space, accessibility, and fire protection. These standards must be based on the size of the building and the number of children to be served in the building; and

(3) limits to fines imposed by the commissioner for violations of this chapter or rules adopted under this chapter.

Sec. 38. **[144H.07] SERVICES; LIMITATIONS.**

Subdivision 1. **Services.** A PPEC center must provide basic services to medically complex or technologically dependent children, based on a protocol of care established for each child. A PPEC center may provide services up to 24 hours a day and up to seven days a week.

Subd. 2. **Limitations.** A PPEC center must comply with the following standards related to services:

(1) a child is prohibited from attending a PPEC center for more than 14 hours within a 24-hour period;

(2) a PPEC center is prohibited from providing services other than those provided to medically complex or technologically dependent children; and

(3) the maximum capacity for medically complex or technologically dependent children at a center shall not exceed 45 children.

Sec. 39. **[144H.08] ADMINISTRATION AND MANAGEMENT.**

Subdivision 1. **Duties of owner.** (a) The owner of a PPEC center shall have full legal authority and responsibility for the operation of the center. A PPEC center must be organized according to a written table of organization, describing the lines of authority and communication to the child care level. The organizational structure must be designed to ensure an integrated continuum of services for the children served.

(b) The owner must designate one person as a center administrator, who is responsible and accountable for overall management of the center.

Subd. 2. **Duties of administrator.** The center administrator is responsible and accountable for overall management of the center. The administrator must:

(1) designate in writing a person to be responsible for the center when the administrator is absent from the center for more than 24 hours;

(2) maintain the following written records, in a place and form and using a system that allows for inspection of the records by the commissioner during normal business hours:

(i) a daily census record, which indicates the number of children currently receiving services at the center;

(ii) a record of all accidents or unusual incidents involving any child or staff member that caused, or had the potential to cause, injury or harm to a person at the center or to center property;

(iii) copies of all current agreements with providers of supportive services or contracted services;

(iv) copies of all current agreements with consultants employed by the center, documentation of each consultant's visits, and written, dated reports; and

(v) a personnel record for each employee, which must include an application for employment, references, employment history for the preceding five years, and copies of all performance evaluations;

(3) develop and maintain a current job description for each employee;

(4) provide necessary qualified personnel and ancillary services to ensure the health, safety, and proper care for each child; and

(5) develop and implement infection control policies that comply with rules adopted by the commissioner regarding infection control.

Sec. 40. **[144H.09] ADMISSION, TRANSFER, AND DISCHARGE POLICIES; CONSENT FORM.**

Subdivision 1. **Written policies.** A PPEC center must have written policies and procedures governing the admission, transfer, and discharge of children.

Subd. 2. **Consent form.** A parent or guardian must sign a consent form outlining the purpose of a PPEC center, specifying family responsibilities, authorizing treatment and services, providing appropriate liability releases, and specifying emergency disposition plans, before the child's admission to the center. The center must provide the child's parents or guardians with a copy of the consent form and must maintain the consent form in the child's medical record.

Sec. 41. **[144H.10] MEDICAL DIRECTOR.**

A PPEC center must have a medical director who is a physician licensed in Minnesota and certified by the American Board of Pediatrics.

Sec. 42. **[144H.11] NURSING SERVICES.**

Subdivision 1. **Nursing director.** A PPEC center must have a nursing director who is a registered nurse licensed in Minnesota, holds a current certification in cardiopulmonary resuscitation, and has at least four years of general pediatric nursing experience, at least one year of which must have been spent caring for medically fragile infants or children in a pediatric intensive care, neonatal intensive care, PPEC center, or home care setting during the previous five years. The nursing director is responsible for the daily operation of the PPEC center.

Subd. 2. **Registered nurses.** A registered nurse employed by a PPEC center must be a registered nurse licensed in Minnesota, hold a current certification in cardiopulmonary resuscitation, and have experience in the previous 24 months in being responsible for the care of acutely ill or chronically ill children.

Subd. 3. **Licensed practical nurses.** A licensed practical nurse employed by a PPEC center must be supervised by a registered nurse and must be a licensed practical nurse licensed in Minnesota, have at least two years of experience in pediatrics, and hold a current certification in cardiopulmonary resuscitation.

Subd. 4. **Other direct care personnel.** (a) Direct care personnel governed by this subdivision include nursing assistants and individuals with training and experience in the field of education, social services, or child care.

(b) All direct care personnel employed by a PPEC center must work under the supervision of a registered nurse and are responsible for providing direct care to children at the center. Direct care personnel must have extensive, documented education and skills training in providing care to infants and toddlers, provide employment references documenting skill in the care of infants and children, and hold a current certification in cardiopulmonary resuscitation.

Sec. 43. **[144H.12] TOTAL STAFFING FOR NURSING SERVICES AND DIRECT CARE PERSONNEL.**

A PPEC center must provide total staffing for nursing services and direct care personnel at a ratio of one staff person for every three children at the center. The staffing ratio required in this section is the minimum staffing permitted.

Sec. 44. **[144H.13] MEDICAL RECORD; PROTOCOL OF CARE.**

A medical record and an individualized nursing protocol of care must be developed for each child admitted to a PPEC center, must be maintained for each child, and must be signed by authorized personnel.

Sec. 45. **[144H.14] QUALITY ASSURANCE PROGRAM.**

A PPEC center must have a quality assurance program, in which quarterly reviews are conducted of the PPEC center's medical records and protocols of care for at least half of the children served by the PPEC center. The quarterly review sample must be randomly selected so each child at the center has an equal opportunity to be included in the review. The committee conducting quality assurance reviews must include the medical director, administrator, nursing director, and three other committee members determined by the PPEC center.

Sec. 46. **[144H.15] INSPECTIONS.**

(a) The commissioner may inspect a PPEC center, including records held at the center, at reasonable times as necessary to ensure compliance with this chapter and the rules adopted under this chapter. During an inspection, a center must provide the commissioner with access to all center records.

(b) The commissioner must inspect a PPEC center before issuing or renewing a license under this chapter.

Sec. 47. **[144H.16] COMPLIANCE WITH OTHER LAWS.**

Subdivision 1. **Reporting of maltreatment of minors.** A PPEC center must develop policies and procedures for reporting suspected child maltreatment that fulfill the requirements of section 626.556. The policies and procedures must include the telephone numbers of the local county child protection agency for reporting suspected maltreatment. The policies and procedures specified in this subdivision must be provided to the parents or guardians of all children at the time of admission to the PPEC center and must be available upon request.

Subd. 2. **Crib safety requirements.** A PPEC center must comply with the crib safety requirements in section 245A.146, to the extent they are applicable.

Sec. 48. **[144H.17] DENIAL, SUSPENSION, REVOCATION, REFUSAL TO RENEW A LICENSE.**

(a) The commissioner may deny, suspend, revoke, or refuse to renew a license issued under this chapter for:

(1) a violation of this chapter or rules adopted under this chapter; or

(2) an intentional or negligent act by an employee or contractor at the center that materially affects the health or safety of children at the PPEC center.

(b) Prior to any suspension, revocation, or refusal to renew a license, a licensee shall be entitled to a hearing and review as provided in sections 14.57 to 14.69.

Sec. 49. **[144H.18] FINES; CORRECTIVE ACTION PLANS.**

Subdivision 1. **Corrective action plans.** If the commissioner determines that a PPEC center is not in compliance with this chapter or rules adopted under this chapter, the commissioner may require the center to submit a corrective action plan that demonstrates a good-faith effort to remedy each violation by a specific date, subject to approval by the commissioner.

Subd. 2. **Fines.** The commissioner may issue a fine to a PPEC center, employee, or contractor if the commissioner determines the center, employee, or contractor violated this chapter or rules adopted under this chapter. The fine amount shall not exceed an amount for each violation and an aggregate amount established by the commissioner in rule. The failure to correct a violation by the date set by the commissioner, or a failure to comply with an approved corrective action plan, constitutes a separate violation for each day the failure continues, unless the commissioner approves an extension to a specific date. In determining if a fine is to be imposed and establishing the amount of the fine, the commissioner shall consider:

(1) the gravity of the violation, including the probability that death or serious physical or emotional harm to a child will result or has resulted, the severity of the actual or potential harm, and the extent to which the applicable laws were violated;

(2) actions taken by the owner or administrator to correct violations;

(3) any previous violations; and

(4) the financial benefit to the PPEC center of committing or continuing the violation.

Sec. 50. **[144H.19] CLOSING A PPEC CENTER.**

When a PPEC center voluntarily closes, it must, at least 30 days before closure, inform each child's parents or guardians of the closure and when the closure will occur.

Sec. 51. Minnesota Statutes 2016, section 145.4716, subdivision 2, is amended to read:

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

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

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

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

(4) managing grant programs established under sections 145.4716 to 145.4718~~, and~~; 609.3241, paragraph (c), clause (3); and 609.5315, subdivision 5c, clause (3);

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

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

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

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

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

Sec. 52. **[145.9263] OPIOID PRESCRIBER EDUCATION AND PUBLIC AWARENESS GRANTS.**

The commissioner of health, in coordination with the commissioner of human services, shall award grants to nonprofit organizations for the purpose of expanding prescriber education, public awareness and outreach on the opioid epidemic and overdose prevention programs. The grantees must coordinate with health care systems, professional associations, and emergency medical services providers. Each grantee receiving funds under this section shall report to the commissioner on how the funds were spent and the outcomes achieved.

Sec. 53. Minnesota Statutes 2016, section 145.986, subdivision 1a, is amended to read:

Subd. 1a. **Grants to local communities.** (a) Beginning July 1, 2009, the commissioner of health shall award competitive grants to community health boards and tribal governments to convene, coordinate, and implement evidence-based strategies targeted at reducing the percentage of Minnesotans who are obese or overweight and to reduce the use of tobacco. Grants shall be awarded to all community health boards and tribal governments whose proposals demonstrate the ability to implement programs designed to achieve the purposes in subdivision 1 and other requirements of this section.

(b) Grantee activities shall:

(1) be based on scientific evidence;

(2) be based on community input;

(3) address behavior change at the individual, community, and systems levels;

(4) occur in community, school, work site, and health care settings;

(5) be focused on policy, systems, and environmental changes that support healthy behaviors; and

(6) address the health disparities and inequities that exist in the grantee's community.

(c) To receive a grant under this section, community health boards and tribal governments must submit proposals to the commissioner. A local match of ten percent of the total funding allocation is required. This local match may include funds donated by community partners.

(d) In order to receive a grant, community health boards and tribal governments must submit a health improvement plan to the commissioner of health for approval. The commissioner may require the plan to identify a community leadership team, community partners, and a community action plan that includes an assessment of area strengths and needs, proposed action strategies, technical assistance needs, and a staffing plan.

(e) The grant recipient must implement the health improvement plan, evaluate the effectiveness of the strategies, and modify or discontinue strategies found to be ineffective.

(f) Grant recipients shall report their activities and their progress toward the outcomes established under subdivision 2 to the commissioner in a format and at a time specified by the commissioner.

(g) All grant recipients shall be held accountable for making progress toward the measurable outcomes established in subdivision 2. The commissioner shall require a corrective action plan and may reduce the funding level of grant recipients that do not make adequate progress toward the measurable outcomes.

(h) Beginning November 1, 2015, the commissioner shall offer grant recipients the option of using a grant awarded under this subdivision to implement health improvement strategies that improve the health status, delay the expression of dementia, or slow the progression of dementia, for a targeted population at risk for dementia and shall award at least two of the grants awarded on November 1, 2015, for these purposes. The grants must meet all other requirements of this section. The commissioner shall coordinate grant planning activities with the commissioner of human services, the Minnesota Board on Aging, and community-based organizations with a focus on dementia. Each grant must include selected outcomes and evaluation measures related to the incidence or progression of dementia among the targeted population using the procedure described in subdivision 2.

(i) Beginning July 1, 2017, the commissioner shall offer grant recipients the option of using a grant awarded under this subdivision to confront the opioid addiction and overdose epidemic, and shall award at least two of the grants awarded on or after July 1, 2017, for these purposes. The grants awarded under this paragraph must meet all other requirements of this section. The commissioner shall coordinate grant planning activities with the commissioner of human services. Each grant shall include selected outcomes and evaluation measures related to addressing the opioid epidemic.

Sec. 54. Minnesota Statutes 2016, section 146B.02, subdivision 2, is amended to read:

Subd. 2. **Requirements and term of license.** (a) Each application for an initial mobile or fixed-site establishment license and for renewal must be submitted to the commissioner on a form provided by the commissioner accompanied with the applicable fee required under section 146B.10. The application must contain:

(1) the name(s) of the owner(s) and operator(s) of the establishment;

(2) the location of the establishment;

(3) verification of compliance with all applicable local and state codes;

(4) a description of the general nature of the business; and

(5) any other relevant information deemed necessary by the commissioner.

(b) If the information submitted is complete and complies with the requirements of this chapter, the commissioner shall issue a provisional establishment license. The provisional license is effective until the commissioner determines, after inspection, that the applicant has met the requirements of this chapter. Upon approval, the commissioner shall issue a body art establishment license ~~effective for three years~~.

(c) An establishment license must be renewed every two years.

Sec. 55. Minnesota Statutes 2016, section 146B.02, subdivision 5, is amended to read:

Subd. 5. **Transfer of ownership, relocation, and display of license.** (a) A body art establishment license must be issued to a specific person and location and is not transferable. A license must be prominently displayed in a public area of the establishment.

(b) An owner who has purchased a body art establishment licensed under the previous owner must submit an application to license the establishment within two weeks of the date of sale. Notwithstanding subdivision 1, the new owner may continue to operate for 60 days after the sale while waiting for a new license to be issued.

(c) An owner of a licensed body art establishment who is relocating the establishment must submit an application for the new location. The owner may request that the new application become effective at a specified date in the future. If the relocation is not accomplished by the date expected, and the license at the existing location expires, the owner may apply for a temporary event permit to continue to operate at the old location. The owner may apply for no more than four temporary event permits to continue operating at the old location.

Sec. 56. Minnesota Statutes 2016, section 146B.02, is amended by adding a subdivision to read:

Subd. 7a. **Supervisors.** (a) Only a technician who has been licensed as a body artist for at least two years in Minnesota or in a jurisdiction with which Minnesota has reciprocity may supervise a temporary technician.

(b) Any technician who agrees to supervise more than two temporary technicians during the same time period must explain, to the satisfaction of the commissioner, how the technician

will provide supervision to each temporary technician in accordance with section 146B.01, subdivision 28.

(c) The commissioner may refuse to approve as a supervisor a technician who has been disciplined in Minnesota or in another jurisdiction.

Sec. 57. Minnesota Statutes 2016, section 146B.02, subdivision 8, is amended to read:

Subd. 8. **Temporary ~~events~~ event permit.** (a) An ~~owner or operator of a~~ applicant for a permit to hold a temporary body art ~~establishment~~ event shall submit an application ~~for a temporary events permit~~ to the commissioner. The application must be received at least 14 days before the start of the event. The application must include the specific days and hours of operation. ~~The owner or operator~~ An applicant issued a temporary event permit shall comply with the requirements of this chapter.

(b) Applications received less than 14 days prior to the start of the event may be processed if the commissioner determines it is possible to conduct ~~the~~ all required work, including an inspection.

(c) The temporary ~~events~~ event permit must be prominently displayed in a public area at the location.

(d) The temporary ~~events~~ event permit, if approved, is valid for the specified dates and hours listed on the application. No temporary events permit shall be issued for longer than a 21-day period, and may not be extended.

(e) No individual who does not hold a current body art establishment license may be issued a temporary event permit more than four times within the same calendar year.

(f) No individual who has been disciplined for a serious violation of this chapter within three years preceding the intended start date of a temporary event may be issued a license for a temporary event. Violations that preclude issuance of a temporary event permit include unlicensed practice; practice in an unlicensed location; any of the conditions listed in section 146B.05, clauses (1) to (8), (12), or (13), 146B.08, subdivision 3, clauses (4), (5), and (10) to (12), or any other violation that places the health or safety of a client at risk.

Sec. 58. Minnesota Statutes 2016, section 146B.02, is amended by adding a subdivision to read:

Subd. 10. **Licensure precluded.** (a) The commissioner may choose to deny a body art establishment license to an applicant who has been disciplined for a serious violation under this chapter. Violations that constitute grounds for denial of license are any of the conditions

listed in section 146B.05, subdivision 1, clauses (1) to (8), (12), or (13), 146B.08, subdivision 3, clauses (4), (5), or (10) to (12), or any other violation that places the health or safety of a client at risk.

(b) In considering whether to grant a license to an applicant who has been disciplined for a violation described in this subdivision, the commissioner shall consider evidence of rehabilitation, including the nature and seriousness of the violation, circumstances relative to the violation, the length of time elapsed since the violation, and evidence that demonstrates that the applicant has maintained safe, ethical, and responsible body art practice since the time of the most recent violation.

Sec. 59. Minnesota Statutes 2016, section 146B.03, subdivision 6, is amended to read:

Subd. 6. **Licensure term; renewal.** (a) A technician's license is valid for two years from the date of issuance and may be renewed upon payment of the renewal fee established under section 146B.10.

(b) At renewal, a licensee must submit proof of continuing education approved by the commissioner in the areas identified in subdivision 4.

(c) The commissioner shall notify the technician of the pending expiration of a technician license at least 60 days prior to license expiration.

(d) A technician previously licensed in Minnesota whose license has lapsed for less than six years may apply to renew. A technician previously licensed in Minnesota whose license has lapsed for less than ten years and who was licensed in another jurisdiction or jurisdictions during the entire time of lapse may apply to renew, but must submit proof of licensure in good standing in all other jurisdictions in which the technician was licensed as a body artist during the time of lapse. A technician previously licensed in Minnesota whose license has lapsed for more than six years and who was not continuously licensed in another jurisdiction during the period of Minnesota lapse must reapply for licensure under subdivision 4.

Sec. 60. Minnesota Statutes 2016, section 146B.03, subdivision 7, is amended to read:

Subd. 7. **Temporary licensure.** (a) The commissioner may issue a temporary license to an applicant who submits to the commissioner on a form provided by the commissioner:

(1) proof that the applicant is over the age of 18;

(2) all fees required under section 148B.10; and

(3) a letter from a licensed technician who has agreed to provide the supervision to meet the supervised experience requirement under subdivision 4.

(b) Upon completion of the required supervised experience, the temporary licensee shall submit documentation of satisfactorily completing the requirements under subdivision 4, and the applicable fee under section 146B.10. The commissioner shall issue a new license in accordance with subdivision 4.

(c) A temporary license issued under this subdivision is valid for one year and may be renewed ~~for one additional year~~ twice.

Sec. 61. Minnesota Statutes 2016, section 146B.07, subdivision 4, is amended to read:

Subd. 4. **Client record maintenance.** (a) For each client, the body art establishment operator shall maintain proper records of each procedure. The records of the procedure must be kept for three years and must be available for inspection by the commissioner upon request. The record must include the following:

(1) the date of the procedure;

(2) the information on the required picture identification showing the name, age, and current address of the client;

(3) a copy of the authorization form signed and dated by the client required under subdivision 1, paragraph (b);

(4) a description of the body art procedure performed;

(5) the name and license number of the technician performing the procedure;

(6) a copy of the consent form required under subdivision 3; and

(7) if the client is under the age of 18 years, a copy of the consent form signed by the parent or legal guardian as required under subdivision 2.

(b) Each body artist shall maintain a copy of the informed consent required under subdivision 3 for three years.

Sec. 62. Minnesota Statutes 2016, section 146B.10, subdivision 1, is amended to read:

Subdivision 1. **Licensing fees.** (a) The fee for the initial technician licensure and biennial licensure renewal is $100.

(b) The fee for temporary technician licensure is $100.

(c) The fee for the temporary guest artist license is $50.

(d) The fee for a dual body art technician license is $100.

(e) The fee for a provisional establishment license is $1,000.

(f) The fee for an initial establishment license and the three-year license renewal period required in section 146B.02, subdivision 2, paragraph (b), is $1,000.

(g) The fee for a temporary body art establishment permit is $75.

(h) The commissioner shall prorate the initial two-year technician license fee and the initial three-year body art establishment license fee based on the number of months in the initial licensure period. The commissioner shall prorate the first renewal fee for the establishment license based on the number of months from issuance of the provisional license to the first renewal.

Sec. 63. Minnesota Statutes 2016, section 148.5194, subdivision 7, is amended to read:

Subd. 7. **Audiologist biennial licensure fee.** ~~(a)~~ The licensure fee for initial applicants is $435. The biennial licensure fee for audiologists for clinical fellowship, doctoral externship, temporary, ~~initial applicants,~~ and renewal ~~licensees~~ licenses is $435.

~~(b) The audiologist fee is for practical examination costs greater than audiologist exam fee receipts and for complaint investigation, enforcement action, and consumer information and assistance expenditures related to hearing instrument dispensing.~~

Sec. 64. Minnesota Statutes 2016, section 157.16, subdivision 1, is amended to read:

Subdivision 1. **License required annually.** A license is required annually for every person, firm, or corporation engaged in the business of conducting a food and beverage service establishment, youth camp, hotel, motel, lodging establishment, public pool, or resort. Any person wishing to operate a place of business licensed in this section shall first make application, pay the required fee specified in this section, and receive approval for operation, including plan review approval. Special event food stands are not required to submit plans. Nonprofit organizations operating a special event food stand with multiple locations at an annual one-day event shall be issued only one license. Application shall be made on forms provided by the commissioner and shall require the applicant to state the full name and address of the owner of the building, structure, or enclosure, the lessee and manager of the food and beverage service establishment, hotel, motel, lodging establishment, public pool, or resort; the name under which the business is to be conducted; and any other information as may be required by the commissioner to complete the application for license.

All fees collected under this section shall be deposited in the state government special revenue fund.

Sec. 65. Minnesota Statutes 2016, section 327.15, subdivision 3, is amended to read:

Subd. 3. **Fees, manufactured home parks and recreational camping areas.** (a) The following fees are required for manufactured home parks and recreational camping areas licensed under this chapter. Fees collected under this section shall be deposited in the state government special revenue fund. Recreational camping areas and manufactured home parks shall pay the highest applicable base fee under paragraph (b). The license fee for new operators of a manufactured home park or recreational camping area previously licensed under this chapter for the same calendar year is one-half of the appropriate annual license fee, plus any penalty that may be required. The license fee for operators opening on or after October 1 is one-half of the appropriate annual license fee, plus any penalty that may be required.

(b) All manufactured home parks and recreational camping areas shall pay the following annual base fee:

(1) a manufactured home park, $150; and

(2) a recreational camping area with:

(i) 24 or less sites, $50;

(ii) 25 to 99 sites, $212; and

(iii) 100 or more sites, $300.

In addition to the base fee, manufactured home parks and recreational camping areas shall pay $4 for each licensed site. This paragraph does not apply to special event recreational camping areas. Operators of a manufactured home park or a recreational camping area also licensed under section 157.16 for the same location shall pay only one base fee, whichever is the highest of the base fees found in this section or section 157.16.

(c) In addition to the fee in paragraph (b), each manufactured home park or recreational camping area shall pay an additional annual fee for each fee category specified in this paragraph:

(1) Manufactured home parks and recreational camping areas with public swimming pools and spas shall pay the appropriate fees specified in section 157.16.

(2) Individual private sewer or water, $60. "Individual private water" means a fee category with a water supply other than a community public water supply as defined in Minnesota

Rules, chapter 4720. "Individual private sewer" means a fee category with a subsurface sewage treatment system which uses subsurface treatment and disposal.

(d) The following fees must accompany a plan review application for initial construction of a manufactured home park or recreational camping area:

(1) for initial construction of less than 25 sites, $375;

(2) for initial construction of 25 to 99 sites, $400; and

(3) for initial construction of 100 or more sites, $500.

(e) The following fees must accompany a plan review application when an existing manufactured home park or recreational camping area is expanded:

(1) for expansion of less than 25 sites, $250;

(2) for expansion of 25 to 99 sites, $300; and

(3) for expansion of 100 or more sites, $450.

Sec. 66. Minnesota Statutes 2016, section 609.5315, subdivision 5c, is amended to read:

Subd. 5c. **Disposition of money; prostitution.** Money forfeited under section 609.5312, subdivision 1, paragraph (b), must be distributed as follows:

(1) 40 percent must be forwarded to the appropriate agency for deposit as a supplement to the agency's operating fund or similar fund for use in law enforcement;

(2) 20 percent must be forwarded to the prosecuting authority that handled the forfeiture for deposit as a supplement to its operating fund or similar fund for prosecutorial purposes; and

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

Sec. 67. Minnesota Statutes 2016, section 626.556, subdivision 2, is amended to read:

Subd. 2. **Definitions.** As used in this section, the following terms have the meanings given them unless the specific content indicates otherwise:

(a) "Accidental" means a sudden, not reasonably foreseeable, and unexpected occurrence or event which:

(1) is not likely to occur and could not have been prevented by exercise of due care; and

(2) if occurring while a child is receiving services from a facility, happens when the facility and the employee or person providing services in the facility are in compliance with the laws and rules relevant to the occurrence or event.

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

(c) "Facility" means:

(1) a licensed or unlicensed day care facility, residential facility, agency, hospital, sanitarium, or other facility or institution required to be licensed under sections 144.50 to 144.58, 241.021, or 245A.01 to 245A.16, or chapter 144H or 245D;

(2) a school as defined in section 120A.05, subdivisions 9, 11, and 13; and chapter 124E; or

(3) a nonlicensed personal care provider organization as defined in section 256B.0625, subdivision 19a.

(d) "Family assessment" means a comprehensive assessment of child safety, risk of subsequent child maltreatment, and family strengths and needs that is applied to a child maltreatment report that does not allege sexual abuse or substantial child endangerment. Family assessment does not include a determination as to whether child maltreatment occurred but does determine the need for services to address the safety of family members and the risk of subsequent maltreatment.

(e) "Investigation" means fact gathering related to the current safety of a child and the risk of subsequent maltreatment that determines whether child maltreatment occurred and whether child protective services are needed. An investigation must be used when reports involve sexual abuse or substantial child endangerment, and for reports of maltreatment in facilities required to be licensed under chapter 245A or 245D; under sections 144.50 to 144.58 and 241.021; in a school as defined in section 120A.05, subdivisions 9, 11, and 13, and chapter 124E; or in a nonlicensed personal care provider association as defined in section 256B.0625, subdivision 19a.

(f) "Mental injury" means an injury to the psychological capacity or emotional stability of a child as evidenced by an observable or substantial impairment in the child's ability to function within a normal range of performance and behavior with due regard to the child's culture.

(g) "Neglect" means the commission or omission of any of the acts specified under clauses (1) to (9), other than by accidental means:

(1) failure by a person responsible for a child's care to supply a child with necessary food, clothing, shelter, health, medical, or other care required for the child's physical or mental health when reasonably able to do so;

(2) failure to protect a child from conditions or actions that seriously endanger the child's physical or mental health when reasonably able to do so, including a growth delay, which may be referred to as a failure to thrive, that has been diagnosed by a physician and is due to parental neglect;

(3) failure to provide for necessary supervision or child care arrangements appropriate for a child after considering factors as the child's age, mental ability, physical condition, length of absence, or environment, when the child is unable to care for the child's own basic needs or safety, or the basic needs or safety of another child in their care;

(4) failure to ensure that the child is educated as defined in sections 120A.22 and 260C.163, subdivision 11, which does not include a parent's refusal to provide the parent's child with sympathomimetic medications, consistent with section 125A.091, subdivision 5;

(5) nothing in this section shall be construed to mean that a child is neglected solely because the child's parent, guardian, or other person responsible for the child's care in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the child in lieu of medical care; except that a parent, guardian, or caretaker, or a person mandated to report pursuant to subdivision 3, has a duty to report if a lack of medical care may cause serious danger to the child's health. This section does not impose upon persons, not otherwise legally responsible for providing a child with necessary food, clothing, shelter, education, or medical care, a duty to provide that care;

(6) prenatal exposure to a controlled substance, as defined in section 253B.02, subdivision 2, used by the mother for a nonmedical purpose, as evidenced by withdrawal symptoms in the child at birth, results of a toxicology test performed on the mother at delivery or the child at birth, medical effects or developmental delays during the child's first year of life that medically indicate prenatal exposure to a controlled substance, or the presence of a fetal alcohol spectrum disorder;

(7) "medical neglect" as defined in section 260C.007, subdivision 6, clause (5);

(8) chronic and severe use of alcohol or a controlled substance by a parent or person responsible for the care of the child that adversely affects the child's basic needs and safety; or

(9) emotional harm from a pattern of behavior which contributes to impaired emotional functioning of the child which may be demonstrated by a substantial and observable effect in the child's behavior, emotional response, or cognition that is not within the normal range for the child's age and stage of development, with due regard to the child's culture.

(h) "Nonmaltreatment mistake" means:

(1) at the time of the incident, the individual was performing duties identified in the center's child care program plan required under Minnesota Rules, part 9503.0045;

(2) the individual has not been determined responsible for a similar incident that resulted in a finding of maltreatment for at least seven years;

(3) the individual has not been determined to have committed a similar nonmaltreatment mistake under this paragraph for at least four years;

(4) any injury to a child resulting from the incident, if treated, is treated only with remedies that are available over the counter, whether ordered by a medical professional or not; and

(5) except for the period when the incident occurred, the facility and the individual providing services were both in compliance with all licensing requirements relevant to the incident.

This definition only applies to child care centers licensed under Minnesota Rules, chapter 9503. If clauses (1) to (5) apply, rather than making a determination of substantiated maltreatment by the individual, the commissioner of human services shall determine that a nonmaltreatment mistake was made by the individual.

(i) "Operator" means an operator or agency as defined in section 245A.02.

(j) "Person responsible for the child's care" means (1) an individual functioning within the family unit and having responsibilities for the care of the child such as a parent, guardian, or other person having similar care responsibilities, or (2) an individual functioning outside the family unit and having responsibilities for the care of the child such as a teacher, school administrator, other school employees or agents, or other lawful custodian of a child having either full-time or short-term care responsibilities including, but not limited to, day care, babysitting whether paid or unpaid, counseling, teaching, and coaching.

(k) "Physical abuse" means any physical injury, mental injury, or threatened injury, inflicted by a person responsible for the child's care on a child other than by accidental means, or any physical or mental injury that cannot reasonably be explained by the child's

history of injuries, or any aversive or deprivation procedures, or regulated interventions, that have not been authorized under section 125A.0942 or 245.825.

Abuse does not include reasonable and moderate physical discipline of a child administered by a parent or legal guardian which does not result in an injury. Abuse does not include the use of reasonable force by a teacher, principal, or school employee as allowed by section 121A.582. Actions which are not reasonable and moderate include, but are not limited to, any of the following:

(1) throwing, kicking, burning, biting, or cutting a child;

(2) striking a child with a closed fist;

(3) shaking a child under age three;

(4) striking or other actions which result in any nonaccidental injury to a child under 18 months of age;

(5) unreasonable interference with a child's breathing;

(6) threatening a child with a weapon, as defined in section 609.02, subdivision 6;

(7) striking a child under age one on the face or head;

(8) striking a child who is at least age one but under age four on the face or head, which results in an injury;

(9) purposely giving a child poison, alcohol, or dangerous, harmful, or controlled substances which were not prescribed for the child by a practitioner, in order to control or punish the child; or other substances that substantially affect the child's behavior, motor coordination, or judgment or that results in sickness or internal injury, or subjects the child to medical procedures that would be unnecessary if the child were not exposed to the substances;

(10) unreasonable physical confinement or restraint not permitted under section 609.379, including but not limited to tying, caging, or chaining; or

(11) in a school facility or school zone, an act by a person responsible for the child's care that is a violation under section 121A.58.

(l) "Practice of social services," for the purposes of subdivision 3, includes but is not limited to employee assistance counseling and the provision of guardian ad litem and parenting time expeditor services.

(m) "Report" means any communication received by the local welfare agency, police department, county sheriff, or agency responsible for child protection pursuant to this section that describes neglect or physical or sexual abuse of a child and contains sufficient content to identify the child and any person believed to be responsible for the neglect or abuse, if known.

(n) "Sexual abuse" means the subjection of a child by a person responsible for the child's care, by a person who has a significant relationship to the child, as defined in section 609.341, or by a person in a position of authority, as defined in section 609.341, subdivision 10, to any act which constitutes a violation of section 609.342 (criminal sexual conduct in the first degree), 609.343 (criminal sexual conduct in the second degree), 609.344 (criminal sexual conduct in the third degree), 609.345 (criminal sexual conduct in the fourth degree), or 609.3451 (criminal sexual conduct in the fifth degree). Sexual abuse also includes any act which involves a minor which constitutes a violation of prostitution offenses under sections 609.321 to 609.324 or 617.246. Effective May 29, 2017, sexual abuse includes all reports of known or suspected child sex trafficking involving a child who is identified as a victim of sex trafficking. Sexual abuse includes child sex trafficking as defined in section 609.321, subdivisions 7a and 7b. Sexual abuse includes threatened sexual abuse which includes the status of a parent or household member who has committed a violation which requires registration as an offender under section 243.166, subdivision 1b, paragraph (a) or (b), or required registration under section 243.166, subdivision 1b, paragraph (a) or (b).

(o) "Substantial child endangerment" means a person responsible for a child's care, by act or omission, commits or attempts to commit an act against a child under their care that constitutes any of the following:

(1) egregious harm as defined in section 260C.007, subdivision 14;

(2) abandonment under section 260C.301, subdivision 2;

(3) neglect as defined in paragraph (g), clause (2), that substantially endangers the child's physical or mental health, including a growth delay, which may be referred to as failure to thrive, that has been diagnosed by a physician and is due to parental neglect;

(4) murder in the first, second, or third degree under section 609.185, 609.19, or 609.195;

(5) manslaughter in the first or second degree under section 609.20 or 609.205;

(6) assault in the first, second, or third degree under section 609.221, 609.222, or 609.223;

(7) solicitation, inducement, and promotion of prostitution under section 609.322;

(8) criminal sexual conduct under sections 609.342 to 609.3451;

(9) solicitation of children to engage in sexual conduct under section 609.352;

(10) malicious punishment or neglect or endangerment of a child under section 609.377 or 609.378;

(11) use of a minor in sexual performance under section 617.246; or

(12) parental behavior, status, or condition which mandates that the county attorney file a termination of parental rights petition under section 260C.503, subdivision 2.

(p) "Threatened injury" means a statement, overt act, condition, or status that represents a substantial risk of physical or sexual abuse or mental injury. Threatened injury includes, but is not limited to, exposing a child to a person responsible for the child's care, as defined in paragraph (j), clause (1), who has:

(1) subjected a child to, or failed to protect a child from, an overt act or condition that constitutes egregious harm, as defined in section 260C.007, subdivision 14, or a similar law of another jurisdiction;

(2) been found to be palpably unfit under section 260C.301, subdivision 1, paragraph (b), clause (4), or a similar law of another jurisdiction;

(3) committed an act that has resulted in an involuntary termination of parental rights under section 260C.301, or a similar law of another jurisdiction; or

(4) committed an act that has resulted in the involuntary transfer of permanent legal and physical custody of a child to a relative under Minnesota Statutes 2010, ~~section 260C.201, subdivision 11, paragraph (d), clause (1),~~ section 260C.515, subdivision 4, or a similar law of another jurisdiction.

A child is the subject of a report of threatened injury when the responsible social services agency receives birth match data under paragraph (q) from the Department of Human Services.

(q) Upon receiving data under section 144.225, subdivision 2b, contained in a birth record or recognition of parentage identifying a child who is subject to threatened injury under paragraph (p), the Department of Human Services shall send the data to the responsible social services agency. The data is known as "birth match" data. Unless the responsible social services agency has already begun an investigation or assessment of the report due to the birth of the child or execution of the recognition of parentage and the parent's previous history with child protection, the agency shall accept the birth match data as a report under this section. The agency may use either a family assessment or investigation to determine whether the child is safe. All of the provisions of this section apply. If the child is determined

to be safe, the agency shall consult with the county attorney to determine the appropriateness of filing a petition alleging the child is in need of protection or services under section 260C.007, subdivision 6, clause (16), in order to deliver needed services. If the child is determined not to be safe, the agency and the county attorney shall take appropriate action as required under section 260C.503, subdivision 2.

(r) Persons who conduct assessments or investigations under this section shall take into account accepted child-rearing practices of the culture in which a child participates and accepted teacher discipline practices, which are not injurious to the child's health, welfare, and safety.

Sec. 68. Minnesota Statutes 2016, section 626.556, subdivision 3, is amended to read:

Subd. 3. **Persons mandated to report; persons voluntarily reporting.** (a) A person who knows or has reason to believe a child is being neglected or physically or sexually abused, as defined in subdivision 2, or has been neglected or physically or sexually abused within the preceding three years, shall immediately report the information to the local welfare agency, agency responsible for assessing or investigating the report, police department, county sheriff, tribal social services agency, or tribal police department if the person is:

(1) a professional or professional's delegate who is engaged in the practice of the healing arts, social services, hospital administration, psychological or psychiatric treatment, child care, education, correctional supervision, probation and correctional services, or law enforcement; or

(2) employed as a member of the clergy and received the information while engaged in ministerial duties, provided that a member of the clergy is not required by this subdivision to report information that is otherwise privileged under section 595.02, subdivision 1, paragraph (c).

(b) Any person may voluntarily report to the local welfare agency, agency responsible for assessing or investigating the report, police department, county sheriff, tribal social services agency, or tribal police department if the person knows, has reason to believe, or suspects a child is being or has been neglected or subjected to physical or sexual abuse.

(c) A person mandated to report physical or sexual child abuse or neglect occurring within a licensed facility shall report the information to the agency responsible for licensing the facility under sections 144.50 to 144.58; 241.021; 245A.01 to 245A.16; or chapter 144H or 245D; or a nonlicensed personal care provider organization as defined in section 256B.0625, subdivision ~~19~~ 19a. A health or corrections agency receiving a report may

request the local welfare agency to provide assistance pursuant to subdivisions 10, 10a, and 10b. A board or other entity whose licensees perform work within a school facility, upon receiving a complaint of alleged maltreatment, shall provide information about the circumstances of the alleged maltreatment to the commissioner of education. Section 13.03, subdivision 4, applies to data received by the commissioner of education from a licensing entity.

(d) Notification requirements under subdivision 10 apply to all reports received under this section.

(e) For purposes of this section, "immediately" means as soon as possible but in no event longer than 24 hours.

Sec. 69. Minnesota Statutes 2016, section 626.556, subdivision 3c, is amended to read:

Subd. 3c. **Local welfare agency, Department of Human Services or Department of Health responsible for assessing or investigating reports of maltreatment.** (a) The county local welfare agency is the agency responsible for assessing or investigating allegations of maltreatment in child foster care, family child care, legally unlicensed child care, juvenile correctional facilities licensed under section 241.021 located in the local welfare agency's county, and reports involving children served by an unlicensed personal care provider organization under section 256B.0659. Copies of findings related to personal care provider organizations under section 256B.0659 must be forwarded to the Department of Human Services provider enrollment.

(b) The Department of Human Services is the agency responsible for assessing or investigating allegations of maltreatment in facilities licensed under chapters 245A and 245D, except for child foster care and family child care.

(c) The Department of Health is the agency responsible for assessing or investigating allegations of child maltreatment in facilities licensed under sections 144.50 to 144.58 and 144A.43 to 144A.482 or chapter 144H.

Sec. 70. Minnesota Statutes 2016, section 626.556, subdivision 10d, is amended to read:

Subd. 10d. **Notification of neglect or abuse in facility.** (a) When a report is received that alleges neglect, physical abuse, sexual abuse, or maltreatment of a child while in the care of a licensed or unlicensed day care facility, residential facility, agency, hospital, sanitarium, or other facility or institution required to be licensed according to sections 144.50 to 144.58; 241.021; or 245A.01 to 245A.16; or chapter 144H or 245D, or a school as defined

in section 120A.05, subdivisions 9, 11, and 13; and chapter 124E; or a nonlicensed personal care provider organization as defined in section 256B.0625, subdivision 19a, the commissioner of the agency responsible for assessing or investigating the report or local welfare agency investigating the report shall provide the following information to the parent, guardian, or legal custodian of a child alleged to have been neglected, physically abused, sexually abused, or the victim of maltreatment of a child in the facility: the name of the facility; the fact that a report alleging neglect, physical abuse, sexual abuse, or maltreatment of a child in the facility has been received; the nature of the alleged neglect, physical abuse, sexual abuse, or maltreatment of a child in the facility; that the agency is conducting an assessment or investigation; any protective or corrective measures being taken pending the outcome of the investigation; and that a written memorandum will be provided when the investigation is completed.

(b) The commissioner of the agency responsible for assessing or investigating the report or local welfare agency may also provide the information in paragraph (a) to the parent, guardian, or legal custodian of any other child in the facility if the investigative agency knows or has reason to believe the alleged neglect, physical abuse, sexual abuse, or maltreatment of a child in the facility has occurred. In determining whether to exercise this authority, the commissioner of the agency responsible for assessing or investigating the report or local welfare agency shall consider the seriousness of the alleged neglect, physical abuse, sexual abuse, or maltreatment of a child in the facility; the number of children allegedly neglected, physically abused, sexually abused, or victims of maltreatment of a child in the facility; the number of alleged perpetrators; and the length of the investigation. The facility shall be notified whenever this discretion is exercised.

(c) When the commissioner of the agency responsible for assessing or investigating the report or local welfare agency has completed its investigation, every parent, guardian, or legal custodian previously notified of the investigation by the commissioner or local welfare agency shall be provided with the following information in a written memorandum: the name of the facility investigated; the nature of the alleged neglect, physical abuse, sexual abuse, or maltreatment of a child in the facility; the investigator's name; a summary of the investigation findings; a statement whether maltreatment was found; and the protective or corrective measures that are being or will be taken. The memorandum shall be written in a manner that protects the identity of the reporter and the child and shall not contain the name, or to the extent possible, reveal the identity of the alleged perpetrator or of those interviewed during the investigation. If maltreatment is determined to exist, the commissioner or local welfare agency shall also provide the written memorandum to the parent, guardian, or legal

custodian of each child in the facility who had contact with the individual responsible for the maltreatment. When the facility is the responsible party for maltreatment, the commissioner or local welfare agency shall also provide the written memorandum to the parent, guardian, or legal custodian of each child who received services in the population of the facility where the maltreatment occurred. This notification must be provided to the parent, guardian, or legal custodian of each child receiving services from the time the maltreatment occurred until either the individual responsible for maltreatment is no longer in contact with a child or children in the facility or the conclusion of the investigation. In the case of maltreatment within a school facility, as defined in section 120A.05, subdivisions 9, 11, and 13, and chapter 124E, the commissioner of education need not provide notification to parents, guardians, or legal custodians of each child in the facility, but shall, within ten days after the investigation is completed, provide written notification to the parent, guardian, or legal custodian of any student alleged to have been maltreated. The commissioner of education may notify the parent, guardian, or legal custodian of any student involved as a witness to alleged maltreatment.

Sec. 71. Laws 2014, chapter 312, article 23, section 9, is amended by adding a subdivision to read:

Subd. 5a. **Report to legislature.** (a) The Legislative Health Care Workforce Commission must provide a preliminary report to the legislature by December 31, 2018. The report must include the following:

(1) baseline data on the current supply and distribution of health care providers in the state;

(2) current projections of the demand for health professionals;

(3) other data and analysis the commission is able to complete; and

(4) recommendations on actions needed.

(b) The commission must provide a final report to the legislature by December 31, 2020. The final report must include a comprehensive five-year workforce plan that:

(1) identifies current and anticipated health care workforce shortages by both provider type and geography;

(2) evaluates the effectiveness of incentives currently available to develop, attract, and retain a highly skilled and diverse health care workforce;

(3) evaluates alternative incentives to develop, attract, and retain a highly skilled and diverse health care workforce;

(4) identifies current causes and potential solutions to barriers related to the primary care workforce including, but not limited to, training and residency shortages, disparities in income between primary care and other providers, and negative perceptions of primary care among students;

(5) assesses the current supply and distribution of health care providers in the state, trends in health care delivery, access, reform, and the effects of these trends on workforce needs;

(6) analyzes the effects of changing models of health care delivery, including team models of care and emerging professions, on the demand for health professionals;

(7) projects the five-year demand and supply of health professionals necessary to meet the needs of health care within the state;

(8) identifies all funding sources for which the state has administrative control that are available for health professions training;

(9) recommends how to improve data evaluation and analysis;

(10) recommends how to improve oral health, mental health, and primary care training and practice;

(11) recommends how to improve the long-term care workforce; and

(12) recommends actions needed to meet the projected demand for health professionals over the five years of the plan.

Sec. 72. Laws 2014, chapter 312, article 23, section 9, subdivision 8, is amended to read:

Subd. 8. **Expiration.** The Legislative Health Care Workforce Commission expires on January 1, ~~2017~~ 2021.

Sec. 73. Laws 2015, chapter 71, article 14, section 3, subdivision 2, as amended by Laws 2015, First Special Session chapter 6, section 2, is amended to read:

Subd. 2. **Health Improvement**

	Appropriations by Fund	
General	68,653,000	68,984,000
State Government Special Revenue	6,264,000	6,182,000

Health Care Access	33,987,000	33,421,000
Federal TANF	11,713,000	11,713,000

Violence Against Asian Women Working Group. $200,000 in fiscal year 2016 from the general fund is for the working group on violence against Asian women and children.

MERC Program. $1,000,000 in fiscal year 2016 and $1,000,000 in fiscal year 2017 are from the general fund for the MERC program under Minnesota Statutes, section 62J.692, subdivision 4.

Poison Information Center Grants. $750,000 in fiscal year 2016 and $750,000 in fiscal year 2017 are from the general fund for regional poison information center grants under Minnesota Statutes, section 145.93.

Advanced Care Planning. $250,000 in fiscal year 2016 is from the general fund to award a grant to a statewide advance care planning resource organization that has expertise in convening and coordinating community-based strategies to encourage individuals, families, caregivers, and health care providers to begin conversations regarding end-of-life care choices that express an individual's health care values and preferences and are based on informed health care decisions. This is a onetime appropriation.

Early Dental Prevention Initiatives. $172,000 in fiscal year 2016 and $140,000 in fiscal year 2017 are for the development and distribution of the early dental prevention initiative under Minnesota Statutes, section 144.3875.

International Medical Graduate Assistance Program. (a) $500,000 in fiscal year 2016 and $500,000 in fiscal year 2017 are from the health care access fund for the grant programs and necessary contracts under Minnesota Statutes, section 144.1911, subdivisions 3, paragraph (a), clause (4), and 4 and 5. The commissioner may use up to $133,000 per year of the appropriation for international medical graduate assistance program administration duties in Minnesota Statutes, section 144.1911, subdivisions 3, 9, and 10, and for administering the grant programs under Minnesota Statutes, section 144.1911, subdivisions 4, 5, and 6. The commissioner shall develop recommendations for any additional funding required for initiatives needed to achieve the objectives of Minnesota Statutes, section 144.1911. The commissioner shall report the funding recommendations to the legislature by January 15, 2016, in the report required under Minnesota Statutes, section 144.1911, subdivision 10. The base for this purpose is $1,000,000 in fiscal years 2018 and 2019.

(b) $500,000 in fiscal year 2016 and $500,000 in fiscal year 2017 are from the health care access fund for transfer to the revolving international medical graduate residency account established in Minnesota Statutes, section 144.1911, subdivision 6. This is a onetime appropriation.

Federally Qualified Health Centers. $1,000,000 in fiscal year 2016 and $1,000,000 in fiscal year 2017 are from the general fund

to provide subsidies to federally qualified health centers under Minnesota Statutes, section 145.9269. This is a onetime appropriation.

Organ Donation. $200,000 in fiscal year 2016 is from the general fund to establish a grant program to develop and create culturally appropriate outreach programs that provide education about the importance of organ donation. Grants shall be awarded to a federally designated organ procurement organization and hospital system that performs transplants. This is a onetime appropriation.

Primary Care Residency. $1,500,000 in fiscal year 2016 and $1,500,000 in fiscal year 2017 are from the general fund for the purposes of the primary care residency expansion grant program under Minnesota Statutes, section 144.1506.

Somali ~~Women's Health Pilot~~ Autism Program. ~~(a)~~ The commissioner of health shall ~~establish a pilot program between one or more federally qualified health centers, as defined under Minnesota Statutes, section 145.9269, a nonprofit organization that helps Somali women, and the Minnesota Evaluation Studies Institute, to develop a promising strategy to address the preventative and primary health care needs of, and address health inequities experienced by, first generation Somali women. The pilot program must collaboratively develop a patient flow process for first generation Somali women by:~~

~~(1) addressing and identifying clinical and cultural barriers to Somali women accessing~~

~~preventative and primary care, including, but not limited to, cervical and breast cancer screenings;~~

~~(2) developing a culturally appropriate health curriculum for Somali women based on the outcomes from the community-based participatory research report "Cultural Traditions and the Reproductive Health of Somali Refugees and Immigrants" to increase the health literacy of Somali women and develop culturally specific health care information; and~~

~~(3) training the federally qualified health center's providers and staff to enhance provider and staff cultural competence regarding the cultural barriers, including female genital cutting.~~

~~(b) The pilot program must develop a process that results in increased screening rates for cervical and breast cancer and can be replicated by other providers serving ethnic minorities. The pilot program must conduct an evaluation of the new patient flow process used by Somali women to access federally qualified health centers services~~ award a grant to Dakota County to partner with a community-based organization with expertise in serving Somali children with autism. The grant must address barriers to accessing health care and other resources by providing outreach to Somali families on available support and training to providers on Somali culture.

~~(c) The pilot program must report the outcomes to the commissioner by June 30, 2017.~~

~~(d)~~ $110,000 in fiscal year 2016 is for the ~~Somali women's health pilot program~~ grant to Dakota County. Of this appropriation, the commissioner may use up to $10,000 to administer the ~~program~~ grant to Dakota County. This appropriation is available until June 30, 2017. This is a onetime appropriation.

Menthol Cigarette Usage in African-American Community Intervention Grants. Of the health care access fund appropriation for the statewide health improvement program, $200,000 in fiscal year 2016 is for at least one grant that must be awarded by the commissioner to implement strategies and interventions to reduce the disproportionately high usage of cigarettes by African-Americans, especially the use of menthol-flavored cigarettes, as well as the disproportionate harm tobacco causes in that community. The grantee shall engage members of the African-American community and community-based organizations. This grant shall be awarded as part of the statewide health improvement program grants awarded on November 1, 2015, and must meet the requirements of Minnesota Statutes, section 145.986.

Targeted Home Visiting System. (a) $75,000 in fiscal year 2016 is for the commissioner of health, in consultation with the commissioners of human services and education, community health boards, tribal nations, and other home visiting stakeholders, to design baseline training for new home visitors to ensure

statewide coordination across home visiting programs.

(b) $575,000 in fiscal year 2016 and $2,000,000 fiscal year 2017 are to provide grants to community health boards and tribal nations for start-up grants for new nurse-family partnership programs and for grants to expand existing programs to serve first-time mothers, prenatally by 28 weeks gestation until the child is two years of age, who are eligible for medical assistance under Minnesota Statutes, chapter 256B, or the federal Special Supplemental Nutrition Program for Women, Infants, and Children. The commissioner shall award grants to community health boards or tribal nations in metropolitan and rural areas of the state. Priority for all grants shall be given to nurse-family partnership programs that provide services through a Minnesota health care program-enrolled provider that accepts medical assistance. Additionally, priority for grants to rural areas shall be given to community health boards and tribal nations that expand services within regional partnerships that provide the nurse-family partnership program. Funding available under this paragraph may only be used to supplement, not to replace, funds being used for nurse-family partnership home visiting services as of June 30, 2015.

Opiate Antagonists. $270,000 in fiscal year 2016 and $20,000 in fiscal year 2017 are from the general fund for grants to the eight regional emergency medical services programs to

purchase opiate antagonists and educate and train emergency medical services persons, as defined in Minnesota Statutes, section 144.7401, subdivision 4, clauses (1) and (2), in the use of these antagonists in the event of an opioid or heroin overdose. For the purposes of this paragraph, "opiate antagonist" means naloxone hydrochloride or any similarly acting drug approved by the federal Food and Drug Administration for the treatment of drug overdose. Grants under this paragraph must be distributed to all eight regional emergency medical services programs. This is a onetime appropriation and is available until June 30, 2017. The commissioner may use up to $20,000 of the amount for opiate antagonists for administration.

Local and Tribal Public Health Grants. (a) $894,000 in fiscal year 2016 and $894,000 in fiscal year 2017 are for an increase in local public health grants for community health boards under Minnesota Statutes, section 145A.131, subdivision 1, paragraph (e).

(b) $106,000 in fiscal year 2016 and $106,000 in fiscal year 2017 are for an increase in special grants to tribal governments under Minnesota Statutes, section 145A.14, subdivision 2a.

HCBS Employee Scholarships. $1,000,000 in fiscal year 2016 and $1,000,000 in fiscal year 2017 are from the general fund for the home and community-based services employee scholarship program under Minnesota Statutes, section 144.1503. The commissioner may use up to $50,000 of the

amount for the HCBS employee scholarships for administration.

Family Planning Special Projects. $1,000,000 in fiscal year 2016 and $1,000,000 in fiscal year 2017 are from the general fund for family planning special project grants under Minnesota Statutes, section 145.925.

Positive Alternatives. $1,000,000 in fiscal year 2016 and $1,000,000 in fiscal year 2017 are from the general fund for positive abortion alternatives under Minnesota Statutes, section 145.4235.

Safe Harbor for Sexually Exploited Youth. $700,000 in fiscal year 2016 and $700,000 in fiscal year 2017 are from the general fund for the safe harbor program under Minnesota Statutes, sections 145.4716 to 145.4718. Funds shall be used for grants to increase the number of regional navigators; training for professionals who engage with exploited or at-risk youth; implementing statewide protocols and best practices for effectively identifying, interacting with, and referring sexually exploited youth to appropriate resources; and program operating costs.

Health Care Grants for Uninsured Individuals. (a) $62,500 in fiscal year 2016 and $62,500 in fiscal year 2017 are from the health care access fund for dental provider grants in Minnesota Statutes, section 145.929, subdivision 1.

(b) $218,750 in fiscal year 2016 and $218,750 in fiscal year 2017 are from the health care access fund for community mental health

program grants in Minnesota Statutes, section 145.929, subdivision 2.

(c) $750,000 in fiscal year 2016 and $750,000 in fiscal year 2017 are from the health care access fund for the emergency medical assistance outlier grant program in Minnesota Statutes, section 145.929, subdivision 3.

(d) $218,750 of the health care access fund appropriation in fiscal year 2016 and $218,750 in fiscal year 2017 are for community health center grants under Minnesota Statutes, section 145.9269. A community health center that receives a grant from this appropriation is not eligible for a grant under paragraph (b).

(e) The commissioner may use up to $25,000 of the appropriations for health care grants for uninsured individuals in fiscal years 2016 and 2017 for grant administration.

TANF Appropriations. (a) $1,156,000 of the TANF funds is appropriated each year of the biennium to the commissioner for family planning grants under Minnesota Statutes, section 145.925.

(b) $3,579,000 of the TANF funds is appropriated each year of the biennium to the commissioner for home visiting and nutritional services listed under Minnesota Statutes, section 145.882, subdivision 7, clauses (6) and (7). Funds must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1.

(c) $2,000,000 of the TANF funds is appropriated each year of the biennium to the commissioner for decreasing racial and ethnic

disparities in infant mortality rates under Minnesota Statutes, section 145.928, subdivision 7.

(d) $4,978,000 of the TANF funds is appropriated each year of the biennium to the commissioner for the family home visiting grant program according to Minnesota Statutes, section 145A.17. $4,000,000 of the funding must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1. $978,000 of the funding must be distributed to tribal governments as provided in Minnesota Statutes, section 145A.14, subdivision 2a.

(e) The commissioner may use up to 6.23 percent of the funds appropriated each fiscal year to conduct the ongoing evaluations required under Minnesota Statutes, section 145A.17, subdivision 7, and training and technical assistance as required under Minnesota Statutes, section 145A.17, subdivisions 4 and 5.

TANF Carryforward. Any unexpended balance of the TANF appropriation in the first year of the biennium does not cancel but is available for the second year.

Health Professional Loan Forgiveness. $2,631,000 in fiscal year 2016 and $2,631,000 in fiscal year 2017 are from the health care access fund for the purposes of Minnesota Statutes, section 144.1501. Of this appropriation, the commissioner may use up to $131,000 each year to administer the program.

Minnesota Stroke System. $350,000 in fiscal year 2016 and $350,000 in fiscal year 2017 are from the general fund for the Minnesota stroke system.

Prevention of Violence in Health Care. $50,000 in fiscal year 2016 is to continue the prevention of violence in health care program and creating violence prevention resources for hospitals and other health care providers to use in training their staff on violence prevention. This is a onetime appropriation and is available until June 30, 2017.

Health Care Savings Determinations. (a) The health care access fund base for the state health improvement program is decreased by $261,000 in fiscal year 2016 and decreased by $110,000 in fiscal year 2017.

(b) $261,000 in fiscal year 2016 and $110,000 in fiscal year 2017 are from the health care access fund for the forecasting, cost reporting, and analysis required by Minnesota Statutes, section 62U.10, subdivisions 6 and 7.

Base Level Adjustments. The general fund base is decreased by $1,070,000 in fiscal year 2018 and by $1,020,000 in fiscal year 2019. The state government special revenue fund base is increased by $33,000 in fiscal year 2018. The health care access fund base is increased by $610,000 in fiscal year 2018 and by $23,000 in fiscal year 2019.

Sec. 74. **STUDY AND REPORT ON HOME CARE NURSING WORKFORCE SHORTAGE.**

(a) The chair and ranking minority member of the senate Human Services Reform Finance and Policy Committee and the chair and ranking minority member of the house of

representatives Health and Human Services Finance Committee shall convene a working group to study and report on the shortage of registered nurses and licensed practical nurses available to provide low-complexity regular home care services to clients in need of such services, especially clients covered by medical assistance, and to provide recommendations for ways to address the workforce shortage. The working group shall consist of 12 members appointed as follows:

(1) the chair of the senate Human Services Reform Finance and Policy Committee or a designee;

(2) the ranking minority member of the senate Human Services Reform Finance and Policy Committee or a designee;

(3) the chair of the house of representatives Health and Human Services Finance Committee or a designee;

(4) the ranking minority member of the house of representatives Health and Human Services Finance Committee or a designee;

(5) the commissioner of human services or a designee;

(6) the commissioner of health or a designee;

(7) one representative appointed by the Professional Home Care Coalition;

(8) one representative appointed by the Minnesota Home Care Association;

(9) one representative appointed by the Minnesota Board of Nursing;

(10) one representative appointed by the Minnesota Nurses Association;

(11) one representative appointed by the Minnesota Licensed Practical Nurses Association;

(12) one representative appointed by the Minnesota Society of Medical Assistants;

(13) one client who receives regular home care nursing services and is covered by medical assistance appointed by the commissioner of human services after consulting with the appointing authorities identified in clauses (7) to (12); and

(14) one county public health nurse who is a certified assessor appointed by the commissioner of health after consulting with the Minnesota Home Care Association.

(b) The appointing authorities must appoint members by August 1, 2017.

(c) The convening authorities shall convene the first meeting of the working group no later than August 15, 2017, and caucus staff shall provide support and meeting space for

the working group. The home care and assisted living program advisory council established under Minnesota Statutes, section 144A.4799, shall provide advice and recommendations to the working group. Working group members shall serve without compensation and shall not be reimbursed for expenses.

(d) The working group shall:

(1) quantify the number of low-complexity regular home care nursing hours that are authorized but not provided to clients covered by medical assistance, due to the shortage of registered nurses and licensed practical nurses available to provide these home care services;

(2) quantify the current and projected workforce shortages of registered nurses and licensed practical nurses available to provide low-complexity regular home care nursing services to clients, especially clients covered by medical assistance;

(3) develop recommendations for actions to take in the next two years to address the regular home care nursing workforce shortage, including identifying other health care professionals who may be able to provide low-complexity regular home care nursing services with additional training; what additional training may be necessary for these health care professionals; and how to address scope of practice and licensing issues;

(4) compile reimbursement rates for regular home care nursing from other states and determine Minnesota's national ranking with respect to reimbursement for regular home care nursing;

(5) determine whether reimbursement rates for regular home care nursing fully reimburse providers for the cost of providing the service and whether the discrepancy, if any, between rates and costs contributes to lack of access to regular home care nursing; and

(6) by January 15, 2018, report on the findings and recommendations of the working group to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance. The working group's report shall include draft legislation.

(e) The working group shall elect a chair from among its members at its first meeting.

(f) The meetings of the working group shall be open to the public.

(g) This section expires January 16, 2018, or the day after submitting the report required by this section, whichever is earlier.

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

Sec. 75. **ACCOUNTABLE COMMUNITY FOR HEALTH OPIOID ABUSE PREVENTION PILOT PROJECTS.**

(a) The commissioner of health shall establish up to 12 opioid abuse prevention pilot projects that provide innovative and collaborative solutions to confront opioid abuse. Each pilot project must:

(1) be designed to reduce emergency room and other health care provider visits resulting from opioid use or abuse, and reduce rates of opioid addiction in the community;

(2) establish multidisciplinary controlled substance care teams that may consist of physicians, pharmacists, social workers, nurse care coordinators, and mental health professionals;

(3) deliver health care services and care coordination, through controlled substance care teams, to reduce the inappropriate use of opioids by patients and rates of opioid addiction;

(4) address any unmet social service needs that create barriers to managing pain effectively and obtaining optimal health outcomes;

(5) provide prescriber and dispenser education and assistance to reduce the inappropriate prescribing and dispensing of opioids;

(6) promote the adoption of best practices related to opioid disposal and reducing opportunities for illegal access to opioids; and

(7) engage partners outside of the health care system, including schools, law enforcement, and social services, to address root causes of opioid abuse and addiction at the community level.

(b) The commissioner shall contract with an accountable community for health that operates an opioid abuse prevention project and can document success in reducing opioid use through the use of controlled substance care teams, to assist the commissioner in administering this section and to provide technical assistance to the commissioner and to entities selected to operate a pilot project.

(c) The contract under paragraph (b) shall require the accountable community for health to evaluate the extent to which the pilot projects were successful in reducing the inappropriate use of opioids. The evaluation must analyze changes in the number of opioid prescriptions, the number of emergency room visits related to opioid use, and other relevant measures. The accountable community for health shall report evaluation results to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance and public safety by December 15, 2019.

Sec. 76. **COMPREHENSIVE PLAN TO END HIV/AIDS.**

(a) The commissioner of health, in coordination with the commissioner of human services, and in consultation with community stakeholders, shall develop a strategic statewide comprehensive plan that establishes a set of priorities and actions to address the state's HIV epidemic by reducing the number of newly infected individuals; ensuring that individuals living with HIV have access to quality, life-extending care regardless of race, gender, sexual orientation, or socioeconomic circumstances; and ensuring the coordination of a statewide response to reach the ultimate goal of the elimination of HIV in Minnesota.

(b) The plan must identify strategies that are consistent with the National HIV/AIDS Strategy plan, that reflect the scientific developments in HIV medical care and prevention that have occurred, and that work toward the elimination of HIV. The plan must:

(1) determine the appropriate level of testing, care, and services necessary to achieve the goal of the elimination of HIV, beginning with meeting the following outcomes:

(i) reduce the number of new diagnoses by at least 75 percent;

(ii) increase the percentage of individuals living with HIV who know their serostatus to at least 90 percent;

(iii) increase the percentage of individuals living with HIV who are receiving HIV treatment to at least 90 percent; and

(iv) increase the percentage of individuals living with HIV who are virally suppressed to at least 90 percent;

(2) provide recommendations for the optimal allocation and alignment of existing state and federal funding in order to achieve the greatest impact and ensure a coordinated statewide effort; and

(3) provide recommendations for evaluating new and enhanced interventions and an estimate of additional resources needed to provide these interventions.

(c) The commissioner shall submit the comprehensive plan and recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by February 1, 2018.

(d) The commissioner, after consulting with stakeholders, may implement this section utilizing existing efforts being carried out for similar purposes in order to reduce the resources required to implement this section.

Sec. 77. **SAFE HARBOR FOR ALL; STATEWIDE SEX TRAFFICKING VICTIMS STRATEGIC PLAN.**

(a) By October 1, 2018, the commissioner of health, in consultation with the commissioners of public safety and human services, shall develop a comprehensive strategic plan to address the needs of sex trafficking victims statewide.

(b) In developing the plan, the commissioner of health shall seek recommendations from professionals, community members, and stakeholders from across the state, with an emphasis on the communities most impacted by sex trafficking. At a minimum, the commissioner must seek input from the following groups: sex trafficking survivors and their family members, statewide crime victim services coalitions, victim services providers, nonprofit organizations, task forces, prosecutors, public defenders, tribal governments, public safety and corrections professionals, public health professionals, human services professionals, and impacted community members.

(c) By January 15, 2019, the commissioner of health shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services and criminal justice finance and policy on developing the statewide strategic plan, including recommendations for additional legislation and funding. The report must contain policy considerations regarding decriminalization of Minnesota Statutes, section 609.324, subdivisions 6 and 7.

(d) As used in this section, "sex trafficking victim" has the meaning given in Minnesota Statutes, section 609.321, subdivision 7b.

Sec. 78. **DIRECTION TO THE COMMISSIONER OF HEALTH.**

The commissioner of health shall work with interested stakeholders to evaluate whether existing laws, including laws governing housing with services establishments, board and lodging establishments with special services, assisted living designations, and home care providers, as well as building code requirements and landlord tenancy laws, sufficiently protect the health and safety of persons diagnosed with Alzheimer's disease or a related dementia.

Sec. 79. **PALLIATIVE CARE ADVISORY COUNCIL.**

The appointing authorities shall appoint the first members of the Palliative Care Advisory Council under Minnesota Statutes, section 144.059, by October 1, 2017. The commissioner of health shall convene the first meeting by November 15, 2017, and the commissioner or

the commissioner's designee shall act as chair until the council elects a chair at its first meeting.

Sec. 80. **COUNTY-BASED PURCHASING PLANS.**

The commissioner of health shall explore ways to allow county-based purchasing plans meeting the requirements under Minnesota Statutes, section 256B.692, to sell health insurance coverage in the individual and group health insurance markets.

Sec. 81. **REPEALER.**

Laws 2014, chapter 312, article 23, section 9, subdivision 5, is repealed.

ARTICLE 11

HEALTH LICENSING BOARDS

Section 1. Minnesota Statutes 2016, section 147.01, subdivision 7, is amended to read:

Subd. 7. **Physician application ~~fee~~ and license fees.** (a) The board may charge ~~a~~ the following nonrefundable application and license fees processed pursuant to sections 147.02, 147.03, 147.037, 147.0375, and 147.38:

(1) physician application fee ~~of~~, $200~~.~~;

(2) physician annual registration renewal fee, $192;

(3) physician endorsement to other states, $40;

(4) physician emeritus license, $50;

(5) physician temporary licenses, $60;

(6) physician late fee, $60;

(7) duplicate license fee, $20;

(8) certification letter fee, $25;

(9) education or training program approval fee, $100;

(10) report creation and generation fee, $60;

(11) examination administration fee (half day), $50;

(12) examination administration fee (full day), $80; and

(13) fees developed by the Interstate Commission for determining physician qualification to register and participate in the interstate medical licensure compact, as established in rules authorized in and pursuant to section 147.38, not to exceed $1,000.

(b) The board may prorate the initial annual license fee. All licensees are required to pay the full fee upon license renewal. The revenue generated from the fee must be deposited in an account in the state government special revenue fund.

Sec. 2. Minnesota Statutes 2016, section 147.02, subdivision 1, is amended to read:

Subdivision 1. **United States or Canadian medical school graduates.** The board shall issue a license to practice medicine to a person not currently licensed in another state or Canada and who meets the requirements in paragraphs (a) to (i).

(a) An applicant for a license shall file a written application on forms provided by the board, showing to the board's satisfaction that the applicant is of good moral character and satisfies the requirements of this section.

(b) The applicant shall present evidence satisfactory to the board of being a graduate of a medical or osteopathic medical school located in the United States, its territories or Canada, and approved by the board based upon its faculty, curriculum, facilities, accreditation by a recognized national accrediting organization approved by the board, and other relevant data, or is currently enrolled in the final year of study at the school.

(c) The applicant must have passed an examination as described in clause (1) or (2).

(1) The applicant must have passed a comprehensive examination for initial licensure prepared and graded by the National Board of Medical Examiners, the Federation of State Medical Boards, the Medical Council of Canada, the National Board of Osteopathic Examiners, or the appropriate state board that the board determines acceptable. The board shall by rule determine what constitutes a passing score in the examination.

(2) The applicant taking the United States Medical Licensing Examination (USMLE) or Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA) must have passed steps or levels one, two, and three. Step or level three must be passed within five years of passing step or level two, or before the end of residency training. The applicant must pass each of steps or levels one, two, and three with passing scores as recommended by the USMLE program or National Board of Osteopathic Medical Examiners within three attempts. The applicant taking combinations of Federation of State Medical Boards, National Board of Medical Examiners, and USMLE may be accepted only if the combination is

approved by the board as comparable to existing comparable examination sequences and all examinations are completed prior to the year 2000.

(d) The applicant shall present evidence satisfactory to the board of the completion of one year of graduate, clinical medical training in a program accredited by a national accrediting organization approved by the board or other graduate training approved in advance by the board as meeting standards similar to those of a national accrediting organization.

(e) The applicant may make arrangements with the executive director to appear in person before the board or its designated representative to show that the applicant satisfies the requirements of this section. The board may establish as internal operating procedures the procedures or requirements for the applicant's personal presentation.

(f) The applicant shall pay a nonrefundable fee established by the board ~~by rule~~. ~~The fee may not be refunded.~~ Upon application or notice of license renewal, the board must provide notice to the applicant and to the person whose license is scheduled to be issued or renewed of any additional fees, surcharges, or other costs which the person is obligated to pay as a condition of licensure. The notice must:

(1) state the dollar amount of the additional costs; and

(2) clearly identify to the applicant the payment schedule of additional costs.

(g) The applicant must not be under license suspension or revocation by the licensing board of the state or jurisdiction in which the conduct that caused the suspension or revocation occurred.

(h) The applicant must not have engaged in conduct warranting disciplinary action against a licensee, or have been subject to disciplinary action other than as specified in paragraph (g). If the applicant does not satisfy the requirements stated in this paragraph, the board may issue a license only on the applicant's showing that the public will be protected through issuance of a license with conditions and limitations the board considers appropriate.

(i) If the examination in paragraph (c) was passed more than ten years ago, the applicant must either:

(1) pass the special purpose examination of the Federation of State Medical Boards with a score of 75 or better within three attempts; or

(2) have a current certification by a specialty board of the American Board of Medical Specialties, of the American Osteopathic Association, the Royal College of Physicians and Surgeons of Canada, or of the College of Family Physicians of Canada.

Sec. 3. Minnesota Statutes 2016, section 147.03, subdivision 1, is amended to read:

Subdivision 1. **Endorsement; reciprocity.** (a) The board may issue a license to practice medicine to any person who satisfies the requirements in paragraphs (b) to ~~(f)~~(e).

(b) The applicant shall satisfy all the requirements established in section 147.02, subdivision 1, paragraphs (a), (b), (d), (e), and (f).

(c) The applicant shall:

(1) have passed an examination prepared and graded by the Federation of State Medical Boards, the National Board of Medical Examiners, or the United States Medical Licensing Examination (USMLE) program in accordance with section 147.02, subdivision 1, paragraph (c), clause (2); the National Board of Osteopathic Medical Examiners; or the Medical Council of Canada; and

(2) have a current license from the equivalent licensing agency in another state or Canada and, if the examination in clause (1) was passed more than ten years ago, either:

(i) pass the Special Purpose Examination of the Federation of State Medical Boards with a score of 75 or better within three attempts; or

(ii) have a current certification by a specialty board of the American Board of Medical Specialties, of the American Osteopathic Association, the Royal College of Physicians and Surgeons of Canada, or of the College of Family Physicians of Canada; or

(3) if the applicant fails to meet the requirement established in section 147.02, subdivision 1, paragraph (c), clause (2), because the applicant failed to pass each of steps one, two, and three of the USMLE within the required three attempts, the applicant may be granted a license provided the applicant:

(i) has passed each of steps one, two, and three with passing scores as recommended by the USMLE program within no more than four attempts for any of the three steps;

(ii) is currently licensed in another state; and

(iii) has current certification by a specialty board of the American Board of Medical Specialties, the American Osteopathic Association Bureau of Professional Education, the Royal College of Physicians and Surgeons of Canada, or the College of Family Physicians of Canada.

~~(d) The applicant shall pay a fee established by the board by rule. The fee may not be refunded.~~

~~(e)~~ (d) The applicant must not be under license suspension or revocation by the licensing board of the state or jurisdiction in which the conduct that caused the suspension or revocation occurred.

~~(f)~~ (e) The applicant must not have engaged in conduct warranting disciplinary action against a licensee, or have been subject to disciplinary action other than as specified in paragraph ~~(e)~~(d). If an applicant does not satisfy the requirements stated in this paragraph, the board may issue a license only on the applicant's showing that the public will be protected through issuance of a license with conditions or limitations the board considers appropriate.

~~(g)~~ (f) Upon the request of an applicant, the board may conduct the final interview of the applicant by teleconference.

Sec. 4. **[147A.28] PHYSICIAN ASSISTANT APPLICATION AND LICENSE FEES.**

(a) The board may charge the following nonrefundable fees:

(1) physician assistant application fee, $120;

(2) physician assistant annual registration renewal fee (prescribing authority), $135;

(3) physician assistant annual registration renewal fee (no prescribing authority), $115;

(4) physician assistant temporary registration, $115;

(5) physician assistant temporary permit, $60;

(6) physician assistant locum tenens permit, $25;

(7) physician assistant late fee, $50;

(8) duplicate license fee, $20;

(9) certification letter fee, $25;

(10) education or training program approval fee, $100; and

(11) report creation and generation fee, $60.

(b) The board may prorate the initial annual license fee. All licensees are required to pay the full fee upon license renewal. The revenue generated from the fees must be deposited in an account in the state government special revenue fund.

Sec. 5. Minnesota Statutes 2016, section 147B.08, is amended by adding a subdivision to read:

Subd. 4. **Acupuncturist application and license fees.** (a) The board may charge the following nonrefundable fees:

(1) acupuncturist application fee, $150;

(2) acupuncturist annual registration renewal fee, $150;

(3) acupuncturist temporary registration fee, $60;

(4) acupuncturist inactive status fee, $50;

(5) acupuncturist late fee, $50;

(6) duplicate license fee, $20;

(7) certification letter fee, $25;

(8) education or training program approval fee, $100; and

(9) report creation and generation fee, $60.

(b) The board may prorate the initial annual license fee. All licensees are required to pay the full fee upon license renewal. The revenue generated from the fees must be deposited in an account in the state government special revenue fund.

Sec. 6. Minnesota Statutes 2016, section 147C.40, is amended by adding a subdivision to read:

Subd. 5. **Respiratory therapist application and license fees.** (a) The board may charge the following nonrefundable fees:

(1) respiratory therapist application fee, $100;

(2) respiratory therapist annual registration renewal fee, $90;

(3) respiratory therapist inactive status fee, $50;

(4) respiratory therapist temporary registration fee, $90;

(5) respiratory therapist temporary permit, $60;

(6) respiratory therapist late fee, $50;

(7) duplicate license fee, $20;

(8) certification letter fee, $25;

(9) education or training program approval fee, $100; and

(10) report creation and generation fee, $60.

(b) The board may prorate the initial annual license fee. All licensees are required to pay the full fee upon license renewal. The revenue generated from the fees must be deposited in an account in the state government special revenue fund.

Sec. 7. Minnesota Statutes 2016, section 148.6402, subdivision 4, is amended to read:

Subd. 4. **~~Commissioner~~ Board.** "~~Commissioner~~ Board" means the ~~commissioner of health or a designee~~ Board of Occupational Therapy Practice established in section 148.6449.

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

Sec. 8. Minnesota Statutes 2016, section 148.6405, is amended to read:

148.6405 LICENSURE APPLICATION REQUIREMENTS: PROCEDURES AND QUALIFICATIONS.

(a) An applicant for licensure must comply with the application requirements in section 148.6420. To qualify for licensure, an applicant must satisfy one of the requirements in paragraphs (b) to (f) and not be subject to denial of licensure under section 148.6448.

(b) A person who applies for licensure as an occupational therapist and who has not been credentialed by the National Board for Certification in Occupational Therapy or another jurisdiction must meet the requirements in section 148.6408.

(c) A person who applies for licensure as an occupational therapy assistant and who has not been credentialed by the National Board for Certification in Occupational Therapy or another jurisdiction must meet the requirements in section 148.6410.

(d) A person who is certified by the National Board for Certification in Occupational Therapy may apply for licensure by equivalency and must meet the requirements in section 148.6412.

(e) A person who is credentialed in another jurisdiction may apply for licensure by reciprocity and must meet the requirements in section 148.6415.

(f) A person who applies for temporary licensure must meet the requirements in section 148.6418.

(g) A person who applies for licensure under paragraph (b), (c), or (f) more than two and less than four years after meeting the requirements in section 148.6408 or 148.6410 must submit the following:

(1) a completed and signed application for licensure on forms provided by the ~~commissioner~~ board;

(2) the license application fee required under section 148.6445;

(3) if applying for occupational therapist licensure, proof of having met a minimum of 24 contact hours of continuing education in the two years preceding licensure application, or if applying for occupational therapy assistant licensure, proof of having met a minimum of 18 contact hours of continuing education in the two years preceding licensure application;

(4) verified documentation of successful completion of 160 hours of supervised practice approved by the ~~commissioner~~ board under a limited license specified in section 148.6425, subdivision 3, paragraph (c); and

(5) additional information as requested by the ~~commissioner~~ board to clarify information in the application, including information to determine whether the individual has engaged in conduct warranting disciplinary action under section 148.6448. The information must be submitted within 30 days after the ~~commissioner's~~ board's request.

(h) A person who applied for licensure under paragraph (b), (c), or (f) four years or more after meeting the requirements in section 148.6408 or 148.6410 must meet all the requirements in paragraph (g) except clauses (3) and (4), submit documentation of having retaken and passed the credentialing examination for occupational therapist or occupational therapy assistant, or of having completed an occupational therapy refresher program that contains both a theoretical and clinical component approved by the ~~commissioner~~ board, and verified documentation of successful completion of 480 hours of supervised practice approved by the ~~commissioner~~ board under a limited license specified in section 148.6425, subdivision 3, paragraph (c). The 480 hours of supervised practice must be completed in six months and may be completed at the applicant's place of work. Only refresher courses completed within one year prior to the date of application qualify for approval.

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

Sec. 9. Minnesota Statutes 2016, section 148.6408, subdivision 2, is amended to read:

Subd. 2. **Qualifying examination score required.** (a) An applicant must achieve a qualifying score on the credentialing examination for occupational therapist.

(b) The ~~commissioner~~ board shall determine the qualifying score for the credentialing examination for occupational therapist. In determining the qualifying score, the ~~commissioner~~ board shall consider the cut score recommended by the National Board for Certification in Occupational Therapy, or other national credentialing organization approved by the ~~commissioner~~ board, using the modified Angoff method for determining cut score or another method for determining cut score that is recognized as appropriate and acceptable by industry standards.

(c) The applicant is responsible for:

(1) making arrangements to take the credentialing examination for occupational therapist;

(2) bearing all expenses associated with taking the examination; and

(3) having the examination scores sent directly to the ~~commissioner~~ board from the testing service that administers the examination.

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

Sec. 10. Minnesota Statutes 2016, section 148.6410, subdivision 2, is amended to read:

Subd. 2. **Qualifying examination score required.** (a) An applicant for licensure must achieve a qualifying score on the credentialing examination for occupational therapy assistants.

(b) The ~~commissioner~~ board shall determine the qualifying score for the credentialing examination for occupational therapy assistants. In determining the qualifying score, the ~~commissioner~~ board shall consider the cut score recommended by the National Board for Certification in Occupational Therapy, or other national credentialing organization approved by the ~~commissioner~~ board, using the modified Angoff method for determining cut score or another method for determining cut score that is recognized as appropriate and acceptable by industry standards.

(c) The applicant is responsible for:

(1) making all arrangements to take the credentialing examination for occupational therapy assistants;

(2) bearing all expense associated with taking the examination; and

(3) having the examination scores sent directly to the ~~commissioner~~ board from the testing service that administers the examination.

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

Sec. 11. Minnesota Statutes 2016, section 148.6412, subdivision 2, is amended to read:

Subd. 2. **Persons certified by National Board for Certification in Occupational Therapy after June 17, 1996.** The ~~commissioner~~ board may license any person certified by the National Board for Certification in Occupational Therapy as an occupational therapist after June 17, 1996, if the ~~commissioner~~ board determines the requirements for certification are equivalent to or exceed the requirements for licensure as an occupational therapist under section 148.6408. The ~~commissioner~~ board may license any person certified by the National Board for Certification in Occupational Therapy as an occupational therapy assistant after June 17, 1996, if the ~~commissioner~~ board determines the requirements for certification are equivalent to or exceed the requirements for licensure as an occupational therapy assistant under section 148.6410. Nothing in this section limits the ~~commissioner's~~ board's authority to deny licensure based upon the grounds for discipline in sections 148.6401 to 148.6450.

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

Sec. 12. Minnesota Statutes 2016, section 148.6415, is amended to read:

148.6415 LICENSURE BY RECIPROCITY.

A person who holds a current credential as an occupational therapist in the District of Columbia or a state or territory of the United States whose standards for credentialing are determined by the ~~commissioner~~ board to be equivalent to or exceed the requirements for licensure under section 148.6408 may be eligible for licensure by reciprocity as an occupational therapist. A person who holds a current credential as an occupational therapy assistant in the District of Columbia or a state or territory of the United States whose standards for credentialing are determined by the ~~commissioner~~ board to be equivalent to or exceed the requirements for licensure under section 148.6410 may be eligible for licensure by reciprocity as an occupational therapy assistant. Nothing in this section limits the ~~commissioner's~~ board's authority to deny licensure based upon the grounds for discipline in sections 148.6401 to 148.6450. An applicant must provide:

(1) the application materials as required by section 148.6420, subdivisions 1, 3, and 4;

(2) the fees required by section 148.6445;

(3) a copy of a current and unrestricted credential for the practice of occupational therapy as either an occupational therapist or occupational therapy assistant;

(4) a letter from the jurisdiction that issued the credential describing the applicant's qualifications that entitled the applicant to receive the credential; and

(5) other information necessary to determine whether the credentialing standards of the jurisdiction that issued the credential are equivalent to or exceed the requirements for licensure under sections 148.6401 to 148.6450.

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

Sec. 13. Minnesota Statutes 2016, section 148.6418, subdivision 1, is amended to read:

Subdivision 1. **Application.** The ~~commissioner~~ board shall issue temporary licensure as an occupational therapist or occupational therapy assistant to applicants who are not the subject of a disciplinary action or past disciplinary action, nor disqualified on the basis of items listed in section 148.6448, subdivision 1.

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

Sec. 14. Minnesota Statutes 2016, section 148.6418, subdivision 2, is amended to read:

Subd. 2. **Procedures.** To be eligible for temporary licensure, an applicant must submit a completed application for temporary licensure on forms provided by the ~~commissioner~~ board, the fees required by section 148.6445, and one of the following:

(1) evidence of successful completion of the requirements in section 148.6408, subdivision 1, or 148.6410, subdivision 1;

(2) a copy of a current and unrestricted credential for the practice of occupational therapy as either an occupational therapist or occupational therapy assistant in another jurisdiction; or

(3) a copy of a current and unrestricted certificate from the National Board for Certification in Occupational Therapy stating that the applicant is certified as an occupational therapist or occupational therapy assistant.

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

Sec. 15. Minnesota Statutes 2016, section 148.6418, subdivision 4, is amended to read:

Subd. 4. **Supervision required.** An applicant who has graduated from an accredited occupational therapy program, as required by section 148.6408, subdivision 1, or 148.6410, subdivision 1, and who has not passed the examination required by section 148.6408, subdivision 2, or 148.6410, subdivision 2, must practice under the supervision of a licensed occupational therapist. The supervising therapist must, at a minimum, supervise the person working under temporary licensure in the performance of the initial evaluation, determination of the appropriate treatment plan, and periodic review and modification of the treatment

plan. The supervising therapist must observe the person working under temporary licensure in order to assure service competency in carrying out evaluation, treatment planning, and treatment implementation. The frequency of face-to-face collaboration between the person working under temporary licensure and the supervising therapist must be based on the condition of each patient or client, the complexity of treatment and evaluation procedures, and the proficiencies of the person practicing under temporary licensure. The occupational therapist or occupational therapy assistant working under temporary licensure must provide verification of supervision on the application form provided by the ~~commissioner~~ board.

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

Sec. 16. Minnesota Statutes 2016, section 148.6418, subdivision 5, is amended to read:

Subd. 5. **Expiration of temporary licensure.** A temporary license issued to a person pursuant to subdivision 2, clause (1), expires six months from the date of issuance for occupational therapists and occupational therapy assistants or on the date the ~~commissioner~~ board grants or denies licensure, whichever occurs first. A temporary license issued to a person pursuant to subdivision 2, clause (2) or (3), expires 90 days after it is issued. Upon application for renewal, a temporary license shall be renewed once to persons who have not met the examination requirement under section 148.6408, subdivision 2, or 148.6410, subdivision 2, within the initial temporary licensure period and who are not the subject of a disciplinary action nor disqualified on the basis of items in section 148.6448, subdivision 1. Upon application for renewal, a temporary license shall be renewed once to persons who are able to demonstrate good cause for failure to meet the requirements for licensure under section 148.6412 or 148.6415 within the initial temporary licensure period and who are not the subject of a disciplinary action nor disqualified on the basis of items in section 148.6448, subdivision 1.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 17. Minnesota Statutes 2016, section 148.6420, subdivision 1, is amended to read:

Subdivision 1. **Applications for licensure.** An applicant for licensure must:

(1) submit a completed application for licensure on forms provided by the ~~commissioner~~ board and must supply the information requested on the application, including:

(i) the applicant's name, business address and business telephone number, business setting, and daytime telephone number;

(ii) the name and location of the occupational therapy program the applicant completed;

(iii) a description of the applicant's education and training, including a list of degrees received from educational institutions;

(iv) the applicant's work history for the six years preceding the application, including the number of hours worked;

(v) a list of all credentials currently and previously held in Minnesota and other jurisdictions;

(vi) a description of any jurisdiction's refusal to credential the applicant;

(vii) a description of all professional disciplinary actions initiated against the applicant in any jurisdiction;

(viii) information on any physical or mental condition or chemical dependency that impairs the person's ability to engage in the practice of occupational therapy with reasonable judgment or safety;

(ix) a description of any misdemeanor or felony conviction that relates to honesty or to the practice of occupational therapy;

(x) a description of any state or federal court order, including a conciliation court judgment or a disciplinary order, related to the individual's occupational therapy practice; and

(xi) a statement indicating the physical agent modalities the applicant will use and whether the applicant will use the modalities as an occupational therapist or an occupational therapy assistant under direct supervision;

(2) submit with the application all fees required by section 148.6445;

(3) sign a statement that the information in the application is true and correct to the best of the applicant's knowledge and belief;

(4) sign a waiver authorizing the ~~commissioner~~ board to obtain access to the applicant's records in this or any other state in which the applicant holds or previously held a credential for the practice of an occupation, has completed an accredited occupational therapy education program, or engaged in the practice of occupational therapy;

(5) submit additional information as requested by the ~~commissioner~~ board; and

(6) submit the additional information required for licensure by equivalency, licensure by reciprocity, and temporary licensure as specified in sections 148.6408 to 148.6418.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 18. Minnesota Statutes 2016, section 148.6420, subdivision 3, is amended to read:

Subd. 3. **Applicants certified by National Board for Certification in Occupational Therapy.** An applicant who is certified by the National Board for Certification in Occupational Therapy must provide the materials required in subdivision 1 and the following:

(1) verified documentation from the National Board for Certification in Occupational Therapy stating that the applicant is certified as an occupational therapist, registered or certified occupational therapy assistant, the date certification was granted, and the applicant's certification number. The document must also include a statement regarding disciplinary actions. The applicant is responsible for obtaining this documentation by sending a form provided by the ~~commissioner~~ board to the National Board for Certification in Occupational Therapy; and

(2) a waiver authorizing the ~~commissioner~~ board to obtain access to the applicant's records maintained by the National Board for Certification in Occupational Therapy.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 19. Minnesota Statutes 2016, section 148.6420, subdivision 5, is amended to read:

Subd. 5. **Action on applications for licensure.** (a) The ~~commissioner~~ board shall approve, approve with conditions, or deny licensure. The ~~commissioner~~ board shall act on an application for licensure according to paragraphs (b) to (d).

(b) The ~~commissioner~~ board shall determine if the applicant meets the requirements for licensure. The ~~commissioner~~ board, or the advisory council at the ~~commissioner's~~ board's request, may investigate information provided by an applicant to determine whether the information is accurate and complete.

(c) The ~~commissioner~~ board shall notify an applicant of action taken on the application and, if licensure is denied or approved with conditions, the grounds for the ~~commissioner's~~ board's determination.

(d) An applicant denied licensure or granted licensure with conditions may make a written request to the ~~commissioner~~ board, within 30 days of the date of the ~~commissioner's~~ board's determination, for reconsideration of the ~~commissioner's~~ board's determination. Individuals requesting reconsideration may submit information which the applicant wants considered in the reconsideration. After reconsideration of the ~~commissioner's~~ board's determination to deny licensure or grant licensure with conditions, the ~~commissioner~~ board shall determine whether the original determination should be affirmed or modified. An applicant is allowed no more than one request in any one biennial licensure period for

reconsideration of the ~~commissioner's~~ board's determination to deny licensure or approve licensure with conditions.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 20. Minnesota Statutes 2016, section 148.6423, is amended to read:

148.6423 LICENSURE RENEWAL.

Subdivision 1. **Renewal requirements.** To be eligible for licensure renewal, a licensee must:

(1) submit a completed and signed application for licensure renewal on forms provided by the ~~commissioner~~ board;

(2) submit the renewal fee required under section 148.6445;

(3) submit proof of having met the continuing education requirement of section 148.6443 on forms provided by the ~~commissioner~~ board; and

(4) submit additional information as requested by the ~~commissioner~~ board to clarify information presented in the renewal application. The information must be submitted within 30 days after the ~~commissioner's~~ board's request.

Subd. 2. **Renewal deadline.** (a) Except as provided in paragraph (c), licenses must be renewed every two years. Licensees must comply with the following procedures in paragraphs (b) to (e):

(b) Each license must state an expiration date. An application for licensure renewal must be received by the ~~Department of Health~~ board or postmarked at least 30 calendar days before the expiration date. If the postmark is illegible, the application shall be considered timely if received at least 21 calendar days before the expiration date.

(c) If the ~~commissioner~~ board changes the renewal schedule and the expiration date is less than two years, the fee and the continuing education contact hours to be reported at the next renewal must be prorated.

(d) An application for licensure renewal not received within the time required under paragraph (b), but received on or before the expiration date, must be accompanied by a late fee in addition to the renewal fee specified by section 148.6445.

(e) Licensure renewals received after the expiration date shall not be accepted and persons seeking licensed status must comply with the requirements of section 148.6425.

Subd. 3. **Licensure renewal notice.** At least 60 calendar days before the expiration date in subdivision 2, the ~~commissioner~~ board shall mail a renewal notice to the licensee's last known address on file with the ~~commissioner~~ board. The notice must include an application for licensure renewal and notice of fees required for renewal. The licensee's failure to receive notice does not relieve the licensee of the obligation to meet the renewal deadline and other requirements for licensure renewal.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 21. Minnesota Statutes 2016, section 148.6425, subdivision 2, is amended to read:

Subd. 2. **Licensure renewal after licensure expiration date.** An individual whose application for licensure renewal is received after the licensure expiration date must submit the following:

(1) a completed and signed application for licensure following lapse in licensed status on forms provided by the ~~commissioner~~ board;

(2) the renewal fee and the late fee required under section 148.6445;

(3) proof of having met the continuing education requirements in section 148.6443, subdivision 1; and

(4) additional information as requested by the ~~commissioner~~ board to clarify information in the application, including information to determine whether the individual has engaged in conduct warranting disciplinary action as set forth in section 148.6448. The information must be submitted within 30 days after the ~~commissioner's~~ board's request.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 22. Minnesota Statutes 2016, section 148.6425, subdivision 3, is amended to read:

Subd. 3. **Licensure renewal four years or more after licensure expiration date.** (a) An individual who requests licensure renewal four years or more after the licensure expiration date must submit the following:

(1) a completed and signed application for licensure on forms provided by the ~~commissioner~~ board;

(2) the renewal fee and the late fee required under section 148.6445 if renewal application is based on paragraph (b), clause (1), (2), or (3), or the renewal fee required under section 148.6445 if renewal application is based on paragraph (b), clause (4);

(3) proof of having met the continuing education requirement in section 148.6443, subdivision 1, except the continuing education must be obtained in the two years immediately preceding application renewal; and

(4) at the time of the next licensure renewal, proof of having met the continuing education requirement, which shall be prorated based on the number of months licensed during the two-year licensure period.

(b) In addition to the requirements in paragraph (a), the applicant must submit proof of one of the following:

(1) verified documentation of successful completion of 160 hours of supervised practice approved by the ~~commissioner~~ board as described in paragraph (c);

(2) verified documentation of having achieved a qualifying score on the credentialing examination for occupational therapists or the credentialing examination for occupational therapy assistants administered within the past year;

(3) documentation of having completed a combination of occupational therapy courses or an occupational therapy refresher program that contains both a theoretical and clinical component approved by the ~~commissioner~~ board. Only courses completed within one year preceding the date of the application or one year after the date of the application qualify for approval; or

(4) evidence that the applicant holds a current and unrestricted credential for the practice of occupational therapy in another jurisdiction and that the applicant's credential from that jurisdiction has been held in good standing during the period of lapse.

(c) To participate in a supervised practice as described in paragraph (b), clause (1), the applicant shall obtain limited licensure. To apply for limited licensure, the applicant shall submit the completed limited licensure application, fees, and agreement for supervision of an occupational therapist or occupational therapy assistant practicing under limited licensure signed by the supervising therapist and the applicant. The supervising occupational therapist shall state the proposed level of supervision on the supervision agreement form provided by the ~~commissioner~~ board. The supervising therapist shall determine the frequency and manner of supervision based on the condition of the patient or client, the complexity of the procedure, and the proficiencies of the supervised occupational therapist. At a minimum, a supervising occupational therapist shall be on the premises at all times that the person practicing under limited licensure is working; be in the room ten percent of the hours worked each week by the person practicing under limited licensure; and provide daily face-to-face collaboration for the purpose of observing service competency of the occupational therapist

or occupational therapy assistant, discussing treatment procedures and each client's response to treatment, and reviewing and modifying, as necessary, each treatment plan. The supervising therapist shall document the supervision provided. The occupational therapist participating in a supervised practice is responsible for obtaining the supervision required under this paragraph and must comply with the ~~commissioner's~~ board's requirements for supervision during the entire 160 hours of supervised practice. The supervised practice must be completed in two months and may be completed at the applicant's place of work.

(d) In addition to the requirements in paragraphs (a) and (b), the applicant must submit additional information as requested by the ~~commissioner~~ board to clarify information in the application, including information to determine whether the applicant has engaged in conduct warranting disciplinary action as set forth in section 148.6448. The information must be submitted within 30 days after the ~~commissioner's~~ board's request.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 23. Minnesota Statutes 2016, section 148.6428, is amended to read:

148.6428 CHANGE OF NAME, ADDRESS, OR EMPLOYMENT.

A licensee who changes a name, address, or employment must inform the ~~commissioner~~ board, in writing, of the change of name, address, employment, business address, or business telephone number within 30 days. A change in name must be accompanied by a copy of a marriage certificate or court order. All notices or other correspondence mailed to or served on a licensee by the ~~commissioner~~ board at the licensee's address on file with the ~~commissioner~~ board shall be considered as having been received by the licensee.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 24. Minnesota Statutes 2016, section 148.6443, subdivision 5, is amended to read:

Subd. 5. **Reporting continuing education contact hours.** Within one month following licensure expiration, each licensee shall submit verification that the licensee has met the continuing education requirements of this section on the continuing education report form provided by the ~~commissioner~~ board. The continuing education report form may require the following information:

(1) title of continuing education activity;

(2) brief description of the continuing education activity;

(3) sponsor, presenter, or author;

(4) location and attendance dates;

(5) number of contact hours; and

(6) licensee's notarized affirmation that the information is true and correct.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 25. Minnesota Statutes 2016, section 148.6443, subdivision 6, is amended to read:

Subd. 6. **Auditing continuing education reports.** (a) The ~~commissioner~~ board may audit a percentage of the continuing education reports based on random selection. A licensee shall maintain all documentation required by this section for two years after the last day of the biennial licensure period in which the contact hours were earned.

(b) All renewal applications that are received after the expiration date may be subject to a continuing education report audit.

(c) Any licensee against whom a complaint is filed may be subject to a continuing education report audit.

(d) The licensee shall make the following information available to the ~~commissioner~~ board for auditing purposes:

(1) a copy of the completed continuing education report form for the continuing education reporting period that is the subject of the audit including all supporting documentation required by subdivision 5;

(2) a description of the continuing education activity prepared by the presenter or sponsor that includes the course title or subject matter, date, place, number of program contact hours, presenters, and sponsors;

(3) documentation of self-study programs by materials prepared by the presenter or sponsor that includes the course title, course description, name of sponsor or author, and the number of hours required to complete the program;

(4) documentation of university, college, or vocational school courses by a course syllabus, listing in a course bulletin, or equivalent documentation that includes the course title, instructor's name, course dates, number of contact hours, and course content, objectives, or goals; and

(5) verification of attendance by:

(i) a signature of the presenter or a designee at the continuing education activity on the continuing education report form or a certificate of attendance with the course name, course date, and licensee's name;

(ii) a summary or outline of the educational content of an audio or video educational activity to verify the licensee's participation in the activity if a designee is not available to sign the continuing education report form;

(iii) verification of self-study programs by a certificate of completion or other documentation indicating that the individual has demonstrated knowledge and has successfully completed the program; or

(iv) verification of attendance at a university, college, or vocational course by an official transcript.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 26. Minnesota Statutes 2016, section 148.6443, subdivision 7, is amended to read:

Subd. 7. **Waiver of continuing education requirements.** The ~~commissioner~~ board may grant a waiver of the requirements of this section in cases where the requirements would impose an extreme hardship on the licensee. The request for a waiver must be in writing, state the circumstances that constitute extreme hardship, state the period of time the licensee wishes to have the continuing education requirement waived, and state the alternative measures that will be taken if a waiver is granted. The ~~commissioner~~ board shall set forth, in writing, the reasons for granting or denying the waiver. Waivers granted by the ~~commissioner~~ board shall specify, in writing, the time limitation and required alternative measures to be taken by the licensee. A request for waiver shall be denied if the ~~commissioner~~ board finds that the circumstances stated by the licensee do not support a claim of extreme hardship, the requested time period for waiver is unreasonable, the alternative measures proposed by the licensee are not equivalent to the continuing education activity being waived, or the request for waiver is not submitted to the ~~commissioner~~ board within 60 days after the expiration date.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 27. Minnesota Statutes 2016, section 148.6443, subdivision 8, is amended to read:

Subd. 8. **Penalties for noncompliance.** The ~~commissioner~~ board shall refuse to renew or grant, or shall suspend, condition, limit, or qualify the license of any person who the ~~commissioner~~ board determines has failed to comply with the continuing education

requirements of this section. A licensee may request reconsideration of the ~~commissioner's~~ board's determination of noncompliance or the penalty imposed under this section by making a written request to the ~~commissioner~~ board within 30 days of the date of notification to the applicant. Individuals requesting reconsideration may submit information that the licensee wants considered in the reconsideration.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 28. Minnesota Statutes 2016, section 148.6445, subdivision 1, is amended to read:

Subdivision 1. **Initial licensure fee.** The initial licensure fee for occupational therapists is $145. The initial licensure fee for occupational therapy assistants is $80. The ~~commissioner~~ board shall prorate fees based on the number of quarters remaining in the biennial licensure period.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 29. Minnesota Statutes 2016, section 148.6445, subdivision 10, is amended to read:

Subd. 10. **Use of fees.** All fees are nonrefundable. The ~~commissioner~~ board shall only use fees collected under this section for the purposes of administering this chapter. The legislature must not transfer money generated by these fees from the state government special revenue fund to the general fund. ~~Surcharges collected by the commissioner of health under section 16E.22 are not subject to this subdivision.~~

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 30. Minnesota Statutes 2016, section 148.6448, is amended to read:

148.6448 GROUNDS FOR DENIAL OF LICENSURE OR DISCIPLINE; INVESTIGATION PROCEDURES; DISCIPLINARY ACTIONS.

Subdivision 1. **Grounds for denial of licensure or discipline.** The ~~commissioner~~ board may deny an application for licensure, may approve licensure with conditions, or may discipline a licensee using any disciplinary actions listed in subdivision 3 on proof that the individual has:

(1) intentionally submitted false or misleading information to the ~~commissioner~~ board or the advisory council;

(2) failed, within 30 days, to provide information in response to a written request by the ~~commissioner~~ board or advisory council;

(3) performed services of an occupational therapist or occupational therapy assistant in an incompetent manner or in a manner that falls below the community standard of care;

(4) failed to satisfactorily perform occupational therapy services during a period of temporary licensure;

(5) violated sections 148.6401 to 148.6450;

(6) failed to perform services with reasonable judgment, skill, or safety due to the use of alcohol or drugs, or other physical or mental impairment;

(7) been convicted of violating any state or federal law, rule, or regulation which directly relates to the practice of occupational therapy;

(8) aided or abetted another person in violating any provision of sections 148.6401 to 148.6450;

(9) been disciplined for conduct in the practice of an occupation by the state of Minnesota, another jurisdiction, or a national professional association, if any of the grounds for discipline are the same or substantially equivalent to those in sections 148.6401 to 148.6450;

(10) not cooperated with the ~~commissioner or advisory council~~ board in an investigation conducted according to subdivision 2;

(11) advertised in a manner that is false or misleading;

(12) engaged in dishonest, unethical, or unprofessional conduct in connection with the practice of occupational therapy that is likely to deceive, defraud, or harm the public;

(13) demonstrated a willful or careless disregard for the health, welfare, or safety of a client;

(14) performed medical diagnosis or provided treatment, other than occupational therapy, without being licensed to do so under the laws of this state;

(15) paid or promised to pay a commission or part of a fee to any person who contacts the occupational therapist for consultation or sends patients to the occupational therapist for treatment;

(16) engaged in an incentive payment arrangement, other than that prohibited by clause (15), that promotes occupational therapy overutilization, whereby the referring person or person who controls the availability of occupational therapy services to a client profits unreasonably as a result of client treatment;

(17) engaged in abusive or fraudulent billing practices, including violations of federal Medicare and Medicaid laws, Food and Drug Administration regulations, or state medical assistance laws;

(18) obtained money, property, or services from a consumer through the use of undue influence, high pressure sales tactics, harassment, duress, deception, or fraud;

(19) performed services for a client who had no possibility of benefiting from the services;

(20) failed to refer a client for medical evaluation when appropriate or when a client indicated symptoms associated with diseases that could be medically or surgically treated;

(21) engaged in conduct with a client that is sexual or may reasonably be interpreted by the client as sexual, or in any verbal behavior that is seductive or sexually demeaning to a patient;

(22) violated a federal or state court order, including a conciliation court judgment, or a disciplinary order issued by the ~~commissioner~~ board, related to the person's occupational therapy practice; or

(23) any other just cause related to the practice of occupational therapy.

Subd. 2. **Investigation of complaints.** The ~~commissioner, or the advisory council when authorized by the commissioner,~~ board may initiate an investigation upon receiving a complaint or other oral or written communication that alleges or implies that a person has violated sections 148.6401 to 148.6450. In the receipt, investigation, and hearing of a complaint that alleges or implies a person has violated sections 148.6401 to 148.6450, the ~~commissioner~~ board shall follow the procedures in section 214.10.

Subd. 3. **Disciplinary actions.** If the ~~commissioner~~ board finds that an occupational therapist or occupational therapy assistant should be disciplined according to subdivision 1, the ~~commissioner~~ board may take any one or more of the following actions:

(1) refuse to grant or renew licensure;

(2) approve licensure with conditions;

(3) revoke licensure;

(4) suspend licensure;

(5) any reasonable lesser action including, but not limited to, reprimand or restriction on licensure; or

(6) any action authorized by statute.

Subd. 4. **Effect of specific disciplinary action on use of title.** Upon notice from the ~~commissioner~~ board denying licensure renewal or upon notice that disciplinary actions have been imposed and the person is no longer entitled to practice occupational therapy and use the occupational therapy and licensed titles, the person shall cease to practice occupational therapy, to use titles protected by sections 148.6401 to 148.6450, and to represent to the public that the person is licensed by the ~~commissioner~~ board.

Subd. 5. **Reinstatement requirements after disciplinary action.** A person who has had licensure suspended may request and provide justification for reinstatement following the period of suspension specified by the ~~commissioner~~ board. The requirements of sections 148.6423 and 148.6425 for renewing licensure and any other conditions imposed with the suspension must be met before licensure may be reinstated.

Subd. 6. **Authority to contract.** The ~~commissioner~~ board shall contract with the health professionals services program as authorized by sections 214.31 to 214.37 to provide these services to practitioners under this chapter. The health professionals services program does not affect the ~~commissioner's~~ board's authority to discipline violations of sections 148.6401 to 148.6450.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 31. **[148.6449] BOARD OF OCCUPATIONAL THERAPY PRACTICE.**

Subdivision 1. **Creation.** The Board of Occupational Therapy Practice consists of 11 members appointed by the governor. The members are:

(1) five occupational therapists licensed under sections 148.6401 to 148.6449;

(2) three occupational therapy assistants licensed under sections 148.6401 to 148.6449; and

(3) three public members, including two members who have received occupational therapy services or have a family member who has received occupational therapy services, and one member who is a health care professional or health care provider licensed in Minnesota.

Subd. 2. **Qualifications of board members.** (a) The occupational therapy practitioners appointed to the board must represent a variety of practice areas and settings.

(b) At least two occupational therapy practitioners must be employed outside the seven-county metropolitan area.

(c) Board members shall serve for not more than two consecutive terms.

Subd. 3. **Recommendations for appointment.** Prior to the end of the term of a member of the board, or within 60 days after a position on the board becomes vacant, the Minnesota Occupational Therapy Association and other interested persons and organizations may recommend to the governor members qualified to serve on the board. The governor may appoint members to the board from the list of persons recommended or from among other qualified candidates.

Subd. 4. **Officers.** The board shall biennially elect from its membership a chair, vice-chair, and secretary-treasurer. Each officer shall serve until a successor is elected.

Subd. 5. **Executive director.** The board shall appoint and employ an executive director who is not a member of the board. The employment of the executive director shall be subject to the terms described in section 214.04, subdivision 2a.

Subd. 6. **Terms; compensation; removal of members.** Membership terms, compensation of members, removal of members, the filling of membership vacancies, and fiscal year and reporting requirements shall be as provided in chapter 214. The provision of staff, administrative services, and office space; the review and processing of complaints; the setting of board fees; and other activities relating to board operations shall be conducted according to chapter 214.

Subd. 7. **Duties of the Board of Occupational Therapy Practice.** (a) The board shall:

(1) adopt and enforce rules and laws necessary for licensing occupational therapy practitioners;

(2) adopt and enforce rules for regulating the professional conduct of the practice of occupational therapy;

(3) issue licenses to qualified individuals in accordance with sections 148.6401 to 148.6449;

(4) assess and collect fees for the issuance and renewal of licenses;

(5) educate the public about the requirements for licensing occupational therapy practitioners, educate occupational therapy practitioners about the rules of conduct, and enable the public to file complaints against applicants and licensees who may have violated sections 148.6401 to 148.6449; and

(6) investigate individuals engaging in practices that violate sections 148.6401 to 148.6449 and take necessary disciplinary, corrective, or other action according to section 148.6448.

(b) The board may adopt rules necessary to define standards or carry out the provisions of sections 148.6401 to 148.6449. Rules shall be adopted according to chapter 14.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 32. Minnesota Statutes 2016, section 214.01, subdivision 2, is amended to read:

Subd. 2. **Health-related licensing board.** "Health-related licensing board" means the Board of Examiners of Nursing Home Administrators established pursuant to section 144A.19, the Office of Unlicensed Complementary and Alternative Health Care Practice established pursuant to section 146A.02, the Board of Medical Practice created pursuant to section 147.01, the Board of Nursing created pursuant to section 148.181, the Board of Chiropractic Examiners established pursuant to section 148.02, the Board of Optometry established pursuant to section 148.52, the Board of Occupational Therapy Practice established pursuant to section 148.6449, the Board of Physical Therapy established pursuant to section 148.67, the Board of Psychology established pursuant to section 148.90, the Board of Social Work pursuant to section 148E.025, the Board of Marriage and Family Therapy pursuant to section 148B.30, the Board of Behavioral Health and Therapy established by section 148B.51, the Board of Dietetics and Nutrition Practice established under section 148.622, the Board of Dentistry established pursuant to section 150A.02, the Board of Pharmacy established pursuant to section 151.02, the Board of Podiatric Medicine established pursuant to section 153.02, and the Board of Veterinary Medicine established pursuant to section 156.01.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 33. **BOARD OF OCCUPATIONAL THERAPY PRACTICE.**

The governor shall appoint all members to the Board of Occupational Therapy Practice under Minnesota Statutes, section 148.6449, by October 1, 2017. The governor shall designate one member of the board to convene the first meeting of the board by November 1, 2017. The board shall elect officers at its first meeting.

EFFECTIVE DATE. This section is effective July 1, 2017.

Sec. 34. **REVISOR'S INSTRUCTION.**

In Minnesota Statutes, the revisor of statutes shall replace references to Minnesota Statutes, section 148.6450, with Minnesota Statutes, section 148.6449.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 35. **REPEALER.**

(a) Minnesota Statutes 2016, sections 147A.21; 147B.08, subdivisions 1, 2, and 3; 147C.40, subdivisions 1, 2, 3, and 4; 148.6402, subdivision 2; and 148.6450, are repealed.

(b) Minnesota Rules, part 5600.2500, is repealed.

EFFECTIVE DATE. This section is effective January 1, 2018.

ARTICLE 12

HUMAN SERVICES FORECAST ADJUSTMENTS

Section 1. **DEPARTMENT OF HUMAN SERVICES FORECAST ADJUSTMENT.**

The dollar amounts shown are added to or, if shown in parentheses, are subtracted from the appropriations in Laws 2015, chapter 71, article 14, as amended by Laws 2016, chapter 189, articles 22 and 23, from the general fund, or any other fund named, to the Department of Human Services for the purposes specified in this article, to be available for the fiscal years indicated for each purpose. The figure "2017" used in this article means that the appropriations listed are available for the fiscal year ending June 30, 2017.

	APPROPRIATIONS Available for the Year Ending June 30 2017
Sec. 2. **COMMISSIONER OF HUMAN SERVICES**	
Subdivision 1. **Total Appropriation**	**$ (342,045,000)**
Appropriations by Fund	
2017	
General Fund (198,450,000)	
Health Care Access (146,590,000)	
TANF 2,995,000	
Subd. 2. **Forecasted Programs**	
(a) **MFIP/DWP Grants**	
Appropriations by Fund	
General Fund (2,111,000)	
TANF 2,579,000	
(b) **MFIP Child Care Assistance Grants**	(6,513,000)

(c) **General Assistance Grants** (4,219,000)

(d) **Minnesota Supplemental Aid Grants** (581,000)

(e) **Group Residential Housing Grants** (533,000)

(f) **Northstar Care for Children** 2,613,000

(g) **MinnesotaCare Grants** (145,883,000)

This appropriation is from the health care access fund.

(h) **Medical Assistance Grants**

Appropriations by Fund	
General Fund	(192,744,000)
Health Care Access	(707,000)

(i) **Alternative Care Grants** -0-

(j) **CD Entitlement Grants** 5,638,000

Subd. 3. **Technical Activities** 416,000

This appropriation is from the TANF fund.

Sec. 3. **EFFECTIVE DATE.**

Sections 1 and 2 are effective the day following final enactment.

ARTICLE 13

APPROPRIATIONS

Section 1. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are appropriated to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2018" and "2019" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2018, or June 30, 2019, respectively. "The first year" is fiscal year 2018. "The second year" is fiscal year 2019. "The biennium" is fiscal years 2018 and 2019.

APPROPRIATIONS

Available for the Year

		Ending June 30	
		2018	**2019**

Sec. 2. **COMMISSIONER OF HUMAN SERVICES**

Subdivision 1. **Total Appropriation**	**$**	**7,445,538,000**	**$** **7,511,844,000**

Appropriations by Fund

	2018	2019
General	6,892,112,000	6,948,691,000
State Government Special Revenue	4,274,000	4,274,000
Health Care Access	270,320,000	286,281,000
Federal TANF	276,936,000	270,702,000
Lottery Prize	1,896,000	1,896,000

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **TANF Maintenance of Effort**

(a) The commissioner shall ensure that sufficient qualified nonfederal expenditures are made each year to meet the state's maintenance of effort (MOE) requirements of the TANF block grant specified under Code of Federal Regulations, title 45, section 263.1. In order to meet these basic TANF/MOE requirements, the commissioner may report as TANF/MOE expenditures only nonfederal money expended for allowable activities listed in the following clauses:

(1) MFIP cash, diversionary work program, and food assistance benefits under Minnesota Statutes, chapter 256J;

(2) the child care assistance programs under Minnesota Statutes, sections 119B.03 and 119B.05, and county child care administrative

costs under Minnesota Statutes, section 119B.15;

(3) state and county MFIP administrative costs under Minnesota Statutes, chapters 256J and 256K;

(4) state, county, and tribal MFIP employment services under Minnesota Statutes, chapters 256J and 256K;

(5) expenditures made on behalf of legal noncitizen MFIP recipients who qualify for the MinnesotaCare program under Minnesota Statutes, chapter 256L;

(6) qualifying working family credit expenditures under Minnesota Statutes, section 290.0671;

(7) qualifying Minnesota education credit expenditures under Minnesota Statutes, section 290.0674; and

(8) qualifying Head Start expenditures under Minnesota Statutes, section 119A.50.

(b) For the activities listed in paragraph (a), clauses (2) to (8), the commissioner may report only expenditures that are excluded from the definition of assistance under Code of Federal Regulations, title 45, section 260.31.

(c) The commissioner shall ensure that the MOE used by the commissioner of management and budget for the February and November forecasts required under Minnesota Statutes, section 16A.103, contains expenditures under paragraph (a), clause (1), equal to at least 16 percent of the total required

under Code of Federal Regulations, title 45, section 263.1.

(d) The commissioner may not claim an amount of TANF/MOE in excess of the 75 percent standard in Code of Federal Regulations, title 45, section 263.1(a)(2), except:

(1) to the extent necessary to meet the 80 percent standard under Code of Federal Regulations, title 45, section 263.1(a)(1), if it is determined by the commissioner that the state will not meet the TANF work participation target rate for the current year;

(2) to provide any additional amounts under Code of Federal Regulations, title 45, section 264.5, that relate to replacement of TANF funds due to the operation of TANF penalties; and

(3) to provide any additional amounts that may contribute to avoiding or reducing TANF work participation penalties through the operation of the excess MOE provisions of Code of Federal Regulations, title 45, section 261.43 (a)(2).

(e) For the purposes of paragraph (d), the commissioner may supplement the MOE claim with working family credit expenditures or other qualified expenditures to the extent such expenditures are otherwise available after considering the expenditures allowed in this subdivision.

(f) The requirement in Minnesota Statutes, section 256.011, subdivision 3, that federal grants or aids secured or obtained under that

subdivision be used to reduce any direct appropriations provided by law, does not apply if the grants or aids are federal TANF funds.

(g) **IT Appropriations Generally.** This appropriation includes funds for information technology projects, services, and support. Notwithstanding Minnesota Statutes, section 16E.0466, funding for information technology project costs shall be incorporated into the service level agreement and paid to the Office of MN.IT Services by the Department of Human Services under the rates and mechanism specified in that agreement.

(h) **Receipts for Systems Project.** Appropriations and federal receipts for information systems projects for MAXIS, PRISM, MMIS, ISDS, METS, and SSIS must be deposited in the state systems account authorized in Minnesota Statutes, section 256.014. Money appropriated for computer projects approved by the commissioner of the Office of MN.IT Services, funded by the legislature, and approved by the commissioner of management and budget may be transferred from one project to another and from development to operations as the commissioner of human services considers necessary. Any unexpended balance in the appropriation for these projects does not cancel and is available for ongoing development and operations.

Subd. 3. **Central Office; Operations**

	Appropriations by Fund	
General	108,512,000	107,093,000

State Government		
Special Revenue	4,149,000	4,149,000
Health Care Access	20,025,000	20,025,000
Federal TANF	100,000	100,000

(a) **Administrative Recovery; Set-Aside.** The commissioner may invoice local entities through the SWIFT accounting system as an alternative means to recover the actual cost of administering the following provisions:

(1) Minnesota Statutes, section 125A.744, subdivision 3;

(2) Minnesota Statutes, section 245.495, paragraph (b);

(3) Minnesota Statutes, section 256B.0625, subdivision 20, paragraph (k);

(4) Minnesota Statutes, section 256B.0924, subdivision 6, paragraph (g);

(5) Minnesota Statutes, section 256B.0945, subdivision 4, paragraph (d); and

(6) Minnesota Statutes, section 256F.10, subdivision 6, paragraph (b).

(b) **Vulnerable Adults Complaints Case Management System.** $258,000 in fiscal year 2018 is from the general fund for the Office of Inspector General to implement a case management system for tracking and managing complaints and investigations involving vulnerable adults. In consultation with the Department of Health, Office of Health Facility Complaints, the Office of Inspector General shall ensure that the case management system is capable of:

(1) uniquely tracking each complaint received by the Office of Inspector General and the

Office of Health Facility Complaints, whether the complaint is received through the Minnesota Adult Abuse Reporting Center, by telephone, by referral from another agency or division, or by any other means;

(2) linking each complaint to any and all investigations related to that complaint;

(3) tracking and coordinating referrals and communication between state agencies, including the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; and

(4) securing data as required under the Vulnerable Adults Act and the Government Data Practices Act.

Products and services for the case management system design, implementation, and application hosting must be acquired using a request for proposals. This is a onetime appropriation and is available until June 30, 2019.

(c) **Transfer to Office of Legislative Auditor.** $600,000 in fiscal year 2018 and $600,000 in fiscal year 2019 are for transfer to the Office of the Legislative Auditor for audit activities under Minnesota Statutes, section 3.972, subdivision 2b.

(d) **Base Level Adjustment.** The general fund base is $103,017,000 in fiscal year 2020 and $102,877,000 in fiscal year 2021.

Subd. 4. **Central Office; Children and Families**

Appropriations by Fund		
General	8,892,000	8,648,000

Federal TANF	2,582,000	2,582,000

(a) **Financial Institution Data Match and Payment of Fees.** The commissioner is authorized to allocate up to $310,000 each year in fiscal year 2018 and fiscal year 2019 from the systems special revenue account to make payments to financial institutions in exchange for performing data matches between account information held by financial institutions and the public authority's database of child support obligors as authorized by Minnesota Statutes, section 13B.06, subdivision 7.

(b) **Base Level Adjustment.** The general fund base is $8,588,000 in fiscal year 2020 and $8,588,000 in fiscal year 2021.

Subd. 5. **Central Office; Health Care**

	Appropriations by Fund	
General	16,998,000	22,326,000
Health Care Access	23,697,000	23,804,000

(a) **Trust Guide.** $200,000 in fiscal year 2018 and $150,000 in fiscal year 2019 are for the development of a special needs trust guide that directs the state medical assistance program's trust recovery process and establishes guidelines for the public. This is a onetime appropriation.

(b) **Integrated Health Partnership Health Information Exchange.** $125,000 in fiscal year 2018 and $250,000 in fiscal year 2019 are from the general fund to contract with state-certified health information exchange vendors to support providers participating in an integrated health partnership under

Minnesota Statutes, section 256B.0755, to connect enrollees with community supports and social services and improve collaboration among participating and authorized providers.

(c) **Base Level Adjustment.** The general fund base is $27,441,000 in fiscal year 2020 and $27,674,000 in fiscal year 2021.

Subd. 6. **Central Office; Continuing Care for Older Adults**

	Appropriations by Fund	
General	13,618,000	14,189,000
State Government Special Revenue	125,000	125,000

Base Level Adjustment. The general fund base is$13,909,000 in fiscal year 2020 and $13,909,000 in fiscal year 2021.

Subd. 7. **Central Office; Community Supports**

	Appropriations by Fund	
General	25,251,000	25,273,000
Lottery Prize	163,000	163,000

(a) **Transportation Study.** $250,000 in fiscal year 2018 and $250,000 in fiscal year 2019 are for the transportation study required under article 1, section 43. This is a onetime appropriation.

(b) **Deaf and Hard-of-Hearing Services.** (a) $850,000 in fiscal year 2018 and $700,000 in fiscal year 2019 are from the general fund for the Deaf and Hard-of-Hearing Division under Minnesota Statutes, section 256C.233. $150,000 of this appropriation must be used for technology improvements, technology support, and training for staff on the use of technology for external facing services to

implement Minnesota Statutes, section 256C.24, subdivision 2, clause (12).

(c) **Substance Use Disorder System Study.** $150,000 in fiscal year 2018 and $150,000 in fiscal year 2019 are for a substance use disorder system study. This is a onetime appropriation.

(d) **Base Level Adjustment.** The general fund base is $24,650,000 in fiscal year 2020 and $24,533,000 in fiscal year 2021.

Subd. 8. **Forecasted Programs; MFIP/DWP**

Appropriations by Fund		
General	88,530,000	97,912,000
Federal TANF	94,617,000	88,230,000

Subd. 9. **Forecasted Programs; MFIP Child Care Assistance**	107,340,000	102,181,000
Subd. 10. **Forecasted Programs; General Assistance**	55,536,000	57,221,000

(a) **General Assistance Standard.** The commissioner shall set the monthly standard of assistance for general assistance units consisting of an adult recipient who is childless and unmarried or living apart from parents or a legal guardian at $203. The commissioner may reduce this amount according to Laws 1997, chapter 85, article 3, section 54.

(b) **Emergency General Assistance Limit.** The amount appropriated for emergency general assistance is limited to no more than $6,729,812 in fiscal year 2018 and $6,729,812 in fiscal year 2019. Funds to counties shall be allocated by the commissioner using the allocation method under Minnesota Statutes, section 256D.06.

Subd. 11. **Forecasted Programs; Minnesota Supplemental Aid** 40,484,000 41,634,000

Subd. 12. **Forecasted Programs; Group Residential Housing** 170,337,000 180,668,000

Subd. 13. **Forecasted Programs; Northstar Care for Children** 80,542,000 96,433,000

Subd. 14. **Forecasted Programs; MinnesotaCare** 12,224,000 13,308,000

This appropriation is from the health care access fund.

Subd. 15. **Forecasted Programs; Medical Assistance**

Appropriations by Fund		
General	5,307,513,000	5,306,794,000
Health Care Access	210,159,000	224,929,000

(a) **Behavioral Health Services.** $1,000,000 in fiscal year 2018 and $1,000,000 in fiscal year 2019 are for behavioral health services provided by hospitals identified under Minnesota Statutes, section 256.969, subdivision 2b, paragraph (a), clause (4). The increase in payments shall be made by increasing the adjustment under Minnesota Statutes, section 256.969, subdivision 2b, paragraph (e), clause (2).

(b) **Reform of MnCHOICES Administration.** The commissioner of human services shall reduce expenditures for MnCHOICES by $30,753,000 in fiscal year 2018 and $30,753,000 in fiscal year 2019. To accomplish this reduction in expenditures, the commissioner shall permit lead agencies as defined in Minnesota Statutes, section 256B.0911, subdivision 1a, paragraph (e), to substitute to the greatest extent permitted under federal law, service updates under Minnesota Statutes, section 256B.0911,

subdivision 3f, for reassessments required under Minnesota Statutes, sections 256B.0659, 256B.0911, 256B.0915, 256B.092, 256B.49, and 256B.85, when there is not a significant change in the recipient's condition or need.

Subd. 16. **Forecasted Programs; Alternative Care** 44,587,000 45,444,000

Alternative Care Transfer. Any money allocated to the alternative care program that is not spent for the purposes indicated does not cancel but must be transferred to the medical assistance account.

Subd. 17. **Forecasted Programs; Chemical Dependency Treatment Fund** 116,213,000 135,079,000

Subd. 18. **Grant Programs; Support Services Grants**

Appropriations by Fund		
General	8,715,000	8,715,000
Federal TANF	93,311,000	93,311,000

Subd. 19. **Grant Programs; Basic Sliding Fee Child Care Assistance Grants** 51,932,000 48,207,000

Base Level Adjustment. The general fund base is $48,279,000 in fiscal year 2020 and $48,360,000 in fiscal year 2021.

Subd. 20. **Grant Programs; Child Care Development Grants** 1,737,000 1,737,000

Subd. 21. **Grant Programs; Child Support Enforcement Grants** 50,000 50,000

Subd. 22. **Grant Programs; Children's Services Grants**

Appropriations by Fund		
General	40,340,000	39,465,000
Federal TANF	140,000	140,000

(a) **Title IV-E Adoption Assistance.** (1) The commissioner shall allocate funds from the Title IV-E reimbursement to the state from

the Fostering Connections to Success and Increasing Adoptions Act for adoptive, foster, and kinship families as required in Minnesota Statutes, section 265N.621.

(2) Additional federal reimbursement to the state as a result of the Fostering Connections to Success and Increasing Adoptions Act's expanded eligibility for title IV-E adoption assistance is appropriated to the commissioner for foster care, adoption, and kinship services, including a parent-to-parent support network.

(b) **Adoption Assistance Incentive Grants.** (1) The commissioner shall allocate federal funds available for adoption and guardianship assistance incentive grants for postadoption services to support adoptive, foster, and kinship families as required in Minnesota Statutes, section 256N.621.

(2) Federal funds available during fiscal years 2018 and 2019 for adoption incentive grants must be used for foster care, adoption, and kinship services, including a parent-to-parent support network.

(c) **Adoption Support Services.** The commissioner shall allocate 20 percent of federal funds from Title IV-B, subpart 2, of the Social Security Act, Promoting Safe and Stable Families, for adoption support services under Minnesota Statutes, section 256N.261.

(d) **American Indian Child Welfare Initiative.** $800,000 in fiscal year 2018 is for planning efforts to expand the American Indian Child Welfare Initiative under Minnesota Statutes, section 256.01,

subdivision 14b. Of this amount, $400,000 is for a grant to the Mille Lacs Band of Ojibwe and $400,000 is for a grant to the Red Lake Nation. This is a onetime appropriation.

(e) **Anoka County Family Foster Care.** $75,000 in fiscal year 2018 is from the general fund for a grant to Anoka County to establish and promote family foster care recruitment models. The county shall use the grant funds for the purpose of increasing foster care providers through administrative simplification, nontraditional recruitment models, and family incentive options, and develop a strategic planning model to recruit family foster care providers. This is a onetime appropriation.

(f) **White Earth Band of Ojibwe Child Welfare Services.** $800,000 in fiscal year 2018 and $800,000 in fiscal year 2019 are from the general fund for a grant to the White Earth Band of Ojibwe to deliver child welfare services.

Subd. 23. **Grant Programs; Children and Community Service Grants**	58,201,000	58,201,000
Subd. 24. **Grant Programs; Children and Economic Support Grants**	31,280,000	31,290,000

(a) **Minnesota Food Assistance Program.** Unexpended funds for the Minnesota food assistance program for fiscal year 2018 do not cancel but are available for this purpose in fiscal year 2019.

(b) **At-Home Infant Child Care.** $1,000,000 in fiscal year 2018 and $1,000,000 in fiscal year 2019 are from the general fund for the

at-home infant child care program under Minnesota Statutes, section 119B.035.

(c) **Community Action Grants.** $750,000 in fiscal year 2018 and $750,000 in fiscal year 2019 are for community action grants under Minnesota Statutes, sections 256E.30 to 256E.32.

(d) **Family Assets for Independence.** $250,000 in fiscal year 2018 and $250,000 in fiscal year 2019 are for the family assets for independence program under Minnesota Statutes, section 256E.35.

(e) **Safe Harbor for Sexually Exploited Youth.** (1) $500,000 in fiscal year 2018 and $500,000 in fiscal year 2019 are for emergency shelter and transitional and long-term housing beds for sexually exploited youth and youth at risk of sexual exploitation.

(2) $100,000 in fiscal year 2018 and $100,000 in fiscal year 2019 are for statewide youth outreach workers connecting sexually exploited youth and youth at risk of sexual exploitation with shelter and services.

(3) Youth 24 years of age or younger are eligible for shelter, housing beds, and services under this paragraph. In funding shelter, housing beds, and outreach workers under this paragraph, the commissioner shall emphasize activities that promote capacity-building and development of resources in greater Minnesota.

(f) **Dakota County Child Data Tracking.** $200,000 in fiscal year 2018 is for the Minnesota Birth to Eight pilot project for the

development of the information technology solution that will track the established developmental milestone progress of each child participating in the pilot up to age eight.

(g) **Housing Benefit Web Site.** $130,000 in fiscal year 2018 and $130,000 in fiscal year 2019 are to operate the housing benefit 101 Web site to help people who need affordable housing, and supports to maintain that housing, understand the range of housing options and support services available.

(h) **Base Level Adjustments.** The general fund base is $31,743,000 in fiscal year 2020 and $31,743,000 in fiscal year 2021. The general fund base includes $453,000 in fiscal year 2020 and $453,000 in fiscal year 2021 for community living infrastructure grant allocations under Minnesota Statutes, section 256I.09.

Subd. 25. **Grant Programs; Health Care Grants**

Appropriations by Fund		
General	4,119,000	4,531,000
Health Care Access	3,465,000	3,465,000

(a) **Dental Services Grants.** $820,000 in fiscal year 2018 is from the general fund to award dental services grants. The commissioner may award grants under this section to:

(1) nonprofit community clinics;

(2) federally qualified health centers, rural health clinics, and public health clinics;

(3) hospital-based dental clinics owned and operated by a city, county, or former state hospital as defined in Minnesota Statutes,

section 62Q.19, subdivision 1, paragraph (a), clause (4); and

(4) a dental clinic owned and operated by the University of Minnesota or the Minnesota State Colleges and Universities system.

Grants may be used to fund costs related to maintaining, coordinating, and improving access for medical assistance and MinnesotaCare enrollees to dental care in rural Minnesota.

In awarding grants, the commissioner shall consider a grant applicant's experience in delivering dental services to medical assistance and MinnesotaCare enrollees in rural communities, and the applicant's potential to successfully maintain or expand access to dental services for medical assistance and MinnesotaCare enrollees.

(b) **Base Level Adjustment.** The general fund base is $3,711,000 in fiscal year 2020 and $3,711,000 in fiscal year 2021.

Subd. 26. **Grant Programs; Other Long-Term Care Grants**	3,053,000	3,478,000

(a) **Home and Community-Based Incentive Pool.** $1,553,000 in fiscal year 2018 and $1,533,000 in fiscal year 2019 are for incentive payments under Minnesota Statutes, section 256B.0921. Of this amount, $500,000 in fiscal year 2020 and $500,000 in fiscal year 2021 are for the purposes described in Minnesota Statutes, section 256B.0921, clause (2). The base for these grants is $1,059,000 in fiscal year 2020 and $1,059,000 in fiscal year 2021.

(b) **Base Level Adjustment.** The general fund base is $2,984,000 in fiscal year 2020 and $2,984,000 in fiscal year 2021.

Subd. 27. **Grant Programs; Aging and Adult Services Grants** 30,746,000 32,437,000

Base Level Adjustments. The general fund base is $32,811,000 in fiscal year 2020 and $32,995,000 in fiscal year 2021. The general fund base includes $334,000 in fiscal year 2020 and $477,000 in fiscal year 2021 for the Minnesota Board on Aging for self-directed caregiver grants under Minnesota Statutes, section 256.975, subdivision 12.

Subd. 28. **Grant Programs; Deaf and Hard-of-Hearing Grants** 2,625,000 2,775,000

Expanded Services Grants. $750,000 in fiscal year 2018 and $900,000 in fiscal year 2019 are for deaf and hard-of-hearing grants. The funds must be used to provide services to Minnesotans who are deafblind under Minnesota Statutes, section 256C.261, to provide culturally affirmative psychiatric services, and to provide linguistically and culturally appropriate mental health services to children who are deaf, children who are deafblind, and children who are hard-of-hearing. Of this amount, $103,000 in each year is to increase the grant to provide mentors who have hearing loss to parents of infants and children with newly identified hearing loss. Each year the division must provide funds for training in ProTactile American Sign Language or other communication systems used by people who are deafblind. Training shall be provided to persons who are deafblind and to interpreters,

support service providers, and interveners who work with persons who are deafblind.

Subd. 29. **Grant Programs; Disabilities Grants** 21,374,000 21,375,000

(a) **Disability Waiver Rate System Transition Grants.** $552,000 in fiscal year 2018 and $553,000 in fiscal year 2019 are for grants to home and community-based disability waiver services providers that are projected to receive at least a ten percent decrease in revenues due to transition to rates calculated under Minnesota Statutes, section 256B.4914. The base for these grants is $3,219,000 in fiscal year 2020 and $3,221,000 in fiscal year 2021. The commissioner shall award grants to ensure ongoing access for individuals currently receiving these services and provide stability to providers as they transition to new service delivery models. The general fund base for the grants under this paragraph is $4,650,000 in fiscal year 2020 and $4,650,000 in fiscal year 2021.

(b) **Self-Advocacy Grants.** $183,000 in fiscal year 2018 and $183,000 in fiscal year 2019 are for Minnesota Statutes, section 256.477.

(c) **Individual Community Living Grants.** To the extent funding is available, the commissioner may transfer funds from the semi-independent living services grant to new individual community living grants to pay for transitional costs and facilitate the transition of individuals from corporate foster care to community living.

(d) **Gap Analysis.** $217,000 in fiscal year 2018 and $218,000 in fiscal year 2019 are for

analysis of gaps in long-term care services under Minnesota Statutes, section 144A.351.

(e) **Base Level Adjustment.** The general fund base is $24,041,000 in fiscal year 2020 and $24,043,000 in fiscal year 2021.

Subd. 30. **Grant Programs; Adult Mental Health Grants**

Appropriations by Fund		
General	81,902,000	81,802,000
Health Care Access	750,000	750,000

(a) **Mental Health Innovation Grants.** $2,000,000 in fiscal year 2018 and$2,000,000 in fiscal year 2019 are from the general fund for the mental health innovation grant program under Minnesota Statutes, section 245.4662. The general fund base for these grants is $2,500,000 in fiscal year 2020 and $2,500,000 in fiscal year 2021.

(b) **Peer-Run Respite Services in Wadena County.** $100,000 in fiscal year 2018 is from the general fund for a grant to Wadena County for the planning and development of a peer-run respite center for individuals experiencing mental health conditions or co-occurring substance abuse disorder. This is a onetime appropriation and is available until June 30, 2021. The grant is contingent on Wadena County providing to the commissioner of human services a plan to fund, operate, and sustain the program and services after the onetime state grant is expended. Wadena County must outline the proposed funding stream or mechanism, and any necessary local funding commitment, which will ensure the program will result in a sustainable program

without future state funding. The funding stream may include state funding for programs and services for which the individuals served under this paragraph may be eligible. The commissioner of human services, in collaboration with Wadena County, may explore a plan for continued funding using existing appropriations through eligibility for group residential housing under Minnesota Statutes, chapter 256I.

The peer-run respite center must:

(1) admit individuals who are in need of peer support and supportive services while addressing an increase in symptoms or stressors or exacerbation of their mental health or substance abuse;

(2) admit individuals to reside at the center on a short-term basis, no longer than five days;

(3) be operated by a nonprofit organization;

(4) employ individuals who have personal experience with mental health or co-occurring substance abuse conditions who meet the qualifications of a mental health certified peer specialist under Minnesota Statutes, section 256B.0615, or a recovery peer;

(5) provide at least three but no more than six beds in private rooms; and

(6) not provide clinical services.

By November 1, 2018, the commissioner of human services, in consultation with Wadena County, shall report to the committees in the senate and house of representatives with jurisdiction over mental health issues, the

status of planning and development of the peer-run respite center, and the plan to financially support the program and services after the state grant is expended.

(c) **Base Level Adjustment.** The general fund base is $82,302,000 in fiscal year 2020 and $82,302,000 in fiscal year 2021.

Subd. 31. **Grant Programs; Child Mental Health Grants** 21,361,000 21,426,000

(a) **Children's Mental Health Collaborative Grants.** $600,000 in fiscal year 2018 and $600,000 in fiscal year 2019 are for a grant for a rural multicounty demonstration project to assist transition-aged youth and young adults with emotional behavioral disturbance (EBD) or mental illnesses in making a successful transition into adulthood. This is a onetime appropriation.

Children's mental health collaboratives under Minnesota Statutes, section 245.493, are eligible to apply for the grant under this paragraph. The commissioner shall solicit proposals and award the grant to one proposal that best meets the requirement that a demonstration project must:

(1) build on and streamline transition services by identifying rural youth 15 to 25 years of age currently in the mental health system or with emerging mental health conditions;

(2) support youth to achieve, within the youth's potential, personal goals in employment, education, housing, and community life functioning;

(3) provide individualized motivational coaching;

(4) build on needed social supports;

(5) demonstrate how services can be enhanced for youth to successfully navigate the complexities associated with their unique needs;

(6) use all available funding streams;

(7) demonstrate collaboration with the local children's mental health collaborative in designing and implementing the demonstration project;

(8) evaluate the effectiveness of the project by specifying and measuring outcomes showing the level of progress for involved youth; and

(9) compare differences in outcomes and costs to youth without previous access to this project.

By January 15, 2019, the commissioner shall report to the legislative committees with jurisdiction over mental health issues on the status and outcomes of the demonstration project. The children's mental health collaborative administering the demonstration project shall collect and report outcome data, as requested by the commissioner, to support the development of the report.

(b) **Base Level Adjustment.** The general fund base is $20,826,000 in fiscal year 2020 and $20,826,000 in fiscal year 2021.

Subd. 32. **Grant Programs; Chemical Dependency Treatment Support Grants**

		Appropriations by Fund	
General		2,136,000	2,136,000
Lottery Prize		1,733,000	1,733,000

(a) **Minnesota Transitions Charter School.** Notwithstanding any other law to the contrary, Minnesota Transitions Charter School is eligible to receive grants under Minnesota Statutes, section 254A.03, subdivision 1.

(b) **Problem Gambling.** $225,000 in fiscal year 2018 and $225,000 in fiscal year 2019 are from the lottery prize fund for a grant to the state affiliate recognized by the National Council on Problem Gambling. The affiliate must provide services to increase public awareness of problem gambling, education, and training for individuals and organizations providing effective treatment services to problem gamblers and their families, and research related to problem gambling.

Subd. 33. **Direct Care and Treatment - Generally**

(a) **Transfer Authority.** Money appropriated to budget activities under subdivisions 34, 35, 36, 37, and 38 may be transferred between budget activities and between years of the biennium with the approval of the commissioner of management and budget.

(b) **Dedicated Receipts Available.** Of the revenue received under Minnesota Statutes, section 246.18, subdivision 8, paragraph (a), up to $1,000,000 each year is available for the purposes of Minnesota Statutes, section 246.18, subdivision 8, paragraph (b), clause (1); and up to $2,713,000 each year is available for the purposes of Minnesota

Statutes, section 246.18, subdivision 8, paragraph (b), clause (2).

Subd. 34. **Direct Care and Treatment - Mental Health and Substance Abuse**	114,521,000	114,607,000

(a) **Child and Adolescent Behavioral Health Services.** $405,000 in fiscal year 2018 and $491,000 in fiscal year 2019 are to continue to operate the child and adolescent behavioral health services program under Minnesota Statutes, section 246.014.

(b) **Base Level Adjustment.** The general fund base is $114,116,000 in fiscal year 2020 and $114,116,000 in fiscal year 2021.

Subd. 35. **Direct Care and Treatment - Community-Based Services**	15,298,000	15,298,000
Subd. 36. **Direct Care and Treatment - Forensic Services**	91,658,000	91,675,000
Subd. 37. **Direct Care and Treatment - Sex Offender Program**	86,731,000	86,731,000

(a) **Transfer Authority.** Money appropriated for the Minnesota sex offender program may be transferred between fiscal years of the biennium with the approval of the commissioner of management and budget.

(b) **Minnesota State Industries Enterprise Fund.** Funds remaining in the Minnesota state industries enterprise fund on September 30, 2017, shall be transferred to the Minnesota sex offender program vocational work program established under Minnesota Statutes, section 246B.05.

Subd. 38. **Direct Care and Treatment - Operations**	39,787,000	39,787,000
Subd. 39. **Technical Activities**	86,186,000	86,339,000

This appropriation is from the federal TANF fund.

Base Level Adjustment. The TANF fund base is $86,346,000 in fiscal year 2020 and $86,355,000 in fiscal year 2021.

Sec. 3. **COMMISSIONER OF HEALTH**

Subdivision 1. **Total Appropriation**	**$**	**196,496,000**	**$** **185,774,000**

Appropriations by Fund

	2018	2019
General	97,170,000	87,309,000
State Government Special Revenue	52,703,000	52,429,000
Health Care Access	36,066,000	35,479,000
Federal TANF	10,557,000	10,557,000

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Health Improvement**

Appropriations by Fund

General	75,043,000	65,256,000
State Government Special Revenue	6,215,000	6,182,000
Health Care Access	36,066,000	35,479,000
Federal TANF	10,557,000	10,557,000

(a) **TANF Appropriations.** (1) $3,579,000 of the TANF fund each year is for home visiting and nutritional services listed under Minnesota Statutes, section 145.882, subdivision 7, clauses (6) and (7). Funds must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1.

(2) $2,000,000 of the TANF fund each year is for decreasing racial and ethnic disparities

in infant mortality rates under Minnesota Statutes, section 145.928, subdivision 7.

(3) $4,978,000 of the TANF fund each year is for the family home visiting grant program according to Minnesota Statutes, section 145A.17. $4,000,000 of the funding must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1. $978,000 of the funding must be distributed to tribal governments according to Minnesota Statutes, section 145A.14, subdivision 2a.

(4) The commissioner may use up to 6.23 percent of the funds appropriated each year to conduct the ongoing evaluations required under Minnesota Statutes, section 145A.17, subdivision 7, and training and technical assistance as required under Minnesota Statutes, section 145A.17, subdivisions 4 and 5.

(b) **TANF Carryforward.** Any unexpended balance of the TANF appropriation in the first year of the biennium does not cancel but is available for the second year.

(c) **Targeted Home Visiting.** $2,000,000 in fiscal year 2018 and $2,000,000 in fiscal year 2019 are from the general fund to provide start-up and expansion grants to community health boards, nonprofit organizations, and tribal nations to start up or expand targeted home visiting programs. Grant funds must be used to start up or expand nurse-family partnership programs in the county, reservation, or region to serve families, such as parents with high risk or high needs, parents

with a history of mental illness, domestic abuse, or substance abuse, or first-time mothers prenatally by 28 weeks gestation until the child is four years of age, who are eligible for medical assistance under Minnesota Statutes, chapter 256B, or the federal Special Supplemental Nutrition Program for Women, Infants, and Children. The commissioner shall award grants to community health boards, nonprofits, or tribal nations in metropolitan and rural areas of the state. Priority for grants to rural areas shall be given to community health boards, nonprofits, and tribal nations that expand services within regional partnerships that provide the nurse-family partnership program or other quality targeted home visiting programs. This funding shall only be used to supplement, not to replace, funds being used for nurse-family partnership home visiting services as of June 30, 2017.

(d) **Safe Harbor for Sexually Exploited Youth Services.** $325,000 in fiscal year 2018 and $325,000 in fiscal year 2019 are from the general fund for trauma-informed, culturally specific services for sexually exploited youth. Youth 24 years of age or younger are eligible for services under this paragraph.

(e) **Safe Harbor Program.** $225,000 in fiscal year 2018 and $225,000 in fiscal year 2019 are from the general fund for training, technical assistance, protocol implementation, and evaluation activities related to the safe harbor program. Of these amounts:

(1) $100,000 each fiscal year is for providing training and technical assistance to individuals

and organizations that provide safe harbor services and receive funds for that purpose from the commissioner of human services or commissioner of health;

(2) $100,000 each fiscal year is for protocol implementation, which includes providing technical assistance in establishing best practices-based systems for effectively identifying, interacting with, and referring sexually exploited youth to appropriate resources; and

(3) $25,000 each fiscal year is for program evaluation activities in compliance with Minnesota Statutes, section 145.4718.

(f) **Promoting Safe Harbor Capacity.** In funding services and activities under paragraphs (d) and (e), the commissioner shall emphasize activities that promote capacity-building and development of resources in greater Minnesota.

(g) **Statewide Strategic Plan for Victims of Sex Trafficking.** $75,000 in fiscal year 2018 is from the general fund for the development of a comprehensive statewide strategic plan and report to address the needs of sex trafficking victims statewide.

(h) **Comprehensive Advanced Life Support Educational Program.** $100,000 in fiscal year 2018 and $100,000 in fiscal year 2019 are from the general fund for the comprehensive advanced life support educational program under Minnesota Statutes, section 144.6062.

(i) **Legislative Health Care Workforce Commission.** $130,000 in fiscal year 2018 and $130,000 in fiscal year 2019 are from the general fund for the Legislative Health Care Workforce Commission in Laws 2014, chapter 312, article 23, section 9. The commissioner may transfer part of this appropriation to the Legislative Coordinating Commission to provide per diem and expense reimbursements to the Legislative Health Care Workforce Commission members.

(j) **Local Public Health Grants Payment Delay.** The commissioner shall pay $7,736,000 of local public health grants for fiscal year 2019 on July 1, 2019.

(k) **Opioid Abuse Prevention.** $2,000,000 in fiscal year 2018 is to establish up to 12 accountable community for health opioid abuse prevention pilot projects. This is a onetime appropriation.

(l) **Opioid Prescriber Education.** $500,000 in fiscal year 2018 and $500,000 in fiscal year 2019 are for opioid prescriber education and public awareness grants under Minnesota Statutes, section 145.9263.

(m) **Base Level Adjustments.** The general fund base is $80,678,000 in fiscal year 2020 and $72,992,000 in fiscal year 2021. The health care access fund base is $36,079,000 in fiscal year 2020 and $35,479,000 in fiscal year 2021.

Subd. 3. **Health Protection**

	Appropriations by Fund	
General	14,552,000	14,478,000

State Government Special Revenue	46,488,000	46,247,000	

(a) **Vulnerable Adults in Health Care Settings.** $633,000 in fiscal year 2018 and $559,000 in fiscal year 2019 are added to the appropriation from the general fund for regulating health care and home care settings.

(b) **Base Level Adjustments.** The general fund base is $14,867,000 in fiscal year 2020 and $14,777,000 in fiscal year 2021. The state government special revenue fund base is $46,188,000 in fiscal year 2020 and $46,180,000 in fiscal year 2021.

Subd. 4. **Health Operations**	7,575,000	7,575,000

Sec. 4. **HEALTH-RELATED BOARDS**

Subdivision 1. **Total Appropriation**	**$ 21,543,000**	**$ 21,073,000**

This appropriation is from the state government special revenue fund. The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Board of Chiropractic Examiners**	542,000	542,000

Base Level Adjustment. The base is $547,000 in fiscal year 2020 and $547,000 in fiscal year 2021.

Subd. 3. **Board of Dentistry**	1,366,000	1,366,000
Subd. 4. **Board of Dietetics and Nutrition Practice**	122,000	122,000
Subd. 5. **Board of Marriage and Family Therapy**	296,000	296,000

Base Level Adjustment. The base is $297,000 in fiscal year 2020 and $297,000 in fiscal year 2021.

Subd. 6. **Board of Medical Practice**	4,890,000	4,999,000

This appropriation includes $955,000 in fiscal year 2018 and $964,000 in fiscal year 2019 for the health professional services program. The base for this program is $924,000 in fiscal year 2020 and $924,000 in fiscal year 2021.

Base Level Adjustment. The base is $4,961,000 in fiscal year 2020 and $4,961,000 in fiscal year 2021.

Subd. 7. **Board of Nursing**	4,790,000	4,190,000
Subd. 8. **Board of Nursing Home Administrators**	2,731,000	2,752,000

(a) **Administrative Services Unit - Operating Costs.** Of this appropriation, $2,166,000 in fiscal year 2018 and $2,187,000 in fiscal year 2019 are for operating costs of the administrative services unit. The administrative services unit may receive and expend reimbursements for services it performs for other agencies.

(b) **Administrative Services Unit - Volunteer Health Care Provider Program.** Of this appropriation, $150,000 in fiscal year 2018 and $150,000 in fiscal year 2019 are to pay for medical professional liability coverage required under Minnesota Statutes, section 214.40.

(c) **Administrative Services Unit - Contested Cases and Other Legal Proceedings.** Of this appropriation, $200,000 in fiscal year 2018 and $200,000 in fiscal year 2019 are for costs of contested case hearings and other unanticipated costs of legal proceedings involving health-related boards funded under this section. Upon certification by a health-related board to the administrative

services unit that costs will be incurred and that there is insufficient money available to pay for the costs out of money currently available to that board, the administrative services unit is authorized to transfer money from this appropriation to the board for payment of those costs with the approval of the commissioner of management and budget. The commissioner of management and budget must require any board that has an unexpended balance for an amount transferred under this paragraph to transfer the unexpended amount to the administrative services unit to be deposited in the state government special revenue fund.

Subd. 9. **Board of Optometry**	167,000	167,000
Subd. 10. **Board of Pharmacy**	3,069,000	3,069,000
Subd. 11. **Board of Physical Therapy**	456,000	456,000

Base Level Adjustment. The base is $457,000 in fiscal year 2020 and $458,000 in fiscal year 2021.

Subd. 12. **Board of Podiatric Medicine**	204,000	204,000
Subd. 13. **Board of Psychology**	999,000	999,000
Subd. 14. **Board of Social Work**	1,122,000	1,122,000
Subd. 15. **Board of Veterinary Medicine**	275,000	275,000
Subd. 16. **Board of Behavioral Health and Therapy**	514,000	514,000
Subd. 17. **Board of Occupational Therapy Practice**	374,000	328,000

Sec. 5. **EMERGENCY MEDICAL SERVICES REGULATORY BOARD**	**$ 3,702,000**	**$ 3,702,000**

(a) **Cooper/Sams Volunteer Ambulance Program.**$950,000 in fiscal year 2018 and $950,000 in fiscal year 2019 are for the

Cooper/Sams volunteer ambulance program under Minnesota Statutes, section 144E.40. Of these amounts:

(1)$861,000 in fiscal year 2018 and $861,000 in fiscal year 2019 are for the ambulance service personnel longevity award and incentive program under Minnesota Statutes, section 144E.40; and

(2) $89,000 in fiscal year 2018 and $89,000 in fiscal year 2019 are for the operation of the ambulance service personnel longevity award and incentive program under Minnesota Statutes, section 144E.40.

(b) **EMSRB Board Operations.** $1,391,000 in fiscal year 2018 and $1,391,000 in fiscal year 2019 are for board operations.

(c) **Regional Grants.** $785,000 in fiscal year 2018 and $785,000 in fiscal year 2019 are for regional emergency medical services programs, to be distributed equally to the eight emergency medical service regions under Minnesota Statutes, section 144E.50.

(d) **Ambulance Training Grant.** $470,000 in fiscal year 2018 and $470,000 in fiscal year 2019 are for training grants under Minnesota Statutes, section 144E.35.

(e) **Base Level Adjustment.** The base is $3,704,000 in fiscal year 2020 and $3,704,000 in fiscal year 2021.

Sec. 6. **COUNCIL ON DISABILITY** **$ 651,000 $ 651,000**

Digital Accessibility Staffing. $22,000 in fiscal year 2018 and $22,000 in fiscal year

2019 are for permanently retaining a digital accessibility staff person.

Sec. 7. **OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES** **$ 2,407,000 $ 2,427,000**

Sec. 8. **OMBUDSPERSONS FOR FAMILIES** **$ 543,000 $ 551,000**

Sec. 9. Laws 2009, chapter 101, article 1, section 12, is amended to read:

Sec. 12. **ADMINISTRATION**

Subdivision 1. **Total Appropriation** **$ 19,973,000 $ 19,617,000**

Appropriations by Fund

	2010	2011
General	19,723,000	19,617,000
Special Revenue Fund	250,000	0

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Government and Citizen Services** 18,097,000 17,766,000

Appropriations by Fund

General	17,847,000	17,766,000
Special Revenue Fund	250,000	0

(a) $802,000 the first year and $802,000 the second year are for the Minnesota Geospatial Information Office. Of the total appropriation, $10,000 per year is intended for preparation of township acreage data in Laws 2008, chapter 366, article 17, section 7, subdivision 3.

(b) $74,000 the first year and $74,000 the second year are for the Council on Developmental Disabilities.

~~(c) $127,000 the first year and $127,000 the second year are for transfer to the commissioner of human services for a grant to the Council on Developmental Disabilities for the purpose of establishing a statewide self-advocacy network for persons with intellectual and developmental disabilities (ID/DD). The self-advocacy network shall: (1) ensure that persons with ID/DD are informed of their rights in employment, housing, transportation, voting, government policy, and other issues pertinent to the ID/DD community; (2) provide public education and awareness of the civil and human rights issues persons with ID/DD face; (3) provide funds, technical assistance, and other resources for self-advocacy groups across the state; and (4) organize systems of communications to facilitate an exchange of information between self-advocacy groups. This appropriation must be included in the base budget for the commissioner of human services for the biennium beginning July 1, 2011.~~

(d) $250,000 the first year and $170,000 the second year are to fund activities to prepare for and promote the 2010 census.

(e) $206,000 the first year and $206,000 the second year are for the Office of the State Archaeologist.

(f) $8,388,000 the first year and $8,388,000 the second year are for office space costs of the legislature and veterans organizations, for ceremonial space, and for statutorily free space.

(g) $3,500,000 of the balance in the facilities repair and replacement account in the special revenue fund is canceled to the general fund on July 1, 2009. This is a onetime cancellation.

(h) The requirements imposed on the commissioner of finance and the commissioner of administration under Laws 2007, chapter 148, article 1, section 12, subdivision 2, paragraph (b), relating to the savings attributable to the real property portfolio management system are inoperative.

(i) $250,000 is appropriated to the commissioner of administration from the information and telecommunications account in the special revenue fund to continue planning for data center consolidation, including beginning a predesign study and lifecycle cost analysis, and exploring technologies to reduce energy consumption and operating costs.

Subd. 3. **Administrative Management Support** 1,876,000 1,851,000

$125,000 each year is for the Office of Grant Management. During the biennium ending June 30, 2011, the commissioner must recover this amount through deductions in state grants subject to the jurisdiction of the office. The commissioner may not deduct more than 2.5 percent from the amount of any grant. The amount deducted from appropriations for these grants must be deposited in the general fund.

$25,000 the first year is for the Office of Grants Management to study and make recommendations on improving collaborative activities between the state, nonprofit entities, and the private sector, including: (1)

recommendations for expanding successful initiatives involving not-for-profit organizations that have demonstrated measurable, positive results in addressing high-priority community issues; and (2) recommendations on grant requirements and design to encourage programs receiving grants to become self-sufficient. The office may appoint an advisory group to assist in the study and recommendations. The office must report its recommendations to the legislature by January 15, 2010.

Sec. 10. Laws 2012, chapter 247, article 6, section 2, subdivision 2, is amended to read:

Subd. 2. **Central Office Operations**

(a) **Operations**	118,000	356,000
Base Level Adjustment. The general fund base is increased by $91,000 in fiscal year 2014 and $44,000 in fiscal year 2015.		
(b) **Health Care**	24,000	346,000
This is a onetime appropriation.		
Managed Care Audit Activities. In fiscal year 2014, ~~and in each even-numbered year thereafter,~~ the commissioner shall transfer from the health care access fund $1,740,000 to the legislative auditor for managed care audit services under Minnesota Statutes, section 256B.69, subdivision 9d. This is a biennial appropriation. The health care access fund base is increased by $1,842,000 in fiscal year 2014. ~~Notwithstanding any contrary provision in this article, this paragraph does not expire.~~		
(c) **Continuing Care**	19,000	375,000

Base Level Adjustment. The general fund base is decreased by $159,000 in fiscal years 2014 and 2015.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 11. Laws 2013, chapter 108, article 15, section 2, subdivision 2, is amended to read:

Subd. 2. **Central Office**

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) Operations	2,909,000	8,957,000
Base Adjustment. The general fund base is decreased by $8,916,000 in fiscal year 2016 and $8,916,000 in fiscal year 2017.		
(b) Children and Families	109,000	206,000
(c) Continuing Care	2,849,000	3,574,000
Base Adjustment. The general fund base is decreased by $2,000 in fiscal year 2016 and by $27,000 in fiscal year 2017.		
(d) Group Residential Housing	(1,166,000)	(8,602,000)
(e) Medical Assistance	(3,950,000)	(6,420,000)
(f) Alternative Care	(7,386,000)	(6,851,000)
(g) Child and Community Service Grants	3,000,000	3,000,000
(h) Aging and Adult Services Grants	5,365,000	5,936,000

~~**Gaps Analysis.** In fiscal year 2014, and in each even-numbered year thereafter, $435,000 is appropriated to conduct an analysis of gaps in long-term care services under Minnesota Statutes, section 144A.351. This is a biennial appropriation. The base is increased by $435,000 in fiscal year 2016. Notwithstanding any contrary provisions in this article, this provision does not expire.~~

Base Adjustment. The general fund base is increased by $498,000 in fiscal year 2016, and decreased by $124,000 in fiscal year 2017.

(i) Disabilities Grants	414,000	414,000

Sec. 12. **TRANSFERS.**

Subdivision 1. **Grants.** The commissioner of human services, with the approval of the commissioner of management and budget, may transfer unencumbered appropriation balances for the biennium ending June 30, 2019, within fiscal years among the MFIP, general assistance, medical assistance, MinnesotaCare, MFIP child care assistance under Minnesota Statutes, section 119B.05, Minnesota supplemental aid, and group residential housing programs, the entitlement portion of Northstar Care for Children under Minnesota Statutes, chapter 256N, and the entitlement portion of the chemical dependency consolidated treatment fund, and between fiscal years of the biennium. The commissioner shall inform the chairs and ranking minority members of the senate Health and Human Services Finance Division and the house of representatives Health and Human Services Finance Committee quarterly about transfers made under this subdivision.

Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative money may be transferred within the Departments of Health and Human Services as the commissioners consider necessary, with the advance approval of the commissioner of management and budget. The commissioner shall inform the chairs and ranking minority members of the senate Health and Human Services Finance Division and the house of representatives Health and Human Services Finance Committee quarterly about transfers made under this subdivision.

Sec. 13. **INDIRECT COSTS NOT TO FUND PROGRAMS.**

The commissioners of health and human services shall not use indirect cost allocations to pay for the operational costs of any program for which they are responsible.

Sec. 14. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2019, unless a different expiration date is explicit.

Sec. 15. **EFFECTIVE DATE.**

This article is effective July 1, 2017, unless a different effective date is specified.

APPENDIX
Article locations in S0800-2

13.468 DATA SHARING WITHIN COUNTIES.

County welfare, human services, corrections, public health, and veterans service units within a county may inform each other as to whether an individual or family currently is being served by the county unit, without the consent of the subject of the data. Data that may be shared are limited to the following: the name, telephone number, and last known address of the data subject; and the identification and contact information regarding personnel of the county unit responsible for working with the individual or family. If further information is necessary for the county unit to carry out its duties, each county unit may share additional data if the unit is authorized by state statute or federal law to do so or the individual gives written, informed consent.

147A.21 RULEMAKING AUTHORITY.

The board shall adopt rules:
(1) setting license fees;
(2) setting renewal fees;
(3) setting fees for temporary licenses; and
(4) establishing renewal dates.

147B.08 FEES.

Subdivision 1. **Annual registration fee.** The board shall establish the fee of $150 for initial licensure and $150 annual licensure renewal. The board may prorate the initial licensure fee.

Subd. 2. **Penalty fee for late renewals.** The penalty fee for late submission for renewal application is $50.

Subd. 3. **Deposit.** Fees collected by the board under this section must be deposited in the state government special revenue fund.

147C.40 FEES.

Subdivision 1. **Fees.** The board shall adopt rules setting:
(1) licensure fees;
(2) renewal fees;
(3) late fees;
(4) inactive status fees; and
(5) fees for temporary permits.

Subd. 2. **Proration of fees.** The board may prorate the initial annual license fee. All licensees are required to pay the full fee upon license renewal.

Subd. 3. **Penalty fee for late renewals.** An application for license renewal submitted after the deadline must be accompanied by a late fee in addition to the required fees.

Subd. 4. **Nonrefundable fees.** All of the fees in subdivision 1 are nonrefundable.

148.6402 DEFINITIONS.

Subd. 2. **Advisory council.** "Advisory council" means the Occupational Therapy Practitioners Advisory Council in section 148.6450.

148.6450 OCCUPATIONAL THERAPY PRACTITIONERS ADVISORY COUNCIL.

Subdivision 1. **Membership.** The commissioner shall appoint seven persons to an Occupational Therapy Practitioners Advisory Council consisting of the following:

(1) two public members, as defined in section 214.02. The public members shall be either persons who have received occupational therapy services or family members of or caregivers to such persons;

(2) two members who are occupational therapists and two occupational therapy assistants licensed under sections 148.6401 to 148.6450, each of whom is employed in a different practice area including, but not limited to, long-term care, school therapy, early intervention, administration, gerontology, industrial rehabilitation, cardiac rehabilitation, physical disability, pediatrics, mental health, home health, and hand therapy. Three of the four occupational therapy practitioners who serve on the advisory council must be currently, and for the three years preceding the appointment, engaged in the practice of occupational therapy or employed as an administrator

or an instructor of an occupational therapy program. At least one of the four occupational therapy practitioners who serves on the advisory council must be employed in a rural area; and

(3) one member who is a licensed or registered health care practitioner, or other credentialed practitioner, who works collaboratively with occupational therapy practitioners.

Subd. 2. **Duties.** At the commissioner's request, the advisory council shall:

(1) advise the commissioner regarding the occupational therapy practitioner licensure standards;

(2) advise the commissioner on enforcement of sections 148.6401 to 148.6450;

(3) provide for distribution of information regarding occupational therapy practitioners licensure standards;

(4) review applications and make recommendations to the commissioner on granting or denying licensure or licensure renewal;

(5) review reports of investigations relating to individuals and make recommendations to the commissioner as to whether licensure should be denied or disciplinary action taken against the person; and

(6) perform other duties authorized for advisory councils by chapter 214, as directed by the commissioner.

245A.1915 OPIOID ADDICTION TREATMENT EDUCATION REQUIREMENT FOR PROVIDERS LICENSED TO PROVIDE CHEMICAL DEPENDENCY TREATMENT SERVICES.

All programs serving persons with substance use issues licensed by the commissioner must provide educational information concerning: treatment options for opioid addiction, including the use of a medication for the use of opioid addiction; and recognition of and response to opioid overdose and the use and administration of naloxone, to clients identified as having or seeking treatment for opioid addiction. The commissioner shall develop educational materials that are supported by research and updated periodically that must be used by programs to comply with this requirement.

245A.192 PROVIDERS LICENSED TO PROVIDE TREATMENT OF OPIOID ADDICTION.

Subdivision 1. **Scope.** (a) This section applies to services licensed under this chapter to provide treatment for opioid addiction. In addition to the requirements under Minnesota Rules, parts 9530.6405 to 9530.6505, a program licensed to provide treatment of opioid addiction must meet the requirements in this section.

(b) Where a standard in this section differs from a standard in an otherwise applicable administrative rule, the standards of this section apply.

(c) When federal guidance or interpretations have been issued on federal standards or requirements also required under this section, the federal guidance or interpretations shall apply.

Subd. 2. **Definitions.** (a) For purposes of this section, the terms defined in this subdivision have the meanings given them.

(b) "Diversion" means the use of a medication for the treatment of opioid addiction being diverted from its intended use.

(c) "Guest dose or dosing" means the practice of administering a medication used for the treatment of opioid addiction to a person who is not a client of the program that is administering or dispensing the medication.

(d) "Medical director" means a physician, licensed to practice medicine in the jurisdiction in which the opioid treatment program is located, who assumes responsibility for administering all medical services performed by the program, either by performing them directly or by delegating specific responsibility to authorized program physicians and health care professionals functioning under the medical director's direct supervision.

(e) "Medication used for the treatment of opioid addiction" means a medication approved by the Food and Drug Administration for the treatment of opioid addiction.

(f) "Opioid treatment program" has the meaning given in Code of Federal Regulations, title 42, section 8.12, and includes programs licensed under Minnesota Rules, part 9530.6500.

(g) "Program" means an entity that is licensed under Minnesota Rules, part 9530.6500.

(h) "Unsupervised use" means the use of a medication for the treatment of opioid addiction dispensed for use by a client outside of the program setting. This is also referred to as a "take-home" dose.

(i) "Placing authority" has the meaning given in Minnesota Rules, part 9530.6605, subpart 21a.

(j) "Minnesota health care programs" has the meaning given in section 256B.0636.

Subd. 3. **Medication orders.** Prior to the program administering or dispensing a medication used for the treatment of opioid addiction:

(1) a client-specific order must be received from an appropriately credentialed physician who is enrolled as a Minnesota health care programs provider and meets all applicable provider standards;

(2) the signed order must be documented in the client's record; and

(3) if the physician that issued the order is not able to sign the order when issued, the unsigned order must be entered in the client record at the time it was received, and the physician must review the documentation and sign the order in the client's record within 72 hours of the medication being ordered. The license holder must report to the commissioner any medication error that endangers a patient's health, as determined by the medical director.

Subd. 3a. **High dose requirements.** A client being administered or dispensed a dose beyond that set forth in subdivision 5, paragraph (a), clause (1), that exceeds 150 milligrams of methadone or 24 milligrams of buprenorphine daily, and for each subsequent increase, must meet face-to-face with a prescribing physician. The meeting must occur before the administering or dispensing of the increased dose.

Subd. 4. **Drug testing.** Each client enrolled in the program must receive a minimum of eight random drug abuse tests per 12 months of treatment. These tests must be reasonably disbursed over the 12-month period. A license holder may elect to conduct more drug abuse tests.

Subd. 5. **Criteria for unsupervised use.** (a) To limit the potential for diversion of medication used for the treatment of opioid addiction to the illicit market, any such medications dispensed to patients for unsupervised use shall be subject to the following requirements:

(1) any patient in an opioid treatment program may receive a single take-home dose for a day that the clinic is closed for business, including Sundays and state and federal holidays; and

(2) treatment program decisions on dispensing medications used to treat opioid addiction to patients for unsupervised use beyond that set forth in clause (1) shall be determined by the medical director.

(b) A physician with authority to prescribe must consider the criteria in this subdivision in determining whether a client may be permitted unsupervised or take-home use of such medications. The criteria must also be considered when determining whether dispensing medication for a client's unsupervised use is appropriate to increase or to extend the amount of time between visits to the program. The criteria include:

(1) absence of recent abuse of drugs including but not limited to opioids, nonnarcotics, and alcohol;

(2) regularity of program attendance;

(3) absence of serious behavioral problems at the program;

(4) absence of known recent criminal activity such as drug dealing;

(5) stability of the client's home environment and social relationships;

(6) length of time in comprehensive maintenance treatment;

(7) reasonable assurance that take-home medication will be safely stored within the client's home; and

(8) whether the rehabilitative benefit the client derived from decreasing the frequency of program attendance outweighs the potential risks of diversion or unsupervised use.

(c) The determination, including the basis of the determination, must be consistent with the criteria in this subdivision and must be documented in the client's medical record.

Subd. 6. **Restrictions for unsupervised or take-home use of methadone hydrochloride.** (a) In cases where it is determined that a client meets the criteria in subdivision 5 and may be dispensed a medication used for the treatment of opioid addiction, the restrictions in paragraphs (b) to (g) must be followed when the medication to be dispensed is methadone hydrochloride.

(b) During the first 90 days of treatment, the take-home supply must be limited to a maximum of a single dose each week and the client shall ingest all other doses under direct supervision.

(c) In the second 90 days of treatment, the take-home supply must be limited to two doses per week.

(d) In the third 90 days of treatment, the take-home supply must not exceed three doses per week.

(e) In the remaining months of the first year, a client may be given a maximum six-day supply of take-home medication.

(f) After one year of continuous treatment, a client may be given a maximum two-week supply of take-home medication.

(g) After two years of continuous treatment, a client may be given a maximum one-month supply of take-home medication, but must make monthly visits.

Subd. 7. **Restriction exceptions.** When a license holder has reason to accelerate the number of unsupervised or take-home doses of methadone hydrochloride, the license holder must comply with the requirements of Code of Federal Regulations, title 42, section 8.12, the criteria for unsupervised use in subdivision 5, and must use the exception process provided by the federal Center for Substance Abuse Treatment Division of Pharmacologic Therapies. For the purposes of enforcement of this subdivision, the commissioner has the authority to monitor for compliance with these federal regulations and may issue licensing actions according to sections 245A.05, 245A.06, and 245A.07 based on the commissioner's determination of noncompliance.

Subd. 8. **Guest dosing.** In order to receive a guest dose, the client must be enrolled in an opioid treatment program elsewhere in the state or country and be receiving the medication on a temporary basis because the client is not able to receive the medication at the program in which the client is enrolled. Such arrangements shall not exceed 30 consecutive days in any one program and must not be for the convenience or benefit of either program. Guest dosing may also occur when the client's primary clinic is not open and the client is not receiving take-home doses.

Subd. 9. **Data and reporting.** The license holder must submit data concerning medication used for the treatment of opioid addiction to a central registry. The data must be submitted in a method determined by the commissioner and must be submitted for each client at the time of admission and discharge. The program must document the date the information was submitted. This requirement is effective upon implementation of changes to the Drug and Alcohol Abuse Normative Evaluation System (DAANES) or development of an electronic system by which to submit the data.

Subd. 10. **Nonmedication treatment services; documentation.** (a) The program must offer at least 50 consecutive minutes of individual or group therapy treatment services as defined in Minnesota Rules, part 9530.6430, subpart 1, item A, subitem (1), per week, for the first ten weeks following admission, and at least 50 consecutive minutes per month thereafter. As clinically appropriate, the program may offer these services cumulatively and not consecutively in increments of no less than 15 minutes over the required time period, and for a total of 60 minutes of treatment services over the time period, and must document the reason for providing services cumulatively in the client's record. The program may offer additional levels of service when deemed clinically necessary.

(b) Notwithstanding the requirements of comprehensive assessments in Minnesota Rules, part 9530.6422, the assessment must be completed within 21 days of service initiation.

(c) Notwithstanding the requirements of individual treatment plans set forth in Minnesota Rules, part 9530.6425:

(1) treatment plan contents for maintenance clients are not required to include goals the client must reach to complete treatment and have services terminated;

(2) treatment plans for clients in a taper or detox status must include goals the client must reach to complete treatment and have services terminated;

(3) for the initial ten weeks after admission for all new admissions, readmissions, and transfers, progress notes must be entered in a client's file at least weekly and be recorded in each of the six dimensions upon the development of the treatment plan and thereafter. Subsequently, the counselor must document progress no less than one time monthly, recorded in the six dimensions or when clinical need warrants more frequent notations; and

(4) upon the development of the treatment plan and thereafter, treatment plan reviews must occur weekly, or after each treatment service, whichever is less frequent, for the first ten weeks after the treatment plan is developed. Following the first ten weeks of treatment plan reviews, reviews may occur monthly, unless the client has needs that warrant more frequent revisions or documentation.

Subd. 11. **Prescription monitoring program.** (a) The program must develop and maintain a policy and procedure that requires the ongoing monitoring of the data from the prescription monitoring program for each client. The policy and procedure must include how the program will meet the requirements in paragraph (b).

(b) If a medication used for the treatment of opioid addiction is administered or dispensed to a client, the license holder shall be subject to the following requirements:

(1) upon admission to a methadone clinic outpatient treatment program, clients must be notified in writing that the commissioner of human services and the medical director will monitor the prescription monitoring program to review the prescribed controlled drugs the clients have received;

(2) the medical director or the medical director's delegate must review the data from the Minnesota Board of Pharmacy prescription monitoring program (PMP) established under section 152.126 prior to the client being ordered any controlled substance, as defined under section 152.126, subdivision 1, paragraph (c), including medications used for the treatment of opioid addiction, and subsequent reviews of the PMP data must occur at least every 90 days;

(3) a copy of the PMP data reviewed must be maintained in the client file;

(4) when the PMP data contains a recent history of multiple prescribers or multiple prescriptions for controlled substances, the physician's review of the data and subsequent actions must be documented in the client's individual file within 72 hours and must contain the medical director's determination of whether or not the prescriptions place the client at risk of harm and the actions to be taken in response to the PMP findings. In addition, the provider must conduct subsequent reviews of the PMP on a monthly basis; and

(5) if at any time the medical director believes the use of the controlled substances places the client at risk of harm, the program must seek the client's consent to discuss the client's opioid treatment with other prescribers and must seek consent for the other prescriber to disclose to the opioid treatment program's medical director the client's condition that formed the basis of the other prescriptions. If the information is not obtained within seven days, the medical director must document whether or not changes to the client's medication dose or number of take-home doses are necessary until the information is obtained.

(c) The commissioner shall collaborate with the Minnesota Board of Pharmacy to develop and implement an electronic system through which the commissioner shall routinely access the data from the Minnesota Board of Pharmacy prescription monitoring program established under section 152.126 for the purpose of determining whether any client enrolled in an opioid addiction treatment program licensed according to this section has also been prescribed or dispensed a controlled substance in addition to that administered or dispensed by the opioid addiction treatment program. When the commissioner determines there have been multiple prescribers or multiple prescriptions of controlled substances, the commissioner shall:

(1) inform the medical director of the opioid treatment program only that the commissioner determined the existence of multiple prescribers or multiple prescriptions of controlled substances; and

(2) direct the medical director of the opioid treatment program to access the data directly, review the effect of the multiple prescribers or multiple prescriptions, and document the review.

(d) If determined necessary, the commissioner shall seek a federal waiver of, or exception to, any applicable provision of Code of Federal Regulations, title 42, section 2.34(c), prior to implementing this subdivision.

Subd. 12. **Policies and procedures.** (a) License holders must develop and maintain the policies and procedures required in this subdivision.

(b) For programs that are not open every day of the year, the license holder must maintain a policy and procedure that permits clients to receive a single unsupervised use of medication used for the treatment of opioid addiction for days that the program is closed for business, including, but not limited to, Sundays and state and federal holidays as required under subdivision 5, paragraph (a), clause (1).

(c) The license holder must maintain a policy and procedure that includes specific measures to reduce the possibility of medication used for the treatment of opioid addiction being diverted from its intended treatment use. The policy and procedure must:

(1) specifically identify and define the responsibilities of the medical and administrative staff for carrying out diversion control measures; and

(2) include a process for contacting no less than five percent of clients who have unsupervised use of medication used for the treatment of opioid addiction, excluding those approved solely under subdivision 5, paragraph (a), clause (1), to require them to physically return to the program each month. The system must require clients to return to the program within a stipulated time frame and turn in all unused medication containers related to opioid addiction treatment. The license holder must document all related contacts on a central log and the outcome of the contact for each client in the individual client's record.

(d) Medications used for the treatment of opioid addictions must be ordered, administered, and dispensed according to applicable state and federal regulations and the standards set by applicable accreditation entities. In addition, when an order requires assessment by the person administering or dispensing the medication to determine the amount to be administered or dispensed, the assessment must be completed by an individual whose professional scope of practice permits such assessment. For the purposes of enforcement of this paragraph, the commissioner has the authority to monitor for compliance with these state and federal regulations and the relevant standards of the license holder's accreditation agency and may issue licensing

actions according to sections 245A.05, 245A.06, and 245A.07 based on the commissioner's determination of noncompliance.

Subd. 13. **Quality improvement plan.** The license holder must develop and maintain a quality improvement process and plan. The plan must:

(1) include evaluation of the services provided to clients with the goal of identifying issues that may improve service delivery and client outcomes;

(2) include goals for the program to accomplish based on the evaluation;

(3) be reviewed annually by the management of the program to determine whether the goals were met and, if not, whether additional action is required;

(4) be updated at least annually to include new or continued goals based on an updated evaluation of services; and

(5) identify two specific goal areas, in addition to others identified by the program, including:

(i) a goal concerning oversight and monitoring of the premises around and near the exterior of the program to reduce the possibility of medication used for the treatment of opioid addiction being inappropriately used by clients, including but not limited to the sale or transfer of the medication to others; and

(ii) a goal concerning community outreach, including but not limited to communications with local law enforcement and county human services agencies, with the goal of increasing coordination of services and identification of areas of concern to be addressed in the plan.

Subd. 14. **Placing authorities.** Programs must provide certain notification and client-specific updates to placing authorities for clients who are enrolled in Minnesota health care programs. At the request of the placing authority, the program must provide client-specific updates, including but not limited to informing the placing authority of positive drug screenings and changes in medications used for the treatment of opioid addiction ordered for the client.

Subd. 15. **A program's duty to report suspected drug diversion.** (a) To the fullest extent permitted under Code of Federal Regulations, title 42, sections 2.1 to 2.67, a program shall report to law enforcement any credible evidence that the program or its personnel knows, or reasonably should know, that is directly related to a diversion crime on the premises of the program, or a threat to commit a diversion crime.

(b) "Diversion crime," for the purposes of this section, means diverting, attempting to divert, or conspiring to divert Schedule I, II, III, or IV drugs, as defined in section 152.02, on the program's premises.

(c) The program must document its compliance with the requirement in paragraph (a) in either a client's record or an incident report.

(d) Failure to comply with the duty in paragraph (a) may result in sanctions as provided in sections 245A.06 and 245A.07.

Subd. 16. **Variance.** The commissioner may grant a variance to the requirements of this section.

254A.02 DEFINITIONS.

Subd. 4. **Drug abuse or abuse of drugs.** "Drug abuse or abuse of drugs" is the use of any psychoactive or mood altering chemical substance, without compelling medical reason, in such a manner as to induce mental, emotional or physical impairment and cause socially dysfunctional or socially disordering behavior and which results in psychological or physiological dependency as a function of continued use.

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.19 DIVISION OF COST.

Subd. 1c. **Additional portion of nonfederal share.** (a) Hennepin County shall be responsible for a monthly transfer payment of $1,500,000, due before noon on the 15th of each month and the University of Minnesota shall be responsible for a monthly transfer payment of $500,000 due before noon on the 15th of each month, beginning July 15, 1995. These sums shall be part of the designated governmental unit's portion of the nonfederal share of medical assistance costs.

(b) Beginning July 1, 2001, Hennepin County's payment under paragraph (a) shall be $2,066,000 each month.

(c) Beginning July 1, 2001, the commissioner shall increase annual capitation payments to a demonstration provider serving eligible individuals in Hennepin County under section 256B.69 for the prepaid medical assistance program by approximately $6,800,000 to recognize higher than average medical education costs.

(d) Effective August 1, 2005, Hennepin County's payment under paragraphs (a) and (b) shall be reduced to $566,000, and the University of Minnesota's payment under paragraph (a) shall be reduced to zero. Effective October 1, 2008, to December 31, 2010, Hennepin County's payment under paragraphs (a) and (b) shall be $434,688. Effective January 1, 2011, Hennepin County's payment under paragraphs (a) and (b) shall be $566,000.

(e) Notwithstanding paragraph (d), upon federal enactment of an extension to June 30, 2011, of the enhanced federal medical assistance percentage (FMAP) originally provided under Public Law 111-5, for the six-month period from January 1, 2011, to June 30, 2011, Hennepin County's payment under paragraphs (a) and (b) shall be $434,688.

256B.4914 HOME AND COMMUNITY-BASED SERVICES WAIVERS; RATE SETTING.

Subd. 16. **Budget neutrality adjustments.** (a) The commissioner shall use the following adjustments to the rate generated by the framework to assure budget neutrality until the rate information is available to implement paragraph (b). The rate generated by the framework shall be multiplied by the appropriate factor, as designated below:

(1) for residential services: 1.003;

(2) for day services: 1.000;

(3) for unit-based services with programming: 0.941; and

(4) for unit-based services without programming: 0.796.

(b) Within 12 months of January 1, 2014, the commissioner shall compare estimated spending for all home and community-based waiver services under the new payment rates defined in subdivisions 6 to 9 with estimated spending for the same recipients and services under the rates in effect on July 1, 2013. This comparison must distinguish spending under each of subdivisions 6, 7, 8, and 9. The comparison must be based on actual recipients and services for one or more service months after the new rates have gone into effect. The commissioner shall consult with the commissioner of management and budget on this analysis to ensure budget neutrality. If estimated spending under the new rates for services under one or more subdivisions differs in this comparison by 0.3 percent or more, the commissioner shall assure aggregate budget neutrality across all service areas by adjusting the budget neutrality factor in paragraph (a) in each subdivision so that total estimated spending for each subdivision under the new rates matches estimated spending under the rates in effect on July 1, 2013.

256B.64 ATTENDANTS TO VENTILATOR-DEPENDENT RECIPIENTS.

A ventilator-dependent recipient of medical assistance who has been receiving the services of a home care nurse or personal care assistant in the recipient's home may continue to have a home care nurse or personal care assistant present upon admission to a hospital licensed under chapter 144. The personal care assistant or home care nurse shall perform only the services of

communicator or interpreter for the ventilator-dependent patient during a transition period of up to 120 hours to assure adequate training of the hospital staff to communicate with the patient and to understand the unique comfort, safety, and personal care needs of the patient. The personal care assistant or home care nurse may offer nonbinding advice to the health care professionals in charge of the ventilator-dependent patient's care and treatment on matters pertaining to the comfort and safety of the patient. Within 36 hours of the end of the 120-hour transition period, an assessment may be made by the ventilator-dependent recipient, the attending physician, and the hospital staff caring for the recipient. If the persons making the assessment determine that additional communicator or interpreter services are medically necessary, the hospital must contact the commissioner 24 hours prior to the end of the 120-hour transition period and submit the assessment information to the commissioner. The commissioner shall review the request and determine if it is medically necessary to continue the interpreter services or if the hospital staff has had sufficient opportunity to adequately determine the needs of the patient. The commissioner shall determine if continued service is necessary and appropriate and whether or not payments shall continue. The commissioner may not authorize services beyond the limits of the available appropriations for this section. The commissioner may adopt rules necessary to implement this section. Reimbursement under this section must be at the payment rate and in a manner consistent with the payment rate and manner used in reimbursing these providers for home care services for the ventilator-dependent recipient under the medical assistance program.

256C.23 DEFINITIONS.

Subd. 3. **Regional service center.** "Regional service center" means a facility designed to provide an entry point for deaf, deafblind, and hard-of-hearing persons of that region in need of education, employment, social, human, or other services.

256C.233 DUTIES OF STATE AGENCIES.

Subd. 4. **State commissioners.** The commissioners of all state agencies shall consult with the Deaf and Hard-of-Hearing Services Division concerning the promulgation of public policies, regulations, and programs necessary to address the needs of deaf, deafblind, and hard-of-hearing Minnesotans. Each state agency shall consult with the Deaf and Hard-of-Hearing Services Division concerning the need to forward legislative initiatives to the governor to address the concerns of deaf, deafblind, and hard-of-hearing Minnesotans.

256C.25 INTERPRETER SERVICES.

Subdivision 1. **Establishment.** The Deaf and Hard-of-Hearing Services Division shall maintain and coordinate statewide interpreting or interpreter referral services for use by any public or private agency or individual in the state. The division shall directly coordinate these services but may contract with an appropriate agency to provide this service. The division may collect a $3 fee per referral for interpreter referral services and the actual costs of interpreter services provided by department staff. Fees and payments collected shall be deposited in the general fund. The $3 referral fee shall not be collected from state agencies or local units of government or deaf or hard-of-hearing consumers or interpreters.

Subd. 2. **Duties.** Interpreting or interpreter referral services must include:

(1) statewide access to interpreter referral and direct interpreting services, coordinated with the regional service centers;

(2) maintenance of a statewide directory of qualified interpreters;

(3) assessment of the present and projected supply and demand for interpreter services statewide; and

(4) coordination with the regional service centers on projects to train interpreters and advocate for and evaluate interpreter services.

256J.626 MFIP CONSOLIDATED FUND.

Subd. 5. **Innovation projects.** Beginning January 1, 2005, no more than $3,000,000 of the funds annually appropriated to the commissioner for use in the consolidated fund shall be available to the commissioner to reward high-performing counties and tribes, support promising practices, and test innovative approaches to improving outcomes for MFIP participants, family stabilization services participants, and persons at risk of receiving MFIP as detailed in subdivision 3. Project funds may be targeted to geographic areas with poor outcomes as specified in section 256J.751, subdivision 5, or to subgroups within the MFIP case load who are experiencing poor outcomes.

Laws 2014, chapter 312, article 23, section 9, subdivision 5

Sec. 9. **LEGISLATIVE HEALTH CARE WORKFORCE COMMISSION.**

Subd. 5. **Report to the legislature.** The Legislative Health Care Workforce Commission must provide a preliminary report making recommendations to the legislature by December 31, 2014. The commission must provide a final report to the legislature by December 31, 2016. The final report must:

(1) identify current and anticipated health care workforce shortages, by both provider type and geography;

(2) evaluate the effectiveness of incentives currently available to develop, attract, and retain a highly skilled health care workforce;

(3) study alternative incentives to develop, attract, and retain a highly skilled and diverse health care workforce; and

(4) identify current causes and potential solutions to barriers related to the primary care workforce, including, but not limited to:

(i) training and residency shortages;

(ii) disparities in income between primary care and other providers; and

(iii) negative perceptions of primary care among students.

5600.2500 FEES.

The fees charged by the board are fixed at the following rates:

A. physician application fee, $200;

B. physician annual license, $192;

C. physician endorsement to other states, $40;

D. physician emeritus license, $50;

E. physician temporary licenses, $60;

F. physician late fee, $60;

G. physician assistant application fee, $120;

H. physician assistant annual registration (prescribing), $135;

I. physician assistant annual registration (nonprescribing), $115;

J. physician assistant temporary registration, $115;

K. physician assistant temporary permit, $60;

L. physician assistant locum tenens permit, $25;

M. physician assistant late fee, $50;

N. acupuncture temporary permit, $60;

O. acupuncture inactive status fee, $50;

P. respiratory care annual registration, $90;

Q. respiratory care application fee, $100;

R. respiratory care late fee, $50;

S. respiratory care inactive status, $50;

T. respiratory care temporary permit, $60;

U. respiratory care temporary registration, $90;

V. duplicate license or registration fee, $20;

W. certification letter, $25;

X. verification of status, $10;

Y. education or training program approval fee, $100;

Z. report creation and generation, $60 per hour billed in quarter-hour increments with a quarter-hour minimum; and

AA. examination administrative fee:

(1) half day, $50; and

(2) full day, $80.

The renewal cycle for physician assistants under items H and I begins July 1. The duration of the permit issued under item L is one year.

9530.6405 DEFINITIONS.

Subpart 1. **Scope.** As used in parts 9530.6405 to 9530.6505, the following terms have the meanings given to them.

9530.6405 DEFINITIONS.

Subp. 1a. **Administration of medications.** "Administration of medications" means performing a task to provide medications to a client, and includes the following tasks, performed in the following order:

A. checking the client's medication record;

B. preparing the medication for administration;

C. administering the medication to the client;

D. documenting the administration, or the reason for not administering medications as prescribed; and

E. reporting information to a licensed practitioner or a nurse regarding problems with the administration of the medication or the client's refusal to take the medication.

9530.6405 DEFINITIONS.

Subp. 2. **Adolescent.** "Adolescent" means an individual under 18 years of age.

9530.6405 DEFINITIONS.

Subp. 3. **Alcohol and drug counselor.** "Alcohol and drug counselor" has the meaning given in Minnesota Statutes, section 148C.01, subdivision 2.

9530.6405 DEFINITIONS.

Subp. 4. **Applicant.** "Applicant" means an individual, corporation, partnership, voluntary association, controlling individual, or other organization that has applied for licensure under this chapter.

9530.6405 DEFINITIONS.

Subp. 5. **Capacity management system.** "Capacity management system" means a database operated by the Department of Human Services to compile and make information available to the public about the waiting list status and current admission capability of each program serving intravenous drug abusers.

9530.6405 DEFINITIONS.

Subp. 6. **Central registry.** "Central registry" means a database maintained by the department that collects identifying information from two or more programs about individuals applying for maintenance treatment or detoxification treatment for addiction to opiates for the purpose of avoiding an individual's concurrent enrollment in more than one program.

9530.6405 DEFINITIONS.

Subp. 7. **Chemical.** "Chemical" means alcohol, solvents, controlled substances as defined by Minnesota Statutes, section 152.01, subdivision 4, and other mood altering substances.

9530.6405 DEFINITIONS.

Subp. 7a. **Chemical dependency treatment.** "Chemical dependency treatment" means treatment of a substance use disorder, including the process of assessment of a client's needs, development of planned interventions or services to address those needs, provision of services, facilitation of services provided by other service providers, and reassessment by a qualified professional. The goal of treatment is to assist or support the client's efforts to recover from substance use disorder.

9530.6405 DEFINITIONS.

Subp. 8. **Client.** "Client" means an individual accepted by a license holder for assessment or treatment of a substance use disorder. An individual remains a client until the license holder no longer provides or plans to provide the individual with treatment services.

9530.6405 DEFINITIONS.

Subp. 9. **Commissioner.** "Commissioner" means the commissioner of the Department of Human Services or the commissioner's designee.

9530.6405 DEFINITIONS.

Subp. 10. **Co-occurring or co-occurring client.** "Co-occurring" or "co-occurring client" means a diagnosis that indicates a client suffers from a substance use disorder and a mental health problem.

9530.6405 DEFINITIONS.

Subp. 11. **Department.** "Department" means the Department of Human Services.

9530.6405 DEFINITIONS.

Subp. 12. **Direct client contact.** "Direct client contact" has the meaning given for "direct contact" in Minnesota Statutes, section 245C.02, subdivision 11.

9530.6405 DEFINITIONS.

Subp. 13. **License.** "License" means a certificate issued by the commissioner authorizing the license holder to provide a specific program for a specified period of time in accordance with the terms of the license and the rules of the commissioner.

9530.6405 DEFINITIONS.

Subp. 14. **License holder.** "License holder" means an individual, corporation, partnership, voluntary organization, or other organization that is legally responsible for the operation of the program, has been granted a license by the commissioner under this chapter, and is a controlling individual.

9530.6405 DEFINITIONS.

Subp. 14a. **Licensed practitioner.** "Licensed practitioner" means a person who is authorized to prescribe as defined in Minnesota Statutes, section 151.01, subdivision 23.

9530.6405 DEFINITIONS.

Subp. 15. **Licensed professional in private practice.** "Licensed professional in private practice" means an individual who meets the following criteria:

A. is licensed under Minnesota Statutes, chapter 148C, or is exempt from licensure under that chapter but is otherwise licensed to provide alcohol and drug counseling services;

B. practices solely within the permissible scope of the individual's license as defined in the law authorizing licensure; and

C. does not affiliate with other licensed or unlicensed professionals for the purpose of providing alcohol and drug counseling services. Affiliation does not include conferring with other professionals or making client referrals.

9530.6405 DEFINITIONS.

Subp. 15a. **Nurse.** "Nurse" means a person licensed and currently registered to practice professional or practical nursing as defined in Minnesota Statutes, section 148.171, subdivisions 14 and 15.

9530.6405 DEFINITIONS.

Subp. 16. **Paraprofessional.** "Paraprofessional" means an employee, agent, or independent contractor of the license holder who performs tasks in support of the provision of treatment services. Paraprofessionals may be referred to by a variety of titles including technician, case aide, or counselor assistant. An individual may not be a paraprofessional employed by the license holder if the individual is a client of the license holder.

9530.6405 DEFINITIONS.

Subp. 17. **Program serving intravenous drug abusers.** "Program serving intravenous drug abusers" means a program whose primary purpose is providing agonist medication-assisted therapy to clients who are narcotic dependent, regardless of whether the client's narcotic use was intravenous or by other means.

9530.6405 DEFINITIONS.

Subp. 17a. **Student intern.** "Student intern" means a person who is enrolled in an alcohol and drug counselor education program at an accredited school or educational program and is earning a minimum of nine semester credits per calendar year toward the completion of an associate's, bachelor's, master's, or doctorate degree requirements. Degree requirements must include an additional 18 semester credits or 270 hours of alcohol and drug counseling related course work and 440 hours of practicum.

9530.6405 DEFINITIONS.

Subp. 17b. **Substance.** "Substance" means a "chemical" as defined in subpart 7.

9530.6405 DEFINITIONS.

Subp. 17c. **Substance use disorder.** "Substance use disorder" means a pattern of substance use as defined in the Diagnostic and Statistical Manual of Mental Disorders-IV-TR (DSM), et seq. The DSM-IV-TR is incorporated by reference. The DSM was published by the American

Psychiatric Association in 1994, in Washington D.C., and is not subject to frequent change. The DSM-IV-TR is available through the Minitex interlibrary loan system.

9530.6405 DEFINITIONS.

Subp. 18. **Target population.** "Target population" means individuals experiencing problems with a substance use disorder having the specified characteristics that a license holder proposes to serve.

9530.6405 DEFINITIONS.

Subp. 20. **Treatment director.** "Treatment director" means an individual who meets the qualifications specified under part 9530.6450, subparts 1 and 3, and is designated by the license holder to be responsible for all aspects of the delivery of treatment services.

9530.6405 DEFINITIONS.

Subp. 21. **Treatment service.** "Treatment service" means a therapeutic intervention or series of interventions.

9530.6410 APPLICABILITY.

Subpart 1. **Applicability.** Except as provided in subparts 2 and 3, no person, corporation, partnership, voluntary association, controlling individual, or other organization may provide chemical dependency treatment services to an individual who has a substance use disorder unless licensed by the commissioner.

Subp. 2. **Activities exempt from license requirement.** Parts 9530.6405 to 9530.6505 do not apply to organizations whose primary functions are information, referral, diagnosis, case management, and assessment for the purposes of placement, education, support group services, or self-help programs. Parts 9530.6405 to 9530.6505do not apply to the activities of licensed professionals in private practice which are not paid for by the consolidated chemical dependency treatment fund.

Subp. 3. **Certain hospitals excluded from license requirement.** Parts 9530.6405 to 9530.6505 do not apply to chemical dependency treatment provided by hospitals licensed under Minnesota Statutes, chapter 62J, or under Minnesota Statutes, sections 144.50 to 144.56, unless the hospital accepts funds for chemical dependency treatment under the consolidated chemical dependency treatment fund under Minnesota Statutes, chapter 254B, medical assistance under Minnesota Statutes, chapter 256B, MinnesotaCare or health care cost containment under Minnesota Statutes, chapter 256L, or general assistance medical care under Minnesota Statutes, chapter 256D.

Subp. 4. **Applicability of chapter 2960.** Beginning July 1, 2005, residential adolescent chemical dependency treatment programs must be licensed according to chapter 2960.

9530.6415 LICENSING REQUIREMENTS.

Subpart 1. **General application and license requirements.** An applicant for a license to provide treatment must comply with the general requirements in Minnesota Statutes, chapters 245A and 245C, and Minnesota Statutes, sections 626.556 and 626.557.

Subp. 2. **Contents of application.** Prior to issuance of a license, an applicant must submit, on forms provided by the commissioner, any documents the commissioner requires to demonstrate the following:

A. compliance with parts 9530.6405 to 9530.6505;

B. compliance with applicable building, fire and safety codes, health rules, zoning ordinances, and other applicable rules and regulations or documentation that a waiver has been granted. The granting of a waiver does not constitute modification of any requirement of parts 9530.6405 to 9530.6505;

C. completion of an assessment of need for a new or expanded program according to part 9530.6800; and

D. insurance coverage, including bonding, sufficient to cover all client funds, property, and interests.

Subp. 3. **Changes in license terms.**

A. A license holder must notify the commissioner before one of the following occurs and the commissioner must determine the need for a new license:

(1) a change in the Department of Health's licensure of the program;

(2) a change in whether the license holder provides services specified in parts 9530.6485 to 9530.6505;

(3) a change in location; or

(4) a change in capacity if the license holder meets the requirements of part 9530.6505.

B. A license holder must notify the commissioner and must apply for a new license if there is a change in program ownership.

9530.6420 INITIAL SERVICES PLAN.

The license holder must complete an initial services plan during or immediately following the intake interview. The plan must address the client's immediate health and safety concerns, identify the issues to be addressed in the first treatment sessions, and make treatment suggestions for the client during the time between intake and completion of the treatment plan. The initial services plan must include a determination whether a client is a vulnerable adult as defined in Minnesota Statutes, section 626.5572, subdivision 21. All adult clients of a residential program are vulnerable adults. An individual abuse prevention plan, according to Minnesota Statutes, sections 245A.65, subdivision 2, paragraph (b), and 626.557, subdivision 14, paragraph (b), is required for all clients who meet the definition of "vulnerable adult."

9530.6422 COMPREHENSIVE ASSESSMENT.

Subpart 1. **Comprehensive assessment of substance use disorder.** A comprehensive assessment of the client's substance use disorder must be coordinated by an alcohol and drug counselor and completed within three calendar days after service initiation for a residential program or three sessions of the client's initiation to services for all other programs. The alcohol and drug counselor may rely on current information provided by a referring agency or other sources as a supplement when information is available. Information gathered more than 45 days before the date of admission is not current. If the comprehensive assessment cannot be completed in the time specified, the treatment plan must indicate how and when it will be completed. The assessment must include sufficient information to complete the assessment summary according to subpart 2 and part 9530.6425. The comprehensive assessment must include information about the client's problems that relate to chemical use and personal strengths that support recovery, including:

A. age, sex, cultural background, sexual orientation, living situation, economic status, and level of education;

B. circumstances of service initiation;

C. previous attempts at treatment for chemical use or dependency, compulsive gambling, or mental illness;

D. chemical use history including amounts and types of chemicals used, frequency and duration of use, periods of abstinence, and circumstances of relapse, if any. For each chemical used within the previous 30 days, the information must include the date and time of the most recent use and any previous experience with withdrawal;

E. specific problem behaviors exhibited by the client when under the influence of chemicals;

F. current family status, family history, including history or presence of physical or sexual abuse, level of family support, and chemical use, abuse, or dependency among family members and significant others;

G. physical concerns or diagnoses, the severity of the concerns, and whether or not the concerns are being addressed by a health care professional;

H. mental health history and current psychiatric status, including symptoms, disability, current treatment supports, and psychotropic medication needed to maintain stability;

I. arrests and legal interventions related to chemical use;

J. ability to function appropriately in work and educational settings;

K. ability to understand written treatment materials, including rules and client rights;

L. risk-taking behavior, including behavior that puts the client at risk of exposure to blood borne or sexually transmitted diseases;

M. social network in relation to expected support for recovery and leisure time activities that have been associated with chemical use;

N. whether the client is pregnant and if so, the health of the unborn child and current involvement in prenatal care; and

O. whether the client recognizes problems related to substance use and is willing to follow treatment recommendations.

Subp. 2. **Assessment summary.** An alcohol and drug counselor must prepare an assessment summary within three calendar days for a residential program or within three treatment sessions of service initiation. The narrative summary of the comprehensive assessment results must meet the requirements of items A and B:

A. An assessment summary must be prepared by an alcohol and drug counselor and include:

(1) a risk description according to part 9530.6622 for each dimension listed in item B;

(2) narrative supporting the risk descriptions; and

(3) a determination of whether the client meets the DSM criteria for a person with a substance use disorder.

B. Contain information relevant to treatment planning and recorded in the dimensions in subitems (1) to (6):

(1) Dimension 1, acute intoxication/withdrawal potential. The license holder must consider the client's ability to cope with withdrawal symptoms and current state of intoxication.

(2) Dimension 2, biomedical conditions and complications. The license holder must consider the degree to which any physical disorder would interfere with treatment for substance abuse, and the client's ability to tolerate any related discomfort. The license holder must determine the impact of continued chemical use on the unborn child if the client is pregnant.

(3) Dimension 3, emotional, behavioral, and cognitive conditions and complications. The license holder must determine the degree to which any condition or complications are likely to interfere with treatment for substance abuse or with functioning in significant life areas and the likelihood of risk of harm to self or others.

(4) Dimension 4, readiness for change. The license holder must also consider the amount of support and encouragement necessary to keep the client involved in treatment.

(5) Dimension 5, relapse, continued use, and continued problem potential. The license holder must consider the degree to which the client recognizes relapse issues and has the skills to prevent relapse of either substance use or mental health problems.

(6) Dimension 6, recovery environment. The license holder must consider the degree to which key areas of the client's life are supportive of or antagonistic to treatment participation and recovery.

9530.6425 INDIVIDUAL TREATMENT PLANS.

Subpart 1. **General.** Individual treatment plans for clients in treatment must be completed within seven calendar days of completion of the assessment summary. Treatment plans must continually be updated, based on new information gathered about the client's condition and on whether planned treatment interventions have had the intended effect. Treatment planning must include ongoing assessment in each of the six dimensions according to part 9530.6422, subpart 2. The plan must provide for the involvement of the client's family and those people selected by the client as being important to the success of the treatment experience at the earliest opportunity, consistent with the client's treatment needs and written consent. The plan must be developed after completion of the comprehensive assessment and is subject to amendment until services to the client are terminated. The client must have an opportunity to have active, direct involvement in selecting the anticipated outcomes of the treatment process and in developing the individual treatment plan. The individual treatment plan must be signed by the client and the alcohol and drug counselor. The individual treatment plan may be a continuation of the initial services plan required in part 9530.6420.

Subp. 2. **Plan contents.** An individual treatment plan must be recorded in the six dimensions listed in part 9530.6422, subpart 2, item B, and address each problem identified in the assessment summary, and include:

A. specific methods to be used to address identified problems, including amount, frequency, and anticipated duration of treatment service. The methods must be appropriate to the client's language, reading skills, cultural background, and strengths;

B. resources to which the client is being referred for problems when problems are to be addressed concurrently by another provider; and

C. goals the client must reach to complete treatment and have services terminated.

Subp. 3. **Progress notes and plan review.**

A. Progress notes must be entered in a client's file weekly or after each treatment service, whichever is less frequent, by the staff person providing the service. The note must reference the treatment plan. Progress notes must be recorded and address each of the six dimensions listed in part 9530.6422, subpart 2, item B. Progress notes must:

(1) be entered immediately following any significant event. Significant events include those events which have an impact on the client's relationship with other clients, staff, the client's family, or the client's treatment plan;

(2) indicate the type and amount of each treatment service the client has received;

(3) include monitoring of any physical and mental health problems and the participation of others in the treatment plan;

(4) document the participation of others; and

(5) document that the client has been notified of each treatment plan change and that the client either does or does not agree with the change.

B. Treatment plan review must:

(1) occur weekly or after each treatment service, whichever is less frequent;

(2) address each goal in the treatment plan that has been worked on since the last review;

(3) address whether the strategies to address the goals are effective, and if not, must include changes to the treatment plan; and

(4) include a review and evaluation of the individual abuse prevention plan according to Minnesota Statutes, section 245A.65.

C. All entries in a client's record must be legible, signed, and dated. Late entries must be clearly labeled "late entry." Corrections to an entry must be made in a way in which the original entry can still be read.

Subp. 3a. **Documentation.** Progress notes and plan review do not require separate documentation if the information in the client file meets the requirements of subpart 3, items A and B.

Subp. 4. **Summary at termination of services.** An alcohol and drug counselor must write a discharge summary for each client. The summary must be completed within five days of the client's service termination or within five days from the client's or program's decision to terminate services, whichever is earlier.

A. The summary at termination of services must be recorded in the six dimensions listed in part 9530.6422, subpart 2, item B, and include the following information:

(1) client's problems, strengths, and needs while participating in treatment, including services provided;

(2) client's progress toward achieving each of the goals identified in the individual treatment plan;

(3) reasons for and circumstances of service termination; and

(4) risk description according to part 9530.6622.

B. For clients who successfully complete treatment, the summary must also include:

(1) living arrangements upon discharge;

(2) continuing care recommendations, including referrals made with specific attention to continuity of care for mental health problems, as needed;

(3) service termination diagnosis; and

(4) client's prognosis.

9530.6430 TREATMENT SERVICES.

Subpart 1. **Treatment services offered by license holder.**

A. A license holder must offer the following treatment services unless clinically inappropriate and the justifying clinical rationale is documented:

(1) individual and group counseling to help the client identify and address problems related to chemical use and develop strategies to avoid inappropriate chemical use after discharge;

(2) client education strategies to avoid inappropriate chemical use and health problems related to chemical use and the necessary changes in lifestyle to regain and maintain health. Client education must include information concerning the human immunodeficiency virus, according to Minnesota Statutes, section 245A.19, other sexually transmitted diseases, drug and alcohol use during pregnancy, hepatitis, and tuberculosis;

(3) transition services to help the client integrate gains made during treatment into daily living and to reduce reliance on the license holder's staff for support;

(4) services to address issues related to co-occurring mental illness, including education for clients on basic symptoms of mental illness, the possibility of comorbidity, and the need for continued medication compliance while working on recovery from substance use disorder. Groups must address co-occurring mental illness issues, as needed. When treatment for mental health problems is indicated, it is integrated into the client's treatment plan; and

(5) service coordination to help the client obtain the services and to support the client's need to establish a lifestyle free of the harmful effects of substance use disorder.

B. Treatment services provided to individual clients must be provided according to the individual treatment plan and must address cultural differences and special needs of all clients.

Subp. 2. **Additional treatment services.** A license holder may provide or arrange the following additional treatment services as a part of the individual treatment plan:

A. relationship counseling provided by a qualified professional to help the client identify the impact of the client's substance use disorder on others and to help the client and persons in the client's support structure identify and change behaviors that contribute to the client's substance use disorder;

B. therapeutic recreation to provide the client with an opportunity to participate in recreational activities without the use of mood-altering chemicals and to learn to plan and select leisure activities that do not involve the inappropriate use of chemicals;

C. stress management and physical well-being to help the client reach and maintain an acceptable level of health, physical fitness, and well-being;

D. living skills development to help the client learn basic skills necessary for independent living;

E. employment or educational services to help the client become financially independent;

F. socialization skills development to help the client live and interact with others in a positive and productive manner; and

G. room, board, and supervision provided at the treatment site to give the client a safe and appropriate environment in which to gain and practice new skills.

Subp. 3. **Counselors to provide treatment services.** Treatment services, including therapeutic recreation, must be provided by alcohol and drug counselors qualified according to part 9530.6450, unless the individual providing the service is specifically qualified according to the accepted standards of that profession. Therapeutic recreation does not include planned leisure activities.

Subp. 4. **Location of service provision.** A client of a license holder may only receive services at any of the license holder's licensed locations or at the client's home, except that services under subpart 1, item A, subitems (3) and (5), and subpart 2, items B and E, may be provided in another suitable location.

9530.6435 MEDICAL SERVICES.

Subpart 1. **Health care services description.** An applicant or license holder must maintain a complete description of the health care services, nursing services, dietary services, and emergency physician services offered by the license holder.

Subp. 1a. **Procedures.** The applicant or license holder must have written procedures for obtaining medical interventions when needed for a client, that are approved in writing by a physician who is licensed under Minnesota Statutes, chapter 147, unless:

A. the license holder does not provide services under part 9530.6505; and

B. all medical interventions are referred to 911, the emergency telephone number, or the client's physician.

Subp. 2. **Consultation services.** The license holder must have access to and document the availability of a licensed mental health professional to provide diagnostic assessment and treatment planning assistance.

Subp. 3. **Administration of medications and assistance with self-medication.** A license holder must meet the requirements in items A and B if services include medication administration.

A. A staff member, other than a licensed practitioner or nurse, who is delegated by a licensed practitioner or a registered nurse the task of administration of medication or assistance with self-medication must:

(1) document that the staff member has successfully completed a medication administration training program for unlicensed personnel through an accredited Minnesota postsecondary educational institution. Completion of the course must be documented in writing and placed in the staff member's personnel file; or

(2) be trained according to a formalized training program which is taught by a registered nurse and offered by the license holder. Completion of the course must be documented in writing and placed in the staff member's personnel records; or

(3) demonstrate to a registered nurse competency to perform the delegated activity.

B. A registered nurse must be employed or contracted to develop the policies and procedures for medication administration or assistance with self-administration of medication or both. A registered nurse must provide supervision as defined in part 6321.0100. The registered nurse supervision must include monthly on-site supervision or more often as warranted by client health needs. The policies and procedures must include:

(1) a provision that delegations of administration of medication are limited to administration of those medications which are oral, suppository, eye drops, ear drops, inhalant, or topical;

(2) a provision that each client's file must include documentation indicating whether staff will be administering medication or the client will be doing self-administration or a combination of both;

(3) a provision that clients may carry emergency medication such as nitroglycerin as instructed by their physician;

(4) a provision for medication to be self-administered when a client is scheduled not to be at the facility;

(5) a provision that if medication is to be self-administered at a time when the client is present in the facility, medication will be self-administered under observation of a trained staff person;

(6) a provision that when a license holder serves clients who are parents with children, the parent may only administer medication to the child under staff supervision;

(7) requirements for recording the client's use of medication, including staff signatures with date and time;

(8) guidelines for when to inform a registered nurse of problems with self-administration, including failure to administer, client refusal of a medication, adverse reactions, or errors; and

(9) procedures for acceptance, documentation, and implementation of prescriptions, whether written, verbal, telephonic, or electronic.

Subp. 4. **Control of drugs.** A license holder must have in place and implement written policies and procedures developed by a registered nurse that contains the following provisions:

A. a requirement that all drugs must be stored in a locked compartment. Schedule II drugs, as defined by Minnesota Statutes, section 152.02, must be stored in a separately locked compartment, permanently affixed to the physical plant or medication cart;

B. a system which accounts for all scheduled drugs each shift;

C. a procedure for recording the client's use of medication, including the signature of the administrator of the medication with the time and date;

D. a procedure for destruction of discontinued, outdated, or deteriorated medications;

E. a statement that only authorized personnel are permitted to have access to the keys to the locked drug compartments; and

F. a statement that no legend drug supply for one client will be given to another client.

9530.6440 CLIENT RECORDS.

Subpart 1. **Client records required.** A license holder must maintain a file of current client records on the premises where the treatment services are provided or coordinated. The content and format of client records must be uniform and entries in each case must be signed and dated by

the staff member making the entry. Client records must be protected against loss, tampering, or unauthorized disclosure in compliance with Minnesota Statutes, section 254A.09, Code of Federal Regulations, title 42, chapter 1, part 2, subpart B, sections 2.1 to 2.67, and Code of Federal Regulations, title 45, parts 160 to 164, and, if applicable, Minnesota Statutes, chapter 13.

Subp. 2. **Records retention.** Records of discharged clients must be retained by a license holder for seven years. License holders that cease to provide treatment services must retain client records for seven years from the date of facility closure and must notify the commissioner of the location of the records and the name of a person responsible for maintaining the records.

Subp. 3. **Client records, contents.** Client records must contain the following:

A. documentation that the client was given information on client rights, responsibilities, grievance procedures, tuberculosis, and HIV, and that the client was provided an orientation to the program abuse prevention plan as required under Minnesota Statutes, section 245A.65, subdivision 2, paragraph (a), clause (4);

B. an initial services plan completed according to part 9530.6420;

C. a comprehensive assessment completed according to part 9530.6422;

D. an assessment summary completed according to part 9530.6422, subpart 2;

E. an individual abuse prevention plan that complies with Minnesota Statutes, sections 245A.65, subdivision 2, and 626.557, subdivision 14, when applicable;

F. an individual treatment plan, as required under part 9530.6425, subparts 1 and 2;

G. progress notes, as required in part 9530.6425, subpart 3; and

H. a summary of termination of services, written according to part 9530.6425, subpart 4.

Subp. 4. **Electronic records.** A license holder who intends to use electronic record keeping or electronic signatures to comply with parts 9530.6405 to 9530.6505 must first obtain written permission from the commissioner. The commissioner must grant permission after the license holder provides documentation demonstrating the license holder's use of a system for ensuring security of electronic records. Use of electronic record keeping or electronic signatures does not alter the license holder's obligations under state or federal law, regulation, or rule.

9530.6445 STAFFING REQUIREMENTS.

Subpart 1. **Treatment director required.** A license holder must have a treatment director.

Subp. 2. **Alcohol and drug counselor supervisor requirements.** A license holder must employ an alcohol and drug counselor supervisor who meets the requirements under part 9530.6450, subpart 4. An individual may be simultaneously employed as a treatment director, alcohol and drug counselor supervisor, and an alcohol and drug counselor if the individual meets the qualifications for each position. If an alcohol and drug counselor is simultaneously an alcohol and drug counselor supervisor or treatment director, that individual must be considered a 0.5 full-time equivalent alcohol and drug counselor for purposes of meeting the staffing requirements under subpart 4.

Subp. 3. **Responsible staff person.** A treatment director must designate a staff member who, when present in the facility, is responsible for the delivery of treatment services. A license holder must have a designated staff person during all hours of operation. A license holder providing room and board and treatment at the same site must have a responsible staff person on duty 24 hours a day. The designated staff person must know and understand the implications of parts 9530.6405 to 9530.6505 and Minnesota Statutes, sections 245A.65, 626.556, 626.557, and 626.5572.

Subp. 4. **Staffing requirements.** At least 25 percent of a counselor's scheduled work hours must be allocated to indirect services, including documentation of client services, coordination of services with others, treatment team meetings, and other duties. A counseling group shall not exceed an average of 16 clients during any 30 consecutive calendar days. It is the responsibility of the license holder to determine an acceptable group size based on the client's needs. A counselor in a program treating intravenous drug abusers must not supervise more than 50 clients. The license holder must maintain a record that documents compliance with this subpart.

Subp. 5. **Medical emergencies.** When clients are present, a license holder must have at least one staff person on the premises who has a current American Red Cross standard first aid certificate or an equivalent certificate and at least one staff person on the premises who has a current American Red Cross community, American Heart Association, or equivalent CPR certificate. A single staff person with both certifications satisfies this requirement.

9530.6450 STAFF QUALIFICATIONS.

Subpart 1. **Qualifications of all staff members with direct client contact.** All staff members who have direct client contact must be at least 18 years of age. At the time of hiring, all staff members must meet the qualifications in item A or B. A chemical use problem for purposes of this subpart is a problem listed by the license holder in the personnel policies and procedures according to part 9530.6460, subpart 1, item E.

A. Treatment directors, supervisors, nurses, counselors, and other professionals must be free of chemical use problems for at least the two years immediately preceding their hiring and must sign a statement attesting to that fact.

B. Paraprofessionals and all other staff members with direct client contact must be free of chemical use problems for at least one year immediately preceding their hiring and must sign a statement attesting to that fact.

Subp. 2. **Employment; prohibition on chemical use problems.** Staff members with direct client contact must be free from chemical use problems as a condition of employment, but are not required to sign additional statements. Staff members with direct client contact who are not free from chemical use problems must be removed from any responsibilities that include direct client contact for the time period specified in subpart 1. The time period begins to run on the date the employee begins receiving treatment services or the date of the last incident as described in the list developed according to part 9530.6460, subpart 1, item E.

Subp. 3. **Treatment director qualifications.** In addition to meeting the requirements of subpart 1, a treatment director must know and understand the implications of parts 9530.6405 to 9530.6505 and Minnesota Statutes, chapter 245A, and sections 626.556, 626.557, and 626.5572. A treatment director must:

A. have at least one year of work experience in direct service to individuals with chemical use problems or one year of work experience in the management or administration of direct service to individuals with chemical use problems; and

B. have a baccalaureate degree or three years of work experience in administration or personnel supervision in human services.

Subp. 4. **Alcohol and drug counselor supervisor qualifications.** In addition to meeting the requirements of subpart 1, an alcohol and drug counselor supervisor must meet the following qualifications:

A. the individual is competent in the areas specified in subpart 5;

B. the individual has three or more years of experience providing individual and group counseling to chemically dependent clients except that, prior to January 1, 2005, an individual employed in a program formerly licensed under parts 9530.5000 to 9530.6400is required to have one or more years experience; and

C. the individual knows and understands the implications of parts 9530.6405 to 9530.6505 and Minnesota Statutes, sections 245A.65, 626.556, 626.557, and 626.5572.

Subp. 5. **Alcohol and drug counselor qualifications.** In addition to meeting the requirements of subpart 1, an alcohol and drug counselor must be either licensed or exempt from licensure under Minnesota Statutes, chapter 148C. An alcohol and drug counselor must document competence in screening for and working with clients with mental health problems, through education, training, and experience.

A. Alcohol and drug counselors licensed under Minnesota Statutes, chapter 148C, must comply with rules adopted under Minnesota Statutes, chapter 148C.

B. Counselors exempt under Minnesota Statutes, chapter 148C, must be competent, as evidenced by one of the following:

(1) completion of at least a baccalaureate degree with a major or concentration in social work, nursing, sociology, human services, or psychology, or licensure as a registered nurse; successful completion of a minimum of 120 hours of classroom instruction in which each of the core functions listed in Minnesota Statutes, chapter 148C, is covered; and successful completion of 440 hours of supervised experience as an alcohol and drug counselor, either as a student or as a staff member;

(2) completion of 270 hours of alcohol and drug counselor training in which each of the core functions listed in Minnesota Statutes, chapter 148C, is covered, and successful completion of 880 hours of supervised experience as an alcohol and drug counselor, either as a student, or as a staff member;

(3) current certification as an alcohol and drug counselor or alcohol and drug counselor reciprocal, through the evaluation process established by the International Certification and Reciprocity Consortium Alcohol and Other Drug Abuse, Inc., and published in the Case Presentation Method Trainer's Manual, copyright 1993. The manual is incorporated by reference. It is available at the State Law Library, Judicial Center, 25 Reverend Dr. Martin Luther King Jr. Blvd., St. Paul, Minnesota 55155;

(4) completion of a bachelor's degree including 480 hours of alcohol and drug counseling education from an accredited school or educational program and 880 hours of alcohol and drug counseling practicum; or

(5) employment in a program formerly licensed under parts 9530.5000 to 9530.6400 and successful completion of 6,000 hours of supervised work experience in a licensed program as an alcohol and drug counselor prior to January 1, 2005.

Subp. 6. **Paraprofessional qualifications and duties.** A paraprofessional must comply with subpart 1 and have knowledge of client rights, outlined in Minnesota Statutes, section 148F.165, and of staff responsibilities. A paraprofessional may not admit, transfer, or discharge clients but may be the person responsible for the delivery of treatment services as required in part 9530.6445, subpart 3.

Subp. 7. **Volunteers.** Volunteers may provide treatment services when they are supervised and can be seen or heard by a staff member meeting the criteria in subpart 4 or 5, but may not practice alcohol and drug counseling unless qualified under subpart 5.

Subp. 8. **Student interns.** A qualified staff person must supervise and be responsible for all treatment services performed by student interns and must review and sign all assessments, progress notes, and treatment plans prepared by the intern. Student interns must meet the requirements in subpart 1, item A, and receive the orientation and training required in part 9530.6460, subpart 1, item G, and subpart 2.

Subp. 9. **Individuals with temporary permit.** Individuals with a temporary permit from the Board of Behavioral Health and Therapy may provide chemical dependency treatment services under the conditions in either item A or B.

A. The individual is supervised by a licensed alcohol and drug counselor assigned by the license holder. The licensed alcohol and drug counselor must document the amount and type of supervision at least weekly. The supervision must relate to clinical practices. One licensed alcohol and drug counselor may not supervise more than three individuals with temporary permits, according to Minnesota Statutes, section 148C.01, subdivision 12a.

B. The individual is supervised by a clinical supervisor approved by the Board of Behavioral Health and Therapy. The supervision must be documented and meet the requirements of Minnesota Statutes, section 148C.044, subdivision 4.

9530.6455 PROVIDER POLICIES AND PROCEDURES.

License holders must develop a written policy and procedures manual indexed according to Minnesota Statutes, section 245A.04, subdivision 14, paragraph (c), so that staff may have immediate access to all policies and procedures and so that consumers of the services and other authorized parties may have access to all policies and procedures. The manual must contain the following materials:

A. assessment and treatment planning policies, which include screening for mental health concerns, and the inclusion of treatment objectives related to identified mental health concerns in the client's treatment plan;

B. policies and procedures regarding HIV that comply with Minnesota Statutes, section 245A.19;

C. the methods and resources used by the license holder to provide information on tuberculosis and tuberculosis screening to all clients and to report known cases of tuberculosis infection according to Minnesota Statutes, section 144.4804;

D. personnel policies that comply with part 9530.6460;

E. policies and procedures that protect client rights as required under part 9530.6470;

F. a medical services plan that complies with part 9530.6435;

G. emergency procedures that comply with part 9530.6475;

H. policies and procedures for maintaining client records under part 9530.6440;

I. procedures for reporting the maltreatment of minors under Minnesota Statutes, section 626.556, and vulnerable adults under Minnesota Statutes, sections 245A.65, 626.557, and 626.5572;

J. a description of treatment services including the amount and type of client services provided;

K. the methods used to achieve desired client outcomes; and

L. the hours of operation and target population served.

9530.6460 PERSONNEL POLICIES AND PROCEDURES.

Subpart 1. **Policy requirements.** License holders must have written personnel policies and must make them available to each staff member. The policies must:

A. assure that staff member retention, promotion, job assignment, or pay are not affected by a good faith communication between a staff member and the Department of Health, the Department of Human Services, the ombudsman for mental health and developmental disabilities, law enforcement, or local agencies for the investigation of complaints regarding a client's rights, health, or safety;

B. contain job descriptions for each position specifying responsibilities, degree of authority to execute job responsibilities, and qualifications;

C. provide for job performance evaluations based on standards of job performance to be conducted on a regular and continuing basis, including a written annual review;

D. describe behavior that constitutes grounds for disciplinary action, suspension or dismissal, including policies that address chemical use problems and meet the requirements of part 9530.6450, subpart 1, policies prohibiting personal involvement with clients in violation of Minnesota Statutes, chapter 604, and policies prohibiting client abuse as specified under Minnesota Statutes, sections 245A.65, 626.556, 626.557, and 626.5572;

E. list behaviors or incidents that are considered chemical use problems. The list must include:

(1) receiving treatment for chemical use within the period specified for the position in the staff qualification requirements;

(2) chemical use that has a negative impact on the staff member's job performance;

(3) chemical use that affects the credibility of treatment services with clients, referral sources, or other members of the community; and

(4) symptoms of intoxication or withdrawal on the job;

F. include a chart or description of the organizational structure indicating lines of authority and responsibilities;

G. include orientation within 24 working hours of starting for all new staff based on a written plan that, at a minimum, must provide for training related to the specific job functions for which the staff member was hired, policies and procedures, client confidentiality, the human immunodeficiency virus minimum standards, and client needs; and

H. policies outlining the license holder's response to staff members with behavior problems that interfere with the provision of treatment services.

Subp. 2. **Staff development.** A license holder must ensure that each staff person has the training required in items A to E.

A. All staff must be trained every two years in client confidentiality rules and regulations and client ethical boundaries.

B. All staff must be trained every two years in emergency procedures and client rights as specified in Minnesota Statutes, sections 144.651, 148F.165, and 253B.03.

C. All staff with direct client contact must be trained every year on mandatory reporting as specified under Minnesota Statutes, sections 245A.65, 626.556, 626.5561, 626.5563, 626.557, and 626.5572, including specific training covering the facility's policies concerning obtaining client releases of information.

D. All staff with direct client contact must receive training upon hiring and annually thereafter on the human immunodeficiency virus minimum standards according to Minnesota Statutes, section 245A.19.

E. Treatment directors, supervisors, nurses, and counselors must obtain 12 hours of training in co-occurring mental health problems and substance use disorder that includes competencies related to philosophy, screening, assessment, diagnosis and treatment planning,

documentation, programming, medication, collaboration, mental health consultation, and discharge planning. Staff employed by a license holder on the date this rule is adopted must obtain the training within 12 months of the date of adoption. New staff who have not obtained such training must obtain it within 12 months of the date this rule is adopted or within six months of hire, whichever is later. Staff may request, and the license holder may grant credit for, relevant training obtained prior to January 1, 2005.

Subp. 3. **Personnel files.** The license holder must maintain a separate personnel file for each staff member. At a minimum, the personnel file must be maintained to meet the requirements under parts 9530.6405 to 9530.6505 and contain the following:

A. a completed application for employment signed by the staff member and containing the staff member's qualifications for employment;

B. documentation related to the applicant's background study data, as defined in Minnesota Statutes, chapter 245C;

C. for staff members who will be providing psychotherapy services, employer names and addresses for the past five years for which the staff member provided psychotherapy services, and documentation of an inquiry made to these former employers regarding substantiated sexual contact with a client as required by Minnesota Statutes, chapter 604;

D. documentation of completed orientation and training;

E. documentation demonstrating compliance with parts 9530.6450 and 9530.6485, subpart 2; and

F. documentation demonstrating compliance with part 9530.6435, subpart 3, for staff members who administer medications.

9530.6465 SERVICE INITIATION AND TERMINATION POLICIES.

Subpart 1. **Service initiation policy.** A license holder must have a written service initiation policy containing service initiation preferences which comply with this rule and Code of Federal Regulations, title 45, part 96.131, and specific service initiation criteria. The license holder must not initiate services for individuals who do not meet the service initiation criteria. The service initiation criteria must be either posted in the area of the facility where services for clients are initiated, or given to all interested persons upon request. Titles of all staff members authorized to initiate services for clients must be listed in the services initiation and termination policies. A license holder that serves intravenous drug abusers must have a written policy that provides service initiation preference as required by Code of Federal Regulations, title 45, part 96.131.

Subp. 2. **License holder responsibilities; terminating or denying services.** A license holder has specific responsibilities when terminating services or denying treatment service initiation to clients for reasons of health, behavior, or criminal activity.

A. The license holder must have and comply with a written protocol for assisting clients in need of care not provided by the license holder, and for clients who pose a substantial likelihood of harm to themselves or others, if the behavior is beyond the behavior management capabilities of the staff. All service terminations and denials of service initiation which pose an immediate threat to the health of any individual or require immediate medical intervention must be referred to a medical facility capable of admitting the individual.

B. All service termination policies and denials of service initiation that involve the commission of a crime against a license holder's staff member or on a license holder's property, as provided under Code of Federal Regulations, title 42, section 2.12(c)(5), and Code of Federal Regulations, title 45, parts 160 to 164, must be reported to a law enforcement agency with proper jurisdiction.

Subp. 3. **Service termination and transfer policies.** A license holder must have a written policy specifying the conditions under which clients must be discharged. The policy must include:

A. procedures for individuals whose services have been terminated under subpart 2;

B. a description of client behavior that constitutes reason for a staff-requested service termination and a process for providing this information to clients;

C. procedures consistent with Minnesota Statutes, section 253B.16, subdivision 2, that staff must follow when a client admitted under Minnesota Statutes, chapter 253B, is to have services terminated;

D. procedures staff must follow when a client leaves against staff or medical advice and when the client may be dangerous to self or others;

E. procedures for communicating staff-approved service termination criteria to clients, including the expectations in the client's individual treatment plan according to part 9530.6425; and

F. titles of staff members authorized to terminate client services must be listed in the service initiation and termination policies.

9530.6470 POLICIES AND PROCEDURES THAT PROTECT CLIENT RIGHTS.

Subpart 1. **Client rights; explanation.** Clients have the rights identified in Minnesota Statutes, sections 144.651, 148F.165, and 253B.03, as applicable. The license holder must give each client upon service initiation a written statement of client's rights and responsibilities. Staff must review the statement with clients at that time.

Subp. 2. **Grievance procedure.** Upon service initiation, the license holder must explain the grievance procedure to the client or their representative. The grievance procedure must be posted in a place visible to clients, and made available upon a client's request. The grievance procedure must also be made available to former clients upon request. The grievance procedure must require that:

A. staff help the client develop and process a grievance;

B. telephone numbers and addresses of the Department of Human Services, licensing division; the Office of Ombudsman for Mental Health and Developmental Disabilities; the Minnesota Department of Health, Office of Alcohol and Drug Counselor Licensing Program, and Office of Health Facilities Complaints; when applicable, be made available to clients; and

C. a license holder be obligated to respond to the client's grievance within three days of a staff member's receipt of the grievance, and the client be permitted to bring the grievance to the highest level of authority in the program if not resolved by other staff members.

Subp. 3. **Photographs of client.** All photographs, video tapes, and motion pictures of clients taken in the provision of treatment services are considered client records. Photographs for identification and recordings by video and audio tape for the purpose of enhancing either therapy or staff supervision may be required of clients, but may only be available for use as communications within a program. Clients must be informed when their actions are being recorded by camera or tape, and have the right to deny any taping or photography, except as authorized by this subpart.

9530.6475 BEHAVIORAL EMERGENCY PROCEDURES.

A. A license holder or applicant must have written procedures that staff must follow when responding to a client who exhibits behavior that is threatening to the safety of the client or others. The procedures must include:

(1) a plan designed to prevent the client from hurting themselves or others;

(2) contact information for emergency resources that staff must consult when a client's behavior cannot be controlled by the procedures established in the plan;

(3) types of procedures that may be used;

(4) circumstances under which emergency procedures may be used; and

(5) staff members authorized to implement emergency procedures.

B. Behavioral emergency procedures must not be used to enforce facility rules or for the convenience of staff. Behavioral emergency procedures must not be part of any client's treatment plan, or used at any time for any reason except in response to specific current behaviors that threaten the safety of the client or others. Behavioral emergency procedures may not include the use of seclusion or restraint.

9530.6480 EVALUATION.

Subpart 1. **Participation in drug and alcohol abuse normative evaluation system.** License holders must participate in the drug and alcohol abuse normative evaluation system by submitting information about each client to the commissioner in a format specified by the commissioner.

Subp. 2. **Commissioner requests.** A license holder must submit additional information requested by the commissioner that is necessary to meet statutory or federal funding requirements.

9530.6485 LICENSE HOLDERS SERVING ADOLESCENTS.

Subpart 1. **License holders serving adolescents.** A residential treatment program that serves persons under 18 years of age must be licensed as a residential program for children in out-of-home placement by the department unless the license holder is exempt under Minnesota Statutes, section 245A.03, subdivision 2.

Subp. 2. **Alcohol and drug counselor qualifications.** In addition to the requirements specified in part 9530.6450, subparts 1 and 5, an alcohol and drug counselor providing treatment services to adolescents must have:

A. an additional 30 hours of classroom instruction or one three-credit semester college course in adolescent development. This training need only be completed one time; and

B. at least 150 hours of supervised experience as an adolescent counselor, either as a student or as a staff member.

Subp. 3. **Staffing ratios.** At least 25 percent of a counselor's scheduled work hours must be allocated to indirect services, including documentation of client services, coordination of services with others, treatment team meetings, and other duties. A counseling group consisting entirely of adolescents must not exceed 16 clients. It is the responsibility of the license holder to determine an acceptable group size based on the needs of the clients.

Subp. 4. **Academic program requirements.** Clients who are required to attend school must be enrolled and attending an educational program that has been approved by the Minnesota Department of Education.

Subp. 5. **Program requirements.** In addition to the requirements specified in the client's treatment plan under part 9530.6425, programs serving adolescents must include the following:

A. coordination with the school system to address the client's academic needs;

B. when appropriate, a plan that addresses the client's leisure activities without chemical use; and

C. a plan that addresses family involvement in the adolescent's treatment.

9530.6490 LICENSE HOLDERS SERVING CLIENTS WITH CHILDREN.

Subpart 1. **Health license requirements.** In addition to the requirements of parts 9530.6405 to 9530.6480, all license holders that offer supervision of children of clients are subject to the requirements of this part. License holders providing room and board for clients and their children must have an appropriate facility license from the Minnesota Department of Health.

Subp. 2. **Supervision of children defined.** "Supervision of children" means a caregiver is within sight or hearing of an infant, toddler, or preschooler at all times so that the caregiver can intervene to protect the health and safety of the child. For the school age child it means a caregiver is available to help and care for the child so that the child's health and safety is protected.

Subp. 3. **Policy and schedule required.** License holders must meet the following requirements:

A. license holders must have a policy and schedule delineating the times and circumstances under which the license holder is responsible for supervision of children in the program and when the child's parents are responsible for child supervision. The policy must explain how the program will communicate its policy about child supervision responsibility to the parents; and

B. license holders must have written procedures addressing the actions to be taken by staff if children are neglected or abused including while the children are under the supervision of their parents.

Subp. 4. **Additional licensing requirements.** During the times the license holder is responsible for the supervision of children, the license holder must meet the following standards:

A. child and adult ratios in part 9502.0367;

B. day care training in Minnesota Statutes, section 245A.50;

C. behavior guidance in part 9502.0395;

D. activities and equipment in part 9502.0415;

E. physical environment in part 9502.0425; and

F. water, food, and nutrition in part 9502.0445, unless the license holder has a license from the Minnesota Department of Health.

9530.6495 LICENSE HOLDERS SERVING PERSONS WITH SUBSTANCE USE AND MENTAL HEALTH DISORDERS.

In addition to meeting the requirements of parts 9530.6405 to 9530.6490, license holders specializing in the treatment of persons with substance use disorder and mental health problems must:

A. demonstrate that staffing levels are appropriate for treating clients with substance use disorder and mental health problems, and that there is adequate staff with mental health training;

B. have continuing access to a medical provider with appropriate expertise in prescribing psychotropic medications;

C. have a mental health professional available for staff supervision and consultation;

D. determine group size, structure, and content with consideration for the special needs of those with substance use disorder and mental health disorders;

E. have documentation of active interventions to stabilize mental health symptoms present in treatment plans and progress notes;

F. have continuing documentation of collaboration with continuing care mental health providers, and involvement of those providers in treatment planning meetings;

G. have available program materials adapted to individuals with mental health problems;

H. have policies that provide flexibility for clients who may lapse in treatment or may have difficulty adhering to established treatment rules as a result of a mental illness, with the goal of helping clients successfully complete treatment; and

I. have individual psychotherapy and case management available during the treatment process.

9530.6500 PROGRAMS SERVING INTRAVENOUS DRUG ABUSERS.

Subpart 1. **Additional requirements.** In addition to the requirements of parts 9530.6405 to 9530.6505, programs serving intravenous drug abusers must comply with the requirements of this part.

Subp. 2. **Capacity management and waiting list system compliance.** A program serving intravenous drug abusers must notify the department within seven days of when the program reaches both 90 and 100 percent of the program's capacity to care for clients. Each week, the program must report its capacity, current enrolled dosing clients, and any waiting list. A program reporting 90 percent of capacity must also notify the department when its census has increased or decreased from the 90 percent level.

Subp. 3. **Waiting list.** A program serving intravenous drug abusers must have a waiting list system. Each person seeking admission must be placed on the waiting list if the person cannot be admitted within 14 days of the date of application, unless the applicant is assessed by the program and found not to be eligible for admission according to parts 9530.6405 to 9530.6505, and Code of Federal Regulations, title 42, part 1, subchapter A, section 8.12(e), and Code of Federal Regulations, title 45, parts 160 to 164. The waiting list must assign a unique patient identifier for each intravenous drug abuser seeking treatment while awaiting admission. An applicant on a waiting list who receives no services under part 9530.6430, subpart 1, must not be considered a "client" as defined in part 9530.6405, subpart 8.

Subp. 4. **Client referral.** Programs serving intravenous drug abusers must consult the capacity management system so that persons on waiting lists are admitted at the earliest time to a program providing appropriate treatment within a reasonable geographic area. If the patient has been referred through a public payment system and if the program is not able to serve the client within 14 days of the date of application for admission, the program must contact and inform the referring agency of any available treatment capacity listed in the state capacity management system.

Subp. 5. **Outreach.** Programs serving intravenous drug abusers must carry out activities to encourage individuals in need of treatment to undergo treatment. The program's outreach model must:

A. select, train, and supervise outreach workers;

B. contact, communicate, and follow up with high risk substance abusers, their associates, and neighborhood residents within the constraints of federal and state confidentiality requirements, including Code of Federal Regulations, title 42, sections 2.1 to 2.67, and Code of Federal Regulations, title 45, parts 160 to 164;

C. promote awareness among injecting drug abusers about the relationship between injecting drug abuse and communicable diseases such as HIV; and

D. recommend steps that can be taken to ensure that HIV transmission does not occur.

Subp. 6. **Central registry.** Programs serving intravenous drug abusers must comply with requirements to submit information and necessary consents to the state central registry for each client admitted, as specified by the commissioner. The client's failure to provide the information will prohibit involvement in an opiate treatment program. The information submitted must include the client's:

A. full name and all aliases;

B. date of admission;

C. date of birth;

D. Social Security number or INS number, if any;

E. enrollment status in other current or last known opiate treatment programs;

F. government-issued photo-identification card number; and

G. driver's license number, if any.

The information in items A to G must be submitted in a format prescribed by the commissioner, with the original kept in the client's chart, whenever a client is accepted for treatment, the client's type or dosage of a drug is changed, or the client's treatment is interrupted, resumed, or terminated.

9530.6505 REQUIREMENTS FOR LICENSED RESIDENTIAL TREATMENT.

Subpart 1. **Applicability.** A license holder who provides supervised room and board at the licensed program site as a treatment component is defined as a residential program according to Minnesota Statutes, section 245A.02, subdivision 14, and is subject to this part.

Subp. 2. **Visitors.** Clients must be allowed to receive visitors at times prescribed by the license holder. The license holder must set and post a notice of visiting rules and hours, including both day and evening times. A client's right to receive visitors other than a personal physician, religious advisor, county case manager, parole or probation officer, or attorney may be subject to visiting hours established by the license holder for all clients. The treatment director or designee may impose limitations as necessary for the welfare of a client provided that limitations and the reasons for them are documented in the client's file. Clients must be allowed to receive visits at all reasonable times from their personal physicians, religious advisors, county case managers, parole or probation officers, and attorneys.

Subp. 3. **Client property management.** A license holder who provides room and board and treatment services to clients in the same facility, and any license holder that accepts client property must meet the requirements in Minnesota Statutes, section 245A.04, subdivision 13, for handling resident funds and property. In the course of client property management, license holders:

A. may establish policies regarding the use of personal property to assure that treatment activities and the rights of other patients are not infringed;

B. may take temporary custody of property for violation of facility policies;

C. must retain the client's property for a minimum of seven days after discharge if the client does not reclaim property upon service termination, or for a minimum of 30 days if the client does not reclaim property upon service termination and has received room and board services from the license holder; and

D. must return all property held in trust to the client upon service termination regardless of the client's service termination status, except:

(1) drugs, drug paraphernalia, and drug containers that are forfeited under Minnesota Statutes, section 609.5316, must be destroyed by staff or given over to the custody of a local law enforcement agency, according to Code of Federal Regulations, title 42, chapter 1, part 2, subpart B, sections 2.1 to 2.67, and Code of Federal Regulations, title 45, parts 160 to 164;

(2) weapons, explosives, and other property which can cause serious harm to self or others must be given over to the custody of a local law enforcement agency, and the client must be notified of the transfer and of the right to reclaim any lawful property transferred; and

(3) medications that have been determined by a physician to be harmful after examining the client, except when the client's personal physician approves the medication for continued use.

Subp. 4. **Health facility license.** A license holder who provides room and board and treatment services in the same facility must have the appropriate license from the Department of Health.

Subp. 5. **Facility abuse prevention plan.** A license holder must establish and enforce an ongoing facility abuse prevention plan consistent with Minnesota Statutes, sections 245A.65 and 626.557, subdivision 14.

Subp. 6. **Individual abuse prevention plan.** A license holder must prepare an individual abuse prevention plan for each client as specified under Minnesota Statutes, sections 245A.65, subdivision 2, and 626.557, subdivision 14.

Subp. 7. **Health services.** License holders must have written procedures for assessing and monitoring client health, including a standardized data collection tool for collecting health-related information about each client. The policies and procedures must be approved and signed by a registered nurse.

Subp. 8. **Administration of medications.** License holders must meet the administration of medications requirements of part 9530.6435, subpart 3.