

SENATE
STATE OF MINNESOTA
EIGHTY-NINTH SESSION

S.F. No. 1458

(SENATE AUTHORS: LOUREY)

DATE	D-PG	OFFICIAL STATUS
03/09/2015	599	Introduction and first reading Referred to Finance
04/23/2015	2165a	Comm report: To pass as amended
	2546	Second reading
04/24/2015	2783a	Special Order: Amended
	2801	Third reading Passed
04/29/2015	2940	Returned from House with amendment
	2942	Senate not concur, conference committee of 5 requested
	3170	Senate conferees Lourey; Sheran; Hayden; Franzen; Rosen
04/30/2015	3175	House conferees Dean, M.; Mack; Schomacker; McDonald; Zerwas
05/17/2015	3839c	Conference committee report, delete everything Senate adopted CC report and repassed bill
	4253	Third reading
05/18/2015	4259	House adopted SCC report and repassed bill Presentment date 05/20/15 Governor's action Approval 05/22/15 Secretary of State Chapter 71 05/22/15

A bill for an act

1.1 relating to state government; establishing the health and human services budget;
1.2 modifying provisions governing children and family services, chemical and
1.3 mental health services, withdrawal management programs, direct care and
1.4 treatment, health care, continuing care, Department of Health and public
1.5 health programs, health care delivery, health licensing boards, and MNsure;
1.6 making changes to medical assistance, MFIP, Northstar Care for Children,
1.7 MinnesotaCare, child care assistance, and group residential housing programs;
1.8 establishing uniform requirements for public assistance programs related
1.9 to income calculation, reporting income, and correcting overpayments and
1.10 underpayments; modifying requirements for reporting maltreatment of minors
1.11 and juvenile safety and placement; establishing the Minnesota ABLE plan
1.12 and accounts; modifying child support provisions; establishing standards for
1.13 withdrawal management programs; modifying requirements for background
1.14 studies; making changes to provisions governing the health information
1.15 exchange; providing for protection of born alive infants; authorizing rulemaking;
1.16 requiring reports and studies; making technical changes; modifying certain fees
1.17 for Department of Health programs; modifying fees of certain health-related
1.18 licensing boards; making human services forecast adjustments; appropriating
1.19 money; amending Minnesota Statutes 2014, sections 13.46, subdivisions 2, 7;
1.20 13.461, by adding a subdivision; 16A.724, subdivision 2; 43A.241; 62A.02,
1.21 subdivision 2; 62A.045; 62J.498; 62J.4981; 62J.4982, subdivisions 4, 5;
1.22 62J.692, subdivision 4; 62Q.37, subdivision 2; 62Q.55, subdivision 3; 62U.02,
1.23 subdivisions 1, 2, 3, 4; 62U.04, subdivision 11; 62U.10, by adding subdivisions;
1.24 62V.03, subdivision 2; 62V.05, subdivisions 6, 7, 8, by adding a subdivision;
1.25 119B.011, subdivision 15; 119B.025, subdivision 1; 119B.035, subdivision
1.26 4; 119B.09, subdivision 4; 119B.125, by adding a subdivision; 119B.13,
1.27 subdivision 6; 144.057, subdivision 1; 144.1501, subdivisions 1, 2, 3, 4; 144.291,
1.28 subdivision 2; 144.293, subdivisions 5, 6, 8; 144.298, subdivisions 2, 3; 144.551,
1.29 subdivision 1; 144.9501, subdivisions 6d, 22b, 26b, by adding subdivisions;
1.30 144.9505; 144.9508; 144A.071, subdivision 4a; 144A.70, subdivision 6, by
1.31 adding a subdivision; 144A.71; 144A.72; 144A.73; 144A.75, subdivision
1.32 13; 144D.01, by adding a subdivision; 144E.001, by adding a subdivision;
1.33 144E.275, subdivision 1, by adding a subdivision; 145.4131, subdivision 1;
1.34 145.423; 145.56, subdivisions 2, 4; 145.928, subdivision 13, by adding a
1.35 subdivision; 145.986, subdivisions 1a, 2, 4; 145A.131, subdivision 1; 148.52;
1.36 148.54; 148.57, subdivisions 1, 2, by adding a subdivision; 148.574; 148.575,
1.37 subdivision 2; 148.577; 148.59; 148.603; 148E.075; 148E.080, subdivisions 1, 2;
1.38 148E.180, subdivisions 2, 5; 149A.20, subdivisions 5, 6; 149A.40, subdivision
1.39

2.1 11; 149A.65; 149A.92, subdivision 1; 149A.97, subdivision 7; 150A.06,
 2.2 subdivision 1b; 150A.091, subdivisions 4, 5, 11, by adding subdivisions;
 2.3 150A.31; 151.01, subdivisions 15a, 27; 151.02; 151.065, subdivisions 1, 2, 3, 4;
 2.4 151.102; 151.58, subdivisions 2, 5; 157.15, subdivision 8; 174.29, subdivision
 2.5 1; 174.30, subdivisions 3, 4, by adding subdivisions; 245.4661, subdivisions
 2.6 5, 6, by adding subdivisions; 245.467, subdivision 6; 245.4876, subdivision
 2.7 7; 245.4889, subdivision 1, by adding a subdivision; 245A.06, by adding a
 2.8 subdivision; 245A.155, subdivisions 1, 2; 245A.65, subdivision 2; 245C.03, by
 2.9 adding subdivisions; 245C.04, by adding a subdivision; 245C.08, subdivision 1;
 2.10 245C.10, by adding subdivisions; 245C.12; 245D.02, by adding a subdivision;
 2.11 245D.05, subdivisions 1, 2; 245D.06, subdivisions 1, 2, 7; 245D.07, subdivision
 2.12 2; 245D.071, subdivision 5; 245D.09, subdivisions 3, 5; 245D.22, subdivision
 2.13 4; 245D.31, subdivisions 3, 4, 5; 246.18, subdivision 8; 246.54, subdivision 1;
 2.14 252.27, subdivision 2a; 253B.18, subdivisions 4c, 5; 254B.05, subdivision 5, as
 2.15 amended; 254B.12, subdivision 2; 256.01, by adding subdivisions; 256.015,
 2.16 subdivision 7; 256.017, subdivision 1; 256.478; 256.741, subdivisions 1, 2;
 2.17 256.969, subdivisions 1, 2b, 2d, 3a, 3c, 9; 256.975, by adding a subdivision;
 2.18 256B.056, subdivision 5c; 256B.057, subdivision 9; 256B.059, subdivision
 2.19 5; 256B.06, by adding a subdivision; 256B.0615, subdivision 3; 256B.0622,
 2.20 subdivisions 1, 2, 3, 4, 5, 7, 8, 9, 10, by adding a subdivision; 256B.0624,
 2.21 subdivision 7; 256B.0625, subdivisions 3b, 13, 13e, 13h, 17, 17a, 18a, 18e,
 2.22 28a, 31, 48, 57, 58, by adding subdivisions; 256B.0631; 256B.072; 256B.0757;
 2.23 256B.0913, subdivision 4; 256B.0915, subdivisions 3a, 3e, 3h; 256B.0916,
 2.24 subdivisions 2, 11, by adding a subdivision; 256B.431, subdivisions 2b, 36;
 2.25 256B.434, subdivision 4, by adding a subdivision; 256B.441, subdivisions 1,
 2.26 5, 6, 13, 14, 17, 30, 31, 33, 35, 40, 44, 46c, 48, 50, 51, 51a, 53, 54, 55a, 56,
 2.27 63, by adding subdivisions; 256B.49, subdivision 26, by adding a subdivision;
 2.28 256B.4913, subdivisions 4a, 5; 256B.4914, subdivisions 2, 6, 8, 10, 14, 15;
 2.29 256B.492; 256B.50, subdivision 1; 256B.69, subdivisions 5a, 5i, 9c, 9d, by
 2.30 adding a subdivision; 256B.75; 256B.76, subdivisions 1, 2, 4, as amended;
 2.31 256B.762; 256B.766; 256B.767; 256D.01, subdivision 1a; 256D.02, subdivision
 2.32 8, by adding subdivisions; 256D.06, subdivision 1; 256D.405, subdivision 3;
 2.33 256E.35, subdivision 2, by adding a subdivision; 256I.03, subdivisions 3,
 2.34 7, by adding subdivisions; 256I.04, subdivisions 1, 1a, 2a, 2b, 2c, 3, 4, by
 2.35 adding subdivisions; 256I.05, subdivisions 1c, 1g, 2; 256I.06, subdivisions
 2.36 2, 6, 7, 8; 256J.08, subdivisions 26, 86; 256J.21, subdivision 2, as amended;
 2.37 256J.24, subdivision 5a; 256J.30, subdivisions 1, 9; 256J.33, subdivision
 2.38 4; 256J.35; 256J.40; 256J.95, subdivision 19; 256K.45, subdivisions 1a, 6;
 2.39 256L.01, subdivisions 3a, 5; 256L.03, subdivision 5; 256L.04, subdivisions
 2.40 1c, 7b; 256L.05, subdivisions 3, 3a, 4, by adding a subdivision; 256L.06,
 2.41 subdivision 3; 256L.121, subdivision 1; 256L.15, subdivisions 1, 2; 256N.22,
 2.42 subdivisions 9, 10; 256N.24, subdivision 4; 256N.25, subdivision 1; 256N.27,
 2.43 subdivision 2; 256P.001; 256P.01, subdivision 3, by adding subdivisions;
 2.44 256P.02, by adding a subdivision; 256P.03, subdivision 1; 256P.04, subdivisions
 2.45 1, 4; 256P.05, subdivision 1; 257.75, subdivisions 3, 5; 259A.75; 260C.007,
 2.46 subdivisions 27, 32; 260C.203; 260C.212, subdivision 1, by adding subdivisions;
 2.47 260C.221; 260C.331, subdivision 1; 260C.451, subdivisions 2, 6; 260C.515,
 2.48 subdivision 5; 260C.521, subdivisions 1, 2; 260C.607, subdivision 4; 518A.26,
 2.49 subdivision 14; 518A.32, subdivision 2; 518A.39, subdivision 1, by adding
 2.50 a subdivision; 518A.41, subdivisions 1, 3, 4, 14, 15; 518A.43, by adding
 2.51 a subdivision; 518A.46, subdivision 3, by adding a subdivision; 518A.51;
 2.52 518A.53, subdivisions 1, 4, 10; 518A.60; 518C.802; 626.556, subdivisions 1, as
 2.53 amended, 2, 3, 6a, 7, as amended, 10, 10e, 10j, 10m, 11c, by adding subdivisions;
 2.54 626.559, by adding a subdivision; Laws 2008, chapter 363, article 18, section 3,
 2.55 subdivision 5; Laws 2014, chapter 189, sections 5; 9; 10; 11; 16; 17; 18; 19; 23;
 2.56 24; 27; 28; 29; 31; 43; 50; 51; 52; 73; Laws 2014, chapter 312, article 24, section
 2.57 45, subdivision 2; proposing coding for new law in Minnesota Statutes, chapters
 2.58 62A; 144; 144D; 148; 245; 245A; 256B; 256E; 256M; 256P; 518A; proposing

3.1 coding for new law as Minnesota Statutes, chapters 245F; 256Q; repealing
 3.2 Minnesota Statutes 2014, sections 62V.11, subdivision 3; 148.57, subdivisions 3,
 3.3 4; 148.571; 148.572; 148.573, subdivision 1; 148.575, subdivisions 1, 3, 5, 6;
 3.4 148.576; 148E.060, subdivision 12; 148E.075, subdivisions 4, 5, 6, 7; 256.01,
 3.5 subdivision 35; 256.969, subdivisions 23, 30; 256B.434, subdivision 19b;
 3.6 256B.441, subdivisions 14a, 19, 50a, 52, 55, 58, 62; 256B.69, subdivision 32;
 3.7 256D.0513; 256D.06, subdivision 8; 256D.09, subdivision 6; 256D.49; 256J.38;
 3.8 256L.02, subdivision 3; 256L.05, subdivisions 1b, 1c, 3c, 5; Laws 2012, chapter
 3.9 247, article 4, section 47, as amended; Minnesota Rules, parts 3400.0170,
 3.10 subparts 5, 6, 12, 13; 8840.5900, subparts 12, 14.

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

3.12 ARTICLE 1

3.13 CHILDREN AND FAMILY SERVICES

3.14 Section 1. Minnesota Statutes 2014, section 119B.125, is amended by adding a
 3.15 subdivision to read:

3.16 Subd. 7. **Failure to comply with attendance record requirements.** (a) In
 3.17 establishing an overpayment claim for failure to provide attendance records in compliance
 3.18 with section 119B.125, subdivision 6, the county or commissioner is limited to the six
 3.19 years prior to the date the county or the commissioner requested the attendance records.

3.20 (b) The commissioner may periodically audit child care providers to determine
 3.21 compliance with section 119B.125, subdivision 6.

3.22 (c) When the commissioner or county establishes an overpayment claim against a
 3.23 current or former provider, the commissioner or county must provide notice of the claim to
 3.24 the provider. A notice of overpayment claim must specify the reason for the overpayment,
 3.25 the authority for making the overpayment claim, the time period in which the overpayment
 3.26 occurred, the amount of the overpayment, and the provider's right to appeal.

3.27 (d) The commissioner or county shall seek to recoup or recover overpayments paid
 3.28 to a current or former provider.

3.29 (e) When a provider has been disqualified or convicted of fraud under section
 3.30 256.98, theft under section 609.52, or a federal crime relating to theft of state funds
 3.31 or fraudulent billing for a program administered by the commissioner or a county,
 3.32 recoupment or recovery must be sought regardless of the amount of overpayment.

3.33 Sec. 2. Minnesota Statutes 2014, section 119B.13, subdivision 6, is amended to read:

3.34 Subd. 6. **Provider payments.** (a) The provider shall bill for services provided
 3.35 within ten days of the end of the service period. If bills are submitted within ten days of
 3.36 the end of the service period, payments under the child care fund shall be made within 30

4.1 days of receiving a bill from the provider. Counties or the state may establish policies that
4.2 make payments on a more frequent basis.

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

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

4.14 (d) A county or the commissioner may refuse to issue a child care authorization
4.15 to a licensed or legal nonlicensed provider, revoke an existing child care authorization
4.16 to a licensed or legal nonlicensed provider, stop payment issued to a licensed or legal
4.17 nonlicensed provider, or refuse to pay a bill submitted by a licensed or legal nonlicensed
4.18 provider if:

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

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

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

4.26 (4) the provider is operating after ~~receipt of~~ of:

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

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

4.29 ~~the provider has been issued an order citing violations of licensing standards that~~

4.30 ~~affect the health and safety of children in care due to the nature, chronicity, or severity~~

4.31 ~~of the licensing violations, until the licensing agency determines those violations have~~

4.32 ~~been corrected;~~ (iii) a final order of conditional license issued by the commissioner for as

4.33 long as the conditional license is in effect;

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

4.36 (6) the provider gives false child care price information.

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

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

5.8 Sec. 3. Minnesota Statutes 2014, section 245C.03, is amended by adding a subdivision
5.9 to read:

5.10 Subd. 10. **Providers of group residential housing or supplementary services.**
5.11 The commissioner shall conduct background studies on any individual required under
5.12 section 256I.04 to have a background study completed under this chapter.

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

5.14 Sec. 4. Minnesota Statutes 2014, section 245C.03, is amended by adding a subdivision
5.15 to read:

5.16 Subd. 11. **Child protection workers or social services staff having responsibility**
5.17 **for child protective duties.** (a) The commissioner must complete background studies,
5.18 according to paragraph (b) and 245C.04, subdivision 10, when initiated by a county social
5.19 services agency or by a local welfare agency according to section 626.559, subdivision 1b.

5.20 (b) For background studies completed by the commissioner under this subdivision,
5.21 the commissioner shall not make a disqualification decision, but shall provide the
5.22 background study information received to the county that initiated the study.

5.23 Sec. 5. Minnesota Statutes 2014, section 245C.04, is amended by adding a subdivision
5.24 to read:

5.25 Subd. 10. **Child protection workers or social services staff having responsibility**
5.26 **for child protective duties.** The commissioner shall conduct background studies of
5.27 employees of county social services and local welfare agencies having responsibility
5.28 for child protection duties when the background study is initiated according to section
5.29 626.559, subdivision 1b.

5.30 Sec. 6. Minnesota Statutes 2014, section 245C.10, is amended by adding a subdivision
5.31 to read:

6.1 Subd. 11. **Providers of group residential housing or supplementary services.**

6.2 The commissioner shall recover the cost of background studies initiated by providers of
6.3 group residential housing or supplementary services under section 256I.04 through a fee
6.4 of no more than \$20 per study. The fees collected under this subdivision are appropriated
6.5 to the commissioner for the purpose of conducting background studies.

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

6.7 Sec. 7. Minnesota Statutes 2014, section 245C.10, is amended by adding a subdivision
6.8 to read:

6.9 Subd. 12. **Child protection workers or social services staff having responsibility**
6.10 **for child protective duties.** The commissioner shall recover the cost of background studies
6.11 initiated by county social services agencies and local welfare agencies for individuals
6.12 who are required to have a background study under section 626.559, subdivision 1b,
6.13 through a fee of no more than \$20 per study. The fees collected under this subdivision are
6.14 appropriated to the commissioner for the purpose of conducting background studies.

6.15 Sec. 8. Minnesota Statutes 2014, section 256.01, is amended by adding a subdivision
6.16 to read:

6.17 Subd. 12a. **Department of Human Services child fatality and near fatality**
6.18 **review team.** The commissioner shall establish a Department of Human Services child
6.19 fatality and near fatality review team to review child fatalities and near fatalities due to
6.20 child maltreatment and child fatalities and near fatalities that occur in licensed facilities
6.21 and are not due to natural causes. The review team shall assess the entire child protection
6.22 services process from the point of a mandated reporter reporting the alleged maltreatment
6.23 through the ongoing case management process. Department staff shall lead and conduct
6.24 on-site local reviews and utilize supervisors from local county and tribal child welfare
6.25 agencies as peer reviewers. The review process must focus on critical elements of the case
6.26 and on the involvement of the child and family with the county or tribal child welfare
6.27 agency. The review team shall identify necessary program improvement planning to
6.28 address any practice issues identified and training and technical assistance needs of
6.29 the local agency. Summary reports of each review shall be provided to the state child
6.30 mortality review panel when completed.

6.31 Sec. 9. Minnesota Statutes 2014, section 256.017, subdivision 1, is amended to read:

6.32 Subdivision 1. **Authority and purpose.** The commissioner shall administer a
6.33 compliance system for the Minnesota family investment program, the food stamp or food

7.1 support program, emergency assistance, general assistance, medical assistance, emergency
 7.2 general assistance, Minnesota supplemental assistance, group residential housing,
 7.3 preadmission screening, alternative care grants, the child care assistance program, and
 7.4 all other programs administered by the commissioner or on behalf of the commissioner
 7.5 under the powers and authorities named in section 256.01, subdivision 2. The purpose of
 7.6 the compliance system is to permit the commissioner to supervise the administration of
 7.7 public assistance programs and to enforce timely and accurate distribution of benefits,
 7.8 completeness of service and efficient and effective program management and operations,
 7.9 to increase uniformity and consistency in the administration and delivery of public
 7.10 assistance programs throughout the state, and to reduce the possibility of sanctions and
 7.11 fiscal disallowances for noncompliance with federal regulations and state statutes. The
 7.12 commissioner, or the commissioner's representative, may issue administrative subpoenas
 7.13 as needed in administering the compliance system.

7.14 The commissioner shall utilize training, technical assistance, and monitoring
 7.15 activities, as specified in section 256.01, subdivision 2, to encourage county agency
 7.16 compliance with written policies and procedures.

7.17 Sec. 10. Minnesota Statutes 2014, section 256.741, subdivision 1, is amended to read:

7.18 Subdivision 1. **Definitions.** (a) The term "direct support" as used in this chapter and
 7.19 chapters 257, 518, 518A, and 518C refers to an assigned support payment from an obligor
 7.20 which is paid directly to a recipient of public assistance.

7.21 (b) The term "public assistance" as used in this chapter and chapters 257, 518, 518A,
 7.22 and 518C, includes any form of assistance provided under the AFDC program formerly
 7.23 codified in sections 256.72 to 256.87, MFIP and MFIP-R formerly codified under chapter
 7.24 256, MFIP under chapter 256J, work first program formerly codified under chapter 256K;
 7.25 child care assistance provided through the child care fund under chapter 119B; any form
 7.26 of medical assistance under chapter 256B; ~~MinnesotaCare under chapter 256L~~; and foster
 7.27 care as provided under title IV-E of the Social Security Act. MinnesotaCare and health
 7.28 plans subsidized by federal premium tax credits or federal cost-sharing reductions are not
 7.29 considered public assistance for purposes of a child support referral.

7.30 (c) The term "child support agency" as used in this section refers to the public
 7.31 authority responsible for child support enforcement.

7.32 (d) The term "public assistance agency" as used in this section refers to a public
 7.33 authority providing public assistance to an individual.

7.34 (e) The terms "child support" and "arrear" as used in this section have the meanings
 7.35 provided in section 518A.26.

8.1 (f) The term "maintenance" as used in this section has the meaning provided in
8.2 section 518.003.

8.3 Sec. 11. Minnesota Statutes 2014, section 256.741, subdivision 2, is amended to read:

8.4 Subd. 2. **Assignment of support and maintenance rights.** (a) An individual
8.5 receiving public assistance in the form of assistance under any of the following programs:
8.6 the AFDC program formerly codified in sections 256.72 to 256.87, MFIP under chapter
8.7 256J, MFIP-R and MFIP formerly codified under chapter 256, or work first program
8.8 formerly codified under chapter 256K is considered to have assigned to the state at the
8.9 time of application all rights to child support and maintenance from any other person the
8.10 applicant or recipient may have in the individual's own behalf or in the behalf of any other
8.11 family member for whom application for public assistance is made. An assistance unit is
8.12 ineligible for the Minnesota family investment program unless the caregiver assigns all
8.13 rights to child support and maintenance benefits according to this section.

8.14 (1) The assignment is effective as to any current child support and current
8.15 maintenance.

8.16 (2) Any child support or maintenance arrears that accrue while an individual is
8.17 receiving public assistance in the form of assistance under any of the programs listed in
8.18 this paragraph are permanently assigned to the state.

8.19 (3) The assignment of current child support and current maintenance ends on the
8.20 date the individual ceases to receive or is no longer eligible to receive public assistance
8.21 under any of the programs listed in this paragraph.

8.22 (b) An individual receiving public assistance in the form of medical assistance;
8.23 ~~including MinnesotaCare~~, is considered to have assigned to the state at the time of
8.24 application all rights to medical support from any other person the individual may have
8.25 in the individual's own behalf or in the behalf of any other family member for whom
8.26 medical assistance is provided.

8.27 (1) An assignment made after September 30, 1997, is effective as to any medical
8.28 support accruing after the date of medical assistance ~~or MinnesotaCare~~ eligibility.

8.29 (2) Any medical support arrears that accrue while an individual is receiving public
8.30 assistance in the form of medical assistance, ~~including MinnesotaCare~~, are permanently
8.31 assigned to the state.

8.32 (3) The assignment of current medical support ends on the date the individual ceases
8.33 to receive or is no longer eligible to receive public assistance in the form of medical
8.34 assistance ~~or MinnesotaCare~~.

9.1 (c) An individual receiving public assistance in the form of child care assistance
 9.2 under the child care fund pursuant to chapter 119B is considered to have assigned to the
 9.3 state at the time of application all rights to child care support from any other person the
 9.4 individual may have in the individual's own behalf or in the behalf of any other family
 9.5 member for whom child care assistance is provided.

9.6 (1) The assignment is effective as to any current child care support.

9.7 (2) Any child care support arrears that accrue while an individual is receiving public
 9.8 assistance in the form of child care assistance under the child care fund in chapter 119B
 9.9 are permanently assigned to the state.

9.10 (3) The assignment of current child care support ends on the date the individual
 9.11 ceases to receive or is no longer eligible to receive public assistance in the form of child
 9.12 care assistance under the child care fund under chapter 119B.

9.13 Sec. 12. **[256E.28] CHILD PROTECTION GRANTS TO ADDRESS CHILD**
 9.14 **WELFARE DISPARITIES.**

9.15 Subdivision 1. Child welfare disparities grant program established. The
 9.16 commissioner may award grants to eligible entities for the development, implementation,
 9.17 and evaluation of activities to address racial disparities and disproportionality in the child
 9.18 welfare system by:

9.19 (1) identifying and addressing structural factors that contribute to inequities in
 9.20 outcomes;

9.21 (2) identifying and implementing strategies to reduce racial disparities in treatment
 9.22 and outcomes;

9.23 (3) using cultural values, beliefs, and practices of families, communities, and tribes
 9.24 for case planning, service design, and decision-making processes;

9.25 (4) using placement and reunification strategies to maintain and support relationships
 9.26 and connections between parents, siblings, children, kin, significant others, and tribes; and

9.27 (5) supporting families in the context of their communities and tribes to safely divert
 9.28 them from the child welfare system, whenever possible.

9.29 Subd. 2. State-community partnerships; plan. The commissioner, in partnership
 9.30 with the legislative task force on child protection; culturally based community
 9.31 organizations; the Indian Affairs Council under section 3.922; the Council on Affairs of
 9.32 Chicano/Latino People under section 3.9223; the Council on Black Minnesotans under
 9.33 section 3.9225; the Council on Asian-Pacific Minnesotans under section 3.9226; the
 9.34 American Indian Child Welfare Advisory Council under section 260.835; counties; and

10.1 tribal governments, shall develop and implement a comprehensive, coordinated plan to
10.2 award funds under this section for the priority areas identified in subdivision 1.

10.3 Subd. 3. **Measurable outcomes.** The commissioner, in consultation with the
10.4 state-community partners listed in subdivision 2, shall establish measurable outcomes to
10.5 determine the effectiveness of the grants and other activities funded under this section in
10.6 reducing disparities identified in subdivision 1. The development of measurable outcomes
10.7 must be completed before any funds are distributed under this section.

10.8 Subd. 4. **Process.** (a) The commissioner, in consultation with the state-community
10.9 partners listed in subdivision 2, shall develop the criteria and procedures to allocate
10.10 competitive grants under this section. In developing the criteria, the commissioner shall
10.11 establish an administrative cost limit for grant recipients. A county awarded a grant shall
10.12 not spend more than three percent of the grant on administrative costs. When a grant
10.13 is awarded, the commissioner must provide a grant recipient with information on the
10.14 outcomes established according to subdivision 3.

10.15 (b) A grant recipient must coordinate its activities with other entities receiving funds
10.16 under this section that are in the grant recipient's service area.

10.17 (c) Grant funds must not be used to supplant any state or federal funds received
10.18 for child welfare services.

10.19 Subd. 5. **Grant program criteria.** (a) The commissioner shall award competitive
10.20 grants to eligible applicants for local or regional projects and initiatives directed at
10.21 reducing disparities in the child welfare system.

10.22 (b) The commissioner may award up to 20 percent of the funds available as planning
10.23 grants. Planning grants must be used to address such areas as community assessment,
10.24 coordination activities, and development of community-supported strategies.

10.25 (c) Eligible applicants may include, but are not limited to, faith-based organizations,
10.26 social service organizations, community nonprofit organizations, counties, and tribal
10.27 governments. Applicants must submit proposals to the commissioner. A proposal must
10.28 specify the strategies to be implemented to address one or more of the priority areas in
10.29 subdivision 1 and must be targeted to achieve the outcomes established according to
10.30 subdivision 3.

10.31 (d) The commissioner shall give priority to applicants who demonstrate that their
10.32 proposed project or initiative:

10.33 (1) is supported by the community the applicant will serve;

10.34 (2) is evidence-based;

10.35 (3) is designed to complement other related community activities;

10.36 (4) utilizes strategies that positively impact priority areas;

11.1 (5) reflects culturally appropriate approaches; or
 11.2 (6) will be implemented through or with community-based organizations that reflect
 11.3 the culture of the population to be reached.

11.4 Subd. 6. **Evaluation.** (a) Using the outcomes established according to subdivision
 11.5 3, the commissioner shall conduct a biennial evaluation of the grant program funded under
 11.6 this section. Grant recipients shall cooperate with the commissioner in the evaluation and
 11.7 shall provide the commissioner with the information needed to conduct the evaluation.

11.8 (b) The commissioner shall consult with the legislative task force on child protection
 11.9 during the evaluation process and shall submit a biennial evaluation report to the task
 11.10 force and to the chairs and ranking minority members of the house of representatives and
 11.11 senate committees with jurisdiction over child protection funding.

11.12 Subd. 7. **American Indian child welfare projects.** Of the amount appropriated for
 11.13 purposes of this section, the commissioner shall award \$75,000 to each tribe authorized to
 11.14 provide tribal delivery of child welfare services under section 256.01, subdivision 14b. To
 11.15 receive funds under this subdivision, a participating tribe is not required to apply to the
 11.16 commissioner for grant funds. Participating tribes are also eligible for competitive grant
 11.17 funds under this section.

11.18 Sec. 13. Minnesota Statutes 2014, section 256E.35, subdivision 2, is amended to read:

11.19 Subd. 2. **Definitions.** (a) The definitions in this subdivision apply to this section.

11.20 (b) "Eligible educational institution" means the following:

11.21 (1) an institution of higher education described in section 101 or 102 of the Higher
 11.22 Education Act of 1965; or

11.23 (2) an area vocational education school, as defined in subparagraph (C) or (D) of
 11.24 United States Code, title 20, chapter 44, section 2302 (3) (the Carl D. Perkins Vocational
 11.25 and Applied Technology Education Act), which is located within any state, as defined in
 11.26 United States Code, title 20, chapter 44, section 2302 (30). This clause is applicable only
 11.27 to the extent section 2302 is in effect on August 1, 2008.

11.28 ~~(b)~~ (c) "Family asset account" means a savings account opened by a household
 11.29 participating in the Minnesota family assets for independence initiative.

11.30 ~~(e)~~ (d) "Fiduciary organization" means:

11.31 (1) a community action agency that has obtained recognition under section 256E.31;

11.32 (2) a federal community development credit union serving the seven-county
 11.33 metropolitan area; or

11.34 (3) a women-oriented economic development agency serving the seven-county
 11.35 metropolitan area.

12.1 (e) "Financial coach" means a person who:

12.2 (1) has completed an intensive financial literacy training workshop that includes
 12.3 curriculum on budgeting to increase savings, debt reduction and asset building, building a
 12.4 good credit rating, and consumer protection;

12.5 (2) participates in ongoing statewide family assets for independence in Minnesota
 12.6 (FAIM) network training meetings under FAIM program supervision; and

12.7 (3) provides financial coaching to program participants under subdivision 4a.

12.8 ~~(d)~~ (f) "Financial institution" means a bank, bank and trust, savings bank, savings
 12.9 association, or credit union, the deposits of which are insured by the Federal Deposit
 12.10 Insurance Corporation or the National Credit Union Administration.

12.11 (g) "Household" means all individuals who share use of a dwelling unit as primary
 12.12 quarters for living and eating separate from other individuals.

12.13 ~~(e)~~ (h) "Permissible use" means:

12.14 (1) postsecondary educational expenses at an eligible educational institution as
 12.15 defined in paragraph ~~(g)~~ (b), including books, supplies, and equipment required for
 12.16 courses of instruction;

12.17 (2) acquisition costs of acquiring, constructing, or reconstructing a residence,
 12.18 including any usual or reasonable settlement, financing, or other closing costs;

12.19 (3) business capitalization expenses for expenditures on capital, plant, equipment,
 12.20 working capital, and inventory expenses of a legitimate business pursuant to a business
 12.21 plan approved by the fiduciary organization; and

12.22 (4) acquisition costs of a principal residence within the meaning of section 1034 of
 12.23 the Internal Revenue Code of 1986 which do not exceed 100 percent of the average area
 12.24 purchase price applicable to the residence determined according to section 143(e)(2) and
 12.25 (3) of the Internal Revenue Code of 1986.

12.26 ~~(f) "Household" means all individuals who share use of a dwelling unit as primary~~
 12.27 ~~quarters for living and eating separate from other individuals.~~

12.28 ~~(g) "Eligible educational institution" means the following:~~

12.29 ~~(1) an institution of higher education described in section 101 or 102 of the Higher~~
 12.30 ~~Education Act of 1965; or~~

12.31 ~~(2) an area vocational education school, as defined in subparagraph (C) or (D) of~~
 12.32 ~~United States Code, title 20, chapter 44, section 2302 (3) (the Carl D. Perkins Vocational~~
 12.33 ~~and Applied Technology Education Act), which is located within any state, as defined in~~
 12.34 ~~United States Code, title 20, chapter 44, section 2302 (30). This clause is applicable only~~
 12.35 ~~to the extent section 2302 is in effect on August 1, 2008.~~

13.1 Sec. 14. Minnesota Statutes 2014, section 256E.35, is amended by adding a subdivision
13.2 to read:

13.3 Subd. 4a. **Financial coaching.** A financial coach shall provide the following
13.4 to program participants:

13.5 (1) financial education relating to budgeting, debt reduction, asset-specific training,
13.6 and financial stability activities;

13.7 (2) asset-specific training related to buying a home, acquiring postsecondary
13.8 education, or starting or expanding a small business; and

13.9 (3) financial stability education and training to improve and sustain financial security.

13.10 Sec. 15. Minnesota Statutes 2014, section 256I.03, subdivision 3, is amended to read:

13.11 Subd. 3. **Group residential housing.** "Group residential housing" means a group
13.12 living situation that provides at a minimum room and board to unrelated persons who
13.13 meet the eligibility requirements of section 256I.04. ~~This definition includes foster care~~
13.14 ~~settings or community residential settings for a single adult.~~ To receive payment for a
13.15 group residence rate, the residence must meet the requirements under section 256I.04,
13.16 ~~subdivision~~ subdivisions 2a to 2f.

13.17 Sec. 16. Minnesota Statutes 2014, section 256I.03, subdivision 7, is amended to read:

13.18 Subd. 7. **Countable income.** "Countable income" means all income received by
13.19 an applicant or recipient less any applicable exclusions or disregards. For a recipient of
13.20 any cash benefit from the SSI program, countable income means the SSI benefit limit in
13.21 effect at the time the person is ~~in a GRH~~ a recipient of group residential housing, less the
13.22 medical assistance personal needs allowance under section 256B.35. If the SSI limit
13.23 ~~has been or benefit is~~ reduced for a person due to events ~~occurring prior to the persons~~
13.24 ~~entering the GRH setting~~ other than receipt of additional income, countable income means
13.25 actual income less any applicable exclusions and disregards.

13.26 Sec. 17. Minnesota Statutes 2014, section 256I.03, is amended by adding a subdivision
13.27 to read:

13.28 Subd. 9. **Direct contact.** "Direct contact" means providing face-to-face care,
13.29 training, supervision, counseling, consultation, or medication assistance to recipients of
13.30 group residential housing.

13.31 Sec. 18. Minnesota Statutes 2014, section 256I.03, is amended by adding a subdivision
13.32 to read:

14.1 Subd. 10. **Habitability inspection.** "Habitability inspection" means an inspection to
14.2 determine whether the housing occupied by an individual meets the habitability standards
14.3 specified by the commissioner. The standards must be provided to the applicant in writing
14.4 and posted on the Department of Human Services Web site.

14.5 Sec. 19. Minnesota Statutes 2014, section 256I.03, is amended by adding a subdivision
14.6 to read:

14.7 Subd. 11. **Long-term homelessness.** "Long-term homelessness" means lacking a
14.8 permanent place to live:

14.9 (1) continuously for one year or more; or

14.10 (2) at least four times in the past three years.

14.11 Sec. 20. Minnesota Statutes 2014, section 256I.03, is amended by adding a subdivision
14.12 to read:

14.13 Subd. 12. **Professional statement of need.** "Professional statement of need" means
14.14 a statement about an individual's illness, injury, or incapacity that is signed by a qualified
14.15 professional. The statement must specify that the individual has an illness or incapacity
14.16 which limits the individual's ability to work and provide self-support. The statement
14.17 must also specify that the individual needs assistance to access or maintain housing, as
14.18 evidenced by the need for two or more of the following services:

14.19 (1) tenancy supports to assist an individual with finding the individual's own
14.20 home, landlord negotiation, securing furniture and household supplies, understanding
14.21 and maintaining tenant responsibilities, conflict negotiation, and budgeting and financial
14.22 education;

14.23 (2) supportive services to assist with basic living and social skills, household
14.24 management, monitoring of overall well-being, and problem solving;

14.25 (3) employment supports to assist with maintaining or increasing employment,
14.26 increasing earnings, understanding and utilizing appropriate benefits and services,
14.27 improving physical or mental health, moving toward self-sufficiency, and achieving
14.28 personal goals; or

14.29 (4) health supervision services to assist in the preparation and administration of
14.30 medications other than injectables, the provision of therapeutic diets, taking vital signs, or
14.31 providing assistance in dressing, grooming, bathing, or with walking devices.

14.32 Sec. 21. Minnesota Statutes 2014, section 256I.03, is amended by adding a subdivision
14.33 to read:

15.1 Subd. 13. **Prospective budgeting.** "Prospective budgeting" means estimating the
15.2 amount of monthly income a person will have in the payment month.

15.3 Sec. 22. Minnesota Statutes 2014, section 256I.03, is amended by adding a subdivision
15.4 to read:

15.5 Subd. 14. **Qualified professional.** "Qualified professional" means an individual as
15.6 defined in section 256J.08, subdivision 73a, or Minnesota Rules, part 9530.6450, subpart
15.7 3, 4, or 5; or an individual approved by the director of human services or a designee
15.8 of the director.

15.9 Sec. 23. Minnesota Statutes 2014, section 256I.03, is amended by adding a subdivision
15.10 to read:

15.11 Subd. 15. **Supportive housing.** "Supportive housing" means housing with support
15.12 services according to the continuum of care coordinated assessment system established
15.13 under Code of Federal Regulations, title 24, section 578.3.

15.14 Sec. 24. Minnesota Statutes 2014, section 256I.04, subdivision 1, is amended to read:

15.15 Subdivision 1. **Individual eligibility requirements.** An individual is eligible for
15.16 and entitled to a group residential housing payment to be made on the individual's behalf
15.17 if the agency has approved the individual's residence in a group residential housing setting
15.18 and the individual meets the requirements in paragraph (a) or (b).

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

15.28 (b) The individual meets a category of eligibility under section 256D.05, subdivision
15.29 1, paragraph (a), clauses (1), (3), (5) to (9), and (14), and paragraph (b), if applicable, and
15.30 the individual's resources are less than the standards specified by section 256P.02, and
15.31 the individual's countable income as determined under sections 256D.01 to 256D.21, less
15.32 the medical assistance personal needs allowance under section 256B.35 is less than the

16.1 monthly rate specified in the agency's agreement with the provider of group residential
 16.2 housing in which the individual resides.

16.3 **EFFECTIVE DATE.** This section is effective September 1, 2015.

16.4 Sec. 25. Minnesota Statutes 2014, section 256I.04, subdivision 1a, is amended to read:

16.5 Subd. 1a. **County approval.** (a) A county agency may not approve a group
 16.6 residential housing payment for an individual in any setting with a rate in excess of the
 16.7 MSA equivalent rate for more than 30 days in a calendar year unless the ~~county agency~~
 16.8 ~~has developed or approved~~ individual has a plan for the individual which specifies that:

16.9 (1) ~~the individual has an illness or incapacity which prevents the person from living~~
 16.10 ~~independently in the community; and~~

16.11 (2) ~~the individual's illness or incapacity requires the services which are available in~~
 16.12 ~~the group residence.~~

16.13 ~~The plan must be signed or countersigned by any of the following employees of the~~
 16.14 ~~county of financial responsibility: the director of human services or a designee of the~~
 16.15 ~~director; a social worker; or a case aide~~ professional statement of need under section
 16.16 256I.03, subdivision 12.

16.17 (b) If a county agency determines that an applicant is ineligible due to not meeting
 16.18 eligibility requirements under this section, a county agency may accept a signed personal
 16.19 statement from the applicant in lieu of documentation verifying ineligibility.

16.20 (c) Effective July 1, 2016, to be eligible for supplementary service payments,
 16.21 providers must enroll in the provider enrollment system identified by the commissioner.

16.22 Sec. 26. Minnesota Statutes 2014, section 256I.04, subdivision 2a, is amended to read:

16.23 Subd. 2a. **License required; staffing qualifications.** ~~A county~~ (a) Except
 16.24 as provided in paragraph (b), an agency may not enter into an agreement with an
 16.25 establishment to provide group residential housing unless:

16.26 (1) the establishment is licensed by the Department of Health as a hotel and
 16.27 restaurant; a board and lodging establishment; ~~a residential care home;~~ a boarding care
 16.28 home before March 1, 1985; or a supervised living facility, and the service provider
 16.29 for residents of the facility is licensed under chapter 245A. However, an establishment
 16.30 licensed by the Department of Health to provide lodging need not also be licensed to
 16.31 provide board if meals are being supplied to residents under a contract with a food vendor
 16.32 who is licensed by the Department of Health;

16.33 (2) the residence is: (i) licensed by the commissioner of human services under
 16.34 Minnesota Rules, parts 9555.5050 to 9555.6265; (ii) certified by a county human services

17.1 agency prior to July 1, 1992, using the standards under Minnesota Rules, parts 9555.5050
17.2 to 9555.6265; (iii) a residence licensed by the commissioner under Minnesota Rules, parts
17.3 2960.0010 to 2960.0120, with a variance under section 245A.04, subdivision 9; or (iv)
17.4 licensed under section 245D.02, subdivision 4a, as a community residential setting by
17.5 the commissioner of human services; or

17.6 (3) the establishment is registered under chapter 144D and provides three meals a
17.7 day, ~~or is an establishment voluntarily registered under section 144D.025 as a supportive~~
17.8 ~~housing establishment; or.~~

17.9 (4) ~~an establishment voluntarily registered under section 144D.025, other than~~
17.10 ~~a supportive housing establishment under clause (3), is not eligible to provide group~~
17.11 ~~residential housing.~~

17.12 (b) The requirements under clauses (1) to (4) paragraph (a) do not apply to
17.13 establishments exempt from state licensure because they are:

17.14 (1) located on Indian reservations and subject to tribal health and safety
17.15 requirements; or

17.16 (2) a supportive housing establishment that has an approved habitability inspection
17.17 and an individual lease agreement and that serves people who have experienced long-term
17.18 homelessness and were referred through a coordinated assessment in section 256I.03,
17.19 subdivision 15.

17.20 (c) Supportive housing establishments and emergency shelters must participate in
17.21 the homeless management information system.

17.22 (d) Effective July 1, 2016, an agency shall not have an agreement with a provider
17.23 of group residential housing or supplementary services unless all staff members who
17.24 have direct contact with recipients:

17.25 (1) have skills and knowledge acquired through one or more of the following:

17.26 (i) a course of study in a health- or human services-related field leading to a bachelor
17.27 of arts, bachelor of science, or associate's degree;

17.28 (ii) one year of experience with the target population served;

17.29 (iii) experience as a certified peer specialist according to section 256B.0615; or

17.30 (iv) meeting the requirements for unlicensed personnel under sections 144A.43
17.31 to 144A.483;

17.32 (2) hold a current Minnesota driver's license appropriate to the vehicle driven
17.33 if transporting recipients;

17.34 (3) complete training on vulnerable adults mandated reporting and child
17.35 maltreatment mandated reporting, where applicable; and

18.1 (4) complete group residential housing orientation training offered by the
 18.2 commissioner.

18.3 Sec. 27. Minnesota Statutes 2014, section 256I.04, subdivision 2b, is amended to read:

18.4 Subd. 2b. **Group residential housing agreements.** (a) Agreements between county
 18.5 agencies and providers of group residential housing or supplementary services must be in
 18.6 writing on a form developed and approved by the commissioner and must specify the name
 18.7 and address under which the establishment subject to the agreement does business and
 18.8 under which the establishment, or service provider, if different from the group residential
 18.9 housing establishment, is licensed by the Department of Health or the Department of
 18.10 Human Services; the specific license or registration from the Department of Health or the
 18.11 Department of Human Services held by the provider and the number of beds subject to
 18.12 that license; the address of the location or locations at which group residential housing is
 18.13 provided under this agreement; the per diem and monthly rates that are to be paid from
 18.14 group residential housing or supplementary service funds for each eligible resident at each
 18.15 location; the number of beds at each location which are subject to the group residential
 18.16 housing agreement; whether the license holder is a not-for-profit corporation under section
 18.17 501(c)(3) of the Internal Revenue Code; and a statement that the agreement is subject to
 18.18 the provisions of sections 256I.01 to 256I.06 and subject to any changes to those sections.

18.19 (b) Providers are required to verify the following minimum requirements in the
 18.20 agreement:

18.21 (1) current license or registration, including authorization if managing or monitoring
 18.22 medications;

18.23 (2) all staff who have direct contact with recipients meet the staff qualifications;

18.24 (3) the provision of group residential housing;

18.25 (4) the provision of supplementary services, if applicable;

18.26 (5) reports of adverse events, including recipient death or serious injury; and

18.27 (6) submission of residency requirements that could result in recipient eviction.

18.28 ~~Group residential housing~~ (c) Agreements may be terminated with or without cause by
 18.29 either the county commissioner, the agency, or the provider with two calendar months prior
 18.30 notice. The commissioner may immediately terminate an agreement under subdivision 2d.

18.31 Sec. 28. Minnesota Statutes 2014, section 256I.04, subdivision 2c, is amended to read:

18.32 Subd. 2c. ~~Crisis shelters~~ **Background study requirements.** ~~Secure crisis shelters~~
 18.33 ~~for battered women and their children designated by the Minnesota Department of~~
 18.34 ~~Corrections are not group residences under this chapter.~~ (a) Effective July 1, 2016, a

19.1 provider of group residential housing or supplementary services must initiate background
19.2 studies in accordance with chapter 245C of the following individuals:

19.3 (1) controlling individuals as defined in section 245A.02;

19.4 (2) managerial officials as defined in section 245A.02; and

19.5 (3) all employees and volunteers of the establishment who have direct contact
19.6 with recipients, or who have unsupervised access to recipients, their personal property,
19.7 or their private data.

19.8 (b) The provider of group residential housing or supplementary services must
19.9 maintain compliance with all requirements established for entities initiating background
19.10 studies under chapter 245C.

19.11 (c) Effective July 1, 2017, a provider of group residential housing or supplementary
19.12 services must demonstrate that all individuals required to have a background study
19.13 according to paragraph (a) have a notice stating either that:

19.14 (1) the individual is not disqualified under section 245C.14; or

19.15 (2) the individual is disqualified, but the individual has been issued a set-aside of
19.16 the disqualification for that setting under section 245C.22.

19.17 Sec. 29. Minnesota Statutes 2014, section 256I.04, is amended by adding a subdivision
19.18 to read:

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

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

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

20.1 the provider has breached a material term of the agreement and cure is not possible, the
20.2 commissioner may immediately terminate the agreement.

20.3 Sec. 30. Minnesota Statutes 2014, section 256I.04, is amended by adding a subdivision
20.4 to read:

20.5 Subd. 2e. **Providers holding health or human services licenses.** (a) Except
20.6 for facilities with only a board and lodging license, when group residential housing or
20.7 supplementary service staff are also operating under a license issued by the Department of
20.8 Health or the Department of Human Services, the minimum staff qualification requirements
20.9 for the setting shall be the qualifications listed under the related licensing standards.

20.10 (b) A background study completed for the licensed service must also satisfy the
20.11 background study requirements under this section, if the provider has established the
20.12 background study contact person according to chapter 245C and as directed by the
20.13 Department of Human Services.

20.14 Sec. 31. Minnesota Statutes 2014, section 256I.04, is amended by adding a subdivision
20.15 to read:

20.16 Subd. 2f. **Required services.** In licensed and registered settings under subdivision
20.17 2a, providers shall ensure that participants have at a minimum:

20.18 (1) food preparation and service for three nutritional meals a day on site;

20.19 (2) a bed, clothing storage, linen, bedding, laundering, and laundry supplies or
20.20 service;

20.21 (3) housekeeping, including cleaning and lavatory supplies or service; and

20.22 (4) maintenance and operation of the building and grounds, including heat, water,
20.23 garbage removal, electricity, telephone for the site, cooling, supplies, and parts and tools
20.24 to repair and maintain equipment and facilities.

20.25 Sec. 32. Minnesota Statutes 2014, section 256I.04, is amended by adding a subdivision
20.26 to read:

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

20.30 Sec. 33. Minnesota Statutes 2014, section 256I.04, subdivision 3, is amended to read:

21.1 Subd. 3. **Moratorium on development of group residential housing beds.** (a)

21.2 County Agencies shall not enter into agreements for new group residential housing beds
21.3 with total rates in excess of the MSA equivalent rate except:

21.4 (1) for group residential housing establishments licensed under Minnesota Rules,
21.5 parts 9525.0215 to 9525.0355, provided the facility is needed to meet the census reduction
21.6 targets for persons with developmental disabilities at regional treatment centers;

21.7 (2) up to 80 beds in a single, specialized facility located in Hennepin County that will
21.8 provide housing for chronic inebriates who are repetitive users of detoxification centers
21.9 and are refused placement in emergency shelters because of their state of intoxication,
21.10 and planning for the specialized facility must have been initiated before July 1, 1991,
21.11 in anticipation of receiving a grant from the Housing Finance Agency under section
21.12 462A.05, subdivision 20a, paragraph (b);

21.13 (3) notwithstanding the provisions of subdivision 2a, for up to 190 supportive
21.14 housing units in Anoka, Dakota, Hennepin, or Ramsey County for homeless adults with a
21.15 mental illness, a history of substance abuse, or human immunodeficiency virus or acquired
21.16 immunodeficiency syndrome. For purposes of this section, "homeless adult" means a
21.17 person who is living on the street or in a shelter or discharged from a regional treatment
21.18 center, community hospital, or residential treatment program and has no appropriate
21.19 housing available and lacks the resources and support necessary to access appropriate
21.20 housing. At least 70 percent of the supportive housing units must serve homeless adults
21.21 with mental illness, substance abuse problems, or human immunodeficiency virus or
21.22 acquired immunodeficiency syndrome who are about to be or, within the previous six
21.23 months, has been discharged from a regional treatment center, or a state-contracted
21.24 psychiatric bed in a community hospital, or a residential mental health or chemical
21.25 dependency treatment program. If a person meets the requirements of subdivision 1,
21.26 paragraph (a), and receives a federal or state housing subsidy, the group residential housing
21.27 rate for that person is limited to the supplementary rate under section 256I.05, subdivision
21.28 1a, and is determined by subtracting the amount of the person's countable income that
21.29 exceeds the MSA equivalent rate from the group residential housing supplementary rate.
21.30 A resident in a demonstration project site who no longer participates in the demonstration
21.31 program shall retain eligibility for a group residential housing payment in an amount
21.32 determined under section 256I.06, subdivision 8, using the MSA equivalent rate. Service
21.33 funding under section 256I.05, subdivision 1a, will end June 30, 1997, if federal matching
21.34 funds are available and the services can be provided through a managed care entity. If
21.35 federal matching funds are not available, then service funding will continue under section
21.36 256I.05, subdivision 1a;

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

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

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

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

22.16 (8) for a group residential facility in Hennepin County with a capacity of up to 48
22.17 beds that has been licensed since 1978 as a board and lodging facility and that until August
22.18 1, 2007, operated as a licensed chemical dependency treatment program.

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

22.27 Sec. 34. Minnesota Statutes 2014, section 256I.04, subdivision 4, is amended to read:

22.28 Subd. 4. **Rental assistance.** For participants in the Minnesota supportive housing
22.29 demonstration program under subdivision 3, paragraph (a), clause (5), notwithstanding
22.30 the provisions of section 256I.06, subdivision 8, the amount of the group residential
22.31 housing payment for room and board must be calculated by subtracting 30 percent of the
22.32 recipient's adjusted income as defined by the United States Department of Housing and
22.33 Urban Development for the Section 8 program from the fair market rent established for the
22.34 recipient's living unit by the federal Department of Housing and Urban Development. This
22.35 payment shall be regarded as a state housing subsidy for the purposes of subdivision 3.

23.1 Notwithstanding the provisions of section 256I.06, subdivision 6, the recipient's countable
23.2 income will only be adjusted when a change of greater than \$100 in a month occurs or
23.3 upon annual redetermination of eligibility, whichever is sooner. ~~The commissioner is~~
23.4 ~~directed to study the feasibility of developing a rental assistance program to serve persons~~
23.5 ~~traditionally served in group residential housing settings and report to the legislature by~~
23.6 ~~February 15, 1999.~~

23.7 Sec. 35. Minnesota Statutes 2014, section 256I.05, subdivision 1c, is amended to read:

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

23.11 (a) ~~A county~~ An agency may increase the rates for group residential housing settings
23.12 to the MSA equivalent rate for those settings whose current rate is below the MSA
23.13 equivalent rate.

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

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

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

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

24.1 (f) Until June 30, 1994, ~~a county~~ an agency may increase by up to five percent the
 24.2 total rate paid for recipients of assistance under sections 256D.01 to 256D.21 or 256D.33
 24.3 to 256D.54 who reside in residences that are licensed by the commissioner of health as
 24.4 a boarding care home, but are not certified for the purposes of the medical assistance
 24.5 program. However, an increase under this clause must not exceed an amount equivalent to
 24.6 65 percent of the 1991 medical assistance reimbursement rate for nursing home resident
 24.7 class A, in the geographic grouping in which the facility is located, as established under
 24.8 Minnesota Rules, parts 9549.0050 to 9549.0058.

24.9 Sec. 36. Minnesota Statutes 2014, section 256I.05, subdivision 1g, is amended to read:

24.10 Subd. 1g. **Supplementary service rate for certain facilities.** ~~On or after July 1,~~
 24.11 ~~2005, a county~~ An agency may negotiate a supplementary service rate for recipients of
 24.12 assistance under section 256I.04, subdivision 1, paragraph (a) or (b), who ~~relocate from a~~
 24.13 ~~homeless shelter licensed and registered prior to December 31, 1996, by the Minnesota~~
 24.14 ~~Department of Health under section 157.17, to~~ have experienced long-term homelessness
 24.15 and who live in a supportive housing establishment developed and funded in whole or in
 24.16 part with funds provided specifically as part of the plan to end long-term homelessness
 24.17 required under Laws 2003, chapter 128, article 15, section 9, not to exceed \$456.75 under
 24.18 section 256I.04, subdivision 2a, paragraph (b), clause (2).

24.19 Sec. 37. Minnesota Statutes 2014, section 256I.06, subdivision 2, is amended to read:

24.20 Subd. 2. **Time of payment.** A county agency may make payments to a group
 24.21 residence in advance for an individual whose stay in the group residence is expected
 24.22 to last beyond the calendar month for which the payment is made ~~and who does not~~
 24.23 ~~expect to receive countable earned income during the month for which the payment is~~
 24.24 ~~made.~~ Group residential housing payments made by a county agency on behalf of an
 24.25 individual who is not expected to remain in the group residence beyond the month for
 24.26 which payment is made must be made subsequent to the individual's departure from the
 24.27 group residence. ~~Group residential housing payments made by a county agency on behalf~~
 24.28 ~~of an individual with countable earned income must be made subsequent to receipt of a~~
 24.29 ~~monthly household report form.~~

24.30 **EFFECTIVE DATE.** This section is effective April 1, 2016.

24.31 Sec. 38. Minnesota Statutes 2014, section 256I.06, subdivision 6, is amended to read:

24.32 Subd. 6. **Reports.** Recipients must report changes in circumstances that affect
 24.33 eligibility or group residential housing payment amounts, other than changes in earned

25.1 income, within ten days of the change. Recipients with countable earned income must
 25.2 complete a ~~monthly~~ household report form at least once every six months. If the report
 25.3 form is not received before the end of the month in which it is due, the county agency
 25.4 must terminate eligibility for group residential housing payments. The termination shall
 25.5 be effective on the first day of the month following the month in which the report was due.
 25.6 If a complete report is received within the month eligibility was terminated, the individual
 25.7 is considered to have continued an application for group residential housing payment
 25.8 effective the first day of the month the eligibility was terminated.

25.9 **EFFECTIVE DATE.** This section is effective April 1, 2016.

25.10 Sec. 39. Minnesota Statutes 2014, section 256I.06, subdivision 7, is amended to read:

25.11 Subd. 7. **Determination of rates.** The agency in the county in which a group
 25.12 residence is located ~~will~~ shall determine the amount of group residential housing rate to
 25.13 be paid on behalf of an individual in the ~~group~~ residence regardless of the individual's
 25.14 ~~county~~ agency of financial responsibility.

25.15 Sec. 40. Minnesota Statutes 2014, section 256I.06, subdivision 8, is amended to read:

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

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

25.28 **EFFECTIVE DATE.** Paragraph (b) is effective April 1, 2016.

25.29 Sec. 41. Minnesota Statutes 2014, section 256J.21, subdivision 2, as amended by Laws
 25.30 2015, chapter 21, article 1, section 60, is amended to read:

25.31 Subd. 2. **Income exclusions.** The following must be excluded in determining a
 25.32 family's available income:

- 26.1 (1) payments for basic care, difficulty of care, and clothing allowances received for
26.2 providing family foster care to children or adults under Minnesota Rules, parts 9555.5050
26.3 to 9555.6265, 9560.0521, and 9560.0650 to 9560.0655, payments for family foster care
26.4 for children under section 260C.4411 or chapter 256N, and payments received and used
26.5 for care and maintenance of a third-party beneficiary who is not a household member;
- 26.6 (2) reimbursements for employment training received through the Workforce
26.7 Investment Act of 1998, United States Code, title 20, chapter 73, section 9201;
- 26.8 (3) reimbursement for out-of-pocket expenses incurred while performing volunteer
26.9 services, jury duty, employment, or informal carpooling arrangements directly related to
26.10 employment;
- 26.11 (4) all educational assistance, except the county agency must count graduate student
26.12 teaching assistantships, fellowships, and other similar paid work as earned income and,
26.13 after allowing deductions for any unmet and necessary educational expenses, shall
26.14 count scholarships or grants awarded to graduate students that do not require teaching
26.15 or research as unearned income;
- 26.16 (5) loans, regardless of purpose, from public or private lending institutions,
26.17 governmental lending institutions, or governmental agencies;
- 26.18 (6) loans from private individuals, regardless of purpose, provided an applicant or
26.19 participant documents that the lender expects repayment;
- 26.20 (7)(i) state income tax refunds; and
26.21 (ii) federal income tax refunds;
- 26.22 (8)(i) federal earned income credits;
26.23 (ii) Minnesota working family credits;
26.24 (iii) state homeowners and renters credits under chapter 290A; and
26.25 (iv) federal or state tax rebates;
- 26.26 (9) funds received for reimbursement, replacement, or rebate of personal or real
26.27 property when these payments are made by public agencies, awarded by a court, solicited
26.28 through public appeal, or made as a grant by a federal agency, state or local government,
26.29 or disaster assistance organizations, subsequent to a presidential declaration of disaster;
- 26.30 (10) the portion of an insurance settlement that is used to pay medical, funeral, and
26.31 burial expenses, or to repair or replace insured property;
- 26.32 (11) reimbursements for medical expenses that cannot be paid by medical assistance;
- 26.33 (12) payments by a vocational rehabilitation program administered by the state
26.34 under chapter 268A, except those payments that are for current living expenses;
- 26.35 (13) in-kind income, including any payments directly made by a third party to a
26.36 provider of goods and services;

- 27.1 (14) assistance payments to correct underpayments, but only for the month in which
27.2 the payment is received;
- 27.3 (15) payments for short-term emergency needs under section 256J.626, subdivision 2;
- 27.4 (16) funeral and cemetery payments as provided by section 256.935;
- 27.5 (17) nonrecurring cash gifts of \$30 or less, not exceeding \$30 per participant in
27.6 a calendar month;
- 27.7 (18) any form of energy assistance payment made through Public Law 97-35,
27.8 Low-Income Home Energy Assistance Act of 1981, payments made directly to energy
27.9 providers by other public and private agencies, and any form of credit or rebate payment
27.10 issued by energy providers;
- 27.11 (19) Supplemental Security Income (SSI), including retroactive SSI payments and
27.12 other income of an SSI recipient, except as described in section 256J.37, subdivision 3b;
- 27.13 (20) Minnesota supplemental aid, including retroactive payments;
- 27.14 (21) proceeds from the sale of real or personal property;
- 27.15 (22) adoption or kinship assistance payments under chapter 256N or 259A and
27.16 Minnesota permanency demonstration title IV-E waiver payments;
- 27.17 (23) state-funded family subsidy program payments made under section 252.32 to
27.18 help families care for children with developmental disabilities, consumer support grant
27.19 funds under section 256.476, and resources and services for a disabled household member
27.20 under one of the home and community-based waiver services programs under chapter 256B;
- 27.21 (24) interest payments and dividends from property that is not excluded from and
27.22 that does not exceed the asset limit;
- 27.23 (25) rent rebates;
- 27.24 (26) income earned by a minor caregiver, minor child through age 6, or a minor
27.25 child who is at least a half-time student in an approved elementary or secondary education
27.26 program;
- 27.27 (27) income earned by a caregiver under age 20 who is at least a half-time student in
27.28 an approved elementary or secondary education program;
- 27.29 (28) MFIP child care payments under section 119B.05;
- 27.30 (29) all other payments made through MFIP to support a caregiver's pursuit of
27.31 greater economic stability;
- 27.32 (30) income a participant receives related to shared living expenses;
- 27.33 (31) reverse mortgages;
- 27.34 (32) benefits provided by the Child Nutrition Act of 1966, United States Code, title
27.35 42, chapter 13A, sections 1771 to 1790;

28.1 (33) benefits provided by the women, infants, and children (WIC) nutrition program,
28.2 United States Code, title 42, chapter 13A, section 1786;

28.3 (34) benefits from the National School Lunch Act, United States Code, title 42,
28.4 chapter 13, sections 1751 to 1769e;

28.5 (35) relocation assistance for displaced persons under the Uniform Relocation
28.6 Assistance and Real Property Acquisition Policies Act of 1970, United States Code, title
28.7 42, chapter 61, subchapter II, section 4636, or the National Housing Act, United States
28.8 Code, title 12, chapter 13, sections 1701 to 1750jj;

28.9 (36) benefits from the Trade Act of 1974, United States Code, title 19, chapter
28.10 12, part 2, sections 2271 to 2322;

28.11 (37) war reparations payments to Japanese Americans and Aleuts under United
28.12 States Code, title 50, sections 1989 to 1989d;

28.13 (38) payments to veterans or their dependents as a result of legal settlements
28.14 regarding Agent Orange or other chemical exposure under Public Law 101-239, section
28.15 10405, paragraph (a)(2)(E);

28.16 (39) income that is otherwise specifically excluded from MFIP consideration in
28.17 federal law, state law, or federal regulation;

28.18 (40) security and utility deposit refunds;

28.19 (41) American Indian tribal land settlements excluded under Public Laws 98-123,
28.20 98-124, and 99-377 to the Mississippi Band Chippewa Indians of White Earth, Leech
28.21 Lake, and Mille Lacs reservations and payments to members of the White Earth Band,
28.22 under United States Code, title 25, chapter 9, section 331, and chapter 16, section 1407;

28.23 (42) all income of the minor parent's parents and stepparents when determining the
28.24 grant for the minor parent in households that include a minor parent living with parents or
28.25 stepparents on MFIP with other children;

28.26 (43) income of the minor parent's parents and stepparents equal to 200 percent of the
28.27 federal poverty guideline for a family size not including the minor parent and the minor
28.28 parent's child in households that include a minor parent living with parents or stepparents
28.29 not on MFIP when determining the grant for the minor parent. The remainder of income is
28.30 deemed as specified in section 256J.37, subdivision 1b;

28.31 (44) payments made to children eligible for relative custody assistance under section
28.32 257.85;

28.33 (45) vendor payments for goods and services made on behalf of a client unless the
28.34 client has the option of receiving the payment in cash;

28.35 (46) the principal portion of a contract for deed payment;

29.1 (47) cash payments to individuals enrolled for full-time service as a volunteer under
 29.2 AmeriCorps programs including AmeriCorps VISTA, AmeriCorps State, AmeriCorps
 29.3 National, and AmeriCorps NCCC; ~~and~~

29.4 (48) housing assistance grants under section 256J.35, paragraph (a); and

29.5 (49) child support payments of up to \$100 for an assistance unit with one child and
 29.6 up to \$200 for an assistance unit with two or more children.

29.7 Sec. 42. Minnesota Statutes 2014, section 256J.24, subdivision 5a, is amended to read:

29.8 Subd. 5a. **Food portion of MFIP transitional standard.** The commissioner shall
 29.9 adjust the food portion of the MFIP transitional standard as needed to reflect adjustments
 29.10 to the Supplemental Nutrition Assistance Program and maintain compliance with federal
 29.11 waivers related to the Supplemental Nutrition Assistance Program under the United States
 29.12 Department of Agriculture. The commissioner shall publish the transitional standard
 29.13 including a breakdown of the cash and food portions for an assistance unit of sizes one to
 29.14 ten in the State Register whenever an adjustment is made.

29.15 Sec. 43. Minnesota Statutes 2014, section 256J.33, subdivision 4, is amended to read:

29.16 Subd. 4. **Monthly income test.** A county agency must apply the monthly income test
 29.17 retrospectively for each month of MFIP eligibility. An assistance unit is not eligible when
 29.18 the countable income equals or exceeds the MFIP standard of need or the family wage level
 29.19 for the assistance unit. The income applied against the monthly income test must include:

29.20 (1) gross earned income from employment, prior to mandatory payroll deductions,
 29.21 voluntary payroll deductions, wage authorizations, and after the disregards in section
 29.22 256J.21, subdivision 4, and the allocations in section 256J.36, unless the employment
 29.23 income is specifically excluded under section 256J.21, subdivision 2;

29.24 (2) gross earned income from self-employment less deductions for self-employment
 29.25 expenses in section 256J.37, subdivision 5, but prior to any reductions for personal or
 29.26 business state and federal income taxes, personal FICA, personal health and life insurance,
 29.27 and after the disregards in section 256J.21, subdivision 4, and the allocations in section
 29.28 256J.36;

29.29 (3) unearned income after deductions for allowable expenses in section 256J.37,
 29.30 subdivision 9, and allocations in section 256J.36, unless the income has been specifically
 29.31 excluded in section 256J.21, subdivision 2;

29.32 (4) gross earned income from employment as determined under clause (1) which
 29.33 is received by a member of an assistance unit who is a minor child or minor caregiver
 29.34 and less than a half-time student;

- 30.1 (5) child support ~~and~~ received by an assistance unit, excluded under section 256J.21,
 30.2 subdivision 2, clause (49), or section 256P.06, subdivision 3, clause (2), item (xvi);
 30.3 (6) spousal support received by an assistance unit;
 30.4 ~~(6)~~ (7) the income of a parent when that parent is not included in the assistance unit;
 30.5 ~~(7)~~ (8) the income of an eligible relative and spouse who seek to be included in
 30.6 the assistance unit; and
 30.7 ~~(8)~~ (9) the unearned income of a minor child included in the assistance unit.

30.8 Sec. 44. Minnesota Statutes 2014, section 256K.45, subdivision 1a, is amended to read:

30.9 Subd. 1a. **Definitions.** (a) The definitions in this subdivision apply to this section.

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

30.11 (c) "Homeless youth" means a person ~~21~~ 24 years of age or younger who is
 30.12 unaccompanied by a parent or guardian and is without shelter where appropriate care and
 30.13 supervision are available, whose parent or legal guardian is unable or unwilling to provide
 30.14 shelter and care, or who lacks a fixed, regular, and adequate nighttime residence. The
 30.15 following are not fixed, regular, or adequate nighttime residences:

30.16 (1) a supervised publicly or privately operated shelter designed to provide temporary
 30.17 living accommodations;

30.18 (2) an institution or a publicly or privately operated shelter designed to provide
 30.19 temporary living accommodations;

30.20 (3) transitional housing;

30.21 (4) a temporary placement with a peer, friend, or family member that has not offered
 30.22 permanent residence, a residential lease, or temporary lodging for more than 30 days; or

30.23 (5) a public or private place not designed for, nor ordinarily used as, a regular
 30.24 sleeping accommodation for human beings.

30.25 Homeless youth does not include persons incarcerated or otherwise detained under
 30.26 federal or state law.

30.27 (d) "Youth at risk of homelessness" means a person ~~21~~ 24 years of age or younger
 30.28 whose status or circumstances indicate a significant danger of experiencing homelessness
 30.29 in the near future. Status or circumstances that indicate a significant danger may include:

30.30 (1) youth exiting out-of-home placements; (2) youth who previously were homeless; (3)
 30.31 youth whose parents or primary caregivers are or were previously homeless; (4) youth
 30.32 who are exposed to abuse and neglect in their homes; (5) youth who experience conflict
 30.33 with parents due to chemical or alcohol dependency, mental health disabilities, or other
 30.34 disabilities; and (6) runaways.

31.1 (e) "Runaway" means an unmarried child under the age of 18 years who is absent
31.2 from the home of a parent or guardian or other lawful placement without the consent of
31.3 the parent, guardian, or lawful custodian.

31.4 Sec. 45. Minnesota Statutes 2014, section 256K.45, subdivision 6, is amended to read:

31.5 Subd. 6. **Funding.** Funds appropriated for this section may be expended on
31.6 programs described under subdivisions 3 to 5, technical assistance, and capacity building
31.7 to meet the greatest need on a statewide basis. The commissioner will provide outreach,
31.8 technical assistance, and program development support to increase capacity to new and
31.9 existing service providers to better meet needs statewide, particularly in areas where
31.10 services for homeless youth have not been established, especially in greater Minnesota.

31.11 Sec. 46. **[256M.41] CHILD PROTECTION GRANT ALLOCATION.**

31.12 Subdivision 1. **Formula for county staffing funds.** (a) The commissioner shall
31.13 allocate state funds appropriated under this section to each county board on a calendar
31.14 year basis in an amount determined according to the following formula:

31.15 (1) 50 percent must be distributed on the basis of the child population residing in the
31.16 county as determined by the most recent data of the state demographer;

31.17 (2) 25 percent must be distributed on the basis of the number of screened-in
31.18 reports of child maltreatment under sections 626.556 and 626.5561, and in the county as
31.19 determined by the most recent data of the commissioner; and

31.20 (3) 25 percent must be distributed on the basis of the number of open child
31.21 protection case management cases in the county as determined by the most recent data of
31.22 the commissioner.

31.23 (b) Notwithstanding this subdivision, no county shall be awarded an allocation of
31.24 less than \$75,000.

31.25 Subd. 2. **Prohibition on supplanting existing funds.** Funds received under this
31.26 section must be used to address staffing for child protection or expand child protection
31.27 services. Funds must not be used to supplant current county expenditures for these
31.28 purposes.

31.29 Subd. 3. **Payments based on performance.** (a) The commissioner shall make
31.30 payments under this section to each county board on a calendar year basis in an amount
31.31 determined under paragraph (b).

31.32 (b) Calendar year allocations under subdivision 1 shall be paid to counties in the
31.33 following manner:

32.1 (1) 80 percent of the allocation as determined in subdivision 1 must be paid to
32.2 counties on or before July 10 of each year;

32.3 (2) ten percent of the allocation shall be withheld until the commissioner determines
32.4 if the county has met the performance outcome threshold of 90 percent based on
32.5 face-to-face contact with alleged child victims. In order to receive the performance
32.6 allocation, the county child protection workers must have a timely face-to-face contact
32.7 with at least 90 percent of all alleged child victims of screened-in maltreatment reports.
32.8 The standard requires that each initial face-to-face contact occur consistent with timelines
32.9 defined in section 626.556, subdivision 10, paragraph (i). The commissioner shall make
32.10 threshold determinations in January of each year and payments to counties meeting the
32.11 performance outcome threshold shall occur in February of each year. Any withheld funds
32.12 from this appropriation for counties that do not meet this requirement shall be reallocated
32.13 by the commissioner to those counties meeting the requirement; and

32.14 (3) ten percent of the allocation shall be withheld until the commissioner determines
32.15 that the county has met the performance outcome threshold of 90 percent based on
32.16 face-to-face visits by the case manager. In order to receive the performance allocation, the
32.17 total number of visits made by caseworkers on a monthly basis to children in foster care
32.18 and children receiving child protection services while residing in their home must be at
32.19 least 90 percent of the total number of such visits that would occur if every child were
32.20 visited once per month. The commissioner shall make such determinations in January
32.21 of each year and payments to counties meeting the performance outcome threshold
32.22 shall occur in February of each year. Any withheld funds from this appropriation for
32.23 counties that do not meet this requirement shall be reallocated by the commissioner to
32.24 those counties meeting the requirement. For 2015, the commissioner shall only apply
32.25 the standard for monthly foster care visits.

32.26 (c) The commissioner shall work with stakeholders and the Human Services
32.27 Performance Council under section 402A.16 to develop recommendations for specific
32.28 outcome measures that counties should meet in order to receive funds withheld under
32.29 paragraph (b), and include in those recommendations a determination as to whether
32.30 the performance measures under paragraph (b) should be modified or phased out. The
32.31 commissioner shall report the recommendations to the legislative committees having
32.32 jurisdiction over child protection issues by January 1, 2018.

32.33 Sec. 47. Minnesota Statutes 2014, section 256N.22, subdivision 9, is amended to read:

32.34 Subd. 9. **Death or incapacity of relative custodian or dissolution modification**
32.35 **of custody.** The Northstar kinship assistance agreement ends upon death or ~~dissolution~~

33.1 incapacity of the relative custodian or modification of the order for permanent legal and
 33.2 physical custody of both relative custodians in the case of assignment of custody to two
 33.3 individuals, or the sole relative custodian in the case of assignment of custody to one
 33.4 individual in which legal or physical custody is removed from the relative custodian.
 33.5 In the case of a relative custodian's death or incapacity, Northstar kinship assistance
 33.6 eligibility may be continued according to subdivision 10.

33.7 Sec. 48. Minnesota Statutes 2014, section 256N.22, subdivision 10, is amended to read:

33.8 Subd. 10. **Assigning a successor relative custodian for a child's Northstar**
 33.9 **kinship assistance to a court-appointed guardian or custodian.** (a) Northstar kinship
 33.10 assistance may be continued with the written consent of the commissioner to In the event
 33.11 of the death or incapacity of the relative custodian, eligibility for Northstar kinship
 33.12 assistance and title IV-E assistance, if applicable, is not affected if the relative custodian
 33.13 is replaced by a successor named in the Northstar kinship assistance benefit agreement.
 33.14 Northstar kinship assistance shall be paid to a named successor who is not the child's legal
 33.15 parent, biological parent or stepparent, or other adult living in the home of the legal parent,
 33.16 biological parent, or stepparent.

33.17 (b) In order to receive Northstar kinship assistance, a named successor must:

33.18 (1) meet the background study requirements in subdivision 4;

33.19 (2) renegotiate the agreement consistent with section 256N.25, subdivision 2,

33.20 including cooperating with an assessment under section 256N.24;

33.21 (3) be ordered by the court to be the child's legal relative custodian in a modification
 33.22 proceeding under section 260C.521, subdivision 2; and

33.23 (4) satisfy the requirements in this paragraph within one year of the relative
 33.24 custodian's death or incapacity unless the commissioner certifies that the named successor
 33.25 made reasonable attempts to satisfy the requirements within one year and failure to satisfy
 33.26 the requirements was not the responsibility of the named successor.

33.27 (c) Payment of Northstar kinship assistance to the successor guardian may be
 33.28 temporarily approved through the policies, procedures, requirements, and deadlines under
 33.29 section 256N.28, subdivision 2. Ongoing payment shall begin in the month when all the
 33.30 requirements in paragraph (b) are satisfied.

33.31 (d) Continued payment of Northstar kinship assistance may occur in the event of the
 33.32 death or incapacity of the relative custodian when no successor has been named in the
 33.33 benefit agreement when the commissioner gives written consent to an individual who is a
 33.34 guardian or custodian appointed by a court for the child upon the death of both relative
 33.35 custodians in the case of assignment of custody to two individuals, or the sole relative

34.1 custodian in the case of assignment of custody to one individual, unless the child is under
34.2 the custody of a county, tribal, or child-placing agency.

34.3 ~~(b)~~ (e) Temporary assignment of Northstar kinship assistance may be approved
34.4 for a maximum of six consecutive months from the death or incapacity of the relative
34.5 custodian or custodians as provided in paragraph (a) and must adhere to the policies ~~and~~,
34.6 procedures, requirements, and deadlines under section 256N.28, subdivision 2, that are
34.7 prescribed by the commissioner. If a court has not appointed a permanent legal guardian
34.8 or custodian within six months, the Northstar kinship assistance must terminate and must
34.9 not be resumed.

34.10 ~~(e)~~ (f) Upon assignment of assistance payments under ~~this subdivision~~ paragraphs
34.11 (d) and (e), assistance must be provided from funds other than title IV-E.

34.12 Sec. 49. Minnesota Statutes 2014, section 256N.24, subdivision 4, is amended to read:

34.13 Subd. 4. **Extraordinary levels.** (a) The assessment tool established under
34.14 subdivision 2 must provide a mechanism through which up to five levels can be added
34.15 to the supplemental difficulty of care for a particular child under section 256N.26,
34.16 subdivision 4. In establishing the assessment tool, the commissioner must design the tool
34.17 so that the levels applicable to the portions of the assessment other than the extraordinary
34.18 levels can accommodate the requirements of this subdivision.

34.19 (b) These extraordinary levels are available when all of the following circumstances
34.20 apply:

34.21 (1) the child has extraordinary needs as determined by the assessment tool provided
34.22 for under subdivision 2, and the child meets other requirements established by the
34.23 commissioner, such as a minimum score on the assessment tool;

34.24 (2) the child's extraordinary needs require extraordinary care and intense supervision
34.25 that is provided by the child's caregiver as part of the parental duties as described in the
34.26 supplemental difficulty of care rate, section 256N.02, subdivision 21. This extraordinary
34.27 care provided by the caregiver is required so that the child can be safely cared for in the
34.28 home and community, and prevents residential placement;

34.29 (3) the child is physically living in a foster family setting, as defined in Minnesota
34.30 Rules, part 2960.3010, subpart 23, in a foster residence setting, or physically living in the
34.31 home with the adoptive parent or relative custodian; and

34.32 (4) the child is receiving the services for which the child is eligible through medical
34.33 assistance programs or other programs that provide necessary services for children with
34.34 disabilities or other medical and behavioral conditions to live with the child's family, but
34.35 the agency with caregiver's input has identified a specific support gap that cannot be met

35.1 through home and community support waivers or other programs that are designed to
35.2 provide support for children with special needs.

35.3 (c) The agency completing an assessment, under subdivision 2, that suggests an
35.4 extraordinary level must document as part of the assessment, the following:

35.5 (1) the assessment tool that determined that the child's needs or disabilities require
35.6 extraordinary care and intense supervision;

35.7 (2) a summary of the extraordinary care and intense supervision that is provided by
35.8 the caregiver as part of the parental duties as described in the supplemental difficulty of
35.9 care rate, section 256N.02, subdivision 21;

35.10 (3) confirmation that the child is currently physically residing in the foster family
35.11 setting or in the home with the adoptive parent or relative custodian;

35.12 (4) the efforts of the agency, caregiver, parents, and others to request support services
35.13 in the home and community that would ease the degree of parental duties provided by the
35.14 caregiver for the care and supervision of the child. This would include documentation of
35.15 the services provided for the child's needs or disabilities, and the services that were denied
35.16 or not available from the local social service agency, community agency, the local school
35.17 district, local public health department, the parent, or child's medical insurance provider;

35.18 (5) the specific support gap identified that places the child's safety and well-being at
35.19 risk in the home or community and is necessary to prevent residential placement; and

35.20 (6) the extraordinary care and intense supervision provided by the foster, adoptive,
35.21 or guardianship caregivers to maintain the child safely in the child's home and prevent
35.22 residential placement that cannot be supported by medical assistance or other programs
35.23 that provide services, necessary care for children with disabilities, or other medical or
35.24 behavioral conditions in the home or community.

35.25 (d) An agency completing an assessment under subdivision 2 that suggests
35.26 an extraordinary level is appropriate must forward the assessment and required
35.27 documentation to the commissioner. If the commissioner approves, the extraordinary
35.28 levels must be retroactive to the date the assessment was forwarded.

35.29 Sec. 50. Minnesota Statutes 2014, section 256N.25, subdivision 1, is amended to read:

35.30 Subdivision 1. **Agreement; Northstar kinship assistance; adoption assistance.** (a)
35.31 In order to receive Northstar kinship assistance or adoption assistance benefits on behalf
35.32 of an eligible child, a written, binding agreement between the caregiver or caregivers,
35.33 the financially responsible agency, or, if there is no financially responsible agency, the
35.34 agency designated by the commissioner, and the commissioner must be established prior
35.35 to finalization of the adoption or a transfer of permanent legal and physical custody. The

36.1 agreement must be negotiated with the caregiver or caregivers under subdivision 2 and
 36.2 renegotiated under subdivision 3, if applicable.

36.3 (b) The agreement must be on a form approved by the commissioner and must
 36.4 specify the following:

36.5 (1) duration of the agreement;

36.6 (2) the nature and amount of any payment, services, and assistance to be provided
 36.7 under such agreement;

36.8 (3) the child's eligibility for Medicaid services;

36.9 (4) the terms of the payment, including any child care portion as specified in section
 36.10 256N.24, subdivision 3;

36.11 (5) eligibility for reimbursement of nonrecurring expenses associated with adopting
 36.12 or obtaining permanent legal and physical custody of the child, to the extent that the
 36.13 total cost does not exceed \$2,000 per child;

36.14 (6) that the agreement must remain in effect regardless of the state of which the
 36.15 adoptive parents or relative custodians are residents at any given time;

36.16 (7) provisions for modification of the terms of the agreement, including renegotiation
 36.17 of the agreement; ~~and~~

36.18 (8) the effective date of the agreement; and

36.19 (9) the successor relative custodian or custodians for Northstar kinship assistance,
 36.20 when applicable. The successor relative custodian or custodians may be added or changed
 36.21 by mutual agreement under subdivision 3.

36.22 (c) The caregivers, the commissioner, and the financially responsible agency, or, if
 36.23 there is no financially responsible agency, the agency designated by the commissioner, must
 36.24 sign the agreement. A copy of the signed agreement must be given to each party. Once
 36.25 signed by all parties, the commissioner shall maintain the official record of the agreement.

36.26 (d) The effective date of the Northstar kinship assistance agreement must be the date
 36.27 of the court order that transfers permanent legal and physical custody to the relative. The
 36.28 effective date of the adoption assistance agreement is the date of the finalized adoption
 36.29 decree.

36.30 (e) Termination or disruption of the preadoptive placement or the foster care
 36.31 placement prior to assignment of custody makes the agreement with that caregiver void.

36.32 Sec. 51. Minnesota Statutes 2014, section 256N.27, subdivision 2, is amended to read:

36.33 Subd. 2. **State share.** The commissioner shall pay the state share of the maintenance
 36.34 payments as determined under subdivision 4, and an identical share of the pre-Northstar
 36.35 Care foster care program under section 260C.4411, subdivision 1, the relative custody

37.1 assistance program under section 257.85, and the pre-Northstar Care for Children adoption
 37.2 assistance program under chapter 259A. ~~The commissioner may transfer funds into the~~
 37.3 ~~account if a deficit occurs.~~

37.4 Sec. 52. Minnesota Statutes 2014, section 257.75, subdivision 3, is amended to read:

37.5 Subd. 3. **Effect of recognition.** (a) Subject to subdivision 2 and section 257.55,
 37.6 subdivision 1, paragraph (g) or (h), the recognition has the force and effect of a judgment or
 37.7 order determining the existence of the parent and child relationship under section 257.66. If
 37.8 the conditions in section 257.55, subdivision 1, paragraph (g) or (h), exist, the recognition
 37.9 creates only a presumption of paternity for purposes of sections 257.51 to 257.74. Once a
 37.10 recognition has been properly executed and filed with the state registrar of vital statistics,
 37.11 if there are no competing presumptions of paternity, a judicial or administrative court may
 37.12 not allow further action to determine parentage regarding the signator of the recognition.
 37.13 An action to determine custody and parenting time may be commenced pursuant to
 37.14 chapter 518 without an adjudication of parentage. Until an a temporary or permanent
 37.15 order is entered granting custody to another, the mother has sole custody.

37.16 (b) Following commencement of an action to determine custody or parenting time
 37.17 under chapter 518, the court may, pursuant to section 518.131, grant temporary parenting
 37.18 time rights and temporary custody to either parent.

37.19 (c) The recognition is:

37.20 (1) a basis for bringing an action for the following:

37.21 (i) to award temporary custody or parenting time pursuant to section 518.131;

37.22 (ii) to award permanent custody or parenting time to either parent;₂

37.23 (iii) establishing a child support obligation which may include up to the two years
 37.24 immediately preceding the commencement of the action;₂

37.25 (iv) ordering a contribution by a parent under section 256.87;~~or~~₂

37.26 (v) ordering a contribution to the reasonable expenses of the mother's pregnancy and
 37.27 confinement, as provided under section 257.66, subdivision 3;₂ or

37.28 (vi) ordering reimbursement for the costs of blood or genetic testing, as provided
 37.29 under section 257.69, subdivision 2;

37.30 (2) determinative for all other purposes related to the existence of the parent and
 37.31 child relationship; and

37.32 (3) entitled to full faith and credit in other jurisdictions.

37.33 **EFFECTIVE DATE.** This section is effective March 1, 2016.

37.34 Sec. 53. Minnesota Statutes 2014, section 257.75, subdivision 5, is amended to read:

38.1 Subd. 5. **Recognition form.** (a) The commissioner of human services shall prepare
38.2 a form for the recognition of parentage under this section. In preparing the form, the
38.3 commissioner shall consult with the individuals specified in subdivision 6. The recognition
38.4 form must be drafted so that the force and effect of the recognition, the alternatives to
38.5 executing a recognition, ~~and the benefits and responsibilities of establishing paternity, and~~
38.6 the limitations of the recognition of parentage for purposes of exercising and enforcing
38.7 custody or parenting time are clear and understandable. ~~The form must include a notice~~
38.8 regarding the finality of a recognition and the revocation procedure under subdivision
38.9 2. ~~The form must include a provision for each parent to verify that the parent has read~~
38.10 ~~or viewed the educational materials prepared by the commissioner of human services~~
38.11 ~~describing the recognition of paternity. The individual providing the form to the parents~~
38.12 ~~for execution shall provide oral notice of the rights, responsibilities, and alternatives to~~
38.13 ~~executing the recognition. Notice may be provided by audiotape, videotape, or similar~~
38.14 ~~means. Each parent must receive a copy of the recognition.~~

38.15 (b) The form must include the following:

38.16 (1) a notice regarding the finality of a recognition and the revocation procedure
38.17 under subdivision 2;

38.18 (2) a notice, in large print, that the recognition does not establish an enforceable right
38.19 to legal custody, physical custody, or parenting time until such rights are awarded pursuant
38.20 to a court action to establish custody and parenting time;

38.21 (3) a notice stating that when a court awards custody and parenting time under
38.22 chapter 518, there is no presumption for or against joint physical custody, except when
38.23 domestic abuse, as defined in section 518B.01, subdivision 2, paragraph (a), has occurred
38.24 between the parties;

38.25 (4) a notice that the recognition of parentage is a basis for:

38.26 (i) bringing a court action to award temporary or permanent custody or parenting time;

38.27 (ii) establishing a child support obligation that may include the two years

38.28 immediately preceding the commencement of the action;

38.29 (iii) ordering a contribution by a parent under section 256.87;

38.30 (iv) ordering a contribution to the reasonable expenses of the mother's pregnancy
38.31 and confinement, as provided under section 257.66, subdivision 3; and

38.32 (v) ordering reimbursement for the costs of blood or genetic testing, as provided
38.33 under section 257.69, subdivision 2; and

38.34 (5) a provision for each parent to verify that the parent has read or viewed the
38.35 educational materials prepared by the commissioner of human services describing the
38.36 recognition of paternity.

39.1 (c) The individual providing the form to the parents for execution shall provide oral
 39.2 notice of the rights, responsibilities, and alternatives to executing the recognition. Notice
 39.3 may be provided in audio or video format, or by other similar means. Each parent must
 39.4 receive a copy of the recognition.

39.5 **EFFECTIVE DATE.** This section is effective March 1, 2016.

39.6 Sec. 54. Minnesota Statutes 2014, section 259A.75, is amended to read:

39.7 **259A.75 REIMBURSEMENT OF CERTAIN AGENCY COSTS; PURCHASE**
 39.8 **OF SERVICE CONTRACTS AND TRIBAL CUSTOMARY ADOPTIONS.**

39.9 Subdivision 1. **General information.** (a) Subject to the procedures required by
 39.10 the commissioner and the provisions of this section, a Minnesota county ~~or tribal social~~
 39.11 ~~services agency~~ shall receive a reimbursement from the commissioner equal to 100 percent
 39.12 of the reasonable and appropriate cost for contracted adoption placement services identified
 39.13 for a specific child that are not reimbursed under other federal or state funding sources.

39.14 (b) The commissioner may spend up to \$16,000 for each purchase of service
 39.15 contract. Only one contract per child per adoptive placement is permitted. Funds
 39.16 encumbered and obligated under the contract for the child remain available until the terms
 39.17 of the contract are fulfilled or the contract is terminated.

39.18 (c) The commissioner shall set aside an amount not to exceed five percent of the
 39.19 total amount of the fiscal year appropriation from the state for the adoption assistance
 39.20 program to reimburse a Minnesota county or tribal social services placing agencies agency
 39.21 for child-specific adoption placement services. When adoption assistance payments for
 39.22 children's needs exceed 95 percent of the total amount of the fiscal year appropriation from
 39.23 the state for the adoption assistance program, the amount of reimbursement available to
 39.24 placing agencies for adoption services is reduced correspondingly.

39.25 Subd. 2. **Purchase of service contract child eligibility criteria.** (a) A child who is
 39.26 the subject of a purchase of service contract must:

39.27 (1) have the goal of adoption, which may include an adoption in accordance with
 39.28 tribal law;

39.29 (2) be under the guardianship of the commissioner of human services or be a ward of
 39.30 tribal court pursuant to section 260.755, subdivision 20; and

39.31 (3) meet all of the special needs criteria according to section 259A.10, subdivision 2.

39.32 (b) A child under the guardianship of the commissioner must have an identified
 39.33 adoptive parent and a fully executed adoption placement agreement according to section
 39.34 260C.613, subdivision 1, paragraph (a).

40.1 Subd. 3. **Agency eligibility criteria.** (a) A Minnesota county ~~or tribal~~ social
40.2 services agency shall receive reimbursement for child-specific adoption placement
40.3 services for an eligible child that it purchases from a private adoption agency licensed in
40.4 Minnesota or any other state or tribal social services agency.

40.5 (b) Reimbursement for adoption services is available only for services provided
40.6 prior to the date of the adoption decree.

40.7 Subd. 4. **Application and eligibility determination.** (a) A county ~~or tribal~~ social
40.8 services agency may request reimbursement of costs for adoption placement services by
40.9 submitting a complete purchase of service application, according to the requirements and
40.10 procedures and on forms prescribed by the commissioner.

40.11 (b) The commissioner shall determine eligibility for reimbursement of adoption
40.12 placement services. If determined eligible, the commissioner of human services shall
40.13 sign the purchase of service agreement, making this a fully executed contract. No
40.14 reimbursement under this section shall be made to an agency for services provided prior to
40.15 the fully executed contract.

40.16 (c) Separate purchase of service agreements shall be made, and separate records
40.17 maintained, on each child. Only one agreement per child per adoptive placement is
40.18 permitted. For siblings who are placed together, services shall be planned and provided to
40.19 best maximize efficiency of the contracted hours.

40.20 Subd. 5. **Reimbursement process.** (a) The agency providing adoption services is
40.21 responsible to track and record all service activity, including billable hours, on a form
40.22 prescribed by the commissioner. The agency shall submit this form to the state for
40.23 reimbursement after services have been completed.

40.24 (b) The commissioner shall make the final determination whether or not the
40.25 requested reimbursement costs are reasonable and appropriate and if the services have
40.26 been completed according to the terms of the purchase of service agreement.

40.27 Subd. 6. **Retention of purchase of service records.** Agencies entering into
40.28 purchase of service contracts shall keep a copy of the agreements, service records, and all
40.29 applicable billing and invoicing according to the department's record retention schedule.
40.30 Agency records shall be provided upon request by the commissioner.

40.31 Subd. 7. **Tribal customary adoptions.** (a) The commissioner shall enter into
40.32 grant contracts with Minnesota tribal social services agencies to provide child-specific
40.33 recruitment and adoption placement services for Indian children under the jurisdiction
40.34 of tribal court.

40.35 (b) Children served under these grant contracts must meet the child eligibility
40.36 criteria in subdivision 2.

41.1 Sec. 55. Minnesota Statutes 2014, section 260C.007, subdivision 27, is amended to read:

41.2 Subd. 27. **Relative.** "Relative" means a person related to the child by blood,
41.3 marriage, or adoption; the legal parent, guardian, or custodian of the child's siblings; or an
41.4 individual who is an important friend with whom the child has resided or had significant
41.5 contact. For an Indian child, relative includes members of the extended family as defined
41.6 by the law or custom of the Indian child's tribe or, in the absence of law or custom, nieces,
41.7 nephews, or first or second cousins, as provided in the Indian Child Welfare Act of 1978,
41.8 United States Code, title 25, section 1903.

41.9 Sec. 56. Minnesota Statutes 2014, section 260C.007, subdivision 32, is amended to read:

41.10 Subd. 32. **Sibling.** "Sibling" means one of two or more individuals who have one or
41.11 both parents in common through blood, marriage, or adoption, ~~including~~. This includes
41.12 siblings as defined by the child's tribal code or custom. Sibling also includes an individual
41.13 who would have been considered a sibling but for a termination of parental rights of one
41.14 or both parents, suspension of parental rights under tribal code, or other disruption of
41.15 parental rights such as the death of a parent.

41.16 Sec. 57. Minnesota Statutes 2014, section 260C.203, is amended to read:

41.17 **260C.203 ADMINISTRATIVE OR COURT REVIEW OF PLACEMENTS.**

41.18 (a) Unless the court is conducting the reviews required under section 260C.202,
41.19 there shall be an administrative review of the out-of-home placement plan of each child
41.20 placed in foster care no later than 180 days after the initial placement of the child in foster
41.21 care and at least every six months thereafter if the child is not returned to the home of the
41.22 parent or parents within that time. The out-of-home placement plan must be monitored and
41.23 updated at each administrative review. The administrative review shall be conducted by
41.24 the responsible social services agency using a panel of appropriate persons at least one of
41.25 whom is not responsible for the case management of, or the delivery of services to, either
41.26 the child or the parents who are the subject of the review. The administrative review shall
41.27 be open to participation by the parent or guardian of the child and the child, as appropriate.

41.28 (b) As an alternative to the administrative review required in paragraph (a), the court
41.29 may, as part of any hearing required under the Minnesota Rules of Juvenile Protection
41.30 Procedure, conduct a hearing to monitor and update the out-of-home placement plan
41.31 pursuant to the procedure and standard in section 260C.201, subdivision 6, paragraph
41.32 (d). The party requesting review of the out-of-home placement plan shall give parties to
41.33 the proceeding notice of the request to review and update the out-of-home placement
41.34 plan. A court review conducted pursuant to section 260C.141, subdivision 2; 260C.193;

42.1 260C.201, subdivision 1; 260C.202; 260C.204; 260C.317; or 260D.06 shall satisfy the
42.2 requirement for the review so long as the other requirements of this section are met.

42.3 (c) As appropriate to the stage of the proceedings and relevant court orders, the
42.4 responsible social services agency or the court shall review:

42.5 (1) the safety, permanency needs, and well-being of the child;

42.6 (2) the continuing necessity for and appropriateness of the placement;

42.7 (3) the extent of compliance with the out-of-home placement plan;

42.8 (4) the extent of progress that has been made toward alleviating or mitigating the
42.9 causes necessitating placement in foster care;

42.10 (5) the projected date by which the child may be returned to and safely maintained in
42.11 the home or placed permanently away from the care of the parent or parents or guardian; and

42.12 (6) the appropriateness of the services provided to the child.

42.13 (d) When a child is age ~~16~~ 14 or older, in addition to any administrative review
42.14 conducted by the agency, at the in-court review required under section 260C.317,
42.15 subdivision 3, clause (3), or 260C.515, subdivision 5 or 6, the court shall review the
42.16 independent living plan required under section 260C.212, subdivision 1, paragraph (c),
42.17 clause ~~(11)~~ (12), and the provision of services to the child related to the well-being of
42.18 the child as the child prepares to leave foster care. The review shall include the actual
42.19 plans related to each item in the plan necessary to the child's future safety and well-being
42.20 when the child is no longer in foster care.

42.21 (e) At the court review required under paragraph (d) for a child age ~~16~~ 14 or older,
42.22 the following procedures apply:

42.23 (1) six months before the child is expected to be discharged from foster care, the
42.24 responsible social services agency shall give the written notice required under section
42.25 260C.451, subdivision 1, regarding the right to continued access to services for certain
42.26 children in foster care past age 18 and of the right to appeal a denial of social services
42.27 under section 256.045. The agency shall file a copy of the notice, including the right to
42.28 appeal a denial of social services, with the court. If the agency does not file the notice by
42.29 the time the child is age 17-1/2, the court shall require the agency to give it;

42.30 (2) consistent with the requirements of the independent living plan, the court shall
42.31 review progress toward or accomplishment of the following goals:

42.32 (i) the child has obtained a high school diploma or its equivalent;

42.33 (ii) the child has completed a driver's education course or has demonstrated the
42.34 ability to use public transportation in the child's community;

42.35 (iii) the child is employed or enrolled in postsecondary education;

43.1 (iv) the child has applied for and obtained postsecondary education financial aid for
43.2 which the child is eligible;

43.3 (v) the child has health care coverage and health care providers to meet the child's
43.4 physical and mental health needs;

43.5 (vi) the child has applied for and obtained disability income assistance for which
43.6 the child is eligible;

43.7 (vii) the child has obtained affordable housing with necessary supports, which does
43.8 not include a homeless shelter;

43.9 (viii) the child has saved sufficient funds to pay for the first month's rent and a
43.10 damage deposit;

43.11 (ix) the child has an alternative affordable housing plan, which does not include a
43.12 homeless shelter, if the original housing plan is unworkable;

43.13 (x) the child, if male, has registered for the Selective Service; and

43.14 (xi) the child has a permanent connection to a caring adult; and

43.15 (3) the court shall ensure that the responsible agency in conjunction with the
43.16 placement provider assists the child in obtaining the following documents prior to the
43.17 child's leaving foster care: a Social Security card; the child's birth certificate; a state
43.18 identification card or driver's license, tribal enrollment identification card, green card, or
43.19 school visa; the child's school, medical, and dental records; a contact list of the child's
43.20 medical, dental, and mental health providers; and contact information for the child's
43.21 siblings, if the siblings are in foster care.

43.22 (f) For a child who will be discharged from foster care at age 18 or older, the
43.23 responsible social services agency is required to develop a personalized transition plan as
43.24 directed by the youth. The transition plan must be developed during the 90-day period
43.25 immediately prior to the expected date of discharge. The transition plan must be as
43.26 detailed as the child may elect and include specific options on housing, health insurance,
43.27 education, local opportunities for mentors and continuing support services, and work force
43.28 supports and employment services. The agency shall ensure that the youth receives, at
43.29 no cost to the youth, a copy of the youth's consumer credit report as defined in section
43.30 13C.001 and assistance in interpreting and resolving any inaccuracies in the report. The
43.31 plan must include information on the importance of designating another individual to
43.32 make health care treatment decisions on behalf of the child if the child becomes unable
43.33 to participate in these decisions and the child does not have, or does not want, a relative
43.34 who would otherwise be authorized to make these decisions. The plan must provide the
43.35 child with the option to execute a health care directive as provided under chapter 145C.

44.1 The agency shall also provide the youth with appropriate contact information if the youth
44.2 needs more information or needs help dealing with a crisis situation through age 21.

44.3 Sec. 58. Minnesota Statutes 2014, section 260C.212, subdivision 1, is amended to read:

44.4 Subdivision 1. **Out-of-home placement; plan.** (a) An out-of-home placement plan
44.5 shall be prepared within 30 days after any child is placed in foster care by court order or a
44.6 voluntary placement agreement between the responsible social services agency and the
44.7 child's parent pursuant to section 260C.227 or chapter 260D.

44.8 (b) An out-of-home placement plan means a written document which is prepared
44.9 by the responsible social services agency jointly with the parent or parents or guardian
44.10 of the child and in consultation with the child's guardian ad litem, the child's tribe, if the
44.11 child is an Indian child, the child's foster parent or representative of the foster care facility,
44.12 and, where appropriate, the child. When a child is age 14 or older, the child may include
44.13 two other individuals on the team preparing the child's out-of-home placement plan. For
44.14 a child in voluntary foster care for treatment under chapter 260D, preparation of the
44.15 out-of-home placement plan shall additionally include the child's mental health treatment
44.16 provider. As appropriate, the plan shall be:

44.17 (1) submitted to the court for approval under section 260C.178, subdivision 7;

44.18 (2) ordered by the court, either as presented or modified after hearing, under section
44.19 260C.178, subdivision 7, or 260C.201, subdivision 6; and

44.20 (3) signed by the parent or parents or guardian of the child, the child's guardian ad
44.21 litem, a representative of the child's tribe, the responsible social services agency, and, if
44.22 possible, the child.

44.23 (c) The out-of-home placement plan shall be explained to all persons involved in its
44.24 implementation, including the child who has signed the plan, and shall set forth:

44.25 (1) a description of the foster care home or facility selected, including how the
44.26 out-of-home placement plan is designed to achieve a safe placement for the child in the
44.27 least restrictive, most family-like, setting available which is in close proximity to the home
44.28 of the parent or parents or guardian of the child when the case plan goal is reunification,
44.29 and how the placement is consistent with the best interests and special needs of the child
44.30 according to the factors under subdivision 2, paragraph (b);

44.31 (2) the specific reasons for the placement of the child in foster care, and when
44.32 reunification is the plan, a description of the problems or conditions in the home of the
44.33 parent or parents which necessitated removal of the child from home and the changes the
44.34 parent or parents must make in order for the child to safely return home;

45.1 (3) a description of the services offered and provided to prevent removal of the child
45.2 from the home and to reunify the family including:

45.3 (i) the specific actions to be taken by the parent or parents of the child to eliminate
45.4 or correct the problems or conditions identified in clause (2), and the time period during
45.5 which the actions are to be taken; and

45.6 (ii) the reasonable efforts, or in the case of an Indian child, active efforts to be made
45.7 to achieve a safe and stable home for the child including social and other supportive
45.8 services to be provided or offered to the parent or parents or guardian of the child, the
45.9 child, and the residential facility during the period the child is in the residential facility;

45.10 (4) a description of any services or resources that were requested by the child or the
45.11 child's parent, guardian, foster parent, or custodian since the date of the child's placement
45.12 in the residential facility, and whether those services or resources were provided and if
45.13 not, the basis for the denial of the services or resources;

45.14 (5) the visitation plan for the parent or parents or guardian, other relatives as defined
45.15 in section 260C.007, subdivision 27, and siblings of the child if the siblings are not placed
45.16 together in foster care, and whether visitation is consistent with the best interest of the
45.17 child, during the period the child is in foster care;

45.18 (6) when a child cannot return to or be in the care of either parent, documentation
45.19 of steps to finalize adoption as the permanency plan for the child, ~~including: (i) through~~
45.20 reasonable efforts to place the child for adoption. At a minimum, the documentation must
45.21 include consideration of whether adoption is in the best interests of the child, child-specific
45.22 recruitment efforts such as relative search and the use of state, regional, and national
45.23 adoption exchanges to facilitate orderly and timely placements in and outside of the state.
45.24 A copy of this documentation shall be provided to the court in the review required under
45.25 section 260C.317, subdivision 3, paragraph (b); and

45.26 ~~(ii) documentation necessary to support the requirements of the kinship placement~~
45.27 ~~agreement under section 256N.22 when adoption is determined not to be in the child's~~
45.28 ~~best interests;~~ (7) when a child cannot return to or be in the care of either parent,
45.29 documentation of steps to finalize the transfer of permanent legal and physical custody
45.30 to a relative as the permanency plan for the child. This documentation must support the
45.31 requirements of the kinship placement agreement under section 256N.22 and must include
45.32 the reasonable efforts used to determine that it is not appropriate for the child to return
45.33 home or be adopted, and reasons why permanent placement with a relative through a
45.34 Northstar kinship assistance arrangement is in the child's best interest; how the child meets
45.35 the eligibility requirements for Northstar kinship assistance payments; agency efforts to
45.36 discuss adoption with the child's relative foster parent and reasons why the relative foster

46.1 parent chose not to pursue adoption, if applicable; and agency efforts to discuss with the
 46.2 child's parent or parents the permanent transfer of permanent legal and physical custody or
 46.3 the reasons why these efforts were not made;

46.4 ~~(7)~~ (8) efforts to ensure the child's educational stability while in foster care, including:

46.5 (i) efforts to ensure that the child remains in the same school in which the child was
 46.6 enrolled prior to placement or upon the child's move from one placement to another,
 46.7 including efforts to work with the local education authorities to ensure the child's
 46.8 educational stability; or

46.9 (ii) if it is not in the child's best interest to remain in the same school that the child
 46.10 was enrolled in prior to placement or move from one placement to another, efforts to
 46.11 ensure immediate and appropriate enrollment for the child in a new school;

46.12 ~~(8)~~ (9) the educational records of the child including the most recent information
 46.13 available regarding:

46.14 (i) the names and addresses of the child's educational providers;

46.15 (ii) the child's grade level performance;

46.16 (iii) the child's school record;

46.17 (iv) a statement about how the child's placement in foster care takes into account
 46.18 proximity to the school in which the child is enrolled at the time of placement; and

46.19 (v) any other relevant educational information;

46.20 ~~(9)~~ (10) the efforts by the local agency to ensure the oversight and continuity of
 46.21 health care services for the foster child, including:

46.22 (i) the plan to schedule the child's initial health screens;

46.23 (ii) how the child's known medical problems and identified needs from the screens,
 46.24 including any known communicable diseases, as defined in section 144.4172, subdivision
 46.25 2, will be monitored and treated while the child is in foster care;

46.26 (iii) how the child's medical information will be updated and shared, including
 46.27 the child's immunizations;

46.28 (iv) who is responsible to coordinate and respond to the child's health care needs,
 46.29 including the role of the parent, the agency, and the foster parent;

46.30 (v) who is responsible for oversight of the child's prescription medications;

46.31 (vi) how physicians or other appropriate medical and nonmedical professionals
 46.32 will be consulted and involved in assessing the health and well-being of the child and
 46.33 determine the appropriate medical treatment for the child; and

46.34 (vii) the responsibility to ensure that the child has access to medical care through
 46.35 either medical insurance or medical assistance;

46.36 ~~(10)~~ (11) the health records of the child including information available regarding:

- 47.1 (i) the names and addresses of the child's health care and dental care providers;
- 47.2 (ii) a record of the child's immunizations;
- 47.3 (iii) the child's known medical problems, including any known communicable
- 47.4 diseases as defined in section 144.4172, subdivision 2;
- 47.5 (iv) the child's medications; and
- 47.6 (v) any other relevant health care information such as the child's eligibility for
- 47.7 medical insurance or medical assistance;
- 47.8 ~~(11)~~ (12) an independent living plan for a child age ~~16~~ 14 or older. The plan should
- 47.9 include, but not be limited to, the following objectives:
- 47.10 (i) educational, vocational, or employment planning;
- 47.11 (ii) health care planning and medical coverage;
- 47.12 (iii) transportation including, where appropriate, assisting the child in obtaining a
- 47.13 driver's license;
- 47.14 (iv) money management, including the responsibility of the agency to ensure that
- 47.15 the youth annually receives, at no cost to the youth, a consumer report as defined under
- 47.16 section 13C.001 and assistance in interpreting and resolving any inaccuracies in the report;
- 47.17 (v) planning for housing;
- 47.18 (vi) social and recreational skills; ~~and~~
- 47.19 (vii) establishing and maintaining connections with the child's family and
- 47.20 community; and
- 47.21 (viii) regular opportunities to engage in age-appropriate or developmentally
- 47.22 appropriate activities typical for the child's age group, taking into consideration the
- 47.23 capacities of the individual child; and
- 47.24 ~~(12)~~ (13) for a child in voluntary foster care for treatment under chapter 260D,
- 47.25 diagnostic and assessment information, specific services relating to meeting the mental
- 47.26 health care needs of the child, and treatment outcomes.
- 47.27 (d) The parent or parents or guardian and the child each shall have the right to legal
- 47.28 counsel in the preparation of the case plan and shall be informed of the right at the time
- 47.29 of placement of the child. The child shall also have the right to a guardian ad litem.
- 47.30 If unable to employ counsel from their own resources, the court shall appoint counsel
- 47.31 upon the request of the parent or parents or the child or the child's legal guardian. The
- 47.32 parent or parents may also receive assistance from any person or social services agency
- 47.33 in preparation of the case plan.
- 47.34 After the plan has been agreed upon by the parties involved or approved or ordered
- 47.35 by the court, the foster parents shall be fully informed of the provisions of the case plan
- 47.36 and shall be provided a copy of the plan.

48.1 Upon discharge from foster care, the parent, adoptive parent, or permanent legal and
48.2 physical custodian, as appropriate, and the child, if appropriate, must be provided with
48.3 a current copy of the child's health and education record.

48.4 Sec. 59. Minnesota Statutes 2014, section 260C.212, is amended by adding a
48.5 subdivision to read:

48.6 Subd. 13. **Protecting missing and runaway children and youth at risk of sex**
48.7 **trafficking.** (a) The local social services agency shall expeditiously locate any child
48.8 missing from foster care.

48.9 (b) The local social services agency shall report immediately, but no later than
48.10 24 hours, after receiving information on a missing or abducted child to the local law
48.11 enforcement agency for entry into the National Crime Information Center (NCIC)
48.12 database of the Federal Bureau of Investigation, and to the National Center for Missing
48.13 and Exploited Children.

48.14 (c) The local social services agency shall not discharge a child from foster care or
48.15 close the social services case until diligent efforts have been exhausted to locate the child
48.16 and the court terminates the agency's jurisdiction.

48.17 (d) The local social services agency shall determine the primary factors that
48.18 contributed to the child's running away or otherwise being absent from care and, to
48.19 the extent possible and appropriate, respond to those factors in current and subsequent
48.20 placements.

48.21 (e) The local social services agency shall determine what the child experienced
48.22 while absent from care, including screening the child to determine if the child is a possible
48.23 sex trafficking victim as defined in section 609.321, subdivision 7b.

48.24 (f) The local social services agency shall report immediately, but no later than 24
48.25 hours, to the local law enforcement agency any reasonable cause to believe a child is, or is
48.26 at risk of being, a sex trafficking victim.

48.27 (g) The local social services agency shall determine appropriate services as described
48.28 in section 145.4717 with respect to any child for whom the local social services agency has
48.29 responsibility for placement, care, or supervision when the local social services agency
48.30 has reasonable cause to believe the child is, or is at risk of being, a sex trafficking victim.

48.31 Sec. 60. Minnesota Statutes 2014, section 260C.212, is amended by adding a
48.32 subdivision to read:

48.33 Subd. 14. **Support age-appropriate and developmentally appropriate activities**
48.34 **for foster children.** Responsible social services agencies and child-placing agencies shall

49.1 support a foster child's emotional and developmental growth by permitting the child
49.2 to participate in activities or events that are generally accepted as suitable for children
49.3 of the same chronological age or are developmentally appropriate for the child. Foster
49.4 parents and residential facility staff are permitted to allow foster children to participate in
49.5 extracurricular, social, or cultural activities that are typical for the child's age by applying
49.6 reasonable and prudent parenting standards. Reasonable and prudent parenting standards
49.7 are characterized by careful and sensible parenting decisions that maintain the child's
49.8 health and safety, and are made in the child's best interest.

49.9 Sec. 61. Minnesota Statutes 2014, section 260C.221, is amended to read:

49.10 **260C.221 RELATIVE SEARCH.**

49.11 (a) The responsible social services agency shall exercise due diligence to identify
49.12 and notify adult relatives prior to placement or within 30 days after the child's removal
49.13 from the parent. The county agency shall consider placement with a relative under this
49.14 section without delay and whenever the child must move from or be returned to foster
49.15 care. The relative search required by this section shall be comprehensive in scope. After a
49.16 finding that the agency has made reasonable efforts to conduct the relative search under
49.17 this paragraph, the agency has the continuing responsibility to appropriately involve
49.18 relatives, who have responded to the notice required under this paragraph, in planning
49.19 for the child and to continue to consider relatives according to the requirements of
49.20 section 260C.212, subdivision 2. At any time during the course of juvenile protection
49.21 proceedings, the court may order the agency to reopen its search for relatives when it is in
49.22 the child's best interest to do so.

49.23 (b) The relative search required by this section shall include both maternal relatives
49.24 and paternal adult relatives of the child; all adult grandparents; all legal parents, guardians
49.25 or custodians; the child's siblings; and any other adult relatives suggested by the child's
49.26 parents, subject to the exceptions due to family violence in paragraph (c). The search shall
49.27 also include getting information from the child in an age-appropriate manner about who
49.28 the child considers to be family members and important friends with whom the child has
49.29 resided or had significant contact. The relative search required under this section must
49.30 fulfill the agency's duties under the Indian Child Welfare Act regarding active efforts
49.31 to prevent the breakup of the Indian family under United States Code, title 25, section
49.32 1912(d), and to meet placement preferences under United States Code, title 25, section
49.33 1915. The relatives must be notified:

50.1 (1) of the need for a foster home for the child, the option to become a placement
50.2 resource for the child, and the possibility of the need for a permanent placement for the
50.3 child;

50.4 (2) of their responsibility to keep the responsible social services agency and the court
50.5 informed of their current address in order to receive notice in the event that a permanent
50.6 placement is sought for the child and to receive notice of the permanency progress review
50.7 hearing under section 260C.204. A relative who fails to provide a current address to the
50.8 responsible social services agency and the court forfeits the right to receive notice of the
50.9 possibility of permanent placement and of the permanency progress review hearing under
50.10 section 260C.204. A decision by a relative not to be identified as a potential permanent
50.11 placement resource or participate in planning for the child at the beginning of the case
50.12 shall not affect whether the relative is considered for placement of the child with that
50.13 relative later;

50.14 (3) that the relative may participate in the care and planning for the child, including
50.15 that the opportunity for such participation may be lost by failing to respond to the notice
50.16 sent under this subdivision. "Participate in the care and planning" includes, but is not
50.17 limited to, participation in case planning for the parent and child, identifying the strengths
50.18 and needs of the parent and child, supervising visits, providing respite and vacation visits
50.19 for the child, providing transportation to appointments, suggesting other relatives who
50.20 might be able to help support the case plan, and to the extent possible, helping to maintain
50.21 the child's familiar and regular activities and contact with friends and relatives;

50.22 (4) of the family foster care licensing requirements, including how to complete an
50.23 application and how to request a variance from licensing standards that do not present a
50.24 safety or health risk to the child in the home under section 245A.04 and supports that are
50.25 available for relatives and children who reside in a family foster home; and

50.26 (5) of the relatives' right to ask to be notified of any court proceedings regarding
50.27 the child, to attend the hearings, and of a relative's right or opportunity to be heard by the
50.28 court as required under section 260C.152, subdivision 5.

50.29 ~~(b)~~ (c) A responsible social services agency may disclose private data, as defined
50.30 in sections 13.02 and 626.556, to relatives of the child for the purpose of locating and
50.31 assessing a suitable placement and may use any reasonable means of identifying and
50.32 locating relatives including the Internet or other electronic means of conducting a search.
50.33 The agency shall disclose data that is necessary to facilitate possible placement with
50.34 relatives and to ensure that the relative is informed of the needs of the child so the
50.35 relative can participate in planning for the child and be supportive of services to the child
50.36 and family. If the child's parent refuses to give the responsible social services agency

51.1 information sufficient to identify the maternal and paternal relatives of the child, the
51.2 agency shall ask the juvenile court to order the parent to provide the necessary information.
51.3 If a parent makes an explicit request that a specific relative not be contacted or considered
51.4 for placement due to safety reasons including past family or domestic violence, the agency
51.5 shall bring the parent's request to the attention of the court to determine whether the
51.6 parent's request is consistent with the best interests of the child and the agency shall not
51.7 contact the specific relative when the juvenile court finds that contacting the specific
51.8 relative would endanger the parent, guardian, child, sibling, or any family member.

51.9 ~~(e)~~ (d) At a regularly scheduled hearing not later than three months after the child's
51.10 placement in foster care and as required in section 260C.202, the agency shall report to
51.11 the court:

51.12 (1) its efforts to identify maternal and paternal relatives of the child and to engage
51.13 the relatives in providing support for the child and family, and document that the relatives
51.14 have been provided the notice required under paragraph (a); and

51.15 (2) its decision regarding placing the child with a relative as required under section
51.16 260C.212, subdivision 2, and to ask relatives to visit or maintain contact with the child in
51.17 order to support family connections for the child, when placement with a relative is not
51.18 possible or appropriate.

51.19 ~~(d)~~ (e) Notwithstanding chapter 13, the agency shall disclose data about particular
51.20 relatives identified, searched for, and contacted for the purposes of the court's review of
51.21 the agency's due diligence.

51.22 ~~(e)~~ (f) When the court is satisfied that the agency has exercised due diligence to
51.23 identify relatives and provide the notice required in paragraph (a), the court may find that
51.24 reasonable efforts have been made to conduct a relative search to identify and provide
51.25 notice to adult relatives as required under section 260.012, paragraph (e), clause (3). If the
51.26 court is not satisfied that the agency has exercised due diligence to identify relatives and
51.27 provide the notice required in paragraph (a), the court may order the agency to continue its
51.28 search and notice efforts and to report back to the court.

51.29 ~~(f)~~ (g) When the placing agency determines that permanent placement proceedings
51.30 are necessary because there is a likelihood that the child will not return to a parent's
51.31 care, the agency must send the notice provided in paragraph ~~(g)~~ (h), may ask the court to
51.32 modify the duty of the agency to send the notice required in paragraph ~~(g)~~ (h), or may
51.33 ask the court to completely relieve the agency of the requirements of paragraph ~~(g)~~ (h).
51.34 The relative notification requirements of paragraph ~~(g)~~ (h) do not apply when the child is
51.35 placed with an appropriate relative or a foster home that has committed to adopting the
51.36 child or taking permanent legal and physical custody of the child and the agency approves

52.1 of that foster home for permanent placement of the child. The actions ordered by the
 52.2 court under this section must be consistent with the best interests, safety, permanency,
 52.3 and welfare of the child.

52.4 ~~(g)~~ (h) Unless required under the Indian Child Welfare Act or relieved of this duty
 52.5 by the court under paragraph ~~(e)~~ (f), when the agency determines that it is necessary to
 52.6 prepare for permanent placement determination proceedings, or in anticipation of filing a
 52.7 termination of parental rights petition, the agency shall send notice to the relatives, any
 52.8 adult with whom the child is currently residing, any adult with whom the child has resided
 52.9 for one year or longer in the past, and any adults who have maintained a relationship or
 52.10 exercised visitation with the child as identified in the agency case plan. The notice must
 52.11 state that a permanent home is sought for the child and that the individuals receiving the
 52.12 notice may indicate to the agency their interest in providing a permanent home. The notice
 52.13 must state that within 30 days of receipt of the notice an individual receiving the notice must
 52.14 indicate to the agency the individual's interest in providing a permanent home for the child
 52.15 or that the individual may lose the opportunity to be considered for a permanent placement.

52.16 Sec. 62. Minnesota Statutes 2014, section 260C.331, subdivision 1, is amended to read:

52.17 Subdivision 1. **Care, examination, or treatment.** (a) Except where parental rights
 52.18 are terminated,

52.19 (1) whenever legal custody of a child is transferred by the court to a responsible
 52.20 social services agency,

52.21 (2) whenever legal custody is transferred to a person other than the responsible social
 52.22 services agency, but under the supervision of the responsible social services agency, or

52.23 (3) whenever a child is given physical or mental examinations or treatment under
 52.24 order of the court, and no provision is otherwise made by law for payment for the care,
 52.25 examination, or treatment of the child, these costs are a charge upon the welfare funds of
 52.26 the county in which proceedings are held upon certification of the judge of juvenile court.

52.27 (b) The court shall order, and the responsible social services agency shall require,
 52.28 the parents or custodian of a child, while the child is under the age of 18, to use the
 52.29 total income and resources attributable to the child for the period of care, examination,
 52.30 or treatment, except for clothing and personal needs allowance as provided in section
 52.31 256B.35, to reimburse the county for the cost of care, examination, or treatment. Income
 52.32 and resources attributable to the child include, but are not limited to, Social Security
 52.33 benefits, Supplemental Security Income (SSI), veterans benefits, railroad retirement
 52.34 benefits and child support. When the child is over the age of 18, and continues to receive
 52.35 care, examination, or treatment, the court shall order, and the responsible social services

53.1 agency shall require, reimbursement from the child for the cost of care, examination, or
53.2 treatment from the income and resources attributable to the child less the clothing and
53.3 personal needs allowance. Income does not include earnings from a child over the age of
53.4 18 who is working as part of a plan under section 260C.212, subdivision 1, paragraph (c),
53.5 clause ~~(11)~~ (12), to transition from foster care, or the income and resources from sources
53.6 other than Supplemental Security Income and child support that are needed to complete
53.7 the requirements listed in section 260C.203.

53.8 (c) If the income and resources attributable to the child are not enough to reimburse
53.9 the county for the full cost of the care, examination, or treatment, the court shall inquire
53.10 into the ability of the parents to support the child and, after giving the parents a reasonable
53.11 opportunity to be heard, the court shall order, and the responsible social services agency
53.12 shall require, the parents to contribute to the cost of care, examination, or treatment of
53.13 the child. When determining the amount to be contributed by the parents, the court shall
53.14 use a fee schedule based upon ability to pay that is established by the responsible social
53.15 services agency and approved by the commissioner of human services. The income of
53.16 a stepparent who has not adopted a child shall be excluded in calculating the parental
53.17 contribution under this section.

53.18 (d) The court shall order the amount of reimbursement attributable to the parents
53.19 or custodian, or attributable to the child, or attributable to both sources, withheld under
53.20 chapter 518A from the income of the parents or the custodian of the child. A parent or
53.21 custodian who fails to pay without good reason may be proceeded against for contempt, or
53.22 the court may inform the county attorney, who shall proceed to collect the unpaid sums,
53.23 or both procedures may be used.

53.24 (e) If the court orders a physical or mental examination for a child, the examination
53.25 is a medically necessary service for purposes of determining whether the service is
53.26 covered by a health insurance policy, health maintenance contract, or other health
53.27 coverage plan. Court-ordered treatment shall be subject to policy, contract, or plan
53.28 requirements for medical necessity. Nothing in this paragraph changes or eliminates
53.29 benefit limits, conditions of coverage, co-payments or deductibles, provider restrictions,
53.30 or other requirements in the policy, contract, or plan that relate to coverage of other
53.31 medically necessary services.

53.32 (f) Notwithstanding paragraph (b), (c), or (d), a parent, custodian, or guardian of the
53.33 child is not required to use income and resources attributable to the child to reimburse
53.34 the county for costs of care and is not required to contribute to the cost of care of the
53.35 child during any period of time when the child is returned to the home of that parent,

54.1 custodian, or guardian pursuant to a trial home visit under section 260C.201, subdivision
54.2 1, paragraph (a).

54.3 Sec. 63. Minnesota Statutes 2014, section 260C.451, subdivision 2, is amended to read:

54.4 Subd. 2. **Independent living plan.** Upon the request of any child in foster care
54.5 immediately prior to the child's 18th birthday and who is in foster care at the time
54.6 of the request, the responsible social services agency shall, in conjunction with the
54.7 child and other appropriate parties, update the independent living plan required under
54.8 section 260C.212, subdivision 1, paragraph (c), clause ~~(H)~~ (12), related to the child's
54.9 employment, vocational, educational, social, or maturational needs. The agency shall
54.10 provide continued services and foster care for the child including those services that are
54.11 necessary to implement the independent living plan.

54.12 Sec. 64. Minnesota Statutes 2014, section 260C.451, subdivision 6, is amended to read:

54.13 Subd. 6. **Reentering foster care and accessing services after age 18.** (a)
54.14 Upon request of an individual between the ages of 18 and 21 who had been under the
54.15 guardianship of the commissioner and who has left foster care without being adopted, the
54.16 responsible social services agency which had been the commissioner's agent for purposes
54.17 of the guardianship shall develop with the individual a plan to increase the individual's
54.18 ability to live safely and independently using the plan requirements of section 260C.212,
54.19 subdivision 1, paragraph ~~(b)~~ (c), clause ~~(H)~~ (12), and to assist the individual to meet
54.20 one or more of the eligibility criteria in subdivision 4 if the individual wants to reenter
54.21 foster care. The agency shall provide foster care as required to implement the plan. The
54.22 agency shall enter into a voluntary placement agreement under section 260C.229 with the
54.23 individual if the plan includes foster care.

54.24 (b) Individuals who had not been under the guardianship of the commissioner of
54.25 human services prior to age 18 and are between the ages of 18 and 21 may ask to reenter
54.26 foster care after age 18 and, to the extent funds are available, the responsible social
54.27 services agency that had responsibility for planning for the individual before discharge
54.28 from foster care may provide foster care or other services to the individual for the purpose
54.29 of increasing the individual's ability to live safely and independently and to meet the
54.30 eligibility criteria in subdivision 3a, if the individual:

54.31 (1) was in foster care for the six consecutive months prior to the person's 18th
54.32 birthday and was not discharged home, adopted, or received into a relative's home under a
54.33 transfer of permanent legal and physical custody under section 260C.515, subdivision 4; or

54.34 (2) was discharged from foster care while on runaway status after age 15.

55.1 (c) In conjunction with a qualifying and eligible individual under paragraph (b) and
 55.2 other appropriate persons, the responsible social services agency shall develop a specific
 55.3 plan related to that individual's vocational, educational, social, or maturational needs
 55.4 and, to the extent funds are available, provide foster care as required to implement the
 55.5 plan. The agency shall enter into a voluntary placement agreement with the individual
 55.6 if the plan includes foster care.

55.7 (d) Youth who left foster care while under guardianship of the commissioner of
 55.8 human services retain eligibility for foster care for placement at any time between the
 55.9 ages of 18 and 21.

55.10 Sec. 65. Minnesota Statutes 2014, section 260C.515, subdivision 5, is amended to read:

55.11 Subd. 5. **Permanent custody to agency.** The court may order permanent custody to
 55.12 the responsible social services agency for continued placement of the child in foster care
 55.13 but only if it approves the responsible social services agency's compelling reasons that no
 55.14 other permanency disposition order is in the child's best interests and:

55.15 (1) the child has reached age ~~12~~ 16 and has been asked about the child's desired
 55.16 permanency outcome;

55.17 ~~(2) the child is a sibling of a child described in clause (1) and the siblings have a~~
 55.18 ~~significant positive relationship and are ordered into the same foster home;~~

55.19 ~~(3)~~ (2) the responsible social services agency has made reasonable efforts to locate
 55.20 and place the child with an adoptive family or a fit and willing relative who would either
 55.21 agree to adopt the child or to a transfer of permanent legal and physical custody of the
 55.22 child, but these efforts have not proven successful; and

55.23 ~~(4)~~ (3) the parent will continue to have visitation or contact with the child and will
 55.24 remain involved in planning for the child.

55.25 Sec. 66. Minnesota Statutes 2014, section 260C.521, subdivision 1, is amended to read:

55.26 Subdivision 1. **Child in permanent custody of responsible social services agency.**

55.27 (a) Court reviews of an order for permanent custody to the responsible social services
 55.28 agency for placement of the child in foster care must be conducted at least yearly at an
 55.29 in-court appearance hearing.

55.30 (b) The purpose of the review hearing is to ensure:

55.31 (1) the order for permanent custody to the responsible social services agency for
 55.32 placement of the child in foster care continues to be in the best interests of the child and
 55.33 that no other permanency disposition order is in the best interests of the child;

56.1 (2) that the agency is assisting the child to build connections to the child's family
56.2 and community; and

56.3 (3) that the agency is appropriately planning with the child for development of
56.4 independent living skills for the child and, as appropriate, for the orderly and successful
56.5 transition to independent living that may occur if the child continues in foster care without
56.6 another permanency disposition order.

56.7 (c) The court must review the child's out-of-home placement plan and the reasonable
56.8 efforts of the agency to finalize an alternative permanent plan for the child including the
56.9 agency's efforts to:

56.10 (1) ensure that permanent custody to the agency with placement of the child in
56.11 foster care continues to be the most appropriate legal arrangement for meeting the child's
56.12 need for permanency and stability or, if not, to identify and attempt to finalize another
56.13 permanency disposition order under this chapter that would better serve the child's needs
56.14 and best interests;

56.15 (2) identify a specific foster home for the child, if one has not already been identified;

56.16 (3) support continued placement of the child in the identified home, if one has been
56.17 identified;

56.18 (4) ensure appropriate services are provided to address the physical health, mental
56.19 health, and educational needs of the child during the period of foster care and also ensure
56.20 appropriate services or assistance to maintain relationships with appropriate family
56.21 members and the child's community; and

56.22 (5) plan for the child's independence upon the child's leaving foster care living as
56.23 required under section 260C.212, subdivision 1.

56.24 (d) The court may find that the agency has made reasonable efforts to finalize the
56.25 permanent plan for the child when:

56.26 (1) the agency has made reasonable efforts to identify a more legally permanent
56.27 home for the child than is provided by an order for permanent custody to the agency
56.28 for placement in foster care; and

56.29 (2) the child has been asked about the child's desired permanency outcome; and

56.30 ~~(2)~~ (3) the agency's engagement of the child in planning for independent living is
56.31 reasonable and appropriate.

56.32 Sec. 67. Minnesota Statutes 2014, section 260C.521, subdivision 2, is amended to read:

56.33 Subd. 2. **Modifying order for permanent legal and physical custody to a**
56.34 **relative.** (a) An order for a relative to have permanent legal and physical custody of a
56.35 child may be modified using standards under sections 518.18 and 518.185.

57.1 (b) When a child is receiving Northstar kinship assistance under chapter 256N, if
 57.2 a relative named as permanent legal and physical custodian in an order made under this
 57.3 chapter becomes incapacitated or dies, a successor custodian named in the Northstar
 57.4 Care for Children kinship assistance benefit agreement under section 256N.25 may file
 57.5 a request to modify the order for permanent legal and physical custody to name the
 57.6 successor custodian as the permanent legal and physical custodian of the child. The court
 57.7 may modify the order to name the successor custodian as the permanent legal and physical
 57.8 custodian upon reviewing the background study required under section 245C.33 if the
 57.9 court finds the modification is in the child's best interests.

57.10 (c) The social services agency is a party to the proceeding and must receive notice.

57.11 Sec. 68. Minnesota Statutes 2014, section 260C.607, subdivision 4, is amended to read:

57.12 Subd. 4. **Content of review.** (a) The court shall review:

57.13 (1) the agency's reasonable efforts under section 260C.605 to finalize an adoption
 57.14 for the child as appropriate to the stage of the case; and

57.15 (2) the child's current out-of-home placement plan required under section 260C.212,
 57.16 subdivision 1, to ensure the child is receiving all services and supports required to meet
 57.17 the child's needs as they relate to the child's:

57.18 (i) placement;

57.19 (ii) visitation and contact with siblings;

57.20 (iii) visitation and contact with relatives;

57.21 (iv) medical, mental, and dental health; and

57.22 (v) education.

57.23 (b) When the child is age ~~16~~ 14 and older, and as long as the child continues in foster
 57.24 care, the court shall also review the agency's planning for the child's independent living
 57.25 after leaving foster care including how the agency is meeting the requirements of section
 57.26 260C.212, subdivision 1, paragraph (c), clause ~~(11)~~ (12). The court shall use the review
 57.27 requirements of section 260C.203 in any review conducted under this paragraph.

57.28 Sec. 69. Minnesota Statutes 2014, section 518A.26, subdivision 14, is amended to read:

57.29 Subd. 14. **Obligor.** "Obligor" means a person obligated to pay maintenance or
 57.30 support. ~~A person who has primary physical custody of a child is presumed not to be~~
 57.31 ~~an obligor for purposes of a child support order under section 518A.34, unless section~~
 57.32 ~~518A.36, subdivision 3, applies or the court makes specific written findings to overcome~~
 57.33 ~~this presumption.~~ For purposes of ordering medical support under section 518A.41, a

58.1 parent who has primary physical custody of a child may be an obligor subject to a payment
58.2 agreement under section 518A.69.

58.3 **EFFECTIVE DATE.** This section is effective March 1, 2016.

58.4 Sec. 70. Minnesota Statutes 2014, section 518A.32, subdivision 2, is amended to read:

58.5 Subd. 2. **Methods.** Determination of potential income must be made according
58.6 to one of three methods, as appropriate:

58.7 (1) the parent's probable earnings level based on employment potential, recent
58.8 work history, and occupational qualifications in light of prevailing job opportunities and
58.9 earnings levels in the community;

58.10 (2) if a parent is receiving unemployment compensation or workers' compensation,
58.11 that parent's income may be calculated using the actual amount of the unemployment
58.12 compensation or workers' compensation benefit received; or

58.13 (3) the amount of income a parent could earn working ~~full-time at 150~~ 30 hours per
58.14 week at 100 percent of the current federal or state minimum wage, whichever is higher.

58.15 **EFFECTIVE DATE.** This section is effective March 1, 2016.

58.16 Sec. 71. Minnesota Statutes 2014, section 518A.39, subdivision 1, is amended to read:

58.17 Subdivision 1. **Authority.** After an order under this chapter or chapter 518 for
58.18 maintenance or support money, temporary or permanent, or for the appointment of trustees
58.19 to receive property awarded as maintenance or support money, the court may from time to
58.20 time, on motion of either of the parties, a copy of which is served on the public authority
58.21 responsible for child support enforcement if payments are made through it, or on motion
58.22 of the public authority responsible for support enforcement, modify the order respecting
58.23 the amount of maintenance or support money or medical support, and the payment of it,
58.24 and also respecting the appropriation and payment of the principal and income of property
58.25 held in trust, and may make an order respecting these matters which it might have made
58.26 in the original proceeding, except as herein otherwise provided. A party or the public
58.27 authority also may bring a motion for contempt of court if the obligor is in arrears in
58.28 support or maintenance payments.

58.29 **EFFECTIVE DATE.** This section is effective January 1, 2016.

58.30 Sec. 72. Minnesota Statutes 2014, section 518A.39, is amended by adding a
58.31 subdivision to read:

59.1 Subd. 8. **Medical support-only modification.** (a) The medical support terms of
 59.2 a support order and determination of the child dependency tax credit may be modified
 59.3 without modification of the full order for support or maintenance, if the order has been
 59.4 established or modified in its entirety within three years from the date of the motion, and
 59.5 upon a showing of one or more of the following:

59.6 (1) a change in the availability of appropriate health care coverage or a substantial
 59.7 increase or decrease in health care coverage costs;

59.8 (2) a change in the eligibility for medical assistance under chapter 256B;

59.9 (3) a party's failure to carry court-ordered coverage, or to provide other medical
 59.10 support as ordered;

59.11 (4) the federal child dependency tax credit is not ordered for the same parent who is
 59.12 ordered to carry health care coverage; or

59.13 (5) the federal child dependency tax credit is not addressed in the order and the
 59.14 noncustodial parent is ordered to carry health care coverage.

59.15 (b) For a motion brought under this subdivision, a modification of the medical
 59.16 support terms of an order may be made retroactive only with respect to any period during
 59.17 which the petitioning party has pending a motion for modification, but only from the date
 59.18 of service of notice of the motion on the responding party and on the public authority if
 59.19 public assistance is being furnished or the county attorney is the attorney of record.

59.20 (c) The court need not hold an evidentiary hearing on a motion brought under this
 59.21 subdivision for modification of medical support only.

59.22 (d) Sections 518.14 and 518A.735 shall govern the award of attorney fees for
 59.23 motions brought under this subdivision.

59.24 (e) The PICS originally stated in the order being modified shall be used to determine
 59.25 the modified medical support order under section 518A.41 for motions brought under
 59.26 this subdivision.

59.27 **EFFECTIVE DATE.** This section is effective January 1, 2016.

59.28 Sec. 73. Minnesota Statutes 2014, section 518A.41, subdivision 1, is amended to read:

59.29 Subdivision 1. **Definitions.** The definitions in this subdivision apply to this chapter
 59.30 and chapter 518.

59.31 (a) "Health care coverage" means medical, dental, or other health care benefits that
 59.32 are provided by one or more health plans. Health care coverage does not include any
 59.33 form of public coverage.

59.34 (b) "Health carrier" means a carrier as defined in sections 62A.011, subdivision
 59.35 2, and 62L.02, subdivision 16.

60.1 (c) "Health plan" means a plan, other than any form of public coverage, that provides
 60.2 medical, dental, or other health care benefits and is:

60.3 (1) provided on an individual or group basis;

60.4 (2) provided by an employer or union;

60.5 (3) purchased in the private market; or

60.6 (4) available to a person eligible to carry insurance for the joint child, including a
 60.7 party's spouse or parent.

60.8 Health plan includes, but is not limited to, a plan meeting the definition under section
 60.9 62A.011, subdivision 3, except that the exclusion of coverage designed solely to provide
 60.10 dental or vision care under section 62A.011, subdivision 3, clause (6), does not apply to
 60.11 the definition of health plan under this section; a group health plan governed under the
 60.12 federal Employee Retirement Income Security Act of 1974 (ERISA); a self-insured plan
 60.13 under sections 43A.23 to 43A.317 and 471.617; and a policy, contract, or certificate issued
 60.14 by a community-integrated service network licensed under chapter 62N.

60.15 (d) "Medical support" means providing health care coverage for a joint child by
 60.16 carrying health care coverage for the joint child or by contributing to the cost of health
 60.17 care coverage, public coverage, unreimbursed medical expenses, and uninsured medical
 60.18 expenses of the joint child.

60.19 (e) "National medical support notice" means an administrative notice issued by the
 60.20 public authority to enforce health insurance provisions of a support order in accordance
 60.21 with Code of Federal Regulations, title 45, section 303.32, in cases where the public
 60.22 authority provides support enforcement services.

60.23 (f) "Public coverage" means health care benefits provided by any form of medical
 60.24 assistance under chapter 256B ~~or MinnesotaCare under chapter 256L~~. Public coverage
 60.25 does not include MinnesotaCare or health plans subsidized by federal premium tax credits
 60.26 or federal cost-sharing reductions.

60.27 (g) "Uninsured medical expenses" means a joint child's reasonable and necessary
 60.28 health-related expenses if the joint child is not covered by a health plan or public coverage
 60.29 when the expenses are incurred.

60.30 (h) "Unreimbursed medical expenses" means a joint child's reasonable and necessary
 60.31 health-related expenses if a joint child is covered by a health plan or public coverage and
 60.32 the plan or coverage does not pay for the total cost of the expenses when the expenses
 60.33 are incurred. Unreimbursed medical expenses do not include the cost of premiums.
 60.34 Unreimbursed medical expenses include, but are not limited to, deductibles, co-payments,
 60.35 and expenses for orthodontia, and prescription eyeglasses and contact lenses, but not
 60.36 over-the-counter medications if coverage is under a health plan.

61.1 Sec. 74. Minnesota Statutes 2014, section 518A.41, subdivision 3, is amended to read:

61.2 Subd. 3. **Determining appropriate health care coverage.** In determining whether
61.3 a parent has appropriate health care coverage for the joint child, the court must consider
61.4 the following factors:

61.5 (1) comprehensiveness of health care coverage providing medical benefits.

61.6 Dependent health care coverage providing medical benefits is presumed comprehensive if
61.7 it includes medical and hospital coverage and provides for preventive, emergency, acute,
61.8 and chronic care; or if it meets the minimum essential coverage definition in United States
61.9 Code, title 26, section 5000A(f). If both parents have health care coverage providing
61.10 medical benefits that is presumed comprehensive under this paragraph, the court must
61.11 determine which parent's coverage is more comprehensive by considering what other
61.12 benefits are included in the coverage;

61.13 (2) accessibility. Dependent health care coverage is accessible if the covered joint
61.14 child can obtain services from a health plan provider with reasonable effort by the parent
61.15 with whom the joint child resides. Health care coverage is presumed accessible if:

61.16 (i) primary care is available within 30 minutes or 30 miles of the joint child's residence
61.17 and specialty care is available within 60 minutes or 60 miles of the joint child's residence;

61.18 (ii) the health care coverage is available through an employer and the employee can
61.19 be expected to remain employed for a reasonable amount of time; and

61.20 (iii) no preexisting conditions exist to unduly delay enrollment in health care
61.21 coverage;

61.22 (3) the joint child's special medical needs, if any; and

61.23 (4) affordability. Dependent health care coverage is affordable if it is reasonable
61.24 in cost. If both parents have health care coverage available for a joint child that is
61.25 comparable with regard to comprehensiveness of medical benefits, accessibility, and the
61.26 joint child's special needs, the least costly health care coverage is presumed to be the most
61.27 appropriate health care coverage for the joint child.

61.28 Sec. 75. Minnesota Statutes 2014, section 518A.41, subdivision 4, is amended to read:

61.29 Subd. 4. **Ordering health care coverage.** (a) If a joint child is presently enrolled
61.30 in health care coverage, the court must order that the parent who currently has the joint
61.31 child enrolled continue that enrollment unless the parties agree otherwise or a party
61.32 requests a change in coverage and the court determines that other health care coverage is
61.33 more appropriate.

61.34 (b) If a joint child is not presently enrolled in health care coverage providing medical
61.35 benefits, upon motion of a parent or the public authority, the court must determine whether

62.1 one or both parents have appropriate health care coverage providing medical benefits
62.2 for the joint child.

62.3 (c) If only one parent has appropriate health care coverage providing medical
62.4 benefits available, the court must order that parent to carry the coverage for the joint child.

62.5 (d) If both parents have appropriate health care coverage providing medical benefits
62.6 available, the court must order the parent with whom the joint child resides to carry the
62.7 coverage for the joint child, unless:

62.8 (1) a party expresses a preference for health care coverage providing medical
62.9 benefits available through the parent with whom the joint child does not reside;

62.10 (2) the parent with whom the joint child does not reside is already carrying
62.11 dependent health care coverage providing medical benefits for other children and the cost
62.12 of contributing to the premiums of the other parent's coverage would cause the parent with
62.13 whom the joint child does not reside extreme hardship; or

62.14 (3) the parties agree as to which parent will carry health care coverage providing
62.15 medical benefits and agree on the allocation of costs.

62.16 (e) If the exception in paragraph (d), clause (1) or (2), applies, the court must
62.17 determine which parent has the most appropriate coverage providing medical benefits
62.18 available and order that parent to carry coverage for the joint child.

62.19 (f) If neither parent has appropriate health care coverage available, the court must
62.20 order the parents to:

62.21 (1) contribute toward the actual health care costs of the joint children based on
62.22 a pro rata share; or

62.23 (2) if the joint child is receiving any form of public coverage, the parent with whom
62.24 the joint child does not reside shall contribute a monthly amount toward the actual cost of
62.25 public coverage. The amount of the noncustodial parent's contribution is determined by
62.26 applying the noncustodial parent's PICS to the premium ~~schedule for public coverage~~ scale
62.27 for MinnesotaCare under section 256L.15, subdivision 2, paragraph (d). If the noncustodial
62.28 parent's PICS meets the eligibility requirements for ~~public coverage~~ MinnesotaCare, the
62.29 contribution is the amount the noncustodial parent would pay for the child's premium. If
62.30 the noncustodial parent's PICS exceeds the eligibility requirements for ~~public coverage~~, the
62.31 contribution is the amount of the premium for the highest eligible income on the ~~appropriate~~
62.32 premium schedule for public coverage scale for MinnesotaCare under section 256L.15,
62.33 subdivision 2, paragraph (d). For purposes of determining the premium amount, the
62.34 noncustodial parent's household size is equal to one parent plus the child or children who
62.35 are the subject of the child support order. The custodial parent's obligation is determined
62.36 under the requirements for public coverage as set forth in chapter 256B ~~or 256L~~; or

63.1 (3) if the noncustodial parent's PICS meet the eligibility requirement for public
 63.2 coverage under chapter 256B or the noncustodial parent receives public assistance, the
 63.3 noncustodial parent must not be ordered to contribute toward the cost of public coverage.

63.4 (g) If neither parent has appropriate health care coverage available, the court may
 63.5 order the parent with whom the child resides to apply for public coverage for the child.

63.6 (h) The commissioner of human services must publish a table with the premium
 63.7 schedule for public coverage and update the chart for changes to the schedule by July
 63.8 1 of each year.

63.9 (i) If a joint child is not presently enrolled in health care coverage providing dental
 63.10 benefits, upon motion of a parent or the public authority, the court must determine whether
 63.11 one or both parents have appropriate dental health care coverage for the joint child, and the
 63.12 court may order a parent with appropriate dental health care coverage available to carry
 63.13 the coverage for the joint child.

63.14 (j) If a joint child is not presently enrolled in available health care coverage
 63.15 providing benefits other than medical benefits or dental benefits, upon motion of a parent
 63.16 or the public authority, the court may determine whether that other health care coverage
 63.17 for the joint child is appropriate, and the court may order a parent with that appropriate
 63.18 health care coverage available to carry the coverage for the joint child.

63.19 **EFFECTIVE DATE.** This section is effective August 1, 2015.

63.20 Sec. 76. Minnesota Statutes 2014, section 518A.41, subdivision 14, is amended to read:

63.21 Subd. 14. **Child support enforcement services.** The public authority must take
 63.22 necessary steps to establish ~~and enforce~~, enforce, and modify an order for medical support
 63.23 if the joint child receives public assistance or a party completes an application for services
 63.24 from the public authority under section 518A.51.

63.25 **EFFECTIVE DATE.** This section is effective January 1, 2016.

63.26 Sec. 77. Minnesota Statutes 2014, section 518A.41, subdivision 15, is amended to read:

63.27 Subd. 15. **Enforcement.** (a) Remedies available for collecting and enforcing child
 63.28 support apply to medical support.

63.29 (b) For the purpose of enforcement, the following are additional support:

63.30 (1) the costs of individual or group health or hospitalization coverage;

63.31 (2) dental coverage;

64.1 (3) medical costs ordered by the court to be paid by either party, including health
 64.2 care coverage premiums paid by the obligee because of the obligor's failure to obtain
 64.3 coverage as ordered; and

64.4 (4) liabilities established under this subdivision.

64.5 (c) A party who fails to carry court-ordered dependent health care coverage is liable
 64.6 for the joint child's uninsured medical expenses unless a court order provides otherwise.
 64.7 A party's failure to carry court-ordered coverage, or to provide other medical support as
 64.8 ordered, is a basis for modification of a medical support order under section 518A.39,
 64.9 subdivision 2 8, unless it meets the presumption in section 518A.39, subdivision 2.

64.10 (d) Payments by the health carrier or employer for services rendered to the dependents
 64.11 that are directed to a party not owed reimbursement must be endorsed over to and forwarded
 64.12 to the vendor or appropriate party or the public authority. A party retaining insurance
 64.13 reimbursement not owed to the party is liable for the amount of the reimbursement.

64.14 **EFFECTIVE DATE.** This section is effective January 1, 2016.

64.15 Sec. 78. Minnesota Statutes 2014, section 518A.43, is amended by adding a
 64.16 subdivision to read:

64.17 **Subd. 1a. Income disparity between parties.** The court may deviate from the
 64.18 presumptive child support obligation under section 518A.34 and elect not to order a party
 64.19 who has between ten and 45 percent parenting time to pay basic support where such a
 64.20 significant disparity of income exists between the parties that an order directing payment
 64.21 of basic support would be detrimental to the parties' joint child.

64.22 **EFFECTIVE DATE.** This section is effective March 1, 2016.

64.23 Sec. 79. Minnesota Statutes 2014, section 518A.46, subdivision 3, is amended to read:

64.24 **Subd. 3. Contents of pleadings.** (a) In cases involving establishment or
 64.25 modification of a child support order, the initiating party shall include the following
 64.26 information, if known, in the pleadings:

64.27 (1) names, addresses, and dates of birth of the parties;

64.28 (2) Social Security numbers of the parties and the minor children of the parties,
 64.29 which information shall be considered private information and shall be available only to
 64.30 the parties, the court, and the public authority;

64.31 (3) other support obligations of the obligor;

64.32 (4) names and addresses of the parties' employers;

64.33 (5) gross income of the parties as calculated in section 518A.29;

- 65.1 (6) amounts and sources of any other earnings and income of the parties;
- 65.2 (7) health insurance coverage of parties;
- 65.3 (8) types and amounts of public assistance received by the parties, including
- 65.4 Minnesota family investment plan, child care assistance, medical assistance,
- 65.5 ~~MinnesotaCare~~, title IV-E foster care, or other form of assistance as defined in section
- 65.6 256.741, subdivision 1; and
- 65.7 (9) any other information relevant to the computation of the child support obligation
- 65.8 under section 518A.34.

65.9 (b) For all matters scheduled in the expedited process, whether or not initiated by

65.10 the public authority, the nonattorney employee of the public authority shall file with the

65.11 court and serve on the parties the following information:

- 65.12 (1) information pertaining to the income of the parties available to the public
- 65.13 authority from the Department of Employment and Economic Development;
- 65.14 (2) a statement of the monthly amount of child support, medical support, child care,
- 65.15 and arrears currently being charged the obligor on Minnesota IV-D cases;
- 65.16 (3) a statement of the types and amount of any public assistance, as defined in
- 65.17 section 256.741, subdivision 1, received by the parties; and
- 65.18 (4) any other information relevant to the determination of support that is known to
- 65.19 the public authority and that has not been otherwise provided by the parties.

65.20 The information must be filed with the court or child support magistrate at least

65.21 five days before any hearing involving child support, medical support, or child care

65.22 reimbursement issues.

65.23 Sec. 80. Minnesota Statutes 2014, section 518A.46, is amended by adding a

65.24 subdivision to read:

65.25 Subd. 3a. **Contents of pleadings for medical support modifications.** (a) In cases

65.26 involving modification of only the medical support portion of a child support order

65.27 under section 518A.39, subdivision 8, the initiating party shall include the following

65.28 information, if known, in the pleadings:

- 65.29 (1) names, addresses, and dates of birth of the parties;
- 65.30 (2) Social Security numbers of the parties and the minor children of the parties,
- 65.31 which shall be considered private information and shall be available only to the parties,
- 65.32 the court, and the public authority;
- 65.33 (3) names and addresses of the parties' employers;
- 65.34 (4) gross income of the parties as stated in the order being modified;
- 65.35 (5) health insurance coverage of the parties; and

66.1 (6) any other information relevant to the determination of the medical support
 66.2 obligation under section 518A.41.

66.3 (b) For all matters scheduled in the expedited process, whether or not initiated by
 66.4 the public authority, the nonattorney employee of the public authority shall file with the
 66.5 court and serve on the parties the following information:

66.6 (1) a statement of the monthly amount of child support, medical support, child care,
 66.7 and arrears currently being charged the obligor on Minnesota IV-D cases;

66.8 (2) a statement of the amount of medical assistance received by the parties; and

66.9 (3) any other information relevant to the determination of medical support that is
 66.10 known to the public authority and that has not been otherwise provided by the parties.

66.11 The information must be filed with the court or child support magistrate at least five
 66.12 days before the hearing on the motion to modify medical support.

66.13 **EFFECTIVE DATE.** This section is effective January 1, 2016.

66.14 Sec. 81. Minnesota Statutes 2014, section 518A.51, is amended to read:

66.15 **518A.51 FEES FOR IV-D SERVICES.**

66.16 (a) When a recipient of IV-D services is no longer receiving assistance under the
 66.17 state's title IV-A, IV-E foster care, or medical assistance, ~~or MinnesotaCare~~ programs, the
 66.18 public authority responsible for child support enforcement must notify the recipient,
 66.19 within five working days of the notification of ineligibility, that IV-D services will be
 66.20 continued unless the public authority is notified to the contrary by the recipient. The
 66.21 notice must include the implications of continuing to receive IV-D services, including the
 66.22 available services and fees, cost recovery fees, and distribution policies relating to fees.

66.23 ~~(b) An application fee of \$25 shall be paid by the person who applies for child~~
 66.24 ~~support and maintenance collection services, except persons who are receiving public~~
 66.25 ~~assistance as defined in section 256.741 and the diversionary work program under section~~
 66.26 ~~256J.95, persons who transfer from public assistance to nonpublic assistance status, and~~
 66.27 ~~minor parents and parents enrolled in a public secondary school, area learning center, or~~
 66.28 ~~alternative learning program approved by the commissioner of education.~~

66.29 ~~(e)~~ (b) In the case of an individual who has never received assistance under a state
 66.30 program funded under title IV-A of the Social Security Act and for whom the public
 66.31 authority has collected at least \$500 of support, the public authority must impose an
 66.32 annual federal collections fee of \$25 for each case in which services are furnished. This
 66.33 fee must be retained by the public authority from support collected on behalf of the
 66.34 individual, but not from the first \$500 collected.

67.1 ~~(d)~~ (c) When the public authority provides full IV-D services to an obligee who
67.2 has applied for those services, upon written notice to the obligee, the public authority
67.3 must charge a cost recovery fee of two percent of the amount collected. This fee must
67.4 be deducted from the amount of the child support and maintenance collected and not
67.5 assigned under section 256.741 before disbursement to the obligee. This fee does not
67.6 apply to an obligee who:

67.7 (1) is currently receiving assistance under the state's title IV-A, IV-E foster care, or
67.8 medical assistance, ~~or MinnesotaCare~~ programs; or

67.9 (2) has received assistance under the state's title IV-A or IV-E foster care programs,
67.10 until the person has not received this assistance for 24 consecutive months.

67.11 ~~(e)~~ (d) When the public authority provides full IV-D services to an obligor who has
67.12 applied for such services, upon written notice to the obligor, the public authority must
67.13 charge a cost recovery fee of two percent of the monthly court-ordered child support and
67.14 maintenance obligation. The fee may be collected through income withholding, as well
67.15 as by any other enforcement remedy available to the public authority responsible for
67.16 child support enforcement.

67.17 ~~(f)~~ (e) Fees assessed by state and federal tax agencies for collection of overdue
67.18 support owed to or on behalf of a person not receiving public assistance must be imposed
67.19 on the person for whom these services are provided. The public authority upon written
67.20 notice to the obligee shall assess a fee of \$25 to the person not receiving public assistance
67.21 for each successful federal tax interception. The fee must be withheld prior to the release
67.22 of the funds received from each interception and deposited in the general fund.

67.23 ~~(g)~~ (f) Federal collections fees collected under paragraph ~~(e)~~ (b) and cost recovery
67.24 fees collected under paragraphs (c) and (d) ~~and (e)~~ retained by the commissioner of human
67.25 services shall be considered child support program income according to Code of Federal
67.26 Regulations, title 45, section 304.50, and shall be deposited in the special revenue fund
67.27 account established under paragraph ~~(f)~~ (h). The commissioner of human services must
67.28 elect to recover costs based on either actual or standardized costs.

67.29 ~~(h)~~ (g) The limitations of this section on the assessment of fees shall not apply to
67.30 the extent inconsistent with the requirements of federal law for receiving funds for the
67.31 programs under title IV-A and title IV-D of the Social Security Act, United States Code,
67.32 title 42, sections 601 to 613 and United States Code, title 42, sections 651 to 662.

67.33 ~~(i)~~ (h) The commissioner of human services is authorized to establish a special
67.34 revenue fund account to receive the federal collections fees collected under paragraph ~~(e)~~
67.35 (b) and cost recovery fees collected under paragraphs (c) and (d) ~~and (e)~~.

68.1 ~~(j)~~ (i) The nonfederal share of the cost recovery fee revenue must be retained by the
 68.2 commissioner and distributed as follows:

68.3 (1) one-half of the revenue must be transferred to the child support system special
 68.4 revenue account to support the state's administration of the child support enforcement
 68.5 program and its federally mandated automated system;

68.6 (2) an additional portion of the revenue must be transferred to the child support
 68.7 system special revenue account for expenditures necessary to administer the fees; and

68.8 (3) the remaining portion of the revenue must be distributed to the counties to aid the
 68.9 counties in funding their child support enforcement programs.

68.10 ~~(k)~~ (j) The nonfederal share of the federal collections fees must be distributed to the
 68.11 counties to aid them in funding their child support enforcement programs.

68.12 ~~(l)~~ (k) The commissioner of human services shall distribute quarterly any of the
 68.13 funds dedicated to the counties under paragraphs (i) and (j) ~~and (k)~~ using the methodology
 68.14 specified in section 256.979, subdivision 11. The funds received by the counties must be
 68.15 reinvested in the child support enforcement program and the counties must not reduce the
 68.16 funding of their child support programs by the amount of the funding distributed.

68.17 **EFFECTIVE DATE.** This section is effective July 1, 2016, except that the
 68.18 amendments striking MinnesotaCare are effective July 1, 2015.

68.19 Sec. 82. Minnesota Statutes 2014, section 518A.53, subdivision 1, is amended to read:

68.20 Subdivision 1. **Definitions.** (a) For the purpose of this section, the following terms
 68.21 have the meanings provided in this subdivision unless otherwise stated.

68.22 (b) "Payor of funds" means any person or entity that provides funds to an obligor,
 68.23 including an employer as defined under chapter 24 of the Internal Revenue Code,
 68.24 section 3401(d), an independent contractor, payor of worker's compensation benefits or
 68.25 unemployment benefits, or a financial institution as defined in section 13B.06.

68.26 (c) "Business day" means a day on which state offices are open for regular business.

68.27 (d) "Arrears" ~~means amounts owed under a support order that are past due~~ has the
 68.28 meaning given in section 518A.26, subdivision 3.

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

68.30 Sec. 83. Minnesota Statutes 2014, section 518A.53, subdivision 4, is amended to read:

68.31 Subd. 4. **Collection services.** (a) The commissioner of human services shall prepare
 68.32 and make available to the courts a notice of services that explains child support and
 68.33 maintenance collection services available through the public authority, including income

69.1 withholding, and the fees for such services. Upon receiving a petition for dissolution of
69.2 marriage or legal separation, the court administrator shall promptly send the notice of
69.3 services to the petitioner and respondent at the addresses stated in the petition.

69.4 (b) Either the obligee or obligor may at any time apply to the public authority for
69.5 either full IV-D services or for income withholding only services.

69.6 (c) For those persons applying for income withholding only services, a monthly
69.7 service fee of \$15 must be charged to the obligor. This fee is in addition to the amount of
69.8 the support order and shall be withheld through income withholding. The public authority
69.9 shall explain the service options in this section to the affected parties and encourage the
69.10 application for full child support collection services.

69.11 (d) If the obligee is not a current recipient of public assistance as defined in section
69.12 256.741, the person who applied for services may at any time choose to terminate either
69.13 full IV-D services or income withholding only services regardless of whether income
69.14 withholding is currently in place. The obligee or obligor may reapply for either full IV-D
69.15 services or income withholding only services at any time. ~~Unless the applicant is a~~
69.16 ~~recipient of public assistance as defined in section 256.741, a \$25 application fee shall be~~
69.17 ~~charged at the time of each application.~~

69.18 (e) When a person terminates IV-D services, if an arrearage for public assistance as
69.19 defined in section 256.741 exists, the public authority may continue income withholding,
69.20 as well as use any other enforcement remedy for the collection of child support, until all
69.21 public assistance arrears are paid in full. Income withholding shall be in an amount equal
69.22 to 20 percent of the support order in effect at the time the services terminated, unless the
69.23 court has ordered a specific monthly payback amount to be applied toward the arrears. If a
69.24 support order includes a specific monthly payback amount, income withholding shall be
69.25 for the specific monthly payback amount ordered.

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

69.27 Sec. 84. Minnesota Statutes 2014, section 518A.53, subdivision 10, is amended to read:

69.28 Subd. 10. **Arrearage order.** (a) This section does not prevent the court from
69.29 ordering the payor of funds to withhold amounts to satisfy the obligor's previous arrearage
69.30 in support order payments. This remedy shall not operate to exclude availability of other
69.31 remedies to enforce judgments. The employer or payor of funds shall withhold from
69.32 the obligor's income an additional amount equal to 20 percent of the monthly child
69.33 support or maintenance obligation until the arrearage is paid, unless the court has ordered
69.34 a specific monthly payback amount toward the arrears. If a support order includes a
69.35 specific monthly payback amount, the employer or payor of funds shall withhold from

70.1 the obligor's income an additional amount equal to the specific monthly payback amount
70.2 ordered until all arrearages are paid.

70.3 (b) Notwithstanding any law to the contrary, funds from income sources included
70.4 in section 518A.26, subdivision 8, whether periodic or lump sum, are not exempt from
70.5 attachment or execution upon a judgment for child support arrearage.

70.6 (c) Absent an order to the contrary, if an arrearage exists at the time a support
70.7 order would otherwise terminate, income withholding shall continue in effect or may be
70.8 implemented in an amount equal to the support order plus an additional 20 percent of the
70.9 monthly child support obligation, until all arrears have been paid in full.

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

70.11 Sec. 85. Minnesota Statutes 2014, section 518A.60, is amended to read:

70.12 **518A.60 COLLECTION; ARREARS ONLY.**

70.13 (a) Remedies available for the collection and enforcement of support in this chapter
70.14 and chapters 256, 257, 518, and 518C also apply to cases in which the child or children
70.15 for whom support is owed are emancipated and the obligor owes past support or has an
70.16 accumulated arrearage as of the date of the youngest child's emancipation. Child support
70.17 arrearages under this section include arrearages for child support, medical support, child
70.18 care, pregnancy and birth expenses, and unreimbursed medical expenses as defined in
70.19 section 518A.41, subdivision 1, paragraph (h).

70.20 (b) This section applies retroactively to any support arrearage that accrued on or
70.21 before June 3, 1997, and to all arrearages accruing after June 3, 1997.

70.22 (c) Past support or pregnancy and confinement expenses ordered for which the
70.23 obligor has specific court ordered terms for repayment may not be enforced using drivers'
70.24 and occupational or professional license suspension; and credit bureau reporting, and
70.25 ~~additional income withholding under section 518A.53, subdivision 10, paragraph (a),~~
70.26 unless the obligor fails to comply with the terms of the court order for repayment.

70.27 (d) If an arrearage exists at the time a support order would otherwise terminate
70.28 and section 518A.53, subdivision 10, paragraph (c), does not apply to this section, the
70.29 arrearage shall be repaid in an amount equal to the current support order until all arrears
70.30 have been paid in full, absent a court order to the contrary.

70.31 (e) If an arrearage exists according to a support order which fails to establish a
70.32 monthly support obligation in a specific dollar amount, the public authority, if it provides
70.33 child support services, or the obligee, may establish a payment agreement which shall
70.34 equal what the obligor would pay for current support after application of section 518A.34,

71.1 plus an additional 20 percent of the current support obligation, until all arrears have been
 71.2 paid in full. If the obligor fails to enter into or comply with a payment agreement, the
 71.3 public authority, if it provides child support services, or the obligee, may move the district
 71.4 court or child support magistrate, if section 484.702 applies, for an order establishing
 71.5 repayment terms.

71.6 (f) If there is no longer a current support order because all of the children of the
 71.7 order are emancipated, the public authority may discontinue child support services and
 71.8 close its case under title IV-D of the Social Security Act if:

71.9 (1) the arrearage is under \$500; or

71.10 (2) the arrearage is considered unenforceable by the public authority because there
 71.11 have been no collections for three years, and all administrative and legal remedies have
 71.12 been attempted or are determined by the public authority to be ineffective because the
 71.13 obligor is unable to pay, the obligor has no known income or assets, and there is no
 71.14 reasonable prospect that the obligor will be able to pay in the foreseeable future.

71.15 (g) At least 60 calendar days before the discontinuation of services under paragraph
 71.16 (f), the public authority must mail a written notice to the obligee and obligor at the
 71.17 obligee's and obligor's last known addresses that the public authority intends to close the
 71.18 child support enforcement case and explaining each party's rights. Seven calendar days
 71.19 after the first notice is mailed, the public authority must mail a second notice under this
 71.20 paragraph to the obligee.

71.21 (h) The case must be kept open if the obligee responds before case closure and
 71.22 provides information that could reasonably lead to collection of arrears. If the case is
 71.23 closed, the obligee may later request that the case be reopened by completing a new
 71.24 application for services, if there is a change in circumstances that could reasonably lead to
 71.25 the collection of arrears.

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

71.27 Sec. 86. **[518A.685] CONSUMER REPORTING AGENCY; REPORTING**
 71.28 **ARREARS.**

71.29 (a) If a public authority determines that an obligor has not paid the current monthly
 71.30 support obligation plus any required arrearage payment for three months, the public
 71.31 authority must report this information to a consumer reporting agency.

71.32 (b) Before reporting that an obligor is in arrears for court-ordered child support,
 71.33 the public authority must:

71.34 (1) provide written notice to the obligor that the public authority intends to report the
 71.35 arrears to a consumer reporting agency; and

72.1 (2) mail the written notice to the obligor's last known mailing address at least 30
 72.2 days before the public authority reports the arrears to a consumer reporting agency.

72.3 (c) The obligor may, within 21 days of receipt of the notice, do the following to
 72.4 prevent the public authority from reporting the arrears to a consumer reporting agency:

72.5 (1) pay the arrears in full; or

72.6 (2) request an administrative review. An administrative review is limited to issues
 72.7 of mistaken identity, a pending legal action involving the arrears, or an incorrect arrears
 72.8 balance.

72.9 (d) If the public authority has reported that an obligor is in arrears for court-ordered
 72.10 child support and subsequently determines that the obligor has paid the court-ordered
 72.11 child support arrears in full, or is paying the current monthly support obligation plus any
 72.12 required arrearage payment, the public authority must report to the consumer reporting
 72.13 agency that the obligor is currently paying child support as ordered by the court.

72.14 (e) A public authority that reports arrearage information under this section must
 72.15 make monthly reports to a consumer reporting agency. The monthly report must be
 72.16 consistent with credit reporting industry standards for child support.

72.17 (f) For purposes of this section, "consumer reporting agency" has the meaning given
 72.18 in section 13C.001, subdivision 4, and United States Code, title 15, section 1681a(f).

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

72.20 Sec. 87. Minnesota Statutes 2014, section 518C.802, is amended to read:

72.21 **518C.802 CONDITIONS OF RENDITION.**

72.22 (a) Before making demand that the governor of another state surrender an individual
 72.23 charged criminally in this state with having failed to provide for the support of an obligee,
 72.24 the governor of this state may require a prosecutor of this state to demonstrate that at least
 72.25 60 days previously the obligee had initiated proceedings for support pursuant to this
 72.26 chapter or that the proceeding would be of no avail.

72.27 (b) If, under this chapter or a law substantially similar to this chapter, ~~the Uniform~~
 72.28 ~~Reciprocal Enforcement of Support Act, or the Revised Uniform Reciprocal Enforcement~~
 72.29 ~~of Support Act,~~ the governor of another state makes a demand that the governor of
 72.30 this state surrender an individual charged criminally in that state with having failed to
 72.31 provide for the support of a child or other individual to whom a duty of support is owed,
 72.32 the governor may require a prosecutor to investigate the demand and report whether
 72.33 a proceeding for support has been initiated or would be effective. If it appears that a

73.1 proceeding would be effective but has not been initiated, the governor may delay honoring
73.2 the demand for a reasonable time to permit the initiation of a proceeding.

73.3 (c) If a proceeding for support has been initiated and the individual whose rendition is
73.4 demanded prevails, the governor may decline to honor the demand. If the petitioner prevails
73.5 and the individual whose rendition is demanded is subject to a support order, the governor
73.6 may decline to honor the demand if the individual is complying with the support order.

73.7 Sec. 88. Minnesota Statutes 2014, section 626.556, subdivision 1, as amended by Laws
73.8 2015, chapter 4, section 1, is amended to read:

73.9 Subdivision 1. **Public policy.** (a) The legislature hereby declares that the public
73.10 policy of this state is to protect children whose health or welfare may be jeopardized
73.11 through physical abuse, neglect, or sexual abuse. While it is recognized that most parents
73.12 want to keep their children safe, sometimes circumstances or conditions interfere with
73.13 their ability to do so. When this occurs, the health and safety of the children ~~shall~~ must be
73.14 of paramount concern. Intervention and prevention efforts ~~shall~~ must address immediate
73.15 concerns for child safety and the ongoing risk of abuse or neglect and should engage the
73.16 protective capacities of families. In furtherance of this public policy, it is the intent of the
73.17 legislature under this section to:

73.18 (1) protect children and promote child safety;

73.19 (2) strengthen the family;

73.20 (3) make the home, school, and community safe for children by promoting
73.21 responsible child care in all settings; and

73.22 (4) provide, when necessary, a safe temporary or permanent home environment for
73.23 physically or sexually abused or neglected children.

73.24 (b) In addition, it is the policy of this state to:

73.25 (1) require the reporting of neglect or physical or sexual abuse of children in the
73.26 home, school, and community settings;

73.27 (2) provide for the voluntary reporting of abuse or neglect of children; ~~to require~~
73.28 ~~a family assessment, when appropriate, as the preferred response to reports not alleging~~
73.29 ~~substantial child endangerment;~~

73.30 (3) require an investigation when the report alleges sexual abuse or substantial
73.31 child endangerment;

73.32 (4) provide a family assessment, if appropriate, when the report does not allege
73.33 sexual abuse or substantial child endangerment; and

73.34 ~~(4)~~ (5) provide protective, family support, and family preservation services when
73.35 needed in appropriate cases.

74.1 Sec. 89. Minnesota Statutes 2014, section 626.556, subdivision 2, is amended to read:

74.2 Subd. 2. **Definitions.** As used in this section, the following terms have the meanings
74.3 given them unless the specific content indicates otherwise:

74.4 (a) "Family assessment" means a comprehensive assessment of child safety, risk of
74.5 subsequent child maltreatment, and family strengths and needs that is applied to a child
74.6 maltreatment report that does not allege sexual abuse or substantial child endangerment.
74.7 Family assessment does not include a determination as to whether child maltreatment
74.8 occurred but does determine the need for services to address the safety of family members
74.9 and the risk of subsequent maltreatment.

74.10 (b) "Investigation" means fact gathering related to the current safety of a child
74.11 and the risk of subsequent maltreatment that determines whether child maltreatment
74.12 occurred and whether child protective services are needed. An investigation must be used
74.13 when reports involve sexual abuse or substantial child endangerment, and for reports of
74.14 maltreatment in facilities required to be licensed under chapter 245A or 245D; under
74.15 sections 144.50 to 144.58 and 241.021; in a school as defined in sections 120A.05,
74.16 subdivisions 9, 11, and 13, and 124D.10; or in a nonlicensed personal care provider
74.17 association as defined in section 256B.0625, subdivision 19a.

74.18 (c) "Substantial child endangerment" means a person responsible for a child's care,
74.19 ~~and in the case of sexual abuse includes a person who has a significant relationship to the~~
74.20 ~~child as defined in section 609.341, or a person in a position of authority as defined in~~
74.21 ~~section 609.341, who~~ by act or omission, commits or attempts to commit an act against a
74.22 child under their care that constitutes any of the following:

74.23 (1) egregious harm as defined in section 260C.007, subdivision 14;

74.24 (2) ~~sexual abuse as defined in paragraph (d);~~

74.25 (3) abandonment under section 260C.301, subdivision 2;

74.26 (4) ~~(3)~~ neglect as defined in paragraph (f), clause (2), that substantially endangers
74.27 the child's physical or mental health, including a growth delay, which may be referred to
74.28 as failure to thrive, that has been diagnosed by a physician and is due to parental neglect;

74.29 (5) ~~(4)~~ murder in the first, second, or third degree under section 609.185, 609.19, or
74.30 609.195;

74.31 (6) ~~(5)~~ manslaughter in the first or second degree under section 609.20 or 609.205;

74.32 (7) ~~(6)~~ assault in the first, second, or third degree under section 609.221, 609.222, or
74.33 609.223;

74.34 (8) ~~(7)~~ solicitation, inducement, and promotion of prostitution under section 609.322;

74.35 (9) ~~(8)~~ criminal sexual conduct under sections 609.342 to 609.3451;

74.36 (10) ~~(9)~~ solicitation of children to engage in sexual conduct under section 609.352;

75.1 ~~(11)~~ (10) malicious punishment or neglect or endangerment of a child under section
75.2 609.377 or 609.378;

75.3 ~~(12)~~ (11) use of a minor in sexual performance under section 617.246; or

75.4 ~~(13)~~ (12) parental behavior, status, or condition which mandates that the county
75.5 attorney file a termination of parental rights petition under section 260C.503, subdivision 2.

75.6 (d) "Sexual abuse" means the subjection of a child by a person responsible for the
75.7 child's care, by a person who has a significant relationship to the child, as defined in
75.8 section 609.341, or by a person in a position of authority, as defined in section 609.341,
75.9 subdivision 10, to any act which constitutes a violation of section 609.342 (criminal sexual
75.10 conduct in the first degree), 609.343 (criminal sexual conduct in the second degree),
75.11 609.344 (criminal sexual conduct in the third degree), 609.345 (criminal sexual conduct
75.12 in the fourth degree), or 609.3451 (criminal sexual conduct in the fifth degree). Sexual
75.13 abuse also includes any act which involves a minor which constitutes a violation of
75.14 prostitution offenses under sections 609.321 to 609.324 or 617.246. Sexual abuse includes
75.15 threatened sexual abuse which includes the status of a parent or household member
75.16 who has committed a violation which requires registration as an offender under section
75.17 243.166, subdivision 1b, paragraph (a) or (b), or required registration under section
75.18 243.166, subdivision 1b, paragraph (a) or (b).

75.19 (e) "Person responsible for the child's care" means (1) an individual functioning
75.20 within the family unit and having responsibilities for the care of the child such as a
75.21 parent, guardian, or other person having similar care responsibilities, or (2) an individual
75.22 functioning outside the family unit and having responsibilities for the care of the child
75.23 such as a teacher, school administrator, other school employees or agents, or other lawful
75.24 custodian of a child having either full-time or short-term care responsibilities including,
75.25 but not limited to, day care, babysitting whether paid or unpaid, counseling, teaching,
75.26 and coaching.

75.27 (f) "Neglect" means the commission or omission of any of the acts specified under
75.28 clauses (1) to (9), other than by accidental means:

75.29 (1) failure by a person responsible for a child's care to supply a child with necessary
75.30 food, clothing, shelter, health, medical, or other care required for the child's physical or
75.31 mental health when reasonably able to do so;

75.32 (2) failure to protect a child from conditions or actions that seriously endanger the
75.33 child's physical or mental health when reasonably able to do so, including a growth delay,
75.34 which may be referred to as a failure to thrive, that has been diagnosed by a physician and
75.35 is due to parental neglect;

76.1 (3) failure to provide for necessary supervision or child care arrangements
76.2 appropriate for a child after considering factors as the child's age, mental ability, physical
76.3 condition, length of absence, or environment, when the child is unable to care for the
76.4 child's own basic needs or safety, or the basic needs or safety of another child in their care;

76.5 (4) failure to ensure that the child is educated as defined in sections 120A.22 and
76.6 260C.163, subdivision 11, which does not include a parent's refusal to provide the parent's
76.7 child with sympathomimetic medications, consistent with section 125A.091, subdivision 5;

76.8 (5) nothing in this section shall be construed to mean that a child is neglected solely
76.9 because the child's parent, guardian, or other person responsible for the child's care in
76.10 good faith selects and depends upon spiritual means or prayer for treatment or care of
76.11 disease or remedial care of the child in lieu of medical care; except that a parent, guardian,
76.12 or caretaker, or a person mandated to report pursuant to subdivision 3, has a duty to report
76.13 if a lack of medical care may cause serious danger to the child's health. This section does
76.14 not impose upon persons, not otherwise legally responsible for providing a child with
76.15 necessary food, clothing, shelter, education, or medical care, a duty to provide that care;

76.16 (6) prenatal exposure to a controlled substance, as defined in section 253B.02,
76.17 subdivision 2, used by the mother for a nonmedical purpose, as evidenced by withdrawal
76.18 symptoms in the child at birth, results of a toxicology test performed on the mother at
76.19 delivery or the child at birth, medical effects or developmental delays during the child's
76.20 first year of life that medically indicate prenatal exposure to a controlled substance, or the
76.21 presence of a fetal alcohol spectrum disorder;

76.22 (7) "medical neglect" as defined in section 260C.007, subdivision 6, clause (5);

76.23 (8) chronic and severe use of alcohol or a controlled substance by a parent or
76.24 person responsible for the care of the child that adversely affects the child's basic needs
76.25 and safety; or

76.26 (9) emotional harm from a pattern of behavior which contributes to impaired
76.27 emotional functioning of the child which may be demonstrated by a substantial and
76.28 observable effect in the child's behavior, emotional response, or cognition that is not
76.29 within the normal range for the child's age and stage of development, with due regard to
76.30 the child's culture.

76.31 (g) "Physical abuse" means any physical injury, mental injury, or threatened injury,
76.32 inflicted by a person responsible for the child's care on a child other than by accidental
76.33 means, or any physical or mental injury that cannot reasonably be explained by the child's
76.34 history of injuries, or any aversive or deprivation procedures, or regulated interventions,
76.35 that have not been authorized under section 125A.0942 or 245.825.

77.1 Abuse does not include reasonable and moderate physical discipline of a child
 77.2 administered by a parent or legal guardian which does not result in an injury. Abuse does
 77.3 not include the use of reasonable force by a teacher, principal, or school employee as
 77.4 allowed by section 121A.582. Actions which are not reasonable and moderate include,
 77.5 but are not limited to, any of the following ~~that are done in anger or without regard to the~~
 77.6 ~~safety of the child:~~

77.7 (1) throwing, kicking, burning, biting, or cutting a child;

77.8 (2) striking a child with a closed fist;

77.9 (3) shaking a child under age three;

77.10 (4) striking or other actions which result in any nonaccidental injury to a child
 77.11 under 18 months of age;

77.12 (5) unreasonable interference with a child's breathing;

77.13 (6) threatening a child with a weapon, as defined in section 609.02, subdivision 6;

77.14 (7) striking a child under age one on the face or head;

77.15 (8) striking a child who is at least age one but under age four on the face or head,
 77.16 which results in an injury;

77.17 ~~(8)~~ (9) purposely giving a child poison, alcohol, or dangerous, harmful, or controlled
 77.18 substances which were not prescribed for the child by a practitioner, in order to control or
 77.19 punish the child; or other substances that substantially affect the child's behavior, motor
 77.20 coordination, or judgment or that results in sickness or internal injury, or subjects the
 77.21 child to medical procedures that would be unnecessary if the child were not exposed
 77.22 to the substances;

77.23 ~~(9)~~ (10) unreasonable physical confinement or restraint not permitted under section
 77.24 609.379, including but not limited to tying, caging, or chaining; or

77.25 ~~(10)~~ (11) in a school facility or school zone, an act by a person responsible for the
 77.26 child's care that is a violation under section 121A.58.

77.27 (h) "Report" means any ~~report~~ communication received by the local welfare agency,
 77.28 police department, county sheriff, or agency responsible for ~~assessing or investigating~~
 77.29 ~~maltreatment~~ child protection pursuant to this section that describes neglect or physical or
 77.30 sexual abuse of a child and contains sufficient content to identify the child and any person
 77.31 believed to be responsible for the neglect or abuse, if known.

77.32 (i) "Facility" means:

77.33 (1) a licensed or unlicensed day care facility, residential facility, agency, hospital,
 77.34 sanitarium, or other facility or institution required to be licensed under sections 144.50 to
 77.35 144.58, 241.021, or 245A.01 to 245A.16, or chapter 245D;

78.1 (2) a school as defined in sections 120A.05, subdivisions 9, 11, and 13; and
78.2 124D.10; or

78.3 (3) a nonlicensed personal care provider organization as defined in section
78.4 256B.0625, subdivision 19a.

78.5 (j) "Operator" means an operator or agency as defined in section 245A.02.

78.6 (k) "Commissioner" means the commissioner of human services.

78.7 (l) "Practice of social services," for the purposes of subdivision 3, includes but is
78.8 not limited to employee assistance counseling and the provision of guardian ad litem and
78.9 parenting time expeditor services.

78.10 (m) "Mental injury" means an injury to the psychological capacity or emotional
78.11 stability of a child as evidenced by an observable or substantial impairment in the child's
78.12 ability to function within a normal range of performance and behavior with due regard to
78.13 the child's culture.

78.14 (n) "Threatened injury" means a statement, overt act, condition, or status that
78.15 represents a substantial risk of physical or sexual abuse or mental injury. Threatened
78.16 injury includes, but is not limited to, exposing a child to a person responsible for the
78.17 child's care, as defined in paragraph (e), clause (1), who has:

78.18 (1) subjected a child to, or failed to protect a child from, an overt act or condition
78.19 that constitutes egregious harm, as defined in section 260C.007, subdivision 14, or a
78.20 similar law of another jurisdiction;

78.21 (2) been found to be palpably unfit under section 260C.301, subdivision 1, paragraph
78.22 (b), clause (4), or a similar law of another jurisdiction;

78.23 (3) committed an act that has resulted in an involuntary termination of parental rights
78.24 under section 260C.301, or a similar law of another jurisdiction; or

78.25 (4) committed an act that has resulted in the involuntary transfer of permanent
78.26 legal and physical custody of a child to a relative under Minnesota Statutes 2010, section
78.27 260C.201, subdivision 11, paragraph (d), clause (1), section 260C.515, subdivision 4, or a
78.28 similar law of another jurisdiction.

78.29 A child is the subject of a report of threatened injury when the responsible social
78.30 services agency receives birth match data under paragraph (o) from the Department of
78.31 Human Services.

78.32 (o) Upon receiving data under section 144.225, subdivision 2b, contained in a
78.33 birth record or recognition of parentage identifying a child who is subject to threatened
78.34 injury under paragraph (n), the Department of Human Services shall send the data to the
78.35 responsible social services agency. The data is known as "birth match" data. Unless the
78.36 responsible social services agency has already begun an investigation or assessment of the

79.1 report due to the birth of the child or execution of the recognition of parentage and the
79.2 parent's previous history with child protection, the agency shall accept the birth match
79.3 data as a report under this section. The agency may use either a family assessment or
79.4 investigation to determine whether the child is safe. All of the provisions of this section
79.5 apply. If the child is determined to be safe, the agency shall consult with the county
79.6 attorney to determine the appropriateness of filing a petition alleging the child is in need
79.7 of protection or services under section 260C.007, subdivision 6, clause (16), in order to
79.8 deliver needed services. If the child is determined not to be safe, the agency and the county
79.9 attorney shall take appropriate action as required under section 260C.503, subdivision 2.

79.10 (p) Persons who conduct assessments or investigations under this section shall take
79.11 into account accepted child-rearing practices of the culture in which a child participates
79.12 and accepted teacher discipline practices, which are not injurious to the child's health,
79.13 welfare, and safety.

79.14 (q) "Accidental" means a sudden, not reasonably foreseeable, and unexpected
79.15 occurrence or event which:

79.16 (1) is not likely to occur and could not have been prevented by exercise of due
79.17 care; and

79.18 (2) if occurring while a child is receiving services from a facility, happens when the
79.19 facility and the employee or person providing services in the facility are in compliance
79.20 with the laws and rules relevant to the occurrence or event.

79.21 (r) "Nonmaltreatment mistake" means:

79.22 (1) at the time of the incident, the individual was performing duties identified in the
79.23 center's child care program plan required under Minnesota Rules, part 9503.0045;

79.24 (2) the individual has not been determined responsible for a similar incident that
79.25 resulted in a finding of maltreatment for at least seven years;

79.26 (3) the individual has not been determined to have committed a similar
79.27 nonmaltreatment mistake under this paragraph for at least four years;

79.28 (4) any injury to a child resulting from the incident, if treated, is treated only with
79.29 remedies that are available over the counter, whether ordered by a medical professional or
79.30 not; and

79.31 (5) except for the period when the incident occurred, the facility and the individual
79.32 providing services were both in compliance with all licensing requirements relevant to the
79.33 incident.

79.34 This definition only applies to child care centers licensed under Minnesota
79.35 Rules, chapter 9503. If clauses (1) to (5) apply, rather than making a determination of

80.1 substantiated maltreatment by the individual, the commissioner of human services shall
80.2 determine that a nonmaltreatment mistake was made by the individual.

80.3 Sec. 90. Minnesota Statutes 2014, section 626.556, subdivision 3, is amended to read:

80.4 Subd. 3. **Persons mandated to report; persons voluntarily reporting.** (a) A
80.5 person who knows or has reason to believe a child is being neglected or physically or
80.6 sexually abused, as defined in subdivision 2, or has been neglected or physically or
80.7 sexually abused within the preceding three years, shall immediately report the information
80.8 to the local welfare agency, agency responsible for assessing or investigating the report,
80.9 police department, ~~or the county sheriff~~, tribal social services agency, or tribal police
80.10 department if the person is:

80.11 (1) a professional or professional's delegate who is engaged in the practice of
80.12 the healing arts, social services, hospital administration, psychological or psychiatric
80.13 treatment, child care, education, correctional supervision, probation and correctional
80.14 services, or law enforcement; or

80.15 (2) employed as a member of the clergy and received the information while
80.16 engaged in ministerial duties, provided that a member of the clergy is not required by
80.17 this subdivision to report information that is otherwise privileged under section 595.02,
80.18 subdivision 1, paragraph (c).

80.19 ~~The police department or the county sheriff, upon receiving a report, shall~~
80.20 ~~immediately notify the local welfare agency or agency responsible for assessing or~~
80.21 ~~investigating the report, orally and in writing. The local welfare agency, or agency~~
80.22 ~~responsible for assessing or investigating the report, upon receiving a report, shall~~
80.23 ~~immediately notify the local police department or the county sheriff orally and in writing.~~
80.24 ~~The county sheriff and the head of every local welfare agency, agency responsible~~
80.25 ~~for assessing or investigating reports, and police department shall each designate a~~
80.26 ~~person within their agency, department, or office who is responsible for ensuring that~~
80.27 ~~the notification duties of this paragraph and paragraph (b) are carried out. Nothing in~~
80.28 ~~this subdivision shall be construed to require more than one report from any institution,~~
80.29 ~~facility, school, or agency.~~

80.30 (b) Any person may voluntarily report to the local welfare agency, agency
80.31 responsible for assessing or investigating the report, police department, ~~or the county~~
80.32 ~~sheriff~~, tribal social services agency, or tribal police department if the person knows,
80.33 has reason to believe, or suspects a child is being or has been neglected or subjected to
80.34 physical or sexual abuse. ~~The police department or the county sheriff, upon receiving~~
80.35 ~~a report, shall immediately notify the local welfare agency or agency responsible for~~

81.1 ~~assessing or investigating the report, orally and in writing. The local welfare agency or~~
 81.2 ~~agency responsible for assessing or investigating the report, upon receiving a report, shall~~
 81.3 ~~immediately notify the local police department or the county sheriff orally and in writing.~~

81.4 (c) A person mandated to report physical or sexual child abuse or neglect occurring
 81.5 within a licensed facility shall report the information to the agency responsible for
 81.6 licensing the facility under sections 144.50 to 144.58; 241.021; 245A.01 to 245A.16; or
 81.7 chapter 245D; or a nonlicensed personal care provider organization as defined in section
 81.8 256B.0625, subdivision 19. A health or corrections agency receiving a report may request
 81.9 the local welfare agency to provide assistance pursuant to subdivisions 10, 10a, and 10b. A
 81.10 board or other entity whose licensees perform work within a school facility, upon receiving
 81.11 a complaint of alleged maltreatment, shall provide information about the circumstances of
 81.12 the alleged maltreatment to the commissioner of education. Section 13.03, subdivision 4,
 81.13 applies to data received by the commissioner of education from a licensing entity.

81.14 ~~(d) Any person mandated to report shall receive a summary of the disposition of~~
 81.15 ~~any report made by that reporter, including whether the case has been opened for child~~
 81.16 ~~protection or other services, or if a referral has been made to a community organization,~~
 81.17 ~~unless release would be detrimental to the best interests of the child. Any person who is~~
 81.18 ~~not mandated to report shall, upon request to the local welfare agency, receive a concise~~
 81.19 ~~summary of the disposition of any report made by that reporter, unless release would be~~
 81.20 ~~detrimental to the best interests of the child. Notification requirements under subdivision~~
 81.21 10 apply to all reports received under this section.

81.22 (e) For purposes of this section, "immediately" means as soon as possible but in
 81.23 no event longer than 24 hours.

81.24 Sec. 91. Minnesota Statutes 2014, section 626.556, subdivision 6a, is amended to read:

81.25 Subd. 6a. **Failure to notify.** If a local welfare agency receives a report under
 81.26 subdivision 3, paragraph (a) or (b), and fails to notify the local police department or county
 81.27 sheriff as required by subdivision 3, ~~paragraph (a) or (b)~~ 10, the person within the agency
 81.28 who is responsible for ensuring that notification is made shall be subject to disciplinary
 81.29 action in keeping with the agency's existing policy or collective bargaining agreement on
 81.30 discipline of employees. If a local police department or a county sheriff receives a report
 81.31 under subdivision 3, paragraph (a) or (b), and fails to notify the local welfare agency as
 81.32 required by subdivision 3, ~~paragraph (a) or (b)~~ 10, the person within the police department
 81.33 or county sheriff's office who is responsible for ensuring that notification is made shall be
 81.34 subject to disciplinary action in keeping with the agency's existing policy or collective
 81.35 bargaining agreement on discipline of employees.

82.1 Sec. 92. Minnesota Statutes 2014, section 626.556, subdivision 7, as amended by Laws
82.2 2015, chapter 4, section 2, is amended to read:

82.3 Subd. 7. **Report; information provided to parent; reporter.** (a) An oral report
82.4 shall be made immediately by telephone or otherwise. An oral report made by a person
82.5 required under subdivision 3 to report shall be followed within 72 hours, exclusive
82.6 of weekends and holidays, by a report in writing to the appropriate police department,
82.7 the county sheriff, the agency responsible for assessing or investigating the report, or
82.8 the local welfare agency.

82.9 (b) The local welfare agency shall determine if the report is ~~accepted for an~~
82.10 ~~assessment or investigation~~ to be screened in or out as soon as possible but in no event
82.11 longer than 24 hours after the report is received. When determining whether a report will
82.12 be screened in or out, the agency receiving the report must consider, when relevant, all
82.13 previous history, including reports that were screened out. The agency may communicate
82.14 with treating professionals and individuals specified under subdivision 10, paragraph
82.15 (i), clause (3), item (iii).

82.16 ~~(b)~~ (c) Any report shall be of sufficient content to identify the child, any person
82.17 believed to be responsible for the abuse or neglect of the child if the person is known, the
82.18 nature and extent of the abuse or neglect and the name and address of the reporter. The
82.19 local welfare agency or agency responsible for assessing or investigating the report shall
82.20 accept a report made under subdivision 3 notwithstanding refusal by a reporter to provide
82.21 the reporter's name or address as long as the report is otherwise sufficient under this
82.22 paragraph. Written reports received by a police department or the county sheriff shall be
82.23 forwarded immediately to the local welfare agency or the agency responsible for assessing
82.24 or investigating the report. The police department or the county sheriff may keep copies of
82.25 reports received by them. Copies of written reports received by a local welfare department
82.26 or the agency responsible for assessing or investigating the report shall be forwarded
82.27 immediately to the local police department or the county sheriff.

82.28 ~~(e)~~ (d) When requested, the agency responsible for assessing or investigating a
82.29 report shall inform the reporter within ten days after the report was made, either orally or
82.30 in writing, whether the report was accepted or not. If the responsible agency determines
82.31 the report does not constitute a report under this section, the agency shall advise the
82.32 reporter the report was screened out. Any person mandated to report shall receive a
82.33 summary of the disposition of any report made by that reporter, including whether the case
82.34 has been opened for child protection or other services, or if a referral has been made to a
82.35 community organization, unless release would be detrimental to the best interests of the
82.36 child. Any person who is not mandated to report shall, upon request to the local welfare

83.1 agency, receive a concise summary of the disposition of any report made by that reporter,
83.2 unless release would be detrimental to the best interests of the child.

83.3 (e) Reports that are screened out must be maintained in accordance with subdivision
83.4 11c, paragraph (a).

83.5 (f) A local welfare agency or agency responsible for investigating or assessing a
83.6 report may use a screened-out report for making an offer of social services to the subjects
83.7 of the screened-out report. A local welfare agency or agency responsible for evaluating a
83.8 report alleging maltreatment of a child shall consider prior reports, including screened-out
83.9 reports, to determine whether an investigation or family assessment must be conducted.

83.10 (d) (g) Notwithstanding paragraph (a), the commissioner of education must inform
83.11 the parent, guardian, or legal custodian of the child who is the subject of a report of
83.12 alleged maltreatment in a school facility within ten days of receiving the report, either
83.13 orally or in writing, whether the commissioner is assessing or investigating the report
83.14 of alleged maltreatment.

83.15 (e) (h) Regardless of whether a report is made under this subdivision, as soon as
83.16 practicable after a school receives information regarding an incident that may constitute
83.17 maltreatment of a child in a school facility, the school shall inform the parent, legal
83.18 guardian, or custodian of the child that an incident has occurred that may constitute
83.19 maltreatment of the child, when the incident occurred, and the nature of the conduct
83.20 that may constitute maltreatment.

83.21 (f) (i) A written copy of a report maintained by personnel of agencies, other than
83.22 welfare or law enforcement agencies, which are subject to chapter 13 shall be confidential.
83.23 An individual subject of the report may obtain access to the original report as provided
83.24 by subdivision 11.

83.25 Sec. 93. Minnesota Statutes 2014, section 626.556, is amended by adding a subdivision
83.26 to read:

83.27 Subd. 7a. **Guidance for screening reports.** (a) Child protection staff, supervisors,
83.28 and others involved in child protection screening shall follow the guidance provided
83.29 in the child maltreatment screening guidelines issued by the commissioner of human
83.30 services and, when notified by the commissioner, shall immediately implement updated
83.31 procedures and protocols.

83.32 (b) Any modifications to the screening guidelines must be preapproved by the
83.33 commissioner of human services and must not be less protective of children than is
83.34 mandated by statute. The county agency must consult with the county attorney before
83.35 proposing modifications to the commissioner. The guidelines may provide additional

84.1 protections for children but must not limit reports that are screened in or provide
84.2 additional limits on consideration of reports that were screened out in making screening
84.3 determinations.

84.4 Sec. 94. Minnesota Statutes 2014, section 626.556, subdivision 10, is amended to read:

84.5 Subd. 10. **Duties of local welfare agency and local law enforcement agency upon**
84.6 **receipt of report; mandatory notification between police or sheriff and agency.** (a)

84.7 The police department or the county sheriff shall immediately notify the local welfare
84.8 agency or agency responsible for child protection reports under this section orally and
84.9 in writing when a report is received. The local welfare agency or agency responsible
84.10 for child protection reports shall immediately notify the local police department or the
84.11 county sheriff orally and in writing when a report is received. The county sheriff and the
84.12 head of every local welfare agency, agency responsible for child protection reports, and
84.13 police department shall each designate a person within their agency, department, or office
84.14 who is responsible for ensuring that the notification duties of this paragraph are carried
84.15 out. When the alleged maltreatment occurred on tribal land, the local welfare agency or
84.16 agency responsible for child protection reports and the local police department or the
84.17 county sheriff shall immediately notify the tribe's social services agency and tribal law
84.18 enforcement orally and in writing when a report is received.

84.19 (b) Upon receipt of a report, the local welfare agency shall determine whether to
84.20 conduct a family assessment or an investigation as appropriate to prevent or provide a
84.21 remedy for child maltreatment. The local welfare agency:

84.22 (1) shall conduct an investigation on reports involving sexual abuse or substantial
84.23 child endangerment;

84.24 (2) shall begin an immediate investigation if, at any time when it is using a family
84.25 assessment response, it determines that there is reason to believe that sexual abuse or
84.26 substantial child endangerment or a serious threat to the child's safety exists;

84.27 (3) may conduct a family assessment for reports that do not allege sexual abuse or
84.28 substantial child endangerment. In determining that a family assessment is appropriate,
84.29 the local welfare agency may consider issues of child safety, parental cooperation, and
84.30 the need for an immediate response; and

84.31 (4) may conduct a family assessment on a report that was initially screened and
84.32 assigned for an investigation. In determining that a complete investigation is not required,
84.33 the local welfare agency must document the reason for terminating the investigation and
84.34 notify the local law enforcement agency if the local law enforcement agency is conducting
84.35 a joint investigation.

85.1 If the report alleges neglect, physical abuse, or sexual abuse by a parent, guardian,
85.2 or individual functioning within the family unit as a person responsible for the child's
85.3 care, or sexual abuse by a person with a significant relationship to the child when that
85.4 person resides in the child's household or by a sibling, the local welfare agency shall
85.5 immediately conduct a family assessment or investigation as identified in clauses (1)
85.6 to (4). In conducting a family assessment or investigation, the local welfare agency
85.7 shall gather information on the existence of substance abuse and domestic violence and
85.8 offer services for purposes of preventing future child maltreatment, safeguarding and
85.9 enhancing the welfare of the abused or neglected minor, and supporting and preserving
85.10 family life whenever possible. If the report alleges a violation of a criminal statute
85.11 involving sexual abuse, physical abuse, or neglect or endangerment, under section
85.12 609.378, the local law enforcement agency and local welfare agency shall coordinate the
85.13 planning and execution of their respective investigation and assessment efforts to avoid a
85.14 duplication of fact-finding efforts and multiple interviews. Each agency shall prepare a
85.15 separate report of the results of its investigation or assessment. In cases of alleged child
85.16 maltreatment resulting in death, the local agency may rely on the fact-finding efforts of a
85.17 law enforcement investigation to make a determination of whether or not maltreatment
85.18 occurred. When necessary the local welfare agency shall seek authority to remove the
85.19 child from the custody of a parent, guardian, or adult with whom the child is living. In
85.20 performing any of these duties, the local welfare agency shall maintain appropriate records.

85.21 If the family assessment or investigation indicates there is a potential for abuse of
85.22 alcohol or other drugs by the parent, guardian, or person responsible for the child's care,
85.23 the local welfare agency shall conduct a chemical use assessment pursuant to Minnesota
85.24 Rules, part 9530.6615.

85.25 ~~(b)~~ (c) When a local agency receives a report or otherwise has information indicating
85.26 that a child who is a client, as defined in section 245.91, has been the subject of physical
85.27 abuse, sexual abuse, or neglect at an agency, facility, or program as defined in section
85.28 245.91, it shall, in addition to its other duties under this section, immediately inform the
85.29 ombudsman established under sections 245.91 to 245.97. The commissioner of education
85.30 shall inform the ombudsman established under sections 245.91 to 245.97 of reports
85.31 regarding a child defined as a client in section 245.91 that maltreatment occurred at a
85.32 school as defined in sections 120A.05, subdivisions 9, 11, and 13, and 124D.10.

85.33 ~~(e)~~ (d) Authority of the local welfare agency responsible for assessing or
85.34 investigating the child abuse or neglect report, the agency responsible for assessing or
85.35 investigating the report, and of the local law enforcement agency for investigating the
85.36 alleged abuse or neglect includes, but is not limited to, authority to interview, without

86.1 parental consent, the alleged victim and any other minors who currently reside with or
86.2 who have resided with the alleged offender. The interview may take place at school or at
86.3 any facility or other place where the alleged victim or other minors might be found or the
86.4 child may be transported to, and the interview conducted at, a place appropriate for the
86.5 interview of a child designated by the local welfare agency or law enforcement agency.
86.6 The interview may take place outside the presence of the alleged offender or parent, legal
86.7 custodian, guardian, or school official. For family assessments, it is the preferred practice
86.8 to request a parent or guardian's permission to interview the child prior to conducting the
86.9 child interview, unless doing so would compromise the safety assessment. Except as
86.10 provided in this paragraph, the parent, legal custodian, or guardian shall be notified by
86.11 the responsible local welfare or law enforcement agency no later than the conclusion of
86.12 the investigation or assessment that this interview has occurred. Notwithstanding rule 32
86.13 of the Minnesota Rules of Procedure for Juvenile Courts, the juvenile court may, after
86.14 hearing on an ex parte motion by the local welfare agency, order that, where reasonable
86.15 cause exists, the agency withhold notification of this interview from the parent, legal
86.16 custodian, or guardian. If the interview took place or is to take place on school property,
86.17 the order shall specify that school officials may not disclose to the parent, legal custodian,
86.18 or guardian the contents of the notification of intent to interview the child on school
86.19 property, as provided under this paragraph, and any other related information regarding
86.20 the interview that may be a part of the child's school record. A copy of the order shall be
86.21 sent by the local welfare or law enforcement agency to the appropriate school official.

86.22 ~~(d)~~ (e) When the local welfare, local law enforcement agency, or the agency
86.23 responsible for assessing or investigating a report of maltreatment determines that an
86.24 interview should take place on school property, written notification of intent to interview
86.25 the child on school property must be received by school officials prior to the interview.
86.26 The notification shall include the name of the child to be interviewed, the purpose of the
86.27 interview, and a reference to the statutory authority to conduct an interview on school
86.28 property. For interviews conducted by the local welfare agency, the notification shall
86.29 be signed by the chair of the local social services agency or the chair's designee. The
86.30 notification shall be private data on individuals subject to the provisions of this paragraph.
86.31 School officials may not disclose to the parent, legal custodian, or guardian the contents
86.32 of the notification or any other related information regarding the interview until notified
86.33 in writing by the local welfare or law enforcement agency that the investigation or
86.34 assessment has been concluded, unless a school employee or agent is alleged to have
86.35 maltreated the child. Until that time, the local welfare or law enforcement agency or the

87.1 agency responsible for assessing or investigating a report of maltreatment shall be solely
87.2 responsible for any disclosures regarding the nature of the assessment or investigation.

87.3 Except where the alleged offender is believed to be a school official or employee,
87.4 the time and place, and manner of the interview on school premises shall be within the
87.5 discretion of school officials, but the local welfare or law enforcement agency shall have
87.6 the exclusive authority to determine who may attend the interview. The conditions as to
87.7 time, place, and manner of the interview set by the school officials shall be reasonable and
87.8 the interview shall be conducted not more than 24 hours after the receipt of the notification
87.9 unless another time is considered necessary by agreement between the school officials and
87.10 the local welfare or law enforcement agency. Where the school fails to comply with the
87.11 provisions of this paragraph, the juvenile court may order the school to comply. Every
87.12 effort must be made to reduce the disruption of the educational program of the child, other
87.13 students, or school staff when an interview is conducted on school premises.

87.14 ~~(e)~~ (f) Where the alleged offender or a person responsible for the care of the alleged
87.15 victim or other minor prevents access to the victim or other minor by the local welfare
87.16 agency, the juvenile court may order the parents, legal custodian, or guardian to produce
87.17 the alleged victim or other minor for questioning by the local welfare agency or the local
87.18 law enforcement agency outside the presence of the alleged offender or any person
87.19 responsible for the child's care at reasonable places and times as specified by court order.

87.20 ~~(f)~~ (g) Before making an order under paragraph ~~(e)~~ (f), the court shall issue an order
87.21 to show cause, either upon its own motion or upon a verified petition, specifying the basis
87.22 for the requested interviews and fixing the time and place of the hearing. The order to
87.23 show cause shall be served personally and shall be heard in the same manner as provided
87.24 in other cases in the juvenile court. The court shall consider the need for appointment of a
87.25 guardian ad litem to protect the best interests of the child. If appointed, the guardian ad
87.26 litem shall be present at the hearing on the order to show cause.

87.27 ~~(g)~~ (h) The commissioner of human services, the ombudsman for mental health and
87.28 developmental disabilities, the local welfare agencies responsible for investigating reports,
87.29 the commissioner of education, and the local law enforcement agencies have the right to
87.30 enter facilities as defined in subdivision 2 and to inspect and copy the facility's records,
87.31 including medical records, as part of the investigation. Notwithstanding the provisions of
87.32 chapter 13, they also have the right to inform the facility under investigation that they are
87.33 conducting an investigation, to disclose to the facility the names of the individuals under
87.34 investigation for abusing or neglecting a child, and to provide the facility with a copy of
87.35 the report and the investigative findings.

88.1 ~~(h)~~ (i) The local welfare agency responsible for conducting a family assessment or
88.2 investigation shall collect available and relevant information to determine child safety,
88.3 risk of subsequent child maltreatment, and family strengths and needs and share not public
88.4 information with an Indian's tribal social services agency without violating any law of the
88.5 state that may otherwise impose duties of confidentiality on the local welfare agency in
88.6 order to implement the tribal state agreement. The local welfare agency or the agency
88.7 responsible for investigating the report shall collect available and relevant information
88.8 to ascertain whether maltreatment occurred and whether protective services are needed.
88.9 Information collected includes, when relevant, information with regard to the person
88.10 reporting the alleged maltreatment, including the nature of the reporter's relationship to the
88.11 child and to the alleged offender, and the basis of the reporter's knowledge for the report;
88.12 the child allegedly being maltreated; the alleged offender; the child's caretaker; and other
88.13 collateral sources having relevant information related to the alleged maltreatment. The
88.14 local welfare agency or the agency responsible for investigating the report may make a
88.15 determination of no maltreatment early in an investigation, and close the case and retain
88.16 immunity, if the collected information shows no basis for a full investigation.

88.17 Information relevant to the assessment or investigation must be asked for, and
88.18 may include:

88.19 (1) the child's sex and age;₂ prior reports of maltreatment, including any
88.20 maltreatment reports that were screened out and not accepted for assessment or
88.21 investigation; information relating to developmental functioning;₂ credibility of the child's
88.22 statement;₂ and whether the information provided under this clause is consistent with other
88.23 information collected during the course of the assessment or investigation;

88.24 (2) the alleged offender's age, a record check for prior reports of maltreatment, and
88.25 criminal charges and convictions. The local welfare agency or the agency responsible for
88.26 assessing or investigating the report must provide the alleged offender with an opportunity
88.27 to make a statement. The alleged offender may submit supporting documentation relevant
88.28 to the assessment or investigation;

88.29 (3) collateral source information regarding the alleged maltreatment and care of the
88.30 child. Collateral information includes, when relevant: (i) a medical examination of the
88.31 child; (ii) prior medical records relating to the alleged maltreatment or the care of the
88.32 child maintained by any facility, clinic, or health care professional and an interview with
88.33 the treating professionals; and (iii) interviews with the child's caretakers, including the
88.34 child's parent, guardian, foster parent, child care provider, teachers, counselors, family
88.35 members, relatives, and other persons who may have knowledge regarding the alleged
88.36 maltreatment and the care of the child; and

89.1 (4) information on the existence of domestic abuse and violence in the home of
89.2 the child, and substance abuse.

89.3 Nothing in this paragraph precludes the local welfare agency, the local law
89.4 enforcement agency, or the agency responsible for assessing or investigating the report
89.5 from collecting other relevant information necessary to conduct the assessment or
89.6 investigation. Notwithstanding sections 13.384 or 144.291 to 144.298, the local welfare
89.7 agency has access to medical data and records for purposes of clause (3). Notwithstanding
89.8 the data's classification in the possession of any other agency, data acquired by the
89.9 local welfare agency or the agency responsible for assessing or investigating the report
89.10 during the course of the assessment or investigation are private data on individuals and
89.11 must be maintained in accordance with subdivision 11. Data of the commissioner of
89.12 education collected or maintained during and for the purpose of an investigation of
89.13 alleged maltreatment in a school are governed by this section, notwithstanding the data's
89.14 classification as educational, licensing, or personnel data under chapter 13.

89.15 In conducting an assessment or investigation involving a school facility as defined
89.16 in subdivision 2, paragraph (i), the commissioner of education shall collect investigative
89.17 reports and data that are relevant to a report of maltreatment and are from local law
89.18 enforcement and the school facility.

89.19 (†) (j) Upon receipt of a report, the local welfare agency shall conduct a face-to-face
89.20 contact with the child reported to be maltreated and with the child's primary caregiver
89.21 sufficient to complete a safety assessment and ensure the immediate safety of the child.
89.22 The face-to-face contact with the child and primary caregiver shall occur immediately
89.23 if sexual abuse or substantial child endangerment is alleged and within five calendar
89.24 days for all other reports. If the alleged offender was not already interviewed as the
89.25 primary caregiver, the local welfare agency shall also conduct a face-to-face interview
89.26 with the alleged offender in the early stages of the assessment or investigation. At the
89.27 initial contact, the local child welfare agency or the agency responsible for assessing or
89.28 investigating the report must inform the alleged offender of the complaints or allegations
89.29 made against the individual in a manner consistent with laws protecting the rights of the
89.30 person who made the report. The interview with the alleged offender may be postponed if
89.31 it would jeopardize an active law enforcement investigation.

89.32 (†) (k) When conducting an investigation, the local welfare agency shall use a
89.33 question and answer interviewing format with questioning as nondirective as possible to
89.34 elicit spontaneous responses. For investigations only, the following interviewing methods
89.35 and procedures must be used whenever possible when collecting information:

89.36 (1) audio recordings of all interviews with witnesses and collateral sources; and

90.1 (2) in cases of alleged sexual abuse, audio-video recordings of each interview with
90.2 the alleged victim and child witnesses.

90.3 ~~(k)~~ (l) In conducting an assessment or investigation involving a school facility
90.4 as defined in subdivision 2, paragraph (i), the commissioner of education shall collect
90.5 available and relevant information and use the procedures in paragraphs ~~(i)~~, (j) and (k),
90.6 and subdivision 3d, except that the requirement for face-to-face observation of the child
90.7 and face-to-face interview of the alleged offender is to occur in the initial stages of the
90.8 assessment or investigation provided that the commissioner may also base the assessment
90.9 or investigation on investigative reports and data received from the school facility and
90.10 local law enforcement, to the extent those investigations satisfy the requirements of
90.11 paragraphs ~~(i)~~ and (j) and (k), and subdivision 3d.

90.12 Sec. 95. Minnesota Statutes 2014, section 626.556, subdivision 10e, is amended to read:

90.13 Subd. 10e. **Determinations.** (a) The local welfare agency shall conclude the family
90.14 assessment or the investigation within 45 days of the receipt of a report. The conclusion of
90.15 the assessment or investigation may be extended to permit the completion of a criminal
90.16 investigation or the receipt of expert information requested within 45 days of the receipt
90.17 of the report.

90.18 (b) After conducting a family assessment, the local welfare agency shall determine
90.19 whether services are needed to address the safety of the child and other family members
90.20 and the risk of subsequent maltreatment.

90.21 (c) After conducting an investigation, the local welfare agency shall make two
90.22 determinations: first, whether maltreatment has occurred; and second, whether child
90.23 protective services are needed. No determination of maltreatment shall be made when the
90.24 alleged perpetrator is a child under the age of ten.

90.25 (d) If the commissioner of education conducts an assessment or investigation,
90.26 the commissioner shall determine whether maltreatment occurred and what corrective
90.27 or protective action was taken by the school facility. If a determination is made that
90.28 maltreatment has occurred, the commissioner shall report to the employer, the school
90.29 board, and any appropriate licensing entity the determination that maltreatment occurred
90.30 and what corrective or protective action was taken by the school facility. In all other cases,
90.31 the commissioner shall inform the school board or employer that a report was received,
90.32 the subject of the report, the date of the initial report, the category of maltreatment alleged
90.33 as defined in paragraph (f), the fact that maltreatment was not determined, and a summary
90.34 of the specific reasons for the determination.

91.1 (e) When maltreatment is determined in an investigation involving a facility,
91.2 the investigating agency shall also determine whether the facility or individual was
91.3 responsible, or whether both the facility and the individual were responsible for the
91.4 maltreatment using the mitigating factors in paragraph (i). Determinations under this
91.5 subdivision must be made based on a preponderance of the evidence and are private data
91.6 on individuals or nonpublic data as maintained by the commissioner of education.

91.7 (f) For the purposes of this subdivision, "maltreatment" means any of the following
91.8 acts or omissions:

91.9 (1) physical abuse as defined in subdivision 2, paragraph (g);

91.10 (2) neglect as defined in subdivision 2, paragraph (f);

91.11 (3) sexual abuse as defined in subdivision 2, paragraph (d);

91.12 (4) mental injury as defined in subdivision 2, paragraph (m); or

91.13 (5) maltreatment of a child in a facility as defined in subdivision 2, paragraph (i).

91.14 (g) For the purposes of this subdivision, a determination that child protective
91.15 services are needed means that the local welfare agency has documented conditions
91.16 during the assessment or investigation sufficient to cause a child protection worker, as
91.17 defined in section 626.559, subdivision 1, to conclude that a child is at significant risk of
91.18 maltreatment if protective intervention is not provided and that the individuals responsible
91.19 for the child's care have not taken or are not likely to take actions to protect the child
91.20 from maltreatment or risk of maltreatment.

91.21 (h) This subdivision does not mean that maltreatment has occurred solely because
91.22 the child's parent, guardian, or other person responsible for the child's care in good faith
91.23 selects and depends upon spiritual means or prayer for treatment or care of disease
91.24 or remedial care of the child, in lieu of medical care. However, if lack of medical care
91.25 may result in serious danger to the child's health, the local welfare agency may ensure
91.26 that necessary medical services are provided to the child.

91.27 (i) When determining whether the facility or individual is the responsible party, or
91.28 whether both the facility and the individual are responsible for determined maltreatment in
91.29 a facility, the investigating agency shall consider at least the following mitigating factors:

91.30 (1) whether the actions of the facility or the individual caregivers were according to,
91.31 and followed the terms of, an erroneous physician order, prescription, individual care plan,
91.32 or directive; however, this is not a mitigating factor when the facility or caregiver was
91.33 responsible for the issuance of the erroneous order, prescription, individual care plan, or
91.34 directive or knew or should have known of the errors and took no reasonable measures to
91.35 correct the defect before administering care;

92.1 (2) comparative responsibility between the facility, other caregivers, and
 92.2 requirements placed upon an employee, including the facility's compliance with related
 92.3 regulatory standards and the adequacy of facility policies and procedures, facility training,
 92.4 an individual's participation in the training, the caregiver's supervision, and facility staffing
 92.5 levels and the scope of the individual employee's authority and discretion; and

92.6 (3) whether the facility or individual followed professional standards in exercising
 92.7 professional judgment.

92.8 The evaluation of the facility's responsibility under clause (2) must not be based on the
 92.9 completeness of the risk assessment or risk reduction plan required under section 245A.66,
 92.10 but must be based on the facility's compliance with the regulatory standards for policies and
 92.11 procedures, training, and supervision as cited in Minnesota Statutes and Minnesota Rules.

92.12 (j) Notwithstanding paragraph (i), when maltreatment is determined to have been
 92.13 committed by an individual who is also the facility license holder, both the individual and
 92.14 the facility must be determined responsible for the maltreatment, and both the background
 92.15 study disqualification standards under section 245C.15, subdivision 4, and the licensing
 92.16 actions under sections 245A.06 or 245A.07 apply.

92.17 ~~(k) Individual counties may implement more detailed definitions or criteria that~~
 92.18 ~~indicate which allegations to investigate, as long as a county's policies are consistent~~
 92.19 ~~with the definitions in the statutes and rules and are approved by the county board. Each~~
 92.20 ~~local welfare agency shall periodically inform mandated reporters under subdivision 3~~
 92.21 ~~who work in the county of the definitions of maltreatment in the statutes and rules and any~~
 92.22 ~~additional definitions or criteria that have been approved by the county board.~~

92.23 Sec. 96. Minnesota Statutes 2014, section 626.556, subdivision 10j, is amended to read:

92.24 Subd. 10j. **Release of data to mandated reporters.** (a) A local social services or
 92.25 child protection agency, or the agency responsible for assessing or investigating the report
 92.26 of maltreatment, ~~may~~ shall provide relevant private data on individuals obtained under
 92.27 this section to a mandated reporters reporter who made the report and who have has an
 92.28 ongoing responsibility for the health, education, or welfare of a child affected by the data,
 92.29 unless the agency determines that providing the data would not be in the best interests
 92.30 of the child. The agency may provide the data to other mandated reporters with ongoing
 92.31 responsibility for the health, education, or welfare of the child. Mandated reporters with
 92.32 ongoing responsibility for the health, education, or welfare of a child affected by the data
 92.33 include the child's teachers or other appropriate school personnel, foster parents, health
 92.34 care providers, respite care workers, therapists, social workers, child care providers,
 92.35 residential care staff, crisis nursery staff, probation officers, and court services personnel.

93.1 Under this section, a mandated reporter need not have made the report to be considered a
 93.2 person with ongoing responsibility for the health, education, or welfare of a child affected
 93.3 by the data. Data provided under this section must be limited to data pertinent to the
 93.4 individual's responsibility for caring for the child.

93.5 (b) A reporter who receives private data on individuals under this subdivision must
 93.6 treat the data according to that classification, regardless of whether the reporter is an
 93.7 employee of a government entity. The remedies and penalties under sections 13.08 and
 93.8 13.09 apply if a reporter releases data in violation of this section or other law.

93.9 Sec. 97. Minnesota Statutes 2014, section 626.556, subdivision 10m, is amended to
 93.10 read:

93.11 Subd. 10m. **Provision of child protective services; consultation with county**
 93.12 **attorney.** (a) The local welfare agency shall create a written plan, in collaboration with
 93.13 the family whenever possible, within 30 days of the determination that child protective
 93.14 services are needed or upon joint agreement of the local welfare agency and the family
 93.15 that family support and preservation services are needed. Child protective services for a
 93.16 family are voluntary unless ordered by the court.

93.17 (b) The local welfare agency shall consult with the county attorney to determine the
 93.18 appropriateness of filing a petition alleging the child is in need of protection or services
 93.19 under section 260C.007, subdivision 6, if:

93.20 (1) the family does not accept or comply with a plan for child protective services;

93.21 (2) voluntary child protective services may not provide sufficient protection for the
 93.22 child; or

93.23 (3) the family is not cooperating with an investigation or assessment.

93.24 Sec. 98. Minnesota Statutes 2014, section 626.556, subdivision 11c, is amended to read:

93.25 Subd. 11c. **Welfare, court services agency, and school records maintained.**

93.26 Notwithstanding sections 138.163 and 138.17, records maintained or records derived
 93.27 from reports of abuse by local welfare agencies, agencies responsible for assessing or
 93.28 investigating the report, court services agencies, or schools under this section shall be
 93.29 destroyed as provided in paragraphs (a) to (d) by the responsible authority.

93.30 (a) For reports alleging child maltreatment that were not accepted for assessment
 93.31 or investigation, family assessment cases, and cases where an investigation results in no
 93.32 determination of maltreatment or the need for child protective services, the ~~assessment or~~
 93.33 ~~investigation~~ records must be maintained for a period of ~~four~~ five years after the date the
 93.34 report was not accepted for assessment or investigation or of the final entry in the case

94.1 record. Records of reports that were not accepted must contain sufficient information to
 94.2 identify the subjects of the report, the nature of the alleged maltreatment, and the reasons
 94.3 as to why the report was not accepted. Records under this paragraph may not be used for
 94.4 employment, background checks, or purposes other than to assist in future screening
 94.5 decisions and risk and safety assessments.

94.6 (b) All records relating to reports which, upon investigation, indicate either
 94.7 maltreatment or a need for child protective services shall be maintained for ten years after
 94.8 the date of the final entry in the case record.

94.9 (c) All records regarding a report of maltreatment, including any notification of intent
 94.10 to interview which was received by a school under subdivision 10, paragraph (d), shall be
 94.11 destroyed by the school when ordered to do so by the agency conducting the assessment or
 94.12 investigation. The agency shall order the destruction of the notification when other records
 94.13 relating to the report under investigation or assessment are destroyed under this subdivision.

94.14 (d) Private or confidential data released to a court services agency under subdivision
 94.15 10h must be destroyed by the court services agency when ordered to do so by the local
 94.16 welfare agency that released the data. The local welfare agency or agency responsible for
 94.17 assessing or investigating the report shall order destruction of the data when other records
 94.18 relating to the assessment or investigation are destroyed under this subdivision.

94.19 ~~(e) For reports alleging child maltreatment that were not accepted for assessment~~
 94.20 ~~or investigation, counties shall maintain sufficient information to identify repeat reports~~
 94.21 ~~alleging maltreatment of the same child or children for 365 days from the date the report~~
 94.22 ~~was screened out. The commissioner of human services shall specify to the counties the~~
 94.23 ~~minimum information needed to accomplish this purpose. Counties shall enter this data~~
 94.24 ~~into the state social services information system.~~

94.25 Sec. 99. Minnesota Statutes 2014, section 626.556, is amended by adding a subdivision
 94.26 to read:

94.27 Subd. 16. Commissioner's duty to provide oversight; quality assurance reviews;
 94.28 annual summary of reviews. (a) The commissioner shall develop a plan to perform
 94.29 quality assurance reviews of local welfare agency screening practices and decisions.
 94.30 The commissioner shall provide oversight and guidance to counties to ensure consistent
 94.31 application of screening guidelines, thorough and appropriate screening decisions, and
 94.32 correct documentation and maintenance of reports. Quality assurance reviews must begin
 94.33 no later than September 30, 2015.

94.34 (b) The commissioner shall produce an annual report of the summary results of the
 94.35 reviews. The report must only contain aggregate data and may not include any data that

95.1 could be used to personally identify any subject whose data is included in the report. The
 95.2 report is public information and must be provided to the chairs and ranking minority
 95.3 members of the legislative committees having jurisdiction over child protection issues.

95.4 Sec. 100. Minnesota Statutes 2014, section 626.559, is amended by adding a
 95.5 subdivision to read:

95.6 Subd. 1b. **Background studies.** (a) County employees hired on or after July 1,
 95.7 2015, who have responsibility for child protection duties or current county employees who
 95.8 are assigned new child protection duties on or after July 1, 2015, are required to undergo a
 95.9 background study. A county may complete these background studies by either:

95.10 (1) use of the Department of Human Services NetStudy 2.0 system according to
 95.11 sections 245C.03 and 245C.10; or

95.12 (2) an alternative process defined by the county.

95.13 (b) County social services agencies and local welfare agencies must initiate
 95.14 background studies before an individual begins a position allowing direct contact with
 95.15 persons served by the agency.

95.16 Sec. 101. Laws 2014, chapter 189, section 5, is amended to read:

95.17 Sec. 5. Minnesota Statutes 2012, section 518C.201, is amended to read:

95.18 **518C.201 BASES FOR JURISDICTION OVER NONRESIDENT.**

95.19 (a) In a proceeding to establish, or enforce, ~~or modify~~ a support order or to determine
 95.20 parentage of a child, a tribunal of this state may exercise personal jurisdiction over a
 95.21 nonresident individual or the individual's guardian or conservator if:

95.22 (1) the individual is personally served with a summons or comparable document
 95.23 within this state;

95.24 (2) the individual submits to the jurisdiction of this state by consent, by entering a
 95.25 general appearance, or by filing a responsive document having the effect of waiving any
 95.26 contest to personal jurisdiction;

95.27 (3) the individual resided with the child in this state;

95.28 (4) the individual resided in this state and provided prenatal expenses or support
 95.29 for the child;

95.30 (5) the child resides in this state as a result of the acts or directives of the individual;

95.31 (6) the individual engaged in sexual intercourse in this state and the child may have
 95.32 been conceived by that act of intercourse;

95.33 (7) the individual asserted parentage of a child under sections 257.51 to 257.75; or

96.1 (8) there is any other basis consistent with the constitutions of this state and the
 96.2 United States for the exercise of personal jurisdiction.

96.3 (b) The bases of personal jurisdiction in paragraph (a) or in any other law of this state
 96.4 may not be used to acquire personal jurisdiction for a tribunal of this state to modify a child
 96.5 support order of another state unless the requirements of section 518C.611 are met, or, in
 96.6 the case of a foreign support order, unless the requirements of section 518C.615 are met.

96.7 Sec. 102. Laws 2014, chapter 189, section 9, is amended to read:

96.8 Sec. 9. Minnesota Statutes 2012, section 518C.205, is amended to read:

96.9 **518C.205 CONTINUING, EXCLUSIVE JURISDICTION TO MODIFY**
 96.10 **CHILD SUPPORT ORDER.**

96.11 (a) A tribunal of this state that has issued a support order consistent with the law
 96.12 of this state has and shall exercise continuing, exclusive jurisdiction to modify its child
 96.13 support order if the order is the controlling order and:

96.14 (1) at the time of the filing of a request for modification this state is the residence of the
 96.15 obligor, the individual obligee, or the child for whose benefit the support order is issued; or

96.16 (2) even if this state is not the residence of the obligor, the individual obligee, or the
 96.17 child for whose benefit the support order is issued, the parties consent in a record or in open
 96.18 court that the tribunal of this state may continue to exercise jurisdiction to modify its order.

96.19 (b) A tribunal of this state that has issued a child support order consistent with the
 96.20 law of this state may not exercise continuing, exclusive jurisdiction to modify the order if:

96.21 (1) all of the parties who are individuals file consent in a record with the tribunal of
 96.22 this state that a tribunal of another state that has jurisdiction over at least one of the parties
 96.23 who is an individual or that is located in the state of residence of the child may modify
 96.24 the order and assume continuing, exclusive jurisdiction; or

96.25 (2) its order is not the controlling order.

96.26 (c) If a tribunal of another state has issued a child support order pursuant to ~~this~~
 96.27 ~~chapter or a law substantially similar to this chapter~~ the Uniform Interstate Family Support
 96.28 Act which modifies a child support order of a tribunal of this state, tribunals of this state
 96.29 shall recognize the continuing, exclusive jurisdiction of the tribunal of the other state.

96.30 (d) A tribunal of this state that lacks continuing, exclusive jurisdiction to modify a
 96.31 child support order may serve as an initiating tribunal to request a tribunal of another state
 96.32 to modify a support order issued in that state.

96.33 (e) A temporary support order issued ex parte or pending resolution of a jurisdictional
 96.34 conflict does not create continuing, exclusive jurisdiction in the issuing tribunal.

97.1 Sec. 103. Laws 2014, chapter 189, section 10, is amended to read:

97.2 Sec. 10. Minnesota Statutes 2012, section 518C.206, is amended to read:

97.3 **~~518C.206 ENFORCEMENT AND MODIFICATION OF SUPPORT ORDER~~**
 97.4 **~~BY TRIBUNAL HAVING CONTINUING JURISDICTION TO ENFORCE CHILD~~**
 97.5 **~~SUPPORT ORDER.~~**

97.6 (a) A tribunal of this state that has issued a child support order consistent with the
 97.7 law of this state may serve as an initiating tribunal to request a tribunal of another state
 97.8 to enforce:

97.9 (1) the order if the order is the controlling order and has not been modified by
 97.10 a tribunal of another state that assumed jurisdiction pursuant to ~~this chapter or a law~~
 97.11 ~~substantially similar to this chapter~~ the Uniform Interstate Family Support Act; or

97.12 (2) a money judgment for arrears of support and interest on the order accrued before
 97.13 a determination that an order of a tribunal of another state is the controlling order.

97.14 (b) A tribunal of this state having continuing, ~~exclusive~~ jurisdiction over a support
 97.15 order may act as a responding tribunal to enforce the order.

97.16 Sec. 104. Laws 2014, chapter 189, section 11, is amended to read:

97.17 Sec. 11. Minnesota Statutes 2012, section 518C.207, is amended to read:

97.18 **~~518C.207 RECOGNITION DETERMINATION OF CONTROLLING CHILD~~**
 97.19 **~~SUPPORT ORDER.~~**

97.20 (a) If a proceeding is brought under this chapter and only one tribunal has issued a
 97.21 child support order, the order of that tribunal ~~is controlling~~ controls and must be recognized.

97.22 (b) If a proceeding is brought under this chapter, and two or more child support
 97.23 orders have been issued by tribunals of this state, another state, or a foreign country with
 97.24 regard to the same obligor and child, a tribunal of this state having personal jurisdiction
 97.25 over both the obligor and the individual obligee shall apply the following rules and by
 97.26 order shall determine which order controls and must be recognized:

97.27 (1) If only one of the tribunals would have continuing, exclusive jurisdiction under
 97.28 this chapter, the order of that tribunal ~~is controlling~~ controls.

97.29 (2) If more than one of the tribunals would have continuing, exclusive jurisdiction
 97.30 under this chapter:

97.31 (i) an order issued by a tribunal in the current home state of the child controls; or

97.32 (ii) if an order has not been issued in the current home state of the child, the order
 97.33 most recently issued controls.

97.34 (3) If none of the tribunals would have continuing, exclusive jurisdiction under this
 97.35 chapter, the tribunal of this state shall issue a child support order, which controls.

98.1 (c) If two or more child support orders have been issued for the same obligor and
 98.2 child, upon request of a party who is an individual or that is a support enforcement agency,
 98.3 a tribunal of this state having personal jurisdiction over both the obligor and the obligee
 98.4 who is an individual shall determine which order controls under paragraph (b). The
 98.5 request may be filed with a registration for enforcement or registration for modification
 98.6 pursuant to sections 518C.601 to 518C.616, or may be filed as a separate proceeding.

98.7 (d) A request to determine which is the controlling order must be accompanied
 98.8 by a copy of every child support order in effect and the applicable record of payments.
 98.9 The requesting party shall give notice of the request to each party whose rights may
 98.10 be affected by the determination.

98.11 (e) The tribunal that issued the controlling order under paragraph (a), (b), or (c) has
 98.12 continuing jurisdiction to the extent provided in section 518C.205, or 518C.206.

98.13 (f) A tribunal of this state which determines by order which is the controlling order
 98.14 under paragraph (b), clause (1) or (2), or paragraph (c), or which issues a new controlling
 98.15 child support order under paragraph (b), clause (3), shall state in that order:

98.16 (1) the basis upon which the tribunal made its determination;

98.17 (2) the amount of prospective support, if any; and

98.18 (3) the total amount of consolidated arrears and accrued interest, if any, under all of
 98.19 the orders after all payments made are credited as provided by section 518C.209.

98.20 (g) Within 30 days after issuance of the order determining which is the controlling
 98.21 order, the party obtaining that order shall file a certified copy of it with each tribunal that
 98.22 issued or registered an earlier order of child support. A party or support enforcement
 98.23 agency obtaining the order that fails to file a certified copy is subject to appropriate
 98.24 sanctions by a tribunal in which the issue of failure to file arises. The failure to file does
 98.25 not affect the validity or enforceability of the controlling order.

98.26 (h) An order that has been determined to be the controlling order, or a judgment for
 98.27 consolidated arrears of support and interest, if any, made pursuant to this section must be
 98.28 recognized in proceedings under this chapter.

98.29 Sec. 105. Laws 2014, chapter 189, section 16, is amended to read:

98.30 Sec. 16. Minnesota Statutes 2012, section 518C.301, is amended to read:

98.31 **518C.301 PROCEEDINGS UNDER THIS CHAPTER.**

98.32 (a) Except as otherwise provided in this chapter, sections 518C.301 to 518C.319
 98.33 apply to all proceedings under this chapter.

98.34 ~~(b) This chapter provides for the following proceedings:~~

99.1 ~~(1) establishment of an order for spousal support or child support pursuant to~~
 99.2 ~~section 518C.401;~~

99.3 ~~(2) enforcement of a support order and income-withholding order of another state or~~
 99.4 ~~a foreign country without registration pursuant to sections 518C.501 and 518C.502;~~

99.5 ~~(3) registration of an order for spousal support or child support of another state or a~~
 99.6 ~~foreign country for enforcement pursuant to sections 518C.601 to 518C.612;~~

99.7 ~~(4) modification of an order for child support or spousal support issued by a tribunal~~
 99.8 ~~of this state pursuant to sections 518C.203 to 518C.206;~~

99.9 ~~(5) registration of an order for child support of another state or a foreign country for~~
 99.10 ~~modification pursuant to sections 518C.601 to 518C.612;~~

99.11 ~~(6) determination of parentage of a child pursuant to section 518C.701; and~~

99.12 ~~(7) assertion of jurisdiction over nonresidents pursuant to sections 518C.201 and~~
 99.13 ~~518C.202.~~

99.14 ~~(e)~~ (b) An individual petitioner or a support enforcement agency may commence
 99.15 a proceeding authorized under this chapter by filing a petition in an initiating tribunal
 99.16 for forwarding to a responding tribunal or by filing a petition or a comparable pleading
 99.17 directly in a tribunal of another state or a foreign country which has or can obtain personal
 99.18 jurisdiction over the respondent.

99.19 Sec. 106. Laws 2014, chapter 189, section 17, is amended to read:

99.20 Sec. 17. Minnesota Statutes 2012, section 518C.303, is amended to read:

99.21 **518C.303 APPLICATION OF LAW OF THIS STATE.**

99.22 Except as otherwise provided by this chapter, a responding tribunal of this state shall:

99.23 (1) apply the procedural and substantive law, ~~including the rules on choice of law,~~
 99.24 generally applicable to similar proceedings originating in this state and may exercise all
 99.25 powers and provide all remedies available in those proceedings; and

99.26 (2) determine the duty of support and the amount payable in accordance with the
 99.27 law and support guidelines of this state.

99.28 Sec. 107. Laws 2014, chapter 189, section 18, is amended to read:

99.29 Sec. 18. Minnesota Statutes 2012, section 518C.304, is amended to read:

99.30 **518C.304 DUTIES OF INITIATING TRIBUNAL.**

99.31 (a) Upon the filing of a petition authorized by this chapter, an initiating tribunal of
 99.32 this state shall forward the petition and its accompanying documents:

99.33 (1) to the responding tribunal or appropriate support enforcement agency in the
 99.34 responding state; or

100.1 (2) if the identity of the responding tribunal is unknown, to the state information
 100.2 agency of the responding state with a request that they be forwarded to the appropriate
 100.3 tribunal and that receipt be acknowledged.

100.4 (b) If requested by the responding tribunal, a tribunal of this state shall issue a
 100.5 certificate or other documents and make findings required by the law of the responding
 100.6 state. If the responding tribunal is in a foreign country, upon request the tribunal of this
 100.7 state shall specify the amount of support sought, convert that amount into the equivalent
 100.8 amount in the foreign currency under applicable official or market exchange rate as
 100.9 publicly reported, and provide other documents necessary to satisfy the requirements of
 100.10 the responding foreign tribunal.

100.11 Sec. 108. Laws 2014, chapter 189, section 19, is amended to read:

100.12 Sec. 19. Minnesota Statutes 2012, section 518C.305, is amended to read:

100.13 **518C.305 DUTIES AND POWERS OF RESPONDING TRIBUNAL.**

100.14 (a) When a responding tribunal of this state receives a petition or comparable
 100.15 pleading from an initiating tribunal or directly pursuant to section 518C.301, paragraph (e)
 100.16 (b), it shall cause the petition or pleading to be filed and notify the petitioner where and
 100.17 when it was filed.

100.18 (b) A responding tribunal of this state, to the extent ~~otherwise authorized by~~ not
 100.19 prohibited by other law, may do one or more of the following:

100.20 (1) establish or enforce a support order, modify a child support order, determine the
 100.21 controlling child support order, or to determine parentage of a child;

100.22 (2) order an obligor to comply with a support order, specifying the amount and
 100.23 the manner of compliance;

100.24 (3) order income withholding;

100.25 (4) determine the amount of any arrearages, and specify a method of payment;

100.26 (5) enforce orders by civil or criminal contempt, or both;

100.27 (6) set aside property for satisfaction of the support order;

100.28 (7) place liens and order execution on the obligor's property;

100.29 (8) order an obligor to keep the tribunal informed of the obligor's current residential
 100.30 address, electronic mail address, telephone number, employer, address of employment,
 100.31 and telephone number at the place of employment;

100.32 (9) issue a bench warrant for an obligor who has failed after proper notice to appear
 100.33 at a hearing ordered by the tribunal and enter the bench warrant in any local and state
 100.34 computer systems for criminal warrants;

100.35 (10) order the obligor to seek appropriate employment by specified methods;

101.1 (11) award reasonable attorney's fees and other fees and costs; and

101.2 (12) grant any other available remedy.

101.3 (c) A responding tribunal of this state shall include in a support order issued under
101.4 this chapter, or in the documents accompanying the order, the calculations on which
101.5 the support order is based.

101.6 (d) A responding tribunal of this state may not condition the payment of a support
101.7 order issued under this chapter upon compliance by a party with provisions for visitation.

101.8 (e) If a responding tribunal of this state issues an order under this chapter, the
101.9 tribunal shall send a copy of the order to the petitioner and the respondent and to the
101.10 initiating tribunal, if any.

101.11 (f) If requested to enforce a support order, arrears, or judgment or modify a support
101.12 order stated in a foreign currency, a responding tribunal of this state shall convert the
101.13 amount stated in the foreign currency to the equivalent amount in dollars under the
101.14 applicable official or market exchange rate as publicly reported.

101.15 Sec. 109. Laws 2014, chapter 189, section 23, is amended to read:

101.16 Sec. 23. Minnesota Statutes 2012, section 518C.310, is amended to read:

101.17 **518C.310 DUTIES OF STATE INFORMATION AGENCY.**

101.18 (a) The unit within the Department of Human Services that receives and disseminates
101.19 incoming interstate actions under title IV-D of the Social Security Act is the State
101.20 Information Agency under this chapter.

101.21 (b) The State Information Agency shall:

101.22 (1) compile and maintain a current list, including addresses, of the tribunals in this
101.23 state which have jurisdiction under this chapter and any support enforcement agencies in
101.24 this state and transmit a copy to the state information agency of every other state;

101.25 (2) maintain a register of names and addresses of tribunals and support enforcement
101.26 agencies received from other states;

101.27 (3) forward to the appropriate tribunal in the place in this state in which the
101.28 individual obligee or the obligor resides, or in which the obligor's property is believed
101.29 to be located, all documents concerning a proceeding under this chapter received from
101.30 another state or a foreign country; and

101.31 (4) obtain information concerning the location of the obligor and the obligor's
101.32 property within this state not exempt from execution, by such means as postal verification
101.33 and federal or state locator services, examination of telephone directories, requests for the
101.34 obligor's address from employers, and examination of governmental records, including, to

102.1 the extent not prohibited by other law, those relating to real property, vital statistics, law
102.2 enforcement, taxation, motor vehicles, driver's licenses, and Social Security.

102.3 Sec. 110. Laws 2014, chapter 189, section 24, is amended to read:

102.4 Sec. 24. Minnesota Statutes 2012, section 518C.311, is amended to read:

102.5 **518C.311 PLEADINGS AND ACCOMPANYING DOCUMENTS.**

102.6 (a) A petitioner seeking to establish or modify a support order, determine parentage
102.7 of a child, or register and modify a support order of a tribunal of another state or a foreign
102.8 country, in a proceeding under this chapter must file a petition. Unless otherwise ordered
102.9 under section 518C.312, the petition or accompanying documents must provide, so far
102.10 as known, the name, residential address, and Social Security numbers of the obligor and
102.11 the obligee or parent and alleged parent, and the name, sex, residential address, Social
102.12 Security number, and date of birth of each child for whom support is sought or whose
102.13 ~~parenthood~~ parentage is to be determined. Unless filed at the time of registration, the
102.14 petition must be accompanied by a ~~certified~~ copy of any support order ~~in effect~~ known
102.15 to have been issued by another tribunal. The petition may include any other information
102.16 that may assist in locating or identifying the respondent.

102.17 (b) The petition must specify the relief sought. The petition and accompanying
102.18 documents must conform substantially with the requirements imposed by the forms
102.19 mandated by federal law for use in cases filed by a support enforcement agency.

102.20 Sec. 111. Laws 2014, chapter 189, section 27, is amended to read:

102.21 Sec. 27. Minnesota Statutes 2012, section 518C.314, is amended to read:

102.22 **518C.314 LIMITED IMMUNITY OF PETITIONER.**

102.23 (a) Participation by a petitioner in a proceeding under this chapter before a
102.24 responding tribunal, whether in person, by private attorney, or through services provided
102.25 by the support enforcement agency, does not confer personal jurisdiction over the
102.26 petitioner in another proceeding.

102.27 (b) A petitioner is not amenable to service of civil process while physically present
102.28 in this state to participate in a proceeding under this chapter.

102.29 (c) The immunity granted by this section does not extend to civil litigation based on
102.30 acts unrelated to a proceeding under this chapter committed by a party while physically
102.31 present in this state to participate in the proceeding.

102.32 Sec. 112. Laws 2014, chapter 189, section 28, is amended to read:

103.1 Sec. 28. Minnesota Statutes 2012, section 518C.316, is amended to read:

103.2 **518C.316 SPECIAL RULES OF EVIDENCE AND PROCEDURE.**

103.3 (a) The physical presence of ~~the petitioner~~ a nonresident party who is an individual
 103.4 in a ~~responding~~ tribunal of this state is not required for the establishment, enforcement,
 103.5 or modification of a support order or the rendition of a judgment determining parentage
 103.6 of a child.

103.7 (b) ~~A verified petition,~~ An affidavit, a document substantially complying with
 103.8 federally mandated forms, and or a document incorporated by reference in any of them,
 103.9 not excluded under the hearsay rule if given in person, is admissible in evidence if given
 103.10 under ~~oath~~ penalty of perjury by a party or witness residing outside this state.

103.11 (c) A copy of the record of child support payments certified as a true copy of the
 103.12 original by the custodian of the record may be forwarded to a responding tribunal. The copy
 103.13 is evidence of facts asserted in it, and is admissible to show whether payments were made.

103.14 (d) Copies of bills for testing for parentage of a child, and for prenatal and postnatal
 103.15 health care of the mother and child, furnished to the adverse party at least ten days before
 103.16 trial, are admissible in evidence to prove the amount of the charges billed and that the
 103.17 charges were reasonable, necessary, and customary.

103.18 (e) Documentary evidence transmitted from outside this state to a tribunal of this state
 103.19 by telephone, telecopier, or other electronic means that do not provide an original record
 103.20 may not be excluded from evidence on an objection based on the means of transmission.

103.21 (f) In a proceeding under this chapter, a tribunal of this state shall permit a party
 103.22 or witness residing outside this state to be deposed or to testify under penalty of perjury
 103.23 by telephone, audiovisual means, or other electronic means at a designated tribunal or
 103.24 other location. A tribunal of this state shall cooperate with other tribunals in designating
 103.25 an appropriate location for the deposition or testimony.

103.26 (g) If a party called to testify at a civil hearing refuses to answer on the ground that
 103.27 the testimony may be self-incriminating, the trier of fact may draw an adverse inference
 103.28 from the refusal.

103.29 (h) A privilege against disclosure of communications between spouses does not
 103.30 apply in a proceeding under this chapter.

103.31 (i) The defense of immunity based on the relationship of husband and wife or parent
 103.32 and child does not apply in a proceeding under this chapter.

103.33 (j) A voluntary acknowledgment of paternity, certified as a true copy, is admissible
 103.34 to establish parentage of a child.

103.35 Sec. 113. Laws 2014, chapter 189, section 29, is amended to read:

104.1 Sec. 29. Minnesota Statutes 2012, section 518C.317, is amended to read:

104.2 **518C.317 COMMUNICATIONS BETWEEN TRIBUNALS.**

104.3 A tribunal of this state may communicate with a tribunal outside this state in
104.4 ~~writing, by e-mail, or a record,~~ or by telephone, electronic mail, or other means, to obtain
104.5 information concerning the laws of that state, the legal effect of a judgment, decree, or
104.6 order of that tribunal, and the status of a proceeding. A tribunal of this state may furnish
104.7 similar information by similar means to a tribunal outside this state.

104.8 Sec. 114. Laws 2014, chapter 189, section 31, is amended to read:

104.9 Sec. 31. Minnesota Statutes 2012, section 518C.319, is amended to read:

104.10 **518C.319 RECEIPT AND DISBURSEMENT OF PAYMENTS.**

104.11 (a) A support enforcement agency or tribunal of this state shall disburse promptly
104.12 any amounts received pursuant to a support order, as directed by the order. The agency
104.13 or tribunal shall furnish to a requesting party or tribunal of another state or a foreign
104.14 country a certified statement by the custodian of the record of the amounts and dates
104.15 of all payments received.

104.16 (b) If neither the obligor, ~~not~~ nor the obligee who is an individual, nor the child
104.17 resides in this state, upon request from the support enforcement agency of this state or
104.18 another state, the support enforcement agency of this state or a tribunal of this state shall:

104.19 (1) direct that the support payment be made to the support enforcement agency in
104.20 the state in which the obligee is receiving services; and

104.21 (2) issue and send to the obligor's employer a conforming income-withholding order
104.22 or an administrative notice of change of payee, reflecting the redirected payments.

104.23 (c) The support enforcement agency of this state receiving redirected payments from
104.24 another state pursuant to a law similar to paragraph (b) shall furnish to a requesting party
104.25 or tribunal of the other state a certified statement by the custodian of the record of the
104.26 amount and dates of all payments received.

104.27 Sec. 115. Laws 2014, chapter 189, section 43, is amended to read:

104.28 Sec. 43. Minnesota Statutes 2012, section 518C.604, is amended to read:

104.29 **518C.604 CHOICE OF LAW.**

104.30 (a) Except as otherwise provided in paragraph (d), the law of the issuing state or
104.31 foreign country governs:

104.32 (1) the nature, extent, amount, and duration of current payments under a registered
104.33 support order;

105.1 (2) the computation and payment of arrearages and accrual of interest on the
105.2 arrearages under the support order; and

105.3 (3) the existence and satisfaction of other obligations under the support order.

105.4 (b) In a proceeding for arrearages under a registered support order, the statute of
105.5 limitation under the laws of this state or of the issuing state or foreign country, whichever
105.6 is longer, applies.

105.7 (c) A responding tribunal of this state shall apply the procedures and remedies of
105.8 this state to enforce current support and collect arrears and interest due on a support order
105.9 of another state or a foreign country registered in this state.

105.10 (d) After a tribunal of this state or another state determines which is the controlling
105.11 order and issues an order consolidating arrears, if any, a tribunal of this state shall
105.12 prospectively apply the law of the state or foreign country issuing the controlling order,
105.13 including its law on interest on arrears, on current and future support, and on consolidated
105.14 arrears.

105.15 Sec. 116. Laws 2014, chapter 189, section 50, is amended to read:

105.16 Sec. 50. Minnesota Statutes 2012, section 518C.611, is amended to read:

105.17 **518C.611 MODIFICATION OF CHILD SUPPORT ORDER OF ANOTHER**
105.18 **STATE.**

105.19 (a) If section 518C.613 does not apply, upon petition a tribunal of this state may
105.20 modify a child support order issued in another state that is registered in this state if, after
105.21 notice and hearing, it finds that:

105.22 (1) the following requirements are met:

105.23 (i) neither the child, nor the obligee who is an individual, nor the obligor resides
105.24 in the issuing state;

105.25 (ii) a petitioner who is a nonresident of this state seeks modification; and

105.26 (iii) the respondent is subject to the personal jurisdiction of the tribunal of this state; or

105.27 (2) this state is the residence of the child, or a party who is an individual is subject to
105.28 the personal jurisdiction of the tribunal of this state and all of the parties who are individuals
105.29 have filed ~~written~~ consents in a record in the issuing tribunal for a tribunal of this state to
105.30 modify the support order and assume continuing, exclusive jurisdiction ~~over the order~~.

105.31 (b) Modification of a registered child support order is subject to the same
105.32 requirements, procedures, and defenses that apply to the modification of an order issued
105.33 by a tribunal of this state and the order may be enforced and satisfied in the same manner.

105.34 (c) A tribunal of this state may not modify any aspect of a child support order that
105.35 may not be modified under the law of the issuing state, including the duration of the

106.1 obligation of support. If two or more tribunals have issued child support orders for the
 106.2 same obligor and child, the order that controls and must be recognized under section
 106.3 518C.207 establishes the aspects of the support order which are nonmodifiable.

106.4 (d) In a proceeding to modify a child support order, the law of the state that is
 106.5 determined to have issued the initial controlling order governs the duration of the
 106.6 obligation of support. The obligor's fulfillment of the duty of support established by that
 106.7 order precludes imposition of a further obligation of support by a tribunal of this state.

106.8 (e) On issuance of an order by a tribunal of this state modifying a child support order
 106.9 issued in another state, a tribunal of this state becomes the tribunal having continuing,
 106.10 exclusive jurisdiction.

106.11 (f) Notwithstanding paragraphs (a) to ~~(d)~~ (e) and section 518C.201, paragraph (b),
 106.12 a tribunal of this state retains jurisdiction to modify an order issued by a tribunal of this
 106.13 state if:

106.14 (1) one party resides in another state; and

106.15 (2) the other party resides outside the United States.

106.16 Sec. 117. Laws 2014, chapter 189, section 51, is amended to read:

106.17 Sec. 51. Minnesota Statutes 2012, section 518C.612, is amended to read:

106.18 **518C.612 RECOGNITION OF ORDER MODIFIED IN ANOTHER STATE.**

106.19 If a child support order issued by a tribunal of this state is modified by a tribunal of
 106.20 another state which assumed jurisdiction ~~according to this chapter or a law substantially~~
 106.21 ~~similar to this chapter~~ pursuant to the Uniform Interstate Family Support Act, a tribunal of
 106.22 this state:

106.23 (1) may enforce its order that was modified only as to arrears and interest accruing
 106.24 before the modification;

106.25 (2) may provide appropriate relief for violations of its order which occurred before
 106.26 the effective date of the modification; and

106.27 (3) shall recognize the modifying order of the other state, upon registration, for the
 106.28 purpose of enforcement.

106.29 Sec. 118. Laws 2014, chapter 189, section 52, is amended to read:

106.30 Sec. 52. Minnesota Statutes 2012, section 518C.613, is amended to read:

106.31 **518C.613 JURISDICTION TO MODIFY SUPPORT ORDER OF ANOTHER**
 106.32 **STATE WHEN INDIVIDUAL PARTIES RESIDE IN THIS STATE.**

107.1 (a) If all of the parties who are individuals reside in this state and the child does not
107.2 reside in the issuing state, a tribunal of this state has jurisdiction to enforce and to modify
107.3 the issuing state's child support order in a proceeding to register that order.

107.4 (b) A tribunal of this state exercising jurisdiction as provided in this section shall apply
107.5 sections 518C.101 to ~~518C.209~~ 518C.211 and 518C.601 to 518C.616 to the enforcement
107.6 or modification proceeding. Sections 518C.301 to 518C.508 and 518C.701 to 518C.802
107.7 do not apply and the tribunal shall apply the procedural and substantive law of this state.

107.8 Sec. 119. Laws 2014, chapter 189, section 73, is amended to read:

107.9 Sec. 73. **EFFECTIVE DATE.**

107.10 This act ~~becomes~~ is effective ~~on the date that the United States deposits the~~
107.11 ~~instrument of ratification for the Hague Convention on the International Recovery of Child~~
107.12 ~~Support and Other Forms of Family Maintenance with the Hague Conference on Private~~
107.13 ~~International Law~~ July 1, 2015.

107.14 **EFFECTIVE DATE.** This section is effective July 1, 2015.

107.15 Sec. 120. **GROUP RESIDENTIAL HOUSING REPORT ON PROGRAM**
107.16 **IMPROVEMENTS.**

107.17 (a) The commissioner shall, in coordination with stakeholders and advocates, build
107.18 on the group residential housing (GRH) reforms made in the 2015 legislative session
107.19 related to program integrity and uniformity, by restructuring the payment rates, exploring
107.20 assessment tools, and proposing any other necessary modifications that will result in a
107.21 more cost-effective program, and report to the members of the legislative committees
107.22 having jurisdiction over GRH issues by December 15, 2016.

107.23 (b) The working group, consisting of the commissioner, stakeholders, and advocates,
107.24 shall examine the feasibility and fiscal implications of restructuring service rates by
107.25 eliminating the supplemental service rates, and developing a plan to fund only those
107.26 services, based on individual need, that are not covered by medical assistance, other
107.27 insurance, or other programs. In addition, the working group shall analyze the payment
107.28 structure, and explore different options, including tiered rates for services, and provide the
107.29 plan and analysis under this paragraph in the report under paragraph (a).

107.30 (c) To determine individual need, the working group shall explore assessment tools,
107.31 and determine the appropriate assessment tool for the different populations served by the
107.32 GRH program, which include homeless individuals, individuals with mental illness, and
107.33 individuals who are chemically dependent. The working group shall coordinate efforts
107.34 with agency staff who have expertise related to these populations, and use relevant

108.1 information and data that is available, to determine the most appropriate and effective
 108.2 assessment tool or tools, and provide the analysis and an assessment recommendation in
 108.3 the report under paragraph (a).

108.4 Sec. 121. **CHILD SUPPORT WORK GROUP.**

108.5 (a) A child support work group is established to review the parenting expense
 108.6 adjustment in Minnesota Statutes, section 518A.36, and to identify and recommend
 108.7 changes to the parenting expense adjustment.

108.8 (b) Members of the work group shall include:

108.9 (1) two members of the house of representatives, one appointed by the speaker of the
 108.10 house and one appointed by the minority leader;

108.11 (2) two members of the senate, one appointed by the majority leader and one
 108.12 appointed by the minority leader;

108.13 (3) the commissioner of human services or a designee;

108.14 (4) one staff member from the Child Support Division of the Department of Human
 108.15 Services, appointed by the commissioner;

108.16 (5) one representative of the Minnesota State Bar Association, Family Law section,
 108.17 appointed by the section;

108.18 (6) one representative of the Minnesota County Attorney's Association, appointed
 108.19 by the association;

108.20 (7) one representative of the Minnesota Legal Services Coalition, appointed by
 108.21 the coalition;

108.22 (8) one representative of the Minnesota Family Support and Recovery Council,
 108.23 appointed by the council; and

108.24 (9) two representatives from parent advocacy groups, one representing custodial
 108.25 parents and one representing noncustodial parents, appointed by the commissioner of
 108.26 human services.

108.27 The commissioner, or the commissioner's designee, shall appoint the work group chair.

108.28 (c) The work group shall be authorized to retain the services of an economist to help
 108.29 create an equitable parenting expense adjustment formula. The work group may hire an
 108.30 economist by use of a sole-source contract.

108.31 (d) The work group shall issue a report to the chairs and ranking minority members
 108.32 of the legislative committees with jurisdiction over civil law, judiciary, and health and
 108.33 human services by January 15, 2016. The report must include recommendations for
 108.34 changes to the computation of child support and recommendations on the composition
 108.35 of a permanent child support task force.

109.1 (e) Terms, compensation, and removal of members and the filling of vacancies are
109.2 governed by Minnesota Statutes, section 15.059.

109.3 (f) The work group expires January 16, 2016.

109.4 Sec. 122. **INSTRUCTIONS TO THE COMMISSIONER; CHILD**
109.5 **MALTREATMENT SCREENING GUIDELINES.**

109.6 (a) No later than October 1, 2015, the commissioner of human services shall update
109.7 the child maltreatment screening guidelines to require agencies to consider prior reports that
109.8 were not screened in when determining whether a new report will or will not be screened
109.9 in. The updated guidelines must emphasize that intervention and prevention efforts are to
109.10 focus on child safety and the ongoing risk of child abuse or neglect, and that the health and
109.11 safety of children are of paramount concern. The commissioner shall work with a diverse
109.12 group of community representatives who are experts on limiting cultural and ethnic bias
109.13 when developing the updated guidelines. The guidelines must be developed with special
109.14 sensitivity to reducing system bias with regard to screening and assessment tools.

109.15 (b) No later than November 1, 2015, the commissioner shall publish and distribute
109.16 the updated guidelines and ensure that all agency staff have received training on the
109.17 updated guidelines.

109.18 (c) Agency staff must implement the guidelines by January 1, 2016.

109.19 Sec. 123. **COMMISSIONER'S DUTY TO PROVIDE TRAINING TO CHILD**
109.20 **PROTECTION SUPERVISORS.**

109.21 The commissioner shall establish requirements for competency-based initial
109.22 training, support, and continuing education for child protection supervisors. This includes
109.23 developing a set of competencies specific to child protection supervisor knowledge, skills,
109.24 and attitudes based on the Minnesota Child Welfare Practice Model. Competency-based
109.25 training of supervisors must advance continuous emphasis and improvement in skills that
109.26 promote the use of the client's culture as a resource and the ability to integrate the client's
109.27 traditions, customs, values, and faith into service delivery.

109.28 Sec. 124. **CHILD PROTECTION UPDATED FORMULA.**

109.29 The commissioner of human services shall evaluate the formulas in Minnesota
109.30 Statutes, section 256M.41, and recommend an updated equitable distribution formula
109.31 beginning in fiscal year 2018, for funding child protection staffing and expanded services
109.32 to counties and tribes, taking into consideration any relief to counties and tribes for child
109.33 welfare and foster care costs, additional tribes delivering social services, and any other

110.1 relevant information that should be considered in developing a new distribution formula.
110.2 The commissioner shall report to the legislative committees having jurisdiction over child
110.3 protection issues by December 15, 2016.

110.4 **Sec. 125. LEGISLATIVE TASK FORCE; CHILD PROTECTION.**

110.5 (a) A legislative task force is created to:

110.6 (1) review the efforts being made to implement the recommendations of the
110.7 Governor's Task Force on the Protection of Children, including a review of the roles and
110.8 functions of the Office of Ombudsperson for Families;

110.9 (2) expand the efforts into related areas of the child welfare system;

110.10 (3) work with the commissioner of human services and community partners to
110.11 establish and evaluate child protection grants to address disparities in child welfare
110.12 pursuant to Minnesota Statutes, section 256E.28; and

110.13 (4) identify additional areas within the child welfare system that need to be addressed
110.14 by the legislature.

110.15 (b) Members of the legislative task force shall include:

110.16 (1) the four legislators who served as members of the Governor's Task Force on
110.17 the Protection of Children;

110.18 (2) two members from the house of representatives appointed by the speaker, one
110.19 from the majority party and one from the minority party; and

110.20 (3) two members from the senate appointed by the majority leader, one from the
110.21 majority party and one from the minority party.

110.22 The speaker and the majority leader shall each appoint a chair and vice-chair from the
110.23 membership of the task force. The gavel shall rotate after each meeting, and the house of
110.24 representatives shall assume the leadership of the task force first.

110.25 (c) The task force may provide oversight and monitoring of:

110.26 (1) the efforts by the Department of Human Services, counties, and tribes to
110.27 implement laws related to child protection;

110.28 (2) efforts by the Department of Human Services, counties, and tribes to implement
110.29 the recommendations of the Governor's Task Force on the Protection of Children;

110.30 (3) efforts by agencies, including but not limited to the Minnesota Department
110.31 of Education, the Minnesota Housing Finance Agency, the Minnesota Department of
110.32 Corrections, and the Minnesota Department of Public Safety, to work with the Department
110.33 of Human Services to assure safety and well-being for children at risk of harm or children
110.34 in the child welfare system; and

111.1 (4) efforts by the Department of Human Services, other agencies, counties, and
 111.2 tribes to implement best practices to ensure every child is protected from maltreatment
 111.3 and neglect and to ensure every child has the opportunity for healthy development.

111.4 (d) The task force, in cooperation with the commissioner of human services, shall
 111.5 issue a report to the legislature and governor February 1, 2016. The report must contain
 111.6 information on the progress toward implementation of changes to the child protection
 111.7 system, recommendations for additional legislative changes and procedures affecting child
 111.8 protection and child welfare, and funding needs to implement recommended changes.

111.9 (e) The task force shall convene upon the effective date of this section and shall
 111.10 continue until the last day of the 2016 legislative session.

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

111.12 Sec. 126. **REVISOR'S INSTRUCTION.**

111.13 The revisor of statutes shall alphabetize the definitions in Minnesota Statutes, section
 111.14 626.556, subdivision 2, and correct related cross-references.

111.15 **ARTICLE 2**

111.16 **CHEMICAL AND MENTAL HEALTH SERVICES**

111.17 Section 1. Minnesota Statutes 2014, section 13.46, subdivision 2, is amended to read:

111.18 Subd. 2. **General.** (a) Data on individuals collected, maintained, used, or
 111.19 disseminated by the welfare system are private data on individuals, and shall not be
 111.20 disclosed except:

111.21 (1) according to section 13.05;

111.22 (2) according to court order;

111.23 (3) according to a statute specifically authorizing access to the private data;

111.24 (4) to an agent of the welfare system and an investigator acting on behalf of a county,
 111.25 the state, or the federal government, including a law enforcement person or attorney in the
 111.26 investigation or prosecution of a criminal, civil, or administrative proceeding relating to
 111.27 the administration of a program;

111.28 (5) to personnel of the welfare system who require the data to verify an individual's
 111.29 identity; determine eligibility, amount of assistance, and the need to provide services
 111.30 to an individual or family across programs; coordinate services for an individual or
 111.31 family; evaluate the effectiveness of programs; assess parental contribution amounts;
 111.32 and investigate suspected fraud;

111.33 (6) to administer federal funds or programs;

- 112.1 (7) between personnel of the welfare system working in the same program;
- 112.2 (8) to the Department of Revenue to assess parental contribution amounts for
112.3 purposes of section 252.27, subdivision 2a, administer and evaluate tax refund or tax credit
112.4 programs and to identify individuals who may benefit from these programs. The following
112.5 information may be disclosed under this paragraph: an individual's and their dependent's
112.6 names, dates of birth, Social Security numbers, income, addresses, and other data as
112.7 required, upon request by the Department of Revenue. Disclosures by the commissioner
112.8 of revenue to the commissioner of human services for the purposes described in this clause
112.9 are governed by section 270B.14, subdivision 1. Tax refund or tax credit programs include,
112.10 but are not limited to, the dependent care credit under section 290.067, the Minnesota
112.11 working family credit under section 290.0671, the property tax refund and rental credit
112.12 under section 290A.04, and the Minnesota education credit under section 290.0674;
- 112.13 (9) between the Department of Human Services, the Department of Employment
112.14 and Economic Development, and when applicable, the Department of Education, for
112.15 the following purposes:
- 112.16 (i) to monitor the eligibility of the data subject for unemployment benefits, for any
112.17 employment or training program administered, supervised, or certified by that agency;
- 112.18 (ii) to administer any rehabilitation program or child care assistance program,
112.19 whether alone or in conjunction with the welfare system;
- 112.20 (iii) to monitor and evaluate the Minnesota family investment program or the child
112.21 care assistance program by exchanging data on recipients and former recipients of food
112.22 support, cash assistance under chapter 256, 256D, 256J, or 256K, child care assistance
112.23 under chapter 119B, or medical programs under chapter 256B, 256D, or 256L; and
- 112.24 (iv) to analyze public assistance employment services and program utilization,
112.25 cost, effectiveness, and outcomes as implemented under the authority established in Title
112.26 II, Sections 201-204 of the Ticket to Work and Work Incentives Improvement Act of
112.27 1999. Health records governed by sections 144.291 to 144.298 and "protected health
112.28 information" as defined in Code of Federal Regulations, title 45, section 160.103, and
112.29 governed by Code of Federal Regulations, title 45, parts 160-164, including health care
112.30 claims utilization information, must not be exchanged under this clause;
- 112.31 (10) to appropriate parties in connection with an emergency if knowledge of
112.32 the information is necessary to protect the health or safety of the individual or other
112.33 individuals or persons;
- 112.34 (11) data maintained by residential programs as defined in section 245A.02 may
112.35 be disclosed to the protection and advocacy system established in this state according
112.36 to Part C of Public Law 98-527 to protect the legal and human rights of persons with

113.1 developmental disabilities or other related conditions who live in residential facilities for
113.2 these persons if the protection and advocacy system receives a complaint by or on behalf
113.3 of that person and the person does not have a legal guardian or the state or a designee of
113.4 the state is the legal guardian of the person;

113.5 (12) to the county medical examiner or the county coroner for identifying or locating
113.6 relatives or friends of a deceased person;

113.7 (13) data on a child support obligor who makes payments to the public agency
113.8 may be disclosed to the Minnesota Office of Higher Education to the extent necessary to
113.9 determine eligibility under section 136A.121, subdivision 2, clause (5);

113.10 (14) participant Social Security numbers and names collected by the telephone
113.11 assistance program may be disclosed to the Department of Revenue to conduct an
113.12 electronic data match with the property tax refund database to determine eligibility under
113.13 section 237.70, subdivision 4a;

113.14 (15) the current address of a Minnesota family investment program participant
113.15 may be disclosed to law enforcement officers who provide the name of the participant
113.16 and notify the agency that:

113.17 (i) the participant:

113.18 (A) is a fugitive felon fleeing to avoid prosecution, or custody or confinement after
113.19 conviction, for a crime or attempt to commit a crime that is a felony under the laws of the
113.20 jurisdiction from which the individual is fleeing; or

113.21 (B) is violating a condition of probation or parole imposed under state or federal law;

113.22 (ii) the location or apprehension of the felon is within the law enforcement officer's
113.23 official duties; and

113.24 (iii) the request is made in writing and in the proper exercise of those duties;

113.25 (16) the current address of a recipient of general assistance or general assistance
113.26 medical care may be disclosed to probation officers and corrections agents who are
113.27 supervising the recipient and to law enforcement officers who are investigating the
113.28 recipient in connection with a felony level offense;

113.29 (17) information obtained from food support applicant or recipient households may
113.30 be disclosed to local, state, or federal law enforcement officials, upon their written request,
113.31 for the purpose of investigating an alleged violation of the Food Stamp Act, according
113.32 to Code of Federal Regulations, title 7, section 272.1(c);

113.33 (18) the address, Social Security number, and, if available, photograph of any
113.34 member of a household receiving food support shall be made available, on request, to a
113.35 local, state, or federal law enforcement officer if the officer furnishes the agency with the
113.36 name of the member and notifies the agency that:

- 114.1 (i) the member:
- 114.2 (A) is fleeing to avoid prosecution, or custody or confinement after conviction, for a
- 114.3 crime or attempt to commit a crime that is a felony in the jurisdiction the member is fleeing;
- 114.4 (B) is violating a condition of probation or parole imposed under state or federal
- 114.5 law; or
- 114.6 (C) has information that is necessary for the officer to conduct an official duty related
- 114.7 to conduct described in subitem (A) or (B);
- 114.8 (ii) locating or apprehending the member is within the officer's official duties; and
- 114.9 (iii) the request is made in writing and in the proper exercise of the officer's official
- 114.10 duty;
- 114.11 (19) the current address of a recipient of Minnesota family investment program,
- 114.12 general assistance, general assistance medical care, or food support may be disclosed to
- 114.13 law enforcement officers who, in writing, provide the name of the recipient and notify the
- 114.14 agency that the recipient is a person required to register under section 243.166, but is not
- 114.15 residing at the address at which the recipient is registered under section 243.166;
- 114.16 (20) certain information regarding child support obligors who are in arrears may be
- 114.17 made public according to section 518A.74;
- 114.18 (21) data on child support payments made by a child support obligor and data on
- 114.19 the distribution of those payments excluding identifying information on obligees may be
- 114.20 disclosed to all obligees to whom the obligor owes support, and data on the enforcement
- 114.21 actions undertaken by the public authority, the status of those actions, and data on the
- 114.22 income of the obligor or obligee may be disclosed to the other party;
- 114.23 (22) data in the work reporting system may be disclosed under section 256.998,
- 114.24 subdivision 7;
- 114.25 (23) to the Department of Education for the purpose of matching Department of
- 114.26 Education student data with public assistance data to determine students eligible for free
- 114.27 and reduced-price meals, meal supplements, and free milk according to United States
- 114.28 Code, title 42, sections 1758, 1761, 1766, 1766a, 1772, and 1773; to allocate federal and
- 114.29 state funds that are distributed based on income of the student's family; and to verify
- 114.30 receipt of energy assistance for the telephone assistance plan;
- 114.31 (24) the current address and telephone number of program recipients and emergency
- 114.32 contacts may be released to the commissioner of health or a community health board as
- 114.33 defined in section 145A.02, subdivision 5, when the commissioner or community health
- 114.34 board has reason to believe that a program recipient is a disease case, carrier, suspect case,
- 114.35 or at risk of illness, and the data are necessary to locate the person;

115.1 (25) to other state agencies, statewide systems, and political subdivisions of this
115.2 state, including the attorney general, and agencies of other states, interstate information
115.3 networks, federal agencies, and other entities as required by federal regulation or law for
115.4 the administration of the child support enforcement program;

115.5 (26) to personnel of public assistance programs as defined in section 256.741, for
115.6 access to the child support system database for the purpose of administration, including
115.7 monitoring and evaluation of those public assistance programs;

115.8 (27) to monitor and evaluate the Minnesota family investment program by
115.9 exchanging data between the Departments of Human Services and Education, on
115.10 recipients and former recipients of food support, cash assistance under chapter 256, 256D,
115.11 256J, or 256K, child care assistance under chapter 119B, or medical programs under
115.12 chapter 256B, 256D, or 256L;

115.13 (28) to evaluate child support program performance and to identify and prevent
115.14 fraud in the child support program by exchanging data between the Department of Human
115.15 Services, Department of Revenue under section 270B.14, subdivision 1, paragraphs (a)
115.16 and (b), without regard to the limitation of use in paragraph (c), Department of Health,
115.17 Department of Employment and Economic Development, and other state agencies as is
115.18 reasonably necessary to perform these functions;

115.19 (29) counties operating child care assistance programs under chapter 119B may
115.20 disseminate data on program participants, applicants, and providers to the commissioner
115.21 of education; ~~or~~

115.22 (30) child support data on the child, the parents, and relatives of the child may be
115.23 disclosed to agencies administering programs under titles IV-B and IV-E of the Social
115.24 Security Act, as authorized by federal law; or

115.25 (31) to a health care provider governed by sections 144.291 to 144.298, to the extent
115.26 necessary to coordinate services.

115.27 (b) Information on persons who have been treated for drug or alcohol abuse may
115.28 only be disclosed according to the requirements of Code of Federal Regulations, title
115.29 42, sections 2.1 to 2.67.

115.30 (c) Data provided to law enforcement agencies under paragraph (a), clause (15),
115.31 (16), (17), or (18), or paragraph (b), are investigative data and are confidential or protected
115.32 nonpublic while the investigation is active. The data are private after the investigation
115.33 becomes inactive under section 13.82, subdivision 5, paragraph (a) or (b).

115.34 (d) Mental health data shall be treated as provided in subdivisions 7, 8, and 9, but are
115.35 not subject to the access provisions of subdivision 10, paragraph (b).

116.1 For the purposes of this subdivision, a request will be deemed to be made in writing
116.2 if made through a computer interface system.

116.3 Sec. 2. Minnesota Statutes 2014, section 13.46, subdivision 7, is amended to read:

116.4 Subd. 7. **Mental health data.** (a) Mental health data are private data on individuals
116.5 and shall not be disclosed, except:

116.6 (1) pursuant to section 13.05, as determined by the responsible authority for the
116.7 community mental health center, mental health division, or provider;

116.8 (2) pursuant to court order;

116.9 (3) pursuant to a statute specifically authorizing access to or disclosure of mental
116.10 health data or as otherwise provided by this subdivision; ~~or~~

116.11 (4) to personnel of the welfare system working in the same program or providing
116.12 services to the same individual or family to the extent necessary to coordinate services,
116.13 provided that a health record may be disclosed only as provided under section 144.293;

116.14 (5) to a health care provider governed by sections 144.291 to 144.298, to the extent
116.15 necessary to coordinate services; or

116.16 (6) with the consent of the client or patient.

116.17 (b) An agency of the welfare system may not require an individual to consent to the
116.18 release of mental health data as a condition for receiving services or for reimbursing a
116.19 community mental health center, mental health division of a county, or provider under
116.20 contract to deliver mental health services.

116.21 (c) Notwithstanding section 245.69, subdivision 2, paragraph (f), or any other law
116.22 to the contrary, the responsible authority for a community mental health center, mental
116.23 health division of a county, or a mental health provider must disclose mental health data to
116.24 a law enforcement agency if the law enforcement agency provides the name of a client or
116.25 patient and communicates that the:

116.26 (1) client or patient is currently involved in an emergency interaction with the law
116.27 enforcement agency; and

116.28 (2) data is necessary to protect the health or safety of the client or patient or of
116.29 another person.

116.30 The scope of disclosure under this paragraph is limited to the minimum necessary for
116.31 law enforcement to respond to the emergency. Disclosure under this paragraph may include,
116.32 but is not limited to, the name and telephone number of the psychiatrist, psychologist,
116.33 therapist, mental health professional, practitioner, or case manager of the client or patient.
116.34 A law enforcement agency that obtains mental health data under this paragraph shall
116.35 maintain a record of the requestor, the provider of the information, and the client or patient

117.1 name. Mental health data obtained by a law enforcement agency under this paragraph
117.2 are private data on individuals and must not be used by the law enforcement agency for
117.3 any other purpose. A law enforcement agency that obtains mental health data under this
117.4 paragraph shall inform the subject of the data that mental health data was obtained.

117.5 (d) In the event of a request under paragraph (a), clause (4), a community mental
117.6 health center, county mental health division, or provider must release mental health data to
117.7 Criminal Mental Health Court personnel in advance of receiving a copy of a consent if the
117.8 Criminal Mental Health Court personnel communicate that the:

117.9 (1) client or patient is a defendant in a criminal case pending in the district court;

117.10 (2) data being requested is limited to information that is necessary to assess whether
117.11 the defendant is eligible for participation in the Criminal Mental Health Court; and

117.12 (3) client or patient has consented to the release of the mental health data and a copy
117.13 of the consent will be provided to the community mental health center, county mental
117.14 health division, or provider within 72 hours of the release of the data.

117.15 For purposes of this paragraph, "Criminal Mental Health Court" refers to a specialty
117.16 criminal calendar of the Hennepin County District Court for defendants with mental illness
117.17 and brain injury where a primary goal of the calendar is to assess the treatment needs of
117.18 the defendants and to incorporate those treatment needs into voluntary case disposition
117.19 plans. The data released pursuant to this paragraph may be used for the sole purpose of
117.20 determining whether the person is eligible for participation in mental health court. This
117.21 paragraph does not in any way limit or otherwise extend the rights of the court to obtain the
117.22 release of mental health data pursuant to court order or any other means allowed by law.

117.23 Sec. 3. Minnesota Statutes 2014, section 62Q.55, subdivision 3, is amended to read:

117.24 Subd. 3. **Emergency services.** As used in this section, "emergency services" means,
117.25 with respect to an emergency medical condition:

117.26 (1) a medical screening examination, as required under section 1867 of the Social
117.27 Security Act, that is within the capability of the emergency department of a hospital,
117.28 including ancillary services routinely available to the emergency department to evaluate
117.29 such emergency medical condition; ~~and~~

117.30 (2) within the capabilities of the staff and facilities available at the hospital, such
117.31 further medical examination and treatment as are required under section 1867 of the Social
117.32 Security Act to stabilize the patient; and

117.33 (3) emergency services as defined in sections 245.462, subdivision 11, and 245.4871,
117.34 subdivision 14.

118.1 Sec. 4. Minnesota Statutes 2014, section 144.293, subdivision 6, is amended to read:

118.2 Subd. 6. **Consent does not expire.** Notwithstanding subdivision 4, if a patient
118.3 explicitly gives informed consent to the release of health records for the purposes and
118.4 restrictions in ~~clauses~~ clause (1) ~~and~~, (2), or (3), the consent does not expire after one
118.5 year for:

118.6 (1) the release of health records to a provider who is being advised or consulted with
118.7 in connection with the releasing provider's current treatment of the patient;

118.8 (2) the release of health records to an accident and health insurer, health service plan
118.9 corporation, health maintenance organization, or third-party administrator for purposes of
118.10 payment of claims, fraud investigation, or quality of care review and studies, provided that:

118.11 (i) the use or release of the records complies with sections 72A.49 to 72A.505;

118.12 (ii) further use or release of the records in individually identifiable form to a person
118.13 other than the patient without the patient's consent is prohibited; and

118.14 (iii) the recipient establishes adequate safeguards to protect the records from
118.15 unauthorized disclosure, including a procedure for removal or destruction of information
118.16 that identifies the patient; or

118.17 (3) the release of health records to a program in the welfare system, as defined in
118.18 section 13.46, to the extent necessary to coordinate services for the patient.

118.19 Sec. 5. Minnesota Statutes 2014, section 144.551, subdivision 1, is amended to read:

118.20 Subdivision 1. **Restricted construction or modification.** (a) The following
118.21 construction or modification may not be commenced:

118.22 (1) any erection, building, alteration, reconstruction, modernization, improvement,
118.23 extension, lease, or other acquisition by or on behalf of a hospital that increases the bed
118.24 capacity of a hospital, relocates hospital beds from one physical facility, complex, or site
118.25 to another, or otherwise results in an increase or redistribution of hospital beds within
118.26 the state; and

118.27 (2) the establishment of a new hospital.

118.28 (b) This section does not apply to:

118.29 (1) construction or relocation within a county by a hospital, clinic, or other health
118.30 care facility that is a national referral center engaged in substantial programs of patient
118.31 care, medical research, and medical education meeting state and national needs that
118.32 receives more than 40 percent of its patients from outside the state of Minnesota;

118.33 (2) a project for construction or modification for which a health care facility held
118.34 an approved certificate of need on May 1, 1984, regardless of the date of expiration of
118.35 the certificate;

- 119.1 (3) a project for which a certificate of need was denied before July 1, 1990, if a
119.2 timely appeal results in an order reversing the denial;
- 119.3 (4) a project exempted from certificate of need requirements by Laws 1981, chapter
119.4 200, section 2;
- 119.5 (5) a project involving consolidation of pediatric specialty hospital services within
119.6 the Minneapolis-St. Paul metropolitan area that would not result in a net increase in the
119.7 number of pediatric specialty hospital beds among the hospitals being consolidated;
- 119.8 (6) a project involving the temporary relocation of pediatric-orthopedic hospital beds
119.9 to an existing licensed hospital that will allow for the reconstruction of a new philanthropic,
119.10 pediatric-orthopedic hospital on an existing site and that will not result in a net increase in
119.11 the number of hospital beds. Upon completion of the reconstruction, the licenses of both
119.12 hospitals must be reinstated at the capacity that existed on each site before the relocation;
- 119.13 (7) the relocation or redistribution of hospital beds within a hospital building or
119.14 identifiable complex of buildings provided the relocation or redistribution does not result
119.15 in: (i) an increase in the overall bed capacity at that site; (ii) relocation of hospital beds
119.16 from one physical site or complex to another; or (iii) redistribution of hospital beds within
119.17 the state or a region of the state;
- 119.18 (8) relocation or redistribution of hospital beds within a hospital corporate system
119.19 that involves the transfer of beds from a closed facility site or complex to an existing site
119.20 or complex provided that: (i) no more than 50 percent of the capacity of the closed facility
119.21 is transferred; (ii) the capacity of the site or complex to which the beds are transferred
119.22 does not increase by more than 50 percent; (iii) the beds are not transferred outside of a
119.23 federal health systems agency boundary in place on July 1, 1983; and (iv) the relocation or
119.24 redistribution does not involve the construction of a new hospital building;
- 119.25 (9) a construction project involving up to 35 new beds in a psychiatric hospital in
119.26 Rice County that primarily serves adolescents and that receives more than 70 percent of its
119.27 patients from outside the state of Minnesota;
- 119.28 (10) a project to replace a hospital or hospitals with a combined licensed capacity
119.29 of 130 beds or less if: (i) the new hospital site is located within five miles of the current
119.30 site; and (ii) the total licensed capacity of the replacement hospital, either at the time of
119.31 construction of the initial building or as the result of future expansion, will not exceed 70
119.32 licensed hospital beds, or the combined licensed capacity of the hospitals, whichever is less;
- 119.33 (11) the relocation of licensed hospital beds from an existing state facility operated
119.34 by the commissioner of human services to a new or existing facility, building, or complex
119.35 operated by the commissioner of human services; from one regional treatment center

120.1 site to another; or from one building or site to a new or existing building or site on the
120.2 same campus;

120.3 (12) the construction or relocation of hospital beds operated by a hospital having a
120.4 statutory obligation to provide hospital and medical services for the indigent that does not
120.5 result in a net increase in the number of hospital beds, notwithstanding section 144.552, 27
120.6 beds, of which 12 serve mental health needs, may be transferred from Hennepin County
120.7 Medical Center to Regions Hospital under this clause;

120.8 (13) a construction project involving the addition of up to 31 new beds in an existing
120.9 nonfederal hospital in Beltrami County;

120.10 (14) a construction project involving the addition of up to eight new beds in an
120.11 existing nonfederal hospital in Otter Tail County with 100 licensed acute care beds;

120.12 (15) a construction project involving the addition of 20 new hospital beds
120.13 used for rehabilitation services in an existing hospital in Carver County serving the
120.14 southwest suburban metropolitan area. Beds constructed under this clause shall not be
120.15 eligible for reimbursement under medical assistance, general assistance medical care,
120.16 or MinnesotaCare;

120.17 (16) a project for the construction or relocation of up to 20 hospital beds for the
120.18 operation of up to two psychiatric facilities or units for children provided that the operation
120.19 of the facilities or units have received the approval of the commissioner of human services;

120.20 (17) a project involving the addition of 14 new hospital beds to be used for
120.21 rehabilitation services in an existing hospital in Itasca County;

120.22 (18) a project to add 20 licensed beds in existing space at a hospital in Hennepin
120.23 County that closed 20 rehabilitation beds in 2002, provided that the beds are used only
120.24 for rehabilitation in the hospital's current rehabilitation building. If the beds are used for
120.25 another purpose or moved to another location, the hospital's licensed capacity is reduced
120.26 by 20 beds;

120.27 (19) a critical access hospital established under section 144.1483, clause (9), and
120.28 section 1820 of the federal Social Security Act, United States Code, title 42, section
120.29 1395i-4, that delicensed beds since enactment of the Balanced Budget Act of 1997, Public
120.30 Law 105-33, to the extent that the critical access hospital does not seek to exceed the
120.31 maximum number of beds permitted such hospital under federal law;

120.32 (20) notwithstanding section 144.552, a project for the construction of a new hospital
120.33 in the city of Maple Grove with a licensed capacity of up to 300 beds provided that:

120.34 (i) the project, including each hospital or health system that will own or control the
120.35 entity that will hold the new hospital license, is approved by a resolution of the Maple
120.36 Grove City Council as of March 1, 2006;

121.1 (ii) the entity that will hold the new hospital license will be owned or controlled by
121.2 one or more not-for-profit hospitals or health systems that have previously submitted a
121.3 plan or plans for a project in Maple Grove as required under section 144.552, and the
121.4 plan or plans have been found to be in the public interest by the commissioner of health
121.5 as of April 1, 2005;

121.6 (iii) the new hospital's initial inpatient services must include, but are not limited
121.7 to, medical and surgical services, obstetrical and gynecological services, intensive
121.8 care services, orthopedic services, pediatric services, noninvasive cardiac diagnostics,
121.9 behavioral health services, and emergency room services;

121.10 (iv) the new hospital:

121.11 (A) will have the ability to provide and staff sufficient new beds to meet the growing
121.12 needs of the Maple Grove service area and the surrounding communities currently being
121.13 served by the hospital or health system that will own or control the entity that will hold
121.14 the new hospital license;

121.15 (B) will provide uncompensated care;

121.16 (C) will provide mental health services, including inpatient beds;

121.17 (D) will be a site for workforce development for a broad spectrum of
121.18 health-care-related occupations and have a commitment to providing clinical training
121.19 programs for physicians and other health care providers;

121.20 (E) will demonstrate a commitment to quality care and patient safety;

121.21 (F) will have an electronic medical records system, including physician order entry;

121.22 (G) will provide a broad range of senior services;

121.23 (H) will provide emergency medical services that will coordinate care with regional
121.24 providers of trauma services and licensed emergency ambulance services in order to
121.25 enhance the continuity of care for emergency medical patients; and

121.26 (I) will be completed by December 31, 2009, unless delayed by circumstances
121.27 beyond the control of the entity holding the new hospital license; and

121.28 (v) as of 30 days following submission of a written plan, the commissioner of health
121.29 has not determined that the hospitals or health systems that will own or control the entity
121.30 that will hold the new hospital license are unable to meet the criteria of this clause;

121.31 (21) a project approved under section 144.553;

121.32 (22) a project for the construction of a hospital with up to 25 beds in Cass County
121.33 within a 20-mile radius of the state Ah-Gwah-Ching facility, provided the hospital's
121.34 license holder is approved by the Cass County Board;

122.1 (23) a project for an acute care hospital in Fergus Falls that will increase the bed
 122.2 capacity from 108 to 110 beds by increasing the rehabilitation bed capacity from 14 to 16
 122.3 and closing a separately licensed 13-bed skilled nursing facility;

122.4 (24) notwithstanding section 144.552, a project for the construction and expansion
 122.5 of a specialty psychiatric hospital in Hennepin County for up to 50 beds, exclusively for
 122.6 patients who are under 21 years of age on the date of admission. The commissioner
 122.7 conducted a public interest review of the mental health needs of Minnesota and the Twin
 122.8 Cities metropolitan area in 2008. No further public interest review shall be conducted for
 122.9 the construction or expansion project under this clause; ~~or~~

122.10 (25) a project for a 16-bed psychiatric hospital in the city of Thief River Falls, if
 122.11 the commissioner finds the project is in the public interest after the public interest review
 122.12 conducted under section 144.552 is complete; or

122.13 (26)(i) a project for a 20-bed psychiatric hospital, within an existing facility in the
 122.14 city of Maple Grove, exclusively for patients who are under 21 years of age on the date of
 122.15 admission, if the commissioner finds the project is in the public interest after the public
 122.16 interest review conducted under section 144.552 is complete;

122.17 (ii) this project shall serve patients in the continuing care benefit program under
 122.18 section 256.9693. The project may also serve patients not in the continuing care benefit
 122.19 program; and

122.20 (iii) if the project ceases to participate in the continuing care benefit program, the
 122.21 commissioner must complete a subsequent public interest review under section 144.552.
 122.22 If the project is found not to be in the public interest, the license must be terminated six
 122.23 months from the date of that finding. If the commissioner of human services terminates the
 122.24 contract without cause or reduces per diem payment rates for patients under the continuing
 122.25 care benefit program below the rates in effect for services provided on December 31, 2015,
 122.26 the project may cease to participate in the continuing care benefit program and continue to
 122.27 operate without a subsequent public interest review.

122.28 Sec. 6. Minnesota Statutes 2014, section 145.56, subdivision 2, is amended to read:

122.29 Subd. 2. **Community-based programs.** To the extent funds are appropriated for the
 122.30 purposes of this subdivision, the commissioner shall establish a grant program to fund:

122.31 (1) community-based programs to provide education, outreach, and advocacy
 122.32 services to populations who may be at risk for suicide;

122.33 (2) community-based programs that educate community helpers and gatekeepers,
 122.34 such as family members, spiritual leaders, coaches, and business owners, employers, and
 122.35 coworkers on how to prevent suicide by encouraging help-seeking behaviors;

123.1 (3) community-based programs that educate populations at risk for suicide and
 123.2 community helpers and gatekeepers that must include information on the symptoms
 123.3 of depression and other psychiatric illnesses, the warning signs of suicide, skills for
 123.4 preventing suicides, and making or seeking effective referrals to intervention and
 123.5 community resources; ~~and~~

123.6 (4) community-based programs to provide evidence-based suicide prevention and
 123.7 intervention education to school staff, parents, and students in grades kindergarten through
 123.8 12, and for students attending Minnesota colleges and universities;

123.9 (5) community-based programs to provide evidence-based suicide prevention and
 123.10 intervention to public school nurses, teachers, administrators, coaches, school social
 123.11 workers, peace officers, firefighters, emergency medical technicians, advanced emergency
 123.12 medical technicians, paramedics, primary care providers, and others; and

123.13 (6) community-based, evidence-based postvention training to mental health
 123.14 professionals and practitioners in order to provide technical assistance to communities
 123.15 after a suicide and to prevent suicide clusters and contagion.

123.16 Sec. 7. Minnesota Statutes 2014, section 145.56, subdivision 4, is amended to read:

123.17 Subd. 4. **Collection and reporting suicide data.** (a) The commissioner shall
 123.18 coordinate with federal, regional, local, and other state agencies to collect, analyze, and
 123.19 annually issue a public report on Minnesota-specific data on suicide and suicidal behaviors.

123.20 (b) The commissioner, in consultation with stakeholders, shall submit a detailed
 123.21 plan identifying proposed methods to improve the timeliness, usefulness, and quality of
 123.22 suicide-related data so that the data can help identify the scope of the suicide problem,
 123.23 identify high-risk groups, set priority prevention activities, and monitor the effects of
 123.24 suicide prevention programs. The report shall include how to improve external cause
 123.25 of injury coding, progress on implementing the Minnesota Violent Death Reporting
 123.26 System, how to obtain and release data in a timely manner, and how to support the use of
 123.27 psychological autopsies.

123.28 (c) The written report must be provided to the chairs and ranking minority members
 123.29 of the house of representatives and senate finance and policy divisions and committees
 123.30 with jurisdiction over health and human services by February 1, 2016.

123.31 Sec. 8. Minnesota Statutes 2014, section 245.4661, subdivision 5, is amended to read:

123.32 Subd. 5. **Planning for pilot projects.** (a) Each local plan for a pilot project, with
 123.33 the exception of the placement of a Minnesota specialty treatment facility as defined in
 123.34 paragraph (c), must be developed under the direction of the county board, or multiple

124.1 county boards acting jointly, as the local mental health authority. The planning process
 124.2 for each pilot shall include, but not be limited to, mental health consumers, families,
 124.3 advocates, local mental health advisory councils, local and state providers, representatives
 124.4 of state and local public employee bargaining units, and the department of human services.
 124.5 As part of the planning process, the county board or boards shall designate a managing
 124.6 entity responsible for receipt of funds and management of the pilot project.

124.7 (b) For Minnesota specialty treatment facilities, the commissioner shall issue a
 124.8 request for proposal for regions in which a need has been identified for services.

124.9 (c) For purposes of this section, "Minnesota specialty treatment facility" is defined
 124.10 as an intensive ~~rehabilitative mental health~~ residential treatment service under section
 124.11 256B.0622, subdivision 2, paragraph (b).

124.12 Sec. 9. Minnesota Statutes 2014, section 245.4661, subdivision 6, is amended to read:

124.13 Subd. 6. **Duties of commissioner.** (a) For purposes of the pilot projects, the
 124.14 commissioner shall facilitate integration of funds or other resources as needed and
 124.15 requested by each project. These resources may include:

124.16 (1) community support services funds administered under Minnesota Rules, parts
 124.17 9535.1700 to 9535.1760;

124.18 (2) other mental health special project funds;

124.19 (3) medical assistance, general assistance medical care, MinnesotaCare and group
 124.20 residential housing if requested by the project's managing entity, and if the commissioner
 124.21 determines this would be consistent with the state's overall health care reform efforts; and

124.22 (4) regional treatment center resources consistent with section 246.0136, subdivision
 124.23 1; and.

124.24 ~~(5) funds transferred from section 246.18, subdivision 8, for grants to providers to~~
 124.25 ~~participate in mental health specialty treatment services, awarded to providers through~~
 124.26 ~~a request for proposal process.~~

124.27 (b) The commissioner shall consider the following criteria in awarding start-up and
 124.28 implementation grants for the pilot projects:

124.29 (1) the ability of the proposed projects to accomplish the objectives described in
 124.30 subdivision 2;

124.31 (2) the size of the target population to be served; and

124.32 (3) geographical distribution.

124.33 (c) The commissioner shall review overall status of the projects initiatives at least
 124.34 every two years and recommend any legislative changes needed by January 15 of each
 124.35 odd-numbered year.

125.1 (d) The commissioner may waive administrative rule requirements which are
 125.2 incompatible with the implementation of the pilot project.

125.3 (e) The commissioner may exempt the participating counties from fiscal sanctions
 125.4 for noncompliance with requirements in laws and rules which are incompatible with the
 125.5 implementation of the pilot project.

125.6 (f) The commissioner may award grants to an entity designated by a county board or
 125.7 group of county boards to pay for start-up and implementation costs of the pilot project.

125.8 Sec. 10. Minnesota Statutes 2014, section 245.4661, is amended by adding a
 125.9 subdivision to read:

125.10 Subd. 9. Services and programs. (a) The following three distinct grant programs
 125.11 are funded under this section:

125.12 (1) mental health crisis services;

125.13 (2) housing with supports for adults with serious mental illness; and

125.14 (3) projects for assistance in transitioning from homelessness (PATH program).

125.15 (b) In addition, the following are eligible for grant funds:

125.16 (1) community education and prevention;

125.17 (2) client outreach;

125.18 (3) early identification and intervention;

125.19 (4) adult outpatient diagnostic assessment and psychological testing;

125.20 (5) peer support services;

125.21 (6) community support program services (CSP);

125.22 (7) adult residential crisis stabilization;

125.23 (8) supported employment;

125.24 (9) assertive community treatment (ACT);

125.25 (10) housing subsidies;

125.26 (11) basic living, social skills, and community intervention;

125.27 (12) emergency response services;

125.28 (13) adult outpatient psychotherapy;

125.29 (14) adult outpatient medication management;

125.30 (15) adult mobile crisis services;

125.31 (16) adult day treatment;

125.32 (17) partial hospitalization;

125.33 (18) adult residential treatment;

125.34 (19) adult mental health targeted case management;

125.35 (20) intensive community residential services (IRCS); and

126.1 (21) transportation.

126.2 Sec. 11. Minnesota Statutes 2014, section 245.4661, is amended by adding a
126.3 subdivision to read:

126.4 Subd. 10. **Commissioner duty to report on use of grant funds biennially.** By
126.5 November 1, 2016, and biennially thereafter, the commissioner of human services shall
126.6 provide sufficient information to the members of the legislative committees having
126.7 jurisdiction over mental health funding and policy issues to evaluate the use of funds
126.8 appropriated under this section of law. The commissioner shall provide, at a minimum,
126.9 the following information:

126.10 (1) the amount of funding to mental health initiatives, what programs and services
126.11 were funded in the previous two years, gaps in services that each initiative brought to
126.12 the attention of the commissioner, and outcome data for the programs and services that
126.13 were funded; and

126.14 (2) the amount of funding for other targeted services and the location of services.

126.15 Sec. 12. Minnesota Statutes 2014, section 245.467, subdivision 6, is amended to read:

126.16 **Subd. 6. Restricted access to data.** The county board shall establish procedures
126.17 to ensure that the names and addresses of persons receiving mental health services are
126.18 disclosed only to:

126.19 (1) county employees who are specifically responsible for determining county of
126.20 financial responsibility or making payments to providers; ~~and~~

126.21 (2) staff who provide treatment services or case management and their clinical
126.22 supervisors; and

126.23 (3) personnel of the welfare system or health care providers who have access to the
126.24 data under section 13.46, subdivision 7.

126.25 Release of mental health data on individuals submitted under subdivisions 4 and 5,
126.26 to persons other than those specified in this subdivision, or use of this data for purposes
126.27 other than those stated in subdivisions 4 and 5, results in civil or criminal liability under
126.28 the standards in section 13.08 or 13.09.

126.29 Sec. 13. Minnesota Statutes 2014, section 245.4876, subdivision 7, is amended to read:

126.30 **Subd. 7. Restricted access to data.** The county board shall establish procedures
126.31 to ensure that the names and addresses of children receiving mental health services and
126.32 their families are disclosed only to:

127.1 (1) county employees who are specifically responsible for determining county of
127.2 financial responsibility or making payments to providers; ~~and~~

127.3 (2) staff who provide treatment services or case management and their clinical
127.4 supervisors; and

127.5 (3) personnel of the welfare system or health care providers who have access to the
127.6 data under section 13.46, subdivision 7.

127.7 Release of mental health data on individuals submitted under subdivisions 5 and 6,
127.8 to persons other than those specified in this subdivision, or use of this data for purposes
127.9 other than those stated in subdivisions 5 and 6, results in civil or criminal liability under
127.10 section 13.08 or 13.09.

127.11 Sec. 14. Minnesota Statutes 2014, section 245.4889, subdivision 1, is amended to read:

127.12 Subdivision 1. **Establishment and authority.** (a) The commissioner is authorized
127.13 to make grants from available appropriations to assist:

127.14 (1) counties;

127.15 (2) Indian tribes;

127.16 (3) children's collaboratives under section 124D.23 or 245.493; or

127.17 (4) mental health service providers

127.18 ~~for providing services to children with emotional disturbances as defined in section~~
127.19 ~~245.4871, subdivision 15, and their families. The commissioner may also authorize~~
127.20 ~~grants to young adults meeting the criteria for transition services in section 245.4875,~~
127.21 ~~subdivision 8, and their families.~~

127.22 (b) The following services are eligible for grants under this section:

127.23 (1) services to children with emotional disturbances as defined in section 245.4871,
127.24 subdivision 15, and their families;

127.25 (2) transition services under section 245.4875, subdivision 8, for young adults under
127.26 age 21 and their families;

127.27 (3) respite care services for children with severe emotional disturbances who are at
127.28 risk of out-of-home placement;

127.29 (4) children's mental health crisis services;

127.30 (5) mental health services for people from cultural and ethnic minorities;

127.31 (6) children's mental health screening and follow-up diagnostic assessment and
127.32 treatment;

127.33 (7) services to promote and develop the capacity of providers to use evidence-based
127.34 practices in providing children's mental health services;

127.35 (8) school-linked mental health services;

- 128.1 (9) building evidence-based mental health intervention capacity for children birth to
 128.2 age five;
- 128.3 (10) suicide prevention and counseling services that use text messaging statewide;
 128.4 (11) mental health first aid training;
- 128.5 (12) training for parents, collaborative partners, and mental health providers on the
 128.6 impact of adverse childhood experiences and trauma and development of an interactive
 128.7 Web site to share information and strategies to promote resilience and prevent trauma;
- 128.8 (13) transition age services to develop or expand mental health treatment and
 128.9 supports for adolescents and young adults 26 years of age or younger;
- 128.10 (14) early childhood mental health consultation;
 128.11 (15) evidence-based interventions for youth at risk of developing or experiencing a
 128.12 first episode of psychosis, and a public awareness campaign on the signs and symptoms of
 128.13 psychosis; and
- 128.14 (16) psychiatric consultation for primary care practitioners.
- 128.15 (c) Services under paragraph (a) (b) must be designed to help each child to function
 128.16 and remain with the child's family in the community and delivered consistent with the
 128.17 child's treatment plan. Transition services to eligible young adults under paragraph (a) (b)
 128.18 must be designed to foster independent living in the community.

128.19 Sec. 15. Minnesota Statutes 2014, section 245.4889, is amended by adding a
 128.20 subdivision to read:

128.21 Subd. 3. **Commissioner duty to report on use of grant funds biennially.** By
 128.22 November 1, 2016, and biennially thereafter, the commissioner of human services shall
 128.23 provide sufficient information to the members of the legislative committees having
 128.24 jurisdiction over mental health funding and policy issues to evaluate the use of funds
 128.25 appropriated under this section. The commissioner shall provide, at a minimum, the
 128.26 following information:

- 128.27 (1) the amount of funding for children's mental health grants, what programs and
 128.28 services were funded in the previous two years, and outcome data for the programs and
 128.29 services that were funded; and
- 128.30 (2) the amount of funding for other targeted services and the location of services.

128.31 Sec. 16. [245.735] EXCELLENCE IN MENTAL HEALTH DEMONSTRATION
 128.32 PROJECT.

129.1 Subdivision 1. **Excellence in Mental Health demonstration project.** The
129.2 commissioner shall develop and execute projects to reform the mental health system by
129.3 participating in the Excellence in Mental Health demonstration project.

129.4 Subd. 2. **Federal proposal.** The commissioner shall develop and submit to the
129.5 United States Department of Health and Human Services a proposal for the Excellence
129.6 in Mental Health demonstration project. The proposal shall include any necessary state
129.7 plan amendments, waivers, requests for new funding, realignment of existing funding, and
129.8 other authority necessary to implement the projects specified in subdivision 3.

129.9 Subd. 3. **Reform projects.** (a) The commissioner shall establish standards for state
129.10 certification of clinics as certified community behavioral health clinics, in accordance with
129.11 the criteria published on or before September 1, 2015, by the United States Department
129.12 of Health and Human Services. Certification standards established by the commissioner
129.13 shall require that:

129.14 (1) clinic staff have backgrounds in diverse disciplines, include licensed mental
129.15 health professionals, and are culturally and linguistically trained to serve the needs of the
129.16 clinic's patient population;

129.17 (2) clinic services are available and accessible and that crisis management services
129.18 are available 24 hours per day;

129.19 (3) fees for clinic services are established using a sliding fee scale and services to
129.20 patients are not denied or limited due to a patient's inability to pay for services;

129.21 (4) clinics provide coordination of care across settings and providers to ensure
129.22 seamless transitions for patients across the full spectrum of health services, including
129.23 acute, chronic, and behavioral needs. Care coordination may be accomplished through
129.24 partnerships or formal contracts with federally qualified health centers, inpatient
129.25 psychiatric facilities, substance use and detoxification facilities, community-based mental
129.26 health providers, and other community services, supports, and providers including
129.27 schools, child welfare agencies, juvenile and criminal justice agencies, Indian Health
129.28 Services clinics, tribally licensed health care and mental health facilities, urban Indian
129.29 health clinics, Department of Veterans Affairs medical centers, outpatient clinics, drop-in
129.30 centers, acute care hospitals, and hospital outpatient clinics;

129.31 (5) services provided by clinics include crisis mental health services, emergency
129.32 crisis intervention services, and stabilization services; screening, assessment, and diagnosis
129.33 services, including risk assessments and level of care determinations; patient-centered
129.34 treatment planning; outpatient mental health and substance use services; targeted case
129.35 management; psychiatric rehabilitation services; peer support and counselor services and

130.1 family support services; and intensive community-based mental health services, including
 130.2 mental health services for members of the armed forces and veterans; and

130.3 (6) clinics comply with quality assurance reporting requirements and other reporting
 130.4 requirements, including any required reporting of encounter data, clinical outcomes data,
 130.5 and quality data.

130.6 (b) The commissioner shall establish standards and methodologies for a prospective
 130.7 payment system for medical assistance payments for mental health services delivered by
 130.8 certified community behavioral health clinics, in accordance with guidance issued on or
 130.9 before September 1, 2015, by the Centers for Medicare and Medicaid Services. During the
 130.10 operation of the demonstration project, payments shall comply with federal requirements
 130.11 for a 90 percent enhanced federal medical assistance percentage.

130.12 Subd. 4. **Public participation.** In developing the projects under subdivision 3, the
 130.13 commissioner shall consult with mental health providers, advocacy organizations, licensed
 130.14 mental health professionals, and Minnesota public health care program enrollees who
 130.15 receive mental health services and their families.

130.16 Subd. 5. **Information systems support.** The commissioner and the state chief
 130.17 information officer shall provide information systems support to the projects as necessary
 130.18 to comply with federal requirements.

130.19 Sec. 17. Minnesota Statutes 2014, section 246.18, subdivision 8, is amended to read:

130.20 **Subd. 8. State-operated services account.** (a) The state-operated services account is
 130.21 established in the special revenue fund. Revenue generated by new state-operated services
 130.22 listed under this section established after July 1, 2010, that are not enterprise activities must
 130.23 be deposited into the state-operated services account, unless otherwise specified in law:

- 130.24 (1) intensive residential treatment services;
 130.25 (2) foster care services; and
 130.26 (3) psychiatric extensive recovery treatment services.

130.27 (b) Funds deposited in the state-operated services account are ~~available~~ appropriated
 130.28 to the commissioner of human services for the purposes of:

- 130.29 (1) providing services needed to transition individuals from institutional settings
 130.30 within state-operated services to the community when those services have no other
 130.31 adequate funding source; and

130.32 (2) ~~grants to providers participating in mental health specialty treatment services~~
 130.33 ~~under section 245.4661; and~~

130.34 (3) to fund the operation of the intensive residential treatment service program in
 130.35 Willmar.

131.1 Sec. 18. Minnesota Statutes 2014, section 253B.18, subdivision 4c, is amended to read:

131.2 Subd. 4c. **Special review board.** (a) The commissioner shall establish one or more
131.3 panels of a special review board. The board shall consist of three members experienced
131.4 in the field of mental illness. One member of each special review board panel shall be a
131.5 psychiatrist or a doctoral level psychologist with forensic experience and one member
131.6 shall be an attorney. No member shall be affiliated with the Department of Human
131.7 Services. The special review board shall meet at least every six months and at the call of
131.8 the commissioner. It shall hear and consider all petitions for a reduction in custody or to
131.9 appeal a revocation of provisional discharge. A "reduction in custody" means transfer
131.10 from a secure treatment facility, discharge, and provisional discharge. Patients may be
131.11 transferred by the commissioner between secure treatment facilities without a special
131.12 review board hearing.

131.13 Members of the special review board shall receive compensation and reimbursement
131.14 for expenses as established by the commissioner.

131.15 (b) The special review board must review each denied petition under subdivision
131.16 5 for barriers and obstacles preventing the patient from progressing in treatment. Based
131.17 on the cases before the board in the previous year, the special review board shall provide
131.18 to the commissioner an annual summation of the barriers to treatment progress, and
131.19 recommendations to achieve the common goal of making progress in treatment.

131.20 (c) A petition filed by a person committed as mentally ill and dangerous to the
131.21 public under this section must be heard as provided in subdivision 5 and, as applicable,
131.22 subdivision 13. A petition filed by a person committed as a sexual psychopathic personality
131.23 or as a sexually dangerous person under chapter 253D, or committed as both mentally ill
131.24 and dangerous to the public under this section and as a sexual psychopathic personality or
131.25 as a sexually dangerous person must be heard as provided in section 253D.27.

131.26 **EFFECTIVE DATE.** This section is effective January 1, 2016.

131.27 Sec. 19. Minnesota Statutes 2014, section 253B.18, subdivision 5, is amended to read:

131.28 Subd. 5. **Petition; notice of hearing; attendance; order.** (a) A petition for
131.29 a reduction in custody or revocation of provisional discharge shall be filed with the
131.30 commissioner and may be filed by the patient or by the head of the treatment facility. A
131.31 patient may not petition the special review board for six months following commitment
131.32 under subdivision 3 or following the final disposition of any previous petition and
131.33 subsequent appeal by the patient. The head of the treatment facility must schedule a
131.34 hearing before the special review board for any patient who has not appeared before the

132.1 special review board in the previous three years, and schedule a hearing at least every
132.2 three years thereafter. The medical director may petition at any time.

132.3 (b) Fourteen days prior to the hearing, the committing court, the county attorney of
132.4 the county of commitment, the designated agency, interested person, the petitioner, and
132.5 the petitioner's counsel shall be given written notice by the commissioner of the time and
132.6 place of the hearing before the special review board. Only those entitled to statutory notice
132.7 of the hearing or those administratively required to attend may be present at the hearing.
132.8 The patient may designate interested persons to receive notice by providing the names
132.9 and addresses to the commissioner at least 21 days before the hearing. The board shall
132.10 provide the commissioner with written findings of fact and recommendations within 21
132.11 days of the hearing. The commissioner shall issue an order no later than 14 days after
132.12 receiving the recommendation of the special review board. A copy of the order shall be
132.13 mailed to every person entitled to statutory notice of the hearing within five days after it
132.14 is signed. No order by the commissioner shall be effective sooner than 30 days after the
132.15 order is signed, unless the county attorney, the patient, and the commissioner agree that
132.16 it may become effective sooner.

132.17 (c) The special review board shall hold a hearing on each petition prior to making
132.18 its recommendation to the commissioner. The special review board proceedings are not
132.19 contested cases as defined in chapter 14. Any person or agency receiving notice that
132.20 submits documentary evidence to the special review board prior to the hearing shall also
132.21 provide copies to the patient, the patient's counsel, the county attorney of the county of
132.22 commitment, the case manager, and the commissioner.

132.23 (d) Prior to the final decision by the commissioner, the special review board may be
132.24 reconvened to consider events or circumstances that occurred subsequent to the hearing.

132.25 (e) In making their recommendations and order, the special review board and
132.26 commissioner must consider any statements received from victims under subdivision 5a.

132.27 **EFFECTIVE DATE.** This section is effective January 1, 2016, with hearings
132.28 starting no later than February 1, 2016.

132.29 Sec. 20. Minnesota Statutes 2014, section 254B.05, subdivision 5, as amended by
132.30 Laws 2015, chapter 21, article 1, section 52, is amended to read:

132.31 Subd. 5. **Rate requirements.** (a) The commissioner shall establish rates for
132.32 chemical dependency services and service enhancements funded under this chapter.

132.33 (b) Eligible chemical dependency treatment services include:

132.34 (1) outpatient treatment services that are licensed according to Minnesota Rules,
132.35 parts 9530.6405 to 9530.6480, or applicable tribal license;

133.1 (2) medication-assisted therapy services that are licensed according to Minnesota
133.2 Rules, parts 9530.6405 to 9530.6480 and 9530.6500, or applicable tribal license;

133.3 (3) medication-assisted therapy plus enhanced treatment services that meet the
133.4 requirements of clause (2) and provide nine hours of clinical services each week;

133.5 (4) high, medium, and low intensity residential treatment services that are licensed
133.6 according to Minnesota Rules, parts 9530.6405 to 9530.6480 and 9530.6505, or applicable
133.7 tribal license which provide, respectively, 30, 15, and five hours of clinical services each
133.8 week;

133.9 (5) hospital-based treatment services that are licensed according to Minnesota Rules,
133.10 parts 9530.6405 to 9530.6480, or applicable tribal license and licensed as a hospital under
133.11 sections 144.50 to 144.56;

133.12 (6) adolescent treatment programs that are licensed as outpatient treatment programs
133.13 according to Minnesota Rules, parts 9530.6405 to 9530.6485, or as residential treatment
133.14 programs according to Minnesota Rules, parts 2960.0010 to 2960.0220, and 2960.0430 to
133.15 2960.0490, or applicable tribal license; ~~and~~

133.16 (7) high-intensity residential treatment services that are licensed according to
133.17 Minnesota Rules, parts 9530.6405 to 9530.6480 and 9530.6505, or applicable tribal
133.18 license, which provide 30 hours of clinical services each week provided by a state-operated
133.19 vendor or to clients who have been civilly committed to the commissioner, present the
133.20 most complex and difficult care needs, and are a potential threat to the community; and

133.21 (8) room and board facilities that meet the requirements of subdivision 1a.

133.22 (c) The commissioner shall establish higher rates for programs that meet the
133.23 requirements of paragraph (b) and the following additional requirements:

133.24 (1) programs that serve parents with their children if the program:

133.25 (i) provides on-site child care during hours of treatment activity that meets the
133.26 requirements in Minnesota Rules, part 9530.6490, or section 245A.03, subdivision 2; or

133.27 (ii) arranges for off-site child care during hours of treatment activity at a facility that
133.28 is licensed under chapter 245A as:

133.29 (A) a child care center under Minnesota Rules, chapter 9503; or

133.30 (B) a family child care home under Minnesota Rules, chapter 9502;

133.31 (2) culturally specific programs as defined in section 254B.01, subdivision 4a, if the
133.32 program meets the requirements in Minnesota Rules, part 9530.6605, subpart 13;

133.33 (3) programs that offer medical services delivered by appropriately credentialed
133.34 health care staff in an amount equal to two hours per client per week if the medical
133.35 needs of the client and the nature and provision of any medical services provided are
133.36 documented in the client file; and

134.1 (4) programs that offer services to individuals with co-occurring mental health and
134.2 chemical dependency problems if:

134.3 (i) the program meets the co-occurring requirements in Minnesota Rules, part
134.4 9530.6495;

134.5 (ii) 25 percent of the counseling staff are licensed mental health professionals, as
134.6 defined in section 245.462, subdivision 18, clauses (1) to (6), or are students or licensing
134.7 candidates under the supervision of a licensed alcohol and drug counselor supervisor and
134.8 licensed mental health professional, except that no more than 50 percent of the mental
134.9 health staff may be students or licensing candidates with time documented to be directly
134.10 related to provisions of co-occurring services;

134.11 (iii) clients scoring positive on a standardized mental health screen receive a mental
134.12 health diagnostic assessment within ten days of admission;

134.13 (iv) the program has standards for multidisciplinary case review that include a
134.14 monthly review for each client that, at a minimum, includes a licensed mental health
134.15 professional and licensed alcohol and drug counselor, and their involvement in the review
134.16 is documented;

134.17 (v) family education is offered that addresses mental health and substance abuse
134.18 disorders and the interaction between the two; and

134.19 (vi) co-occurring counseling staff will receive eight hours of co-occurring disorder
134.20 training annually.

134.21 (d) In order to be eligible for a higher rate under paragraph (c), clause (1), a program
134.22 that provides arrangements for off-site child care must maintain current documentation at
134.23 the chemical dependency facility of the child care provider's current licensure to provide
134.24 child care services. Programs that provide child care according to paragraph (c), clause
134.25 (1), must be deemed in compliance with the licensing requirements in Minnesota Rules,
134.26 part 9530.6490.

134.27 (e) Adolescent residential programs that meet the requirements of Minnesota
134.28 Rules, parts 2960.0430 to 2960.0490 and 2960.0580 to 2960.0690, are exempt from the
134.29 requirements in paragraph (c), clause (4), items (i) to (iv).

134.30 Sec. 21. Minnesota Statutes 2014, section 254B.12, subdivision 2, is amended to read:

134.31 Subd. 2. **Payment methodology for highly specialized vendors.** (a)

134.32 Notwithstanding subdivision 1, the commissioner shall seek federal authority to develop
134.33 separate payment methodologies for chemical dependency treatment services provided
134.34 under the consolidated chemical dependency treatment fund: (1) by a state-operated
134.35 vendor; or (2) for persons who have been civilly committed to the commissioner, present

135.1 the most complex and difficult care needs, and are a potential threat to the community. A
135.2 payment methodology under this subdivision is effective for services provided on or after
135.3 October 1, 2015, or on or after the receipt of federal approval, whichever is later.

135.4 ~~(b) Before implementing an approved payment methodology under paragraph~~
135.5 ~~(a), the commissioner must also receive any necessary legislative approval of required~~
135.6 ~~changes to state law or funding.~~

135.7 Sec. 22. Minnesota Statutes 2014, section 256B.0615, subdivision 3, is amended to read:

135.8 Subd. 3. **Eligibility.** Peer support services may be made available to consumers
135.9 of (1) intensive ~~rehabilitative mental health~~ residential treatment services under section
135.10 256B.0622; (2) adult rehabilitative mental health services under section 256B.0623; and
135.11 (3) crisis stabilization and mental health mobile crisis intervention services under section
135.12 256B.0624.

135.13 Sec. 23. Minnesota Statutes 2014, section 256B.0622, subdivision 1, is amended to read:

135.14 Subdivision 1. **Scope.** Subject to federal approval, medical assistance covers
135.15 medically necessary, ~~intensive nonresidential~~ assertive community treatment and intensive
135.16 residential ~~rehabilitative mental health~~ treatment services as defined in subdivision 2, for
135.17 recipients as defined in subdivision 3, when the services are provided by an entity meeting
135.18 the standards in this section.

135.19 Sec. 24. Minnesota Statutes 2014, section 256B.0622, subdivision 2, is amended to read:

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

135.22 (a) ~~"Intensive nonresidential rehabilitative mental health services" means adult~~
135.23 ~~rehabilitative mental health services as defined in section 256B.0623, subdivision 2,~~
135.24 ~~paragraph (a), except that these services are provided by a multidisciplinary staff using~~
135.25 ~~a total team approach consistent with assertive community treatment, the Fairweather~~
135.26 ~~Lodge treatment model, as defined by the standards established by the National Coalition~~
135.27 ~~for Community Living, and other evidence-based practices, and directed to recipients with~~
135.28 ~~a serious mental illness who require intensive services. "Assertive community treatment"~~
135.29 means intensive nonresidential rehabilitative mental health services provided according
135.30 to the evidence-based practice of assertive community treatment. Core elements of this
135.31 service include, but are not limited to:

135.32 (1) a multidisciplinary staff who utilize a total team approach and who serve as a
135.33 fixed point of responsibility for all service delivery;

136.1 (2) providing services 24 hours per day and 7 days per week;

136.2 (3) providing the majority of services in a community setting;

136.3 (4) offering a low ratio of recipients to staff; and

136.4 (5) providing service that is not time-limited.

136.5 (b) "Intensive residential ~~rehabilitative mental health~~ treatment services" means
 136.6 short-term, time-limited services provided in a residential setting to recipients who are
 136.7 in need of more restrictive settings and are at risk of significant functional deterioration
 136.8 if they do not receive these services. Services are designed to develop and enhance
 136.9 psychiatric stability, personal and emotional adjustment, self-sufficiency, and skills to live
 136.10 in a more independent setting. Services must be directed toward a targeted discharge
 136.11 date with specified client outcomes ~~and must be consistent with the Fairweather Lodge~~
 136.12 ~~treatment model as defined in paragraph (a), and other evidence-based practices.~~

136.13 (c) "Evidence-based practices" are nationally recognized mental health services that
 136.14 are proven by substantial research to be effective in helping individuals with serious
 136.15 mental illness obtain specific treatment goals.

136.16 (d) "Overnight staff" means a member of the intensive residential rehabilitative
 136.17 mental health treatment team who is responsible during hours when recipients are
 136.18 typically asleep.

136.19 (e) "Treatment team" means all staff who provide services under this section to
 136.20 recipients. At a minimum, this includes the clinical supervisor, mental health professionals
 136.21 as defined in section 245.462, subdivision 18, clauses (1) to (6); mental health practitioners
 136.22 as defined in section 245.462, subdivision 17; mental health rehabilitation workers under
 136.23 section 256B.0623, subdivision 5, clause (3); and certified peer specialists under section
 136.24 256B.0615.

136.25 Sec. 25. Minnesota Statutes 2014, section 256B.0622, subdivision 3, is amended to read:

136.26 Subd. 3. **Eligibility.** An eligible recipient is an individual who:

136.27 (1) is age 18 or older;

136.28 (2) is eligible for medical assistance;

136.29 (3) is diagnosed with a mental illness;

136.30 (4) because of a mental illness, has substantial disability and functional impairment
 136.31 in three or more of the areas listed in section 245.462, subdivision 11a, so that
 136.32 self-sufficiency is markedly reduced;

136.33 (5) has one or more of the following: a history of ~~two or more~~ recurring or prolonged
 136.34 inpatient hospitalizations in the past year, significant independent living instability,

137.1 homelessness, or very frequent use of mental health and related services yielding poor
137.2 outcomes; and

137.3 (6) in the written opinion of a licensed mental health professional, has the need for
137.4 mental health services that cannot be met with other available community-based services,
137.5 or is likely to experience a mental health crisis or require a more restrictive setting if
137.6 intensive rehabilitative mental health services are not provided.

137.7 Sec. 26. Minnesota Statutes 2014, section 256B.0622, subdivision 4, is amended to read:

137.8 Subd. 4. **Provider certification and contract requirements.** (a) The intensive
137.9 ~~nonresidential rehabilitative mental health services~~ assertive community treatment
137.10 provider must:

137.11 (1) have a contract with the host county to provide intensive adult rehabilitative
137.12 mental health services; and

137.13 (2) be certified by the commissioner as being in compliance with this section and
137.14 section 256B.0623.

137.15 (b) The intensive residential ~~rehabilitative mental health~~ treatment services provider
137.16 must:

137.17 (1) be licensed under Minnesota Rules, parts 9520.0500 to 9520.0670;

137.18 (2) not exceed 16 beds per site;

137.19 (3) comply with the additional standards in this section; and

137.20 (4) have a contract with the host county to provide these services.

137.21 (c) The commissioner shall develop procedures for counties and providers to submit
137.22 contracts and other documentation as needed to allow the commissioner to determine
137.23 whether the standards in this section are met.

137.24 Sec. 27. Minnesota Statutes 2014, section 256B.0622, subdivision 5, is amended to read:

137.25 Subd. 5. **Standards applicable to both ~~nonresidential~~ assertive community**
137.26 **treatment and residential providers.** (a) Services must be provided by qualified staff as
137.27 defined in section 256B.0623, subdivision 5, who are trained and supervised according to
137.28 section 256B.0623, subdivision 6, except that mental health rehabilitation workers acting
137.29 as overnight staff are not required to comply with section 256B.0623, subdivision 5,
137.30 clause ~~(3)~~ (4), ~~item~~ (iv).

137.31 (b) The clinical supervisor must be an active member of the treatment team. The
137.32 treatment team must meet with the clinical supervisor at least weekly to discuss recipients'
137.33 progress and make rapid adjustments to meet recipients' needs. The team meeting shall
137.34 include recipient-specific case reviews and general treatment discussions among team

138.1 members. Recipient-specific case reviews and planning must be documented in the
138.2 individual recipient's treatment record.

138.3 (c) Treatment staff must have prompt access in person or by telephone to a mental
138.4 health practitioner or mental health professional. The provider must have the capacity to
138.5 promptly and appropriately respond to emergent needs and make any necessary staffing
138.6 adjustments to assure the health and safety of recipients.

138.7 (d) The initial functional assessment must be completed within ten days of intake
138.8 and updated at least every ~~three months~~ 30 days for intensive residential treatment services
138.9 and every six months for assertive community treatment, or prior to discharge from the
138.10 service, whichever comes first.

138.11 (e) The initial individual treatment plan must be completed within ten days of intake
138.12 ~~and~~ for assertive community treatment and within 24 hours of admission for intensive
138.13 residential treatment services. Within ten days of admission, the initial treatment plan
138.14 must be refined and further developed for intensive residential treatment services, except
138.15 for providers certified according to Minnesota Rules, parts 9533.0010 to 9533.0180.
138.16 The individual treatment plan must be reviewed with the recipient and updated at least
138.17 monthly with the recipient for intensive residential treatment services and at least every
138.18 six months for assertive community treatment.

138.19 Sec. 28. Minnesota Statutes 2014, section 256B.0622, subdivision 7, is amended to read:

138.20 Subd. 7. **Additional standards for ~~nonresidential services~~ assertive community**
138.21 **treatment**. The standards in this subdivision apply to ~~intensive nonresidential~~
138.22 ~~rehabilitative mental health~~ assertive community treatment services.

138.23 (1) The treatment team must use team treatment, not an individual treatment model.

138.24 (2) The clinical supervisor must function as a practicing clinician at least on a
138.25 part-time basis.

138.26 (3) The staffing ratio must not exceed ten recipients to one full-time equivalent
138.27 treatment team position.

138.28 (4) Services must be available at times that meet client needs.

138.29 (5) The treatment team must actively and assertively engage and reach out to the
138.30 recipient's family members and significant others, after obtaining the recipient's permission.

138.31 (6) The treatment team must establish ongoing communication and collaboration
138.32 between the team, family, and significant others and educate the family and significant
138.33 others about mental illness, symptom management, and the family's role in treatment.

138.34 (7) The treatment team must provide interventions to promote positive interpersonal
138.35 relationships.

139.1 Sec. 29. Minnesota Statutes 2014, section 256B.0622, subdivision 8, is amended to read:

139.2 Subd. 8. **Medical assistance payment for intensive rehabilitative mental health**
 139.3 **services.** (a) Payment for intensive residential and nonresidential treatment services
 139.4 and assertive community treatment in this section shall be based on one daily rate per
 139.5 provider inclusive of the following services received by an eligible recipient in a given
 139.6 calendar day: all rehabilitative services under this section, staff travel time to provide
 139.7 rehabilitative services under this section, and nonresidential crisis stabilization services
 139.8 under section 256B.0624.

139.9 (b) Except as indicated in paragraph (c), payment will not be made to more than one
 139.10 entity for each recipient for services provided under this section on a given day. If services
 139.11 under this section are provided by a team that includes staff from more than one entity, the
 139.12 team must determine how to distribute the payment among the members.

139.13 (c) The commissioner shall determine one rate for each provider that will bill
 139.14 medical assistance for residential services under this section and one rate for each
 139.15 ~~nonresidential~~ assertive community treatment provider. If a single entity provides both
 139.16 services, one rate is established for the entity's residential services and another rate for the
 139.17 entity's nonresidential services under this section. A provider is not eligible for payment
 139.18 under this section without authorization from the commissioner. The commissioner shall
 139.19 develop rates using the following criteria:

139.20 ~~(1) the cost for similar services in the local trade area;~~

139.21 ~~(2)~~ (1) the provider's cost for services shall include direct services costs, other
 139.22 program costs, and other costs determined as follows:

139.23 (i) the direct services costs must be determined using actual costs of salaries, benefits,
 139.24 payroll taxes, and training of direct service staff and service-related transportation;

139.25 (ii) other program costs not included in item (i) must be determined as a specified
 139.26 percentage of the direct services costs as determined by item (i). The percentage used shall
 139.27 be determined by the commissioner based upon the average of percentages that represent
 139.28 the relationship of other program costs to direct services costs among the entities that
 139.29 provide similar services;

139.30 ~~(iii) in situations where a provider of intensive residential services can demonstrate~~
 139.31 ~~actual program-related physical plant costs in excess of the group residential housing~~
 139.32 ~~reimbursement, the commissioner may include these costs in the program rate, so long~~
 139.33 ~~as the additional reimbursement does not subsidize the room and board expenses of the~~
 139.34 ~~program~~ physical plant costs calculated based on the percentage of space within the
 139.35 program that is entirely devoted to treatment and programming. This does not include
 139.36 administrative or residential space;

140.1 (iv) ~~intensive nonresidential services~~ assertive community treatment physical plant
 140.2 costs must be reimbursed as part of the costs described in item (ii); and

140.3 (v) subject to federal approval, up to an additional five percent of the total rate ~~must~~
 140.4 may be added to the program rate as a quality incentive based upon the entity meeting
 140.5 performance criteria specified by the commissioner;

140.6 ~~(3)~~ (2) actual cost is defined as costs which are allowable, allocable, and reasonable,
 140.7 and consistent with federal reimbursement requirements under Code of Federal
 140.8 Regulations, title 48, chapter 1, part 31, relating to for-profit entities, and Office of
 140.9 Management and Budget Circular Number A-122, relating to nonprofit entities;

140.10 ~~(4)~~ (3) the number of service units;

140.11 ~~(5)~~ (4) the degree to which recipients will receive services other than services under
 140.12 this section; and

140.13 ~~(6)~~ (5) the costs of other services that will be separately reimbursed; and

140.14 ~~(7) input from the local planning process authorized by the adult mental health~~
 140.15 ~~initiative under section 245.4661, regarding recipients' service needs.~~

140.16 (d) The rate for intensive ~~rehabilitative mental health~~ residential treatment services
 140.17 and assertive community treatment must exclude room and board, as defined in section
 140.18 256I.03, subdivision 6, and services not covered under this section, such as partial
 140.19 hospitalization, home care, and inpatient services.

140.20 (e) Physician services that are not separately billed may be included in the rate to the
 140.21 extent that a psychiatrist, or other health care professional providing physician services
 140.22 within their scope of practice, is a member of the treatment team. Physician services,
 140.23 whether billed separately or included in the rate, may be delivered by telemedicine. For
 140.24 purposes of this paragraph, "telemedicine" has the meaning given to "mental health
 140.25 telemedicine" in section 256B.0625, subdivision 46, when telemedicine is used to provide
 140.26 intensive residential treatment services.

140.27 ~~(e)~~ (f) When services under this section are provided by an ~~intensive nonresidential~~
 140.28 ~~service~~ assertive community treatment provider, case management functions must be an
 140.29 integral part of the team.

140.30 ~~(f)~~ (g) The rate for a provider must not exceed the rate charged by that provider for
 140.31 the same service to other payors.

140.32 ~~(g)~~ (h) The rates for existing programs must be established prospectively based upon
 140.33 the expenditures and utilization over a prior 12-month period using the criteria established
 140.34 in paragraph (c). The rates for new programs must be established based upon estimated
 140.35 expenditures and estimated utilization using the criteria established in paragraph (c).

141.1 ~~(h)~~ (i) Entities who discontinue providing services must be subject to a settle-up
 141.2 process whereby actual costs and reimbursement for the previous 12 months are
 141.3 compared. In the event that the entity was paid more than the entity's actual costs plus
 141.4 any applicable performance-related funding due the provider, the excess payment must
 141.5 be reimbursed to the department. If a provider's revenue is less than actual allowed costs
 141.6 due to lower utilization than projected, the commissioner may reimburse the provider to
 141.7 recover its actual allowable costs. The resulting adjustments by the commissioner must
 141.8 be proportional to the percent of total units of service reimbursed by the commissioner
 141.9 and must reflect a difference of greater than five percent.

141.10 ~~(i)~~ (j) A provider may request of the commissioner a review of any rate-setting
 141.11 decision made under this subdivision.

141.12 Sec. 30. Minnesota Statutes 2014, section 256B.0622, subdivision 9, is amended to read:

141.13 Subd. 9. **Provider enrollment; rate setting for county-operated entities.** Counties
 141.14 that employ their own staff to provide services under this section shall apply directly to
 141.15 the commissioner for enrollment and rate setting. In this case, a county contract is not
 141.16 required ~~and the commissioner shall perform the program review and rate setting duties~~
 141.17 ~~which would otherwise be required of counties under this section.~~

141.18 Sec. 31. Minnesota Statutes 2014, section 256B.0622, subdivision 10, is amended to
 141.19 read:

141.20 Subd. 10. **Provider enrollment; rate setting for specialized program.** A county
 141.21 contract is not required for a provider proposing to serve a subpopulation of eligible
 141.22 recipients may bypass the county approval procedures in this section and receive approval
 141.23 for provider enrollment and rate setting directly from the commissioner under the
 141.24 following circumstances:

141.25 (1) the provider demonstrates that the subpopulation to be served requires a
 141.26 specialized program which is not available from county-approved entities; and

141.27 (2) the subpopulation to be served is of such a low incidence that it is not feasible to
 141.28 develop a program serving a single county or regional group of counties.

141.29 ~~For providers meeting the criteria in clauses (1) and (2), the commissioner shall~~
 141.30 ~~perform the program review and rate setting duties which would otherwise be required of~~
 141.31 ~~counties under this section.~~

141.32 Sec. 32. Minnesota Statutes 2014, section 256B.0622, is amended by adding a
 141.33 subdivision to read:

142.1 Subd. 11. **Sustainability grants.** The commissioner may disburse grant funds
142.2 directly to intensive residential treatment services providers and assertive community
142.3 treatment providers to maintain access to these services.

142.4 Sec. 33. Minnesota Statutes 2014, section 256B.0624, subdivision 7, is amended to read:

142.5 Subd. 7. **Crisis stabilization services.** (a) Crisis stabilization services must be
142.6 provided by qualified staff of a crisis stabilization services provider entity and must meet
142.7 the following standards:

142.8 (1) a crisis stabilization treatment plan must be developed which meets the criteria
142.9 in subdivision 11;

142.10 (2) staff must be qualified as defined in subdivision 8; and

142.11 (3) services must be delivered according to the treatment plan and include
142.12 face-to-face contact with the recipient by qualified staff for further assessment, help with
142.13 referrals, updating of the crisis stabilization treatment plan, supportive counseling, skills
142.14 training, and collaboration with other service providers in the community.

142.15 (b) If crisis stabilization services are provided in a supervised, licensed residential
142.16 setting, the recipient must be contacted face-to-face daily by a qualified mental health
142.17 practitioner or mental health professional. The program must have 24-hour-a-day
142.18 residential staffing which may include staff who do not meet the qualifications in
142.19 subdivision 8. The residential staff must have 24-hour-a-day immediate direct or telephone
142.20 access to a qualified mental health professional or practitioner.

142.21 (c) If crisis stabilization services are provided in a supervised, licensed residential
142.22 setting that serves no more than four adult residents, and ~~no more than two are recipients~~
142.23 ~~of crisis stabilization services~~ one or more individuals are present at the setting to receive
142.24 residential crisis stabilization services, the residential staff must include, for at least eight
142.25 hours per day, at least one individual who meets the qualifications in subdivision 8,
142.26 paragraph (a), clause (1) or (2).

142.27 (d) If crisis stabilization services are provided in a supervised, licensed residential
142.28 setting that serves more than four adult residents, and one or more are recipients of crisis
142.29 stabilization services, the residential staff must include, for 24 hours a day, at least one
142.30 individual who meets the qualifications in subdivision 8. During the first 48 hours that a
142.31 recipient is in the residential program, the residential program must have at least two staff
142.32 working 24 hours a day. Staffing levels may be adjusted thereafter according to the needs
142.33 of the recipient as specified in the crisis stabilization treatment plan.

143.1 Sec. 34. Minnesota Statutes 2014, section 256B.0625, is amended by adding a
143.2 subdivision to read:

143.3 Subd. 45a. **Psychiatric residential treatment facility services for persons under**
143.4 **21 years of age.** (a) Medical assistance covers psychiatric residential treatment facility
143.5 services for persons under 21 years of age. Individuals who reach age 21 at the time they
143.6 are receiving services are eligible to continue receiving services until they no longer
143.7 require services or until they reach age 22, whichever occurs first.

143.8 (b) For purposes of this subdivision, "psychiatric residential treatment facility"
143.9 means a facility other than a hospital that provides psychiatric services, as described in
143.10 Code of Federal Regulations, title 42, sections 441.151 to 441.182, to individuals under
143.11 age 21 in an inpatient setting.

143.12 (c) The commissioner shall develop admissions and discharge procedures and
143.13 establish rates consistent with guidelines from the federal Centers for Medicare and
143.14 Medicaid Services.

143.15 (d) The commissioner shall enroll up to 150 certified psychiatric residential
143.16 treatment facility services beds at up to six sites. The commissioner shall select psychiatric
143.17 residential treatment facility services providers through a request for proposals process.
143.18 Providers of state-operated services may respond to the request for proposals.

143.19 **EFFECTIVE DATE.** This section is effective July 1, 2017, or upon federal
143.20 approval, whichever is later. The commissioner of human services shall notify the revisor
143.21 of statutes when federal approval is obtained.

143.22 Sec. 35. Minnesota Statutes 2014, section 256B.0625, subdivision 48, is amended to
143.23 read:

143.24 Subd. 48. **Psychiatric consultation to primary care practitioners.** Medical
143.25 assistance covers consultation provided by a psychiatrist, a psychologist, or an advanced
143.26 practice registered nurse certified in psychiatric mental health, a licensed independent
143.27 clinical social worker, as defined in section 245.462, subdivision 18, clause (2), or a
143.28 licensed marriage and family therapist, as defined in section 245.462, subdivision 18,
143.29 clause (5), via telephone, e-mail, facsimile, or other means of communication to primary
143.30 care practitioners, including pediatricians. The need for consultation and the receipt of the
143.31 consultation must be documented in the patient record maintained by the primary care
143.32 practitioner. If the patient consents, and subject to federal limitations and data privacy
143.33 provisions, the consultation may be provided without the patient present.

144.1 Sec. 36. **[256B.7631] CHEMICAL DEPENDENCY PROVIDER RATE**
144.2 **INCREASE.**

144.3 For the chemical dependency services listed in section 254B.05, subdivision 5, and
144.4 provided on or after July 1, 2015, payment rates shall be increased by two percent over
144.5 the rates in effect on January 1, 2014, for vendors who meet the requirements of section
144.6 254B.05.

144.7 Sec. 37. **CLUBHOUSE PROGRAM SERVICES.**

144.8 The commissioner of human services, in consultation with stakeholders, shall
144.9 develop service standards and a payment methodology for Clubhouse program services
144.10 to be covered under medical assistance when provided by a Clubhouse International
144.11 accredited provider or a provider meeting equivalent standards. The commissioner shall
144.12 seek federal approval for the service standards and payment methodology. Upon federal
144.13 approval, the commissioner must seek and obtain legislative approval of the services
144.14 standards and funding methodology allowing medical assistance coverage of the service.

144.15 Sec. 38. **EXCELLENCE IN MENTAL HEALTH DEMONSTRATION PROJECT.**

144.16 By January 15, 2016, the commissioner of human services shall report to the
144.17 legislative committees in the house of representatives and senate with jurisdiction over
144.18 human services issues on the progress of the Excellence in Mental Health demonstration
144.19 project under Minnesota Statutes, section 245.735. The commissioner shall include in
144.20 the report any recommendations for legislative changes needed to implement the reform
144.21 projects specified in Minnesota Statutes, section 245.735, subdivision 3.

144.22 Sec. 39. **RATE-SETTING METHODOLOGY FOR COMMUNITY-BASED**
144.23 **MENTAL HEALTH SERVICES.**

144.24 The commissioner of human services shall conduct a comprehensive analysis
144.25 of the current rate-setting methodology for all community-based mental health
144.26 services for children and adults. The report shall include an assessment of alternative
144.27 payment structures, consistent with the intent and direction of the federal Centers for
144.28 Medicare and Medicaid Services, that could provide adequate reimbursement to sustain
144.29 community-based mental health services regardless of geographic location. The report
144.30 shall also include recommendations for establishing pay-for-performance measures for
144.31 providers delivering services consistent with evidence-based practices. In developing the
144.32 report, the commissioner shall consult with stakeholders and with outside experts in
144.33 Medicaid financing. The commissioner shall provide a report on the analysis to the chairs

145.1 of the legislative committees with jurisdiction over health and human services finance
145.2 by January 1, 2017.

145.3 Sec. 40. **REPORT ON HUMAN SERVICES DATA SHARING TO**
145.4 **COORDINATE SERVICES AND CARE OF A PATIENT.**

145.5 The commissioner of human services, in coordination with Hennepin County, shall
145.6 report to the legislative committees with jurisdiction over health care financing on the
145.7 fiscal impact, including the estimated savings, resulting from the modifications to the Data
145.8 Practices Act in the 2015 legislative session, permitting the sharing of public welfare data
145.9 and allowing the exchange of health records between providers to the extent necessary to
145.10 coordinate services and care for clients enrolled in public health care programs. Counties
145.11 shall provide information on the fiscal impact, including the estimated savings, resulting
145.12 from the modifications to the Data Practices Act in the 2015 legislative session, the
145.13 number of clients receiving care coordination, and improved outcomes achieved due
145.14 to data sharing, to the commissioner of human services to include in the report. The
145.15 commissioner may establish the form in which the information must be provided. The
145.16 report is due January 1, 2017.

145.17 Sec. 41. **COMPREHENSIVE MENTAL HEALTH PROGRAM IN BELTRAMI**
145.18 **COUNTY.**

145.19 (a) The commissioner of human services shall award a grant to Beltrami County
145.20 to fund the planning and development of a comprehensive mental health program
145.21 contingent upon Beltrami County providing to the commissioner of human services a
145.22 formal commitment and plan to fund, operate, and sustain the program and services after
145.23 the onetime state grant is expended. The county must provide evidence of the funding
145.24 stream or mechanism, and a sufficient local funding commitment, that will ensure that
145.25 the onetime state investment in the program will result in a sustainable program without
145.26 future state grants. The funding stream may include state funding for programs and
145.27 services for which the individuals served under this section may be eligible. The grant
145.28 under this section cannot be used for any purpose that could be funded with state bond
145.29 proceeds. This is a onetime appropriation.

145.30 (b) The planning and development of the program by the county must include an
145.31 integrated care model for the provision of mental health and substance use disorder
145.32 treatment for the individuals served under paragraph (c), in collaboration with existing
145.33 services. The model may include mobile crisis services, crisis residential services,

146.1 outpatient services, and community-based services. The model must be patient-centered,
146.2 culturally competent, and based on evidence-based practices.

146.3 (c) The comprehensive mental health program will serve individuals who are:

146.4 (1) under arrest or subject to arrest who are experiencing a mental health crisis;

146.5 (2) under a transport hold under Minnesota Statutes, section 253B.05, subdivision

146.6 2; or

146.7 (3) in immediate need of mental health crisis services.

146.8 (d) The commissioner of human services may encourage the commissioners of

146.9 the Minnesota Housing Finance Agency, corrections, and health to provide technical

146.10 assistance and support in the planning and development of the mental health program

146.11 under paragraph (a). The commissioners of the Minnesota Housing Finance Agency and

146.12 human services may explore a plan to develop short-term and long-term housing for

146.13 individuals served by the program, and the possibility of using existing appropriations

146.14 available in the housing finance budget for low-income housing or homelessness.

146.15 (e) The commissioner of human services, in consultation with Beltrami County,

146.16 shall report to the senate and house of representatives committees having jurisdiction over

146.17 mental health issues the status of the planning and development of the mental health

146.18 program, and the plan to financially support the program and services after the state grant

146.19 is expended, by November 1, 2017.

146.20 Sec. 42. **MENTAL HEALTH CRISIS SERVICES.**

146.21 The commissioner of human services shall increase access to mental health crisis

146.22 services for children and adults. In order to increase access, the commissioner must:

146.23 (1) develop a central phone number where calls can be routed to the appropriate
146.24 crisis services;

146.25 (2) provide telephone consultation 24 hours a day to mobile crisis teams who are
146.26 servicing people with traumatic brain injury or intellectual disabilities who are experiencing
146.27 a mental health crisis;

146.28 (3) expand crisis services across the state, including rural areas of the state and
146.29 examining access per population;

146.30 (4) establish and implement state standards for crisis services; and

146.31 (5) provide grants to adult mental health initiatives, counties, tribes, or community
146.32 mental health providers to establish new mental health crisis residential service capacity.

146.33 Priority will be given to regions that do not have a mental health crisis residential
146.34 services program, do not have an inpatient psychiatric unit within the region, do not have
146.35 an inpatient psychiatric unit within 90 miles, or have a demonstrated need based on the

147.1 number of crisis residential or intensive residential treatment beds available to meet the
 147.2 needs of the residents in the region. At least 50 percent of the funds must be distributed to
 147.3 programs in rural Minnesota. Grant funds may be used for start-up costs, including but not
 147.4 limited to renovations, furnishings, and staff training. Grant applications shall provide
 147.5 details on how the intended service will address identified needs and shall demonstrate
 147.6 collaboration with crisis teams, other mental health providers, hospitals, and police.

147.7 Sec. 43. **INSTRUCTIONS TO THE COMMISSIONER.**

147.8 The commissioner of human services shall, in consultation with stakeholders, develop
 147.9 recommendations on funding for children's mental health crisis residential services that will
 147.10 allow for timely access without requiring county authorization or child welfare placement.

147.11 **ARTICLE 3**

147.12 **WITHDRAWAL MANAGEMENT PROGRAMS**

147.13 Section 1. **[245F.01] PURPOSE.**

147.14 It is hereby declared to be the public policy of this state that the public interest is best
 147.15 served by providing efficient and effective withdrawal management services to persons
 147.16 in need of appropriate detoxification, assessment, intervention, and referral services.
 147.17 The services shall vary to address the unique medical needs of each patient and shall be
 147.18 responsive to the language and cultural needs of each patient. Services shall not be denied
 147.19 on the basis of a patient's inability to pay.

147.20 Sec. 2. **[245F.02] DEFINITIONS.**

147.21 Subdivision 1. **Scope.** The terms used in this chapter have the meanings given
 147.22 them in this section.

147.23 Subd. 2. **Administration of medications.** "Administration of medications" means
 147.24 performing a task to provide medications to a patient, and includes the following tasks
 147.25 performed in the following order:

147.26 (1) checking the patient's medication record;

147.27 (2) preparing the medication for administration;

147.28 (3) administering the medication to the patient;

147.29 (4) documenting administration of the medication or the reason for not administering
 147.30 the medication as prescribed; and

147.31 (5) reporting information to a licensed practitioner or a registered nurse regarding
 147.32 problems with the administration of the medication or the patient's refusal to take the
 147.33 medication.

148.1 Subd. 3. **Alcohol and drug counselor.** "Alcohol and drug counselor" means an
148.2 individual qualified under Minnesota Rules, part 9530.6450, subpart 5.

148.3 Subd. 4. **Applicant.** "Applicant" means an individual, partnership, voluntary
148.4 association, corporation, or other public or private organization that submits an application
148.5 for licensure under this chapter.

148.6 Subd. 5. **Care coordination.** "Care coordination" means activities intended to bring
148.7 together health services, patient needs, and streams of information to facilitate the aims
148.8 of care. Care coordination includes an ongoing needs assessment, life skills advocacy,
148.9 treatment follow-up, disease management, education, and other services as needed.

148.10 Subd. 6. **Chemical.** "Chemical" means alcohol, solvents, controlled substances as
148.11 defined in section 152.01, subdivision 4, and other mood-altering substances.

148.12 Subd. 7. **Clinically managed program.** "Clinically managed program" means a
148.13 residential setting with staff comprised of a medical director and a licensed practical nurse.
148.14 A licensed practical nurse must be on site 24 hours a day, seven days a week. A qualified
148.15 medical professional must be available by telephone or in person for consultation 24 hours
148.16 a day. Patients admitted to this level of service receive medical observation, evaluation,
148.17 and stabilization services during the detoxification process; access to medications
148.18 administered by trained, licensed staff to manage withdrawal; and a comprehensive
148.19 assessment pursuant to Minnesota Rules, part 9530.6422.

148.20 Subd. 8. **Commissioner.** "Commissioner" means the commissioner of human
148.21 services or the commissioner's designated representative.

148.22 Subd. 9. **Department.** "Department" means the Department of Human Services.

148.23 Subd. 10. **Direct patient contact.** "Direct patient contact" has the meaning given
148.24 for "direct contact" in section 245C.02, subdivision 11.

148.25 Subd. 11. **Discharge plan.** "Discharge plan" means a written plan that states with
148.26 specificity the services the program has arranged for the patient to transition back into
148.27 the community.

148.28 Subd. 12. **Licensed practitioner.** "Licensed practitioner" means a practitioner as
148.29 defined in section 151.01, subdivision 23, who is authorized to prescribe.

148.30 Subd. 13. **Medical director.** "Medical director" means an individual licensed in
148.31 Minnesota as a doctor of osteopathy or physician, or an individual licensed in Minnesota
148.32 as an advanced practice registered nurse by the Board of Nursing and certified to practice
148.33 as a clinical nurse specialist or nurse practitioner by a national nurse organization
148.34 acceptable to the board. The medical director must be employed by or under contract with
148.35 the license holder to direct and supervise health care for patients of a program licensed
148.36 under this chapter.

149.1 Subd. 14. **Medically monitored program.** "Medically monitored program" means
149.2 a residential setting with staff that includes a registered nurse and a medical director. A
149.3 registered nurse must be on site 24 hours a day. A medical director must be on site seven
149.4 days a week, and patients must have the ability to be seen by a medical director within 24
149.5 hours. Patients admitted to this level of service receive medical observation, evaluation,
149.6 and stabilization services during the detoxification process; medications administered by
149.7 trained, licensed staff to manage withdrawal; and a comprehensive assessment pursuant to
149.8 Minnesota Rules, part 9530.6422.

149.9 Subd. 15. **Nurse.** "Nurse" means a person licensed and currently registered to
149.10 practice practical or professional nursing as defined in section 148.171, subdivisions
149.11 14 and 15.

149.12 Subd. 16. **Patient.** "Patient" means an individual who presents or is presented for
149.13 admission to a withdrawal management program that meets the criteria in section 245F.05.

149.14 Subd. 17. **Peer recovery support services.** "Peer recovery support services"
149.15 means mentoring and education, advocacy, and nonclinical recovery support provided
149.16 by a recovery peer.

149.17 Subd. 18. **Program director.** "Program director" means the individual who is
149.18 designated by the license holder to be responsible for all operations of a withdrawal
149.19 management program and who meets the qualifications specified in section 245F.15,
149.20 subdivision 3.

149.21 Subd. 19. **Protective procedure.** "Protective procedure" means an action taken by a
149.22 staff member of a withdrawal management program to protect a patient from imminent
149.23 danger of harming self or others. Protective procedures include the following actions:

149.24 (1) seclusion, which means the temporary placement of a patient, without the
149.25 patient's consent, in an environment to prevent social contact; and

149.26 (2) physical restraint, which means the restraint of a patient by use of physical holds
149.27 intended to limit movement of the body.

149.28 Subd. 20. **Qualified medical professional.** "Qualified medical professional"
149.29 means an individual licensed in Minnesota as a doctor of osteopathy or physician, or an
149.30 individual licensed in Minnesota as an advanced practice registered nurse by the Board of
149.31 Nursing and certified to practice as a clinical nurse specialist or nurse practitioner by a
149.32 national nurse organization acceptable to the board.

149.33 Subd. 21. **Recovery peer.** "Recovery peer" means a person who has progressed in
149.34 the person's own recovery from substance use disorder and is willing to serve as a peer
149.35 to assist others in their recovery.

150.1 Subd. 22. **Responsible staff person.** "Responsible staff person" means the program
150.2 director, the medical director, or a staff person with current licensure as a nurse in
150.3 Minnesota. The responsible staff person must be on the premises and is authorized to
150.4 make immediate decisions concerning patient care and safety.

150.5 Subd. 23. **Substance.** "Substance" means "chemical" as defined in subdivision 6.

150.6 Subd. 24. **Substance use disorder.** "Substance use disorder" means a pattern of
150.7 substance use as defined in the current edition of the Diagnostic and Statistical Manual of
150.8 Mental Disorders.

150.9 Subd. 25. **Technician.** "Technician" means a person who meets the qualifications in
150.10 section 245F.15, subdivision 6.

150.11 Subd. 26. **Withdrawal management program.** "Withdrawal management
150.12 program" means a licensed program that provides short-term medical services on
150.13 a 24-hour basis for the purpose of stabilizing intoxicated patients, managing their
150.14 withdrawal, and facilitating access to substance use disorder treatment as indicated by a
150.15 comprehensive assessment.

150.16 Sec. 3. **[245F.03] APPLICATION.**

150.17 (a) This chapter establishes minimum standards for withdrawal management
150.18 programs licensed by the commissioner that serve one or more unrelated persons.

150.19 (b) This chapter does not apply to a withdrawal management program licensed as a
150.20 hospital under sections 144.50 to 144.581. A withdrawal management program located in
150.21 a hospital licensed under sections 144.50 to 144.581 that chooses to be licensed under this
150.22 chapter is deemed to be in compliance with section 245F.13.

150.23 Sec. 4. **[245F.04] PROGRAM LICENSURE.**

150.24 Subdivision 1. **General application and license requirements.** An applicant
150.25 for licensure as a clinically managed withdrawal management program or medically
150.26 monitored withdrawal management program must meet the following requirements,
150.27 except where otherwise noted. All programs must comply with federal requirements and
150.28 the general requirements in chapters 245A and 245C and sections 626.556, 626.557, and
150.29 626.5572. A withdrawal management program must be located in a hospital licensed under
150.30 sections 144.50 to 144.581, or must be a supervised living facility with a class B license
150.31 from the Department of Health under Minnesota Rules, parts 4665.0100 to 4665.9900.

150.32 Subd. 2. **Contents of application.** Prior to the issuance of a license, an applicant
150.33 must submit, on forms provided by the commissioner, documentation demonstrating
150.34 the following:

151.1 (1) compliance with this section;

151.2 (2) compliance with applicable building, fire, and safety codes; health rules; zoning
 151.3 ordinances; and other applicable rules and regulations or documentation that a waiver
 151.4 has been granted. The granting of a waiver does not constitute modification of any
 151.5 requirement of this section;

151.6 (3) completion of an assessment of need for a new or expanded program as required
 151.7 by Minnesota Rules, part 9530.6800; and

151.8 (4) insurance coverage, including bonding, sufficient to cover all patient funds,
 151.9 property, and interests.

151.10 Subd. 3. **Changes in license terms.** (a) A license holder must notify the
 151.11 commissioner before one of the following occurs and the commissioner must determine
 151.12 the need for a new license:

151.13 (1) a change in the Department of Health's licensure of the program;

151.14 (2) a change in the medical services provided by the program that affects the
 151.15 program's capacity to provide services required by the program's license designation as a
 151.16 clinically managed program or medically monitored program;

151.17 (3) a change in program capacity; or

151.18 (4) a change in location.

151.19 (b) A license holder must notify the commissioner and apply for a new license
 151.20 when a change in program ownership occurs.

151.21 Subd. 4. **Variances.** The commissioner may grant variances to the requirements of
 151.22 this chapter under section 245A.04, subdivision 9.

151.23 Sec. 5. **[245F.05] ADMISSION AND DISCHARGE POLICIES.**

151.24 Subdivision 1. **Admission policy.** A license holder must have a written admission
 151.25 policy containing specific admission criteria. The policy must describe the admission
 151.26 process and the point at which an individual who is eligible under subdivision 2 is
 151.27 admitted to the program. A license holder must not admit individuals who do not meet the
 151.28 admission criteria. The admission policy must be approved and signed by the medical
 151.29 director of the facility and must designate which staff members are authorized to admit
 151.30 and discharge patients. The admission policy must be posted in the area of the facility
 151.31 where patients are admitted and given to all interested individuals upon request.

151.32 Subd. 2. **Admission criteria.** For an individual to be admitted to a withdrawal
 151.33 management program, the program must make a determination that the program services
 151.34 are appropriate to the needs of the individual. A program may only admit individuals who
 151.35 meet the admission criteria and who, at the time of admission:

- 152.1 (1) are impaired as the result of intoxication;
- 152.2 (2) are experiencing physical, mental, or emotional problems due to intoxication or
- 152.3 withdrawal from alcohol or other drugs;
- 152.4 (3) are being held under apprehend and hold orders under section 253B.07,
- 152.5 subdivision 2b;
- 152.6 (4) have been committed under chapter 253B, and need temporary placement;
- 152.7 (5) are held under emergency holds or peace and health officer holds under section
- 152.8 253B.05, subdivision 1 or 2; or
- 152.9 (6) need to stay temporarily in a protective environment because of a crisis related
- 152.10 to substance use disorder. Individuals satisfying this clause may be admitted only at the
- 152.11 request of the county of fiscal responsibility, as determined according to section 256G.02,
- 152.12 subdivision 4. Individuals admitted according to this clause must not be restricted to
- 152.13 the facility.
- 152.14 Subd. 3. **Individuals denied admission by program.** (a) A license holder must
- 152.15 have a written policy and procedure for addressing the needs of individuals who are
- 152.16 denied admission to the program. These individuals include:
- 152.17 (1) individuals whose pregnancy, in combination with their presenting problem,
- 152.18 requires services not provided by the program; and
- 152.19 (2) individuals who are in imminent danger of harming self or others if their
- 152.20 behavior is beyond the behavior management capabilities of the program and staff.
- 152.21 (b) Programs must document denied admissions, including the date and time of
- 152.22 the admission request, reason for the denial of admission, and where the individual was
- 152.23 referred. If the individual did not receive a referral, the program must document why a
- 152.24 referral was not made. This information must be documented on a form approved by the
- 152.25 commissioner and made available to the commissioner upon request.
- 152.26 Subd. 4. **License holder responsibilities; denying admission or terminating**
- 152.27 **services.** (a) If a license holder denies an individual admission to the program or
- 152.28 terminates services to a patient and the denial or termination poses an immediate threat to
- 152.29 the patient's or individual's health or requires immediate medical intervention, the license
- 152.30 holder must refer the patient or individual to a medical facility capable of admitting the
- 152.31 patient or individual.
- 152.32 (b) A license holder must report to a law enforcement agency with proper jurisdiction
- 152.33 all denials of admission and terminations of services that involve the commission of a crime
- 152.34 against a staff member of the license holder or on the license holder's property, as provided
- 152.35 in Code of Federal Regulations, title 42, section 2.12(c)(5), and title 45, parts 160 to 164.

153.1 Subd. 5. **Discharge and transfer policies.** A license holder must have a written
153.2 policy and procedure, approved and signed by the medical director, that specifies
153.3 conditions under which patients may be discharged or transferred. The policy must
153.4 include the following:

153.5 (1) guidelines for determining when a patient is medically stable and whether a
153.6 patient is able to be discharged or transferred to a lower level of care;

153.7 (2) guidelines for determining when a patient needs a transfer to a higher level of care.
153.8 Clinically managed program guidelines must include guidelines for transfer to a medically
153.9 monitored program, hospital, or other acute care facility. Medically monitored program
153.10 guidelines must include guidelines for transfer to a hospital or other acute care facility;

153.11 (3) procedures staff must follow when discharging a patient under each of the
153.12 following circumstances:

153.13 (i) the patient is involved in the commission of a crime against program staff or
153.14 against a license holder's property. The procedures for a patient discharged under this
153.15 item must specify how reports must be made to law enforcement agencies with proper
153.16 jurisdiction as allowed under Code of Federal Regulations, title 42, section 2.12(c)(5), and
153.17 title 45, parts 160 to 164;

153.18 (ii) the patient is in imminent danger of harming self or others and is beyond the
153.19 license holder's capacity to ensure safety;

153.20 (iii) the patient was admitted under chapter 253B; or

153.21 (iv) the patient is leaving against staff or medical advice; and

153.22 (4) a requirement that staff must document where the patient was referred after
153.23 discharge or transfer, and if a referral was not made, the reason the patient was not
153.24 provided a referral.

153.25 **Sec. 6. [245F.06] SCREENING AND COMPREHENSIVE ASSESSMENT.**

153.26 Subdivision 1. **Screening for substance use disorder.** A nurse or an alcohol
153.27 and drug counselor must screen each patient upon admission to determine whether a
153.28 comprehensive assessment is indicated. The license holder must screen patients at
153.29 each admission, except that if the patient has already been determined to suffer from a
153.30 substance use disorder, subdivision 2 applies.

153.31 Subd. 2. **Comprehensive assessment.** (a) Prior to a medically stable discharge,
153.32 but not later than 72 hours following admission, a license holder must provide a
153.33 comprehensive assessment according to section 245.4863, paragraph (a), and Minnesota
153.34 Rules, part 9530.6422, for each patient who has a positive screening for a substance use
153.35 disorder. If a patient's medical condition prevents a comprehensive assessment from

154.1 being completed within 72 hours, the license holder must document why the assessment
154.2 was not completed. The comprehensive assessment must include documentation of the
154.3 appropriateness of an involuntary referral through the civil commitment process.

154.4 (b) If available to the program, a patient's previous comprehensive assessment may
154.5 be used in the patient record. If a previously completed comprehensive assessment is used,
154.6 its contents must be reviewed to ensure the assessment is accurate and current and complies
154.7 with the requirements of this chapter. The review must be completed by a staff person
154.8 qualified according to Minnesota Rules, part 9530.6450, subpart 5. The license holder must
154.9 document that the review was completed and that the previously completed assessment is
154.10 accurate and current, or the license holder must complete an updated or new assessment.

154.11 Sec. 7. [245F.07] STABILIZATION PLANNING.

154.12 Subdivision 1. **Stabilization plan.** Within 12 hours of admission, a license
154.13 holder must develop an individualized stabilization plan for each patient accepted for
154.14 stabilization services. The plan must be based on the patient's initial health assessment
154.15 and continually updated based on new information gathered about the patient's condition
154.16 from the comprehensive assessment, medical evaluation and consultation, and ongoing
154.17 monitoring and observations of the patient. The patient must have an opportunity to have
154.18 direct involvement in the development of the plan. The stabilization plan must:

154.19 (1) identify medical needs and goals to be achieved while the patient is receiving
154.20 services;

154.21 (2) specify stabilization services to address the identified medical needs and goals,
154.22 including amount and frequency of services;

154.23 (3) specify the participation of others in the stabilization planning process and
154.24 specific services where appropriate; and

154.25 (4) document the patient's participation in developing the content of the stabilization
154.26 plan and any updates.

154.27 Subd. 2. **Progress notes.** Progress notes must be entered in the patient's file at least
154.28 daily and immediately following any significant event, including any change that impacts
154.29 the medical, behavioral, or legal status of the patient. Progress notes must:

154.30 (1) include documentation of the patient's involvement in the stabilization services,
154.31 including the type and amount of each stabilization service;

154.32 (2) include the monitoring and observations of the patient's medical needs;

154.33 (3) include documentation of referrals made to other services or agencies;

154.34 (4) specify the participation of others; and

154.35 (5) be legible, signed, and dated by the staff person completing the documentation.

155.1 Subd. 3. **Discharge plan.** Before a patient leaves the facility, the license holder
 155.2 must conduct discharge planning for the patient, document discharge planning in the
 155.3 patient's record, and provide the patient with a copy of the discharge plan. The discharge
 155.4 plan must include:

- 155.5 (1) referrals made to other services or agencies at the time of transition;
- 155.6 (2) the patient's plan for follow-up, aftercare, or other poststabilization services;
- 155.7 (3) documentation of the patient's participation in the development of the transition
 155.8 plan;
- 155.9 (4) any service that will continue after discharge under the direction of the license
 155.10 holder; and
- 155.11 (5) a stabilization summary and final evaluation of the patient's progress toward
 155.12 treatment objectives.

155.13 Sec. 8. **[245F.08] STABILIZATION SERVICES.**

155.14 Subdivision 1. **General.** The license holder must encourage patients to remain in
 155.15 care for an appropriate duration as determined by the patient's stabilization plan, and must
 155.16 encourage all patients to enter programs for ongoing recovery as clinically indicated. In
 155.17 addition, the license holder must offer services that are patient-centered, trauma-informed,
 155.18 and culturally appropriate. Culturally appropriate services must include translation services
 155.19 and dietary services that meet a patient's dietary needs. All services provided to the patient
 155.20 must be documented in the patient's medical record. The following services must be
 155.21 offered unless clinically inappropriate and the justifying clinical rationale is documented:

- 155.22 (1) individual or group motivational counseling sessions;
- 155.23 (2) individual advocacy and case management services;
- 155.24 (3) medical services as required in section 245F.12;
- 155.25 (4) care coordination provided according to subdivision 2;
- 155.26 (5) peer recovery support services provided according to subdivision 3;
- 155.27 (6) patient education provided according to subdivision 4; and
- 155.28 (7) referrals to mutual aid, self-help, and support groups.

155.29 Subd. 2. **Care coordination.** Care coordination services must be initiated for each
 155.30 patient upon admission. The license holder must identify the staff person responsible for
 155.31 the provision of each service. Care coordination services must include:

- 155.32 (1) coordination with significant others to assist in the stabilization planning process
 155.33 whenever possible;
- 155.34 (2) coordination with and follow-up to appropriate medical services as identified by
 155.35 the nurse or licensed practitioner;

- 156.1 (3) referral to substance use disorder services as indicated by the comprehensive
156.2 assessment;
- 156.3 (4) referral to mental health services as identified in the comprehensive assessment;
156.4 (5) referrals to economic assistance, social services, and prenatal care in accordance
156.5 with the patient's needs;
- 156.6 (6) review and approval of the transition plan prior to discharge, except in an
156.7 emergency, by a staff member able to provide direct patient contact;
- 156.8 (7) documentation of the provision of care coordination services in the patient's
156.9 file; and
- 156.10 (8) addressing cultural and socioeconomic factors affecting the patient's access to
156.11 services.

156.12 Subd. 3. **Peer recovery support services.** (a) Peers in recovery serve as mentors or
156.13 recovery-support partners for individuals in recovery, and may provide encouragement,
156.14 self-disclosure of recovery experiences, transportation to appointments, assistance with
156.15 finding resources that will help locate housing, job search resources, and assistance finding
156.16 and participating in support groups.

156.17 (b) Peer recovery support services are provided by a recovery peer and must be
156.18 supervised by the responsible staff person.

156.19 Subd. 4. **Patient education.** A license holder must provide education to each
156.20 patient on the following:

156.21 (1) substance use disorder, including the effects of alcohol and other drugs, specific
156.22 information about the effects of substance use on unborn children, and the signs and
156.23 symptoms of fetal alcohol spectrum disorders;

156.24 (2) tuberculosis and reporting known cases of tuberculosis disease to health care
156.25 authorities according to section 144.4804;

156.26 (3) Hepatitis C treatment and prevention;

156.27 (4) HIV as required in section 245A.19, paragraphs (b) and (c);

156.28 (5) nicotine cessation options, if applicable;

156.29 (6) opioid tolerance and overdose risks, if applicable; and

156.30 (7) long-term withdrawal issues related to use of barbiturates and benzodiazepines,
156.31 if applicable.

156.32 Subd. 5. **Mutual aid, self-help, and support groups.** The license holder must
156.33 refer patients to mutual aid, self-help, and support groups when clinically indicated and
156.34 to the extent available in the community.

156.35 Sec. 9. **[245F.09] PROTECTIVE PROCEDURES.**

157.1 Subdivision 1. Use of protective procedures. (a) Programs must incorporate
157.2 person-centered planning and trauma-informed care into its protective procedure policies.
157.3 Protective procedures may be used only in cases where a less restrictive alternative will
157.4 not protect the patient or others from harm and when the patient is in imminent danger
157.5 of harming self or others. When a program uses a protective procedure, the program
157.6 must continuously observe the patient until the patient may safely be left for 15-minute
157.7 intervals. Use of the procedure must end when the patient is no longer in imminent danger
157.8 of harming self or others.

157.9 (b) Protective procedures may not be used:

157.10 (1) for disciplinary purposes;

157.11 (2) to enforce program rules;

157.12 (3) for the convenience of staff;

157.13 (4) as a part of any patient's health monitoring plan; or

157.14 (5) for any reason except in response to specific, current behaviors which create an
157.15 imminent danger of harm to the patient or others.

157.16 Subd. 2. Protective procedures plan. A license holder must have a written policy
157.17 and procedure that establishes the protective procedures that program staff must follow
157.18 when a patient is in imminent danger of harming self or others. The policy must be
157.19 appropriate to the type of facility and the level of staff training. The protective procedures
157.20 policy must include:

157.21 (1) an approval signed and dated by the program director and medical director prior
157.22 to implementation. Any changes to the policy must also be approved, signed, and dated by
157.23 the current program director and the medical director prior to implementation;

157.24 (2) which protective procedures the license holder will use to prevent patients from
157.25 imminent danger of harming self or others;

157.26 (3) the emergency conditions under which the protective procedures are permitted
157.27 to be used, if any;

157.28 (4) the patient's health conditions that limit the specific procedures that may be used
157.29 and alternative means of ensuring safety;

157.30 (5) emergency resources the program staff must contact when a patient's behavior
157.31 cannot be controlled by the procedures established in the policy;

157.32 (6) the training that staff must have before using any protective procedure;

157.33 (7) documentation of approved therapeutic holds;

157.34 (8) the use of law enforcement personnel as described in subdivision 4;

158.1 (9) standards governing emergency use of seclusion. Seclusion must be used only
158.2 when less restrictive measures are ineffective or not feasible. The standards in items (i) to
158.3 (vii) must be met when seclusion is used with a patient:

158.4 (i) seclusion must be employed solely for the purpose of preventing a patient from
158.5 imminent danger of harming self or others;

158.6 (ii) seclusion rooms must be equipped in a manner that prevents patients from
158.7 self-harm using projections, windows, electrical fixtures, or hard objects, and must allow
158.8 the patient to be readily observed without being interrupted;

158.9 (iii) seclusion must be authorized by the program director, a licensed physician, or
158.10 a registered nurse. If one of these individuals is not present in the facility, the program
158.11 director or a licensed physician or registered nurse must be contacted and authorization
158.12 must be obtained within 30 minutes of initiating seclusion, according to written policies;

158.13 (iv) patients must not be placed in seclusion for more than 12 hours at any one time;

158.14 (v) once the condition of a patient in seclusion has been determined to be safe
158.15 enough to end continuous observation, a patient in seclusion must be observed at a
158.16 minimum of every 15 minutes for the duration of seclusion and must always be within
158.17 hearing range of program staff;

158.18 (vi) a process for program staff to use to remove a patient to other resources available
158.19 to the facility if seclusion does not sufficiently assure patient safety; and

158.20 (vii) a seclusion area may be used for other purposes, such as intensive observation, if
158.21 the room meets normal standards of care for the purpose and if the room is not locked; and

158.22 (10) physical holds may only be used when less restrictive measures are not feasible.

158.23 The standards in items (i) to (iv) must be met when physical holds are used with a patient:

158.24 (i) physical holds must be employed solely for preventing a patient from imminent
158.25 danger of harming self or others;

158.26 (ii) physical holds must be authorized by the program director, a licensed physician,
158.27 or a registered nurse. If one of these individuals is not present in the facility, the program
158.28 director or a licensed physician or a registered nurse must be contacted and authorization
158.29 must be obtained within 30 minutes of initiating a physical hold, according to written
158.30 policies;

158.31 (iii) the patient's health concerns must be considered in deciding whether to use
158.32 physical holds and which holds are appropriate for the patient; and

158.33 (iv) only approved holds may be utilized. Prone holds are not allowed and must
158.34 not be authorized.

158.35 Subd. 3. **Records.** Each use of a protective procedure must be documented in the
158.36 patient record. The patient record must include:

- 159.1 (1) a description of specific patient behavior precipitating a decision to use a
 159.2 protective procedure, including date, time, and program staff present;
- 159.3 (2) the specific means used to limit the patient's behavior;
- 159.4 (3) the time the protective procedure began, the time the protective procedure ended,
 159.5 and the time of each staff observation of the patient during the procedure;
- 159.6 (4) the names of the program staff authorizing the use of the protective procedure,
 159.7 the time of the authorization, and the program staff directly involved in the protective
 159.8 procedure and the observation process;
- 159.9 (5) a brief description of the purpose for using the protective procedure, including
 159.10 less restrictive interventions used prior to the decision to use the protective procedure
 159.11 and a description of the behavioral results obtained through the use of the procedure. If
 159.12 a less restrictive intervention was not used, the reasons for not using a less restrictive
 159.13 intervention must be documented;
- 159.14 (6) documentation by the responsible staff person on duty of reassessment of the
 159.15 patient at least every 15 minutes to determine if seclusion or the physical hold can be
 159.16 terminated;
- 159.17 (7) a description of the physical holds used in escorting a patient; and
- 159.18 (8) any injury to the patient that occurred during the use of a protective procedure.
- 159.19 **Subd. 4. Use of law enforcement.** The program must maintain a central log
 159.20 documenting each incident involving use of law enforcement, including:
- 159.21 (1) the date and time law enforcement arrived at and left the program;
- 159.22 (2) the reason for the use of law enforcement;
- 159.23 (3) if law enforcement used force or a protective procedure and which protective
 159.24 procedure was used; and
- 159.25 (4) whether any injuries occurred.
- 159.26 **Subd. 5. Administrative review.** (a) The license holder must keep a record of all
 159.27 patient incidents and protective procedures used. An administrative review of each use
 159.28 of protective procedures must be completed within 72 hours by someone other than the
 159.29 person who used the protective procedure. The record of the administrative review of the
 159.30 use of protective procedures must state whether:
- 159.31 (1) the required documentation was recorded for each use of a protective procedure;
- 159.32 (2) the protective procedure was used according to the policy and procedures;
- 159.33 (3) the staff who implemented the protective procedure was properly trained; and
- 159.34 (4) the behavior met the standards for imminent danger of harming self or others.

160.1 (b) The license holder must conduct and document a quarterly review of the use of
 160.2 protective procedures with the goal of reducing the use of protective procedures. The
 160.3 review must include:

160.4 (1) any patterns or problems indicated by similarities in the time of day, day of the
 160.5 week, duration of the use of a protective procedure, individuals involved, or other factors
 160.6 associated with the use of protective procedures;

160.7 (2) any injuries resulting from the use of protective procedures;

160.8 (3) whether law enforcement was involved in the use of a protective procedure;

160.9 (4) actions needed to correct deficiencies in the program's implementation of
 160.10 protective procedures;

160.11 (5) an assessment of opportunities missed to avoid the use of protective procedures;

160.12 and

160.13 (6) proposed actions to be taken to minimize the use of protective procedures.

160.14 Sec. 10. **[245F.10] PATIENT RIGHTS AND GRIEVANCE PROCEDURES.**

160.15 Subdivision 1. **Patient rights.** Patients have the rights in sections 144.651,
 160.16 148F.165, and 253B.03, as applicable. The license holder must give each patient, upon
 160.17 admission, a written statement of patient rights. Program staff must review the statement
 160.18 with the patient.

160.19 Subd. 2. **Grievance procedure.** Upon admission, the license holder must explain
 160.20 the grievance procedure to the patient or patient's representative and give the patient a
 160.21 written copy of the procedure. The grievance procedure must be posted in a place visible
 160.22 to the patient and must be made available to current and former patients upon request. A
 160.23 license holder's written grievance procedure must include:

160.24 (1) staff assistance in developing and processing the grievance;

160.25 (2) an initial response to the patient who filed the grievance within 24 hours of the
 160.26 program's receipt of the grievance, and timelines for additional steps to be taken to resolve
 160.27 the grievance, including access to the person with the highest level of authority in the
 160.28 program if the grievance cannot be resolved by other staff members; and

160.29 (3) the current addresses and telephone numbers of the Department of Human
 160.30 Services Licensing Division, Department of Health Office of Health Facilities Complaints,
 160.31 Board of Behavioral Health and Therapy, Board of Medical Practice, Board of Nursing,
 160.32 and Office of the Ombudsman for Mental Health and Developmental Disabilities.

160.33 Sec. 11. **[245F.11] PATIENT PROPERTY MANAGEMENT.**

161.1 A license holder must meet the requirements for handling patient funds and property
161.2 in section 245A.04, subdivision 13, except:

161.3 (1) a license holder must establish policies regarding the use of personal property to
161.4 assure that program activities and the rights of other patients are not infringed, and may
161.5 take temporary custody of personal property if these policies are violated;

161.6 (2) a license holder must retain the patient's property for a minimum of seven days
161.7 after discharge if the patient does not reclaim the property after discharge; and

161.8 (3) the license holder must return to the patient all of the patient's property held in
161.9 trust at discharge, regardless of discharge status, except that:

161.10 (i) drugs, drug paraphernalia, and drug containers that are subject to forfeiture under
161.11 section 609.5316 must be given over to the custody of a local law enforcement agency or,
161.12 if giving the property over to the custody of a local law enforcement agency would violate
161.13 Code of Federal Regulations, title 42, sections 2.1 to 2.67, and title 45, parts 160 to 164,
161.14 destroyed by a staff person designated by the program director; and

161.15 (ii) weapons, explosives, and other property that may cause serious harm to self
161.16 or others must be transferred to a local law enforcement agency. The patient must be
161.17 notified of the transfer and the right to reclaim the property if the patient has a legal right
161.18 to possess the item.

161.19 Sec. 12. **[245F.12] MEDICAL SERVICES.**

161.20 Subdivision 1. **Services provided at all programs.** Withdrawal management
161.21 programs must have:

161.22 (1) a standardized data collection tool for collecting health-related information about
161.23 each patient. The data collection tool must be developed in collaboration with a registered
161.24 nurse and approved and signed by the medical director; and

161.25 (2) written procedures for a nurse to assess and monitor patient health within the
161.26 nurse's scope of practice. The procedures must:

161.27 (i) be approved by the medical director;

161.28 (ii) include a follow-up screening conducted between four and 12 hours after service
161.29 initiation to collect information relating to acute intoxication, other health complaints, and
161.30 behavioral risk factors that the patient may not have communicated at service initiation;

161.31 (iii) specify the physical signs and symptoms that, when present, require consultation
161.32 with a registered nurse or a physician and that require transfer to an acute care facility or
161.33 a higher level of care than that provided by the program;

161.34 (iv) specify those staff members responsible for monitoring patient health and
161.35 provide for hourly observation and for more frequent observation if the initial health

162.1 assessment or follow-up screening indicates a need for intensive physical or behavioral
 162.2 health monitoring; and
 162.3 (v) specify the actions to be taken to address specific complicating conditions,
 162.4 including pregnancy or the presence of physical signs or symptoms of any other medical
 162.5 condition.

162.6 Subd. 2. **Services provided at clinically managed programs.** In addition to the
 162.7 services listed in subdivision 1, clinically managed programs must:

162.8 (1) have a licensed practical nurse on site 24 hours a day and a medical director;

162.9 (2) provide an initial health assessment conducted by a nurse upon admission;

162.10 (3) provide daily on-site medical evaluation by a nurse;

162.11 (4) have a registered nurse available by telephone or in person for consultation
 162.12 24 hours a day;

162.13 (5) have a qualified medical professional available by telephone or in person for
 162.14 consultation 24 hours a day; and

162.15 (6) have appropriately licensed staff available to administer medications according
 162.16 to prescriber-approved orders.

162.17 Subd. 3. **Services provided at medically monitored programs.** In addition to the
 162.18 services listed in subdivision 1, medically monitored programs must have a registered
 162.19 nurse on site 24 hours a day and a medical director. Medically monitored programs must
 162.20 provide intensive inpatient withdrawal management services which must include:

162.21 (1) an initial health assessment conducted by a registered nurse upon admission;

162.22 (2) the availability of a medical evaluation and consultation with a registered nurse
 162.23 24 hours a day;

162.24 (3) the availability of a qualified medical professional by telephone or in person
 162.25 for consultation 24 hours a day;

162.26 (4) the ability to be seen within 24 hours or sooner by a qualified medical
 162.27 professional if the initial health assessment indicates the need to be seen;

162.28 (5) the availability of on-site monitoring of patient care seven days a week by a
 162.29 qualified medical professional; and

162.30 (6) appropriately licensed staff available to administer medications according to
 162.31 prescriber-approved orders.

162.32 Sec. 13. **[245F.13] MEDICATIONS.**

162.33 Subdivision 1. **Administration of medications.** A license holder must employ or
 162.34 contract with a registered nurse to develop the policies and procedures for medication
 162.35 administration. A registered nurse must provide supervision as defined in section 148.171,

163.1 subdivision 23, for the administration of medications. For clinically managed programs,
 163.2 the registered nurse supervision must include on-site supervision at least monthly or more
 163.3 often as warranted by the health needs of the patient. The medication administration
 163.4 policies and procedures must include:

163.5 (1) a provision that patients may carry emergency medication such as nitroglycerin
 163.6 as instructed by their prescriber;

163.7 (2) requirements for recording the patient's use of medication, including staff
 163.8 signatures with date and time;

163.9 (3) guidelines regarding when to inform a licensed practitioner or a registered nurse
 163.10 of problems with medication administration, including failure to administer, patient
 163.11 refusal of a medication, adverse reactions, or errors; and

163.12 (4) procedures for acceptance, documentation, and implementation of prescriptions,
 163.13 whether written, oral, telephonic, or electronic.

163.14 Subd. 2. **Control of drugs.** A license holder must have in place and implement
 163.15 written policies and procedures relating to control of drugs. The policies and procedures
 163.16 must be developed by a registered nurse and must contain the following provisions:

163.17 (1) a requirement that all drugs must be stored in a locked compartment. Schedule II
 163.18 drugs, as defined in section 152.02, subdivision 3, must be stored in a separately locked
 163.19 compartment that is permanently affixed to the physical plant or a medication cart;

163.20 (2) a system for accounting for all scheduled drugs each shift;

163.21 (3) a procedure for recording a patient's use of medication, including staff signatures
 163.22 with time and date;

163.23 (4) a procedure for destruction of discontinued, outdated, or deteriorated medications;

163.24 (5) a statement that only authorized personnel are permitted to have access to the
 163.25 keys to the locked drug compartments; and

163.26 (6) a statement that no legend drug supply for one patient may be given to another
 163.27 patient.

163.28 **Sec. 14. [245F.14] STAFFING REQUIREMENTS AND DUTIES.**

163.29 Subdivision 1. **Program director.** A license holder must employ or contract with a
 163.30 person, on a full-time basis, to serve as program director. The program director must be
 163.31 responsible for all aspects of the facility and the services delivered to the license holder's
 163.32 patients. An individual may serve as program director for more than one program owned
 163.33 by the same license holder.

163.34 Subd. 2. **Responsible staff person.** During all hours of operation, a license holder
 163.35 must designate a staff member as the responsible staff person to be present and awake

164.1 in the facility and be responsible for the program. The responsible staff person must
164.2 have decision-making authority over the day-to-day operation of the program as well
164.3 as the authority to direct the activity of or terminate the shift of any staff member who
164.4 has direct patient contact.

164.5 Subd. 3. **Technician required.** A license holder must have one technician awake
164.6 and on duty at all times for every ten patients in the program. A license holder may assign
164.7 technicians according to the need for care of the patients, except that the same technician
164.8 must not be responsible for more than 15 patients at one time. For purposes of establishing
164.9 this ratio, all staff whose qualifications meet or exceed those for technicians under section
164.10 245F.15, subdivision 6, and who are performing the duties of a technician may be counted
164.11 as technicians. The same individual may not be counted as both a technician and an
164.12 alcohol and drug counselor.

164.13 Subd. 4. **Registered nurse required.** A license holder must employ or contract
164.14 with a registered nurse, who must be available 24 hours a day by telephone or in person
164.15 for consultation. The registered nurse is responsible for:

164.16 (1) establishing and implementing procedures for the provision of nursing care and
164.17 delegated medical care, including:

164.18 (i) a health monitoring plan;

164.19 (ii) a medication control plan;

164.20 (iii) training and competency evaluations for staff performing delegated medical and
164.21 nursing functions;

164.22 (iv) handling serious illness, accident, or injury to patients;

164.23 (v) an infection control program; and

164.24 (vi) a first aid kit;

164.25 (2) delegating nursing functions to other staff consistent with their education,
164.26 competence, and legal authorization;

164.27 (3) assigning, supervising, and evaluating the performance of nursing tasks; and

164.28 (4) implementing condition-specific protocols in compliance with section 151.37,
164.29 subdivision 2.

164.30 Subd. 5. **Medical director required.** A license holder must have a medical director
164.31 available for medical supervision. The medical director is responsible for ensuring the
164.32 accurate and safe provision of all health-related services and procedures. A license
164.33 holder must obtain and document the medical director's annual approval of the following
164.34 procedures before the procedures may be used:

164.35 (1) admission, discharge, and transfer criteria and procedures;

164.36 (2) a health services plan;

165.1 (3) physical indicators for a referral to a physician, registered nurse, or hospital, and
 165.2 procedures for referral;

165.3 (4) procedures to follow in case of accident, injury, or death of a patient;

165.4 (5) formulation of condition-specific protocols regarding the medications that
 165.5 require a withdrawal regimen that will be administered to patients;

165.6 (6) an infection control program;

165.7 (7) protective procedures; and

165.8 (8) a medication control plan.

165.9 Subd. 6. **Alcohol and drug counselor.** A withdrawal management program must
 165.10 provide one full-time equivalent alcohol and drug counselor for every 16 patients served
 165.11 by the program.

165.12 Subd. 7. **Ensuring staff-to-patient ratio.** The responsible staff person under
 165.13 subdivision 2 must ensure that the program does not exceed the staff-to-patient ratios in
 165.14 subdivisions 3 and 6 and must inform admitting staff of the current staffed capacity of
 165.15 the program for that shift. A license holder must have a written policy for documenting
 165.16 staff-to-patient ratios for each shift and actions to take when staffed capacity is reached.

165.17 Sec. 15. **[245F.15] STAFF QUALIFICATIONS.**

165.18 Subdivision 1. **Qualifications for all staff who have direct patient contact.** (a) All
 165.19 staff who have direct patient contact must be at least 18 years of age and must, at the time
 165.20 of hiring, document that they meet the requirements in paragraph (b), (c), or (d).

165.21 (b) Program directors, supervisors, nurses, and alcohol and drug counselors must be
 165.22 free of substance use problems for at least two years immediately preceding their hiring
 165.23 and must sign a statement attesting to that fact.

165.24 (c) Recovery peers must be free of substance use problems for at least one year
 165.25 immediately preceding their hiring and must sign a statement attesting to that fact.

165.26 (d) Technicians and other support staff must be free of substance use problems
 165.27 for at least six months immediately preceding their hiring and must sign a statement
 165.28 attesting to that fact.

165.29 Subd. 2. **Continuing employment; no substance use problems.** License holders
 165.30 must require staff to be free from substance use problems as a condition of continuing
 165.31 employment. Staff are not required to sign statements attesting to their freedom from
 165.32 substance use problems after the initial statement required by subdivision 1. Staff with
 165.33 substance use problems must be immediately removed from any responsibilities that
 165.34 include direct patient contact.

165.35 Subd. 3. **Program director qualifications.** A program director must:

166.1 (1) have at least one year of work experience in direct service to individuals
166.2 with substance use disorders or one year of work experience in the management or
166.3 administration of direct service to individuals with substance use disorders;

166.4 (2) have a baccalaureate degree or three years of work experience in administration
166.5 or personnel supervision in human services; and

166.6 (3) know and understand the requirements of this chapter and chapters 245A and
166.7 245C, and sections 253B.04, 253B.05, 626.556, 626.557, and 626.5572.

166.8 Subd. 4. **Alcohol and drug counselor qualifications.** An alcohol and drug
166.9 counselor must meet the requirements in Minnesota Rules, part 9530.6450, subpart 5.

166.10 Subd. 5. **Responsible staff person qualifications.** Each responsible staff person
166.11 must know and understand the requirements of this chapter and sections 245A.65,
166.12 253B.04, 253B.05, 626.556, 626.557, and 626.5572. In a clinically managed program, the
166.13 responsible staff person must be a licensed practical nurse employed by or under contract
166.14 with the license holder. In a medically monitored program, the responsible staff person
166.15 must be a registered nurse, program director, or physician.

166.16 Subd. 6. **Technician qualifications.** A technician employed by a program must
166.17 demonstrate competency, prior to direct patient contact, in the following areas:

166.18 (1) knowledge of the client bill of rights in section 148F.165, and staff responsibilities
166.19 in sections 144.651 and 253B.03;

166.20 (2) knowledge of and the ability to perform basic health screening procedures with
166.21 intoxicated patients that consist of:

166.22 (i) blood pressure, pulse, temperature, and respiration readings;

166.23 (ii) interviewing to obtain relevant medical history and current health complaints; and

166.24 (iii) visual observation of a patient's health status, including monitoring a patient's
166.25 behavior as it relates to health status;

166.26 (3) a current first aid certificate from the American Red Cross or an equivalent
166.27 organization; a current cardiopulmonary resuscitation certificate from the American Red
166.28 Cross, the American Heart Association, a community organization, or an equivalent
166.29 organization; and knowledge of first aid for seizures, trauma, and loss of consciousness; and

166.30 (4) knowledge of and ability to perform basic activities of daily living and personal
166.31 hygiene.

166.32 Subd. 7. **Recovery peer qualifications.** Recovery peers must:

166.33 (1) be at least 21 years of age and have a high school diploma or its equivalent;

166.34 (2) have a minimum of one year in recovery from substance use disorder;

167.1 (3) have completed a curriculum designated by the commissioner that teaches
167.2 specific skills and training in the domains of ethics and boundaries, advocacy, mentoring
167.3 and education, and recovery and wellness support; and

167.4 (4) receive supervision in areas specific to the domains of their role by qualified
167.5 supervisory staff.

167.6 Subd. 8. **Personal relationships.** A license holder must have a written policy
167.7 addressing personal relationships between patients and staff who have direct patient
167.8 contact. The policy must:

167.9 (1) prohibit direct patient contact between a patient and a staff member if the staff
167.10 member has had a personal relationship with the patient within two years prior to the
167.11 patient's admission to the program;

167.12 (2) prohibit access to a patient's clinical records by a staff member who has had a
167.13 personal relationship with the patient within two years prior to the patient's admission,
167.14 unless the patient consents in writing; and

167.15 (3) prohibit a clinical relationship between a staff member and a patient if the staff
167.16 member has had a personal relationship with the patient within two years prior to the
167.17 patient's admission. If a personal relationship exists, the staff member must report the
167.18 relationship to the staff member's supervisor and recuse the staff member from a clinical
167.19 relationship with that patient.

167.20 Sec. 16. **[245F.16] PERSONNEL POLICIES AND PROCEDURES.**

167.21 Subdivision 1. **Policy requirements.** A license holder must have written personnel
167.22 policies and must make them available to staff members at all times. The personnel
167.23 policies must:

167.24 (1) ensure that staff member's retention, promotion, job assignment, or pay are not
167.25 affected by a good faith communication between the staff member and the Department
167.26 of Human Services, Department of Health, Ombudsman for Mental Health and
167.27 Developmental Disabilities, law enforcement, or local agencies that investigate complaints
167.28 regarding patient rights, health, or safety;

167.29 (2) include a job description for each position that specifies job responsibilities,
167.30 degree of authority to execute job responsibilities, standards of job performance related to
167.31 specified job responsibilities, and qualifications;

167.32 (3) provide for written job performance evaluations for staff members of the license
167.33 holder at least annually;

167.34 (4) describe behavior that constitutes grounds for disciplinary action, suspension, or
167.35 dismissal, including policies that address substance use problems and meet the requirements

168.1 of section 245F.15, subdivisions 1 and 2. The policies and procedures must list behaviors
168.2 or incidents that are considered substance use problems. The list must include:

168.3 (i) receiving treatment for substance use disorder within the period specified for the
168.4 position in the staff qualification requirements;

168.5 (ii) substance use that has a negative impact on the staff member's job performance;

168.6 (iii) substance use that affects the credibility of treatment services with patients,
168.7 referral sources, or other members of the community; and

168.8 (iv) symptoms of intoxication or withdrawal on the job;

168.9 (5) include policies prohibiting personal involvement with patients and policies
168.10 prohibiting patient maltreatment as specified under chapter 604 and sections 245A.65,
168.11 626.556, 626.557, and 626.5572;

168.12 (6) include a chart or description of organizational structure indicating the lines
168.13 of authority and responsibilities;

168.14 (7) include a written plan for new staff member orientation that, at a minimum,
168.15 includes training related to the specific job functions for which the staff member was hired,
168.16 program policies and procedures, patient needs, and the areas identified in subdivision 2,
168.17 paragraphs (b) to (e); and

168.18 (8) include a policy on the confidentiality of patient information.

168.19 Subd. 2. **Staff development.** (a) A license holder must ensure that each staff
168.20 member receives orientation training before providing direct patient care and at least
168.21 30 hours of continuing education every two years. A written record must be kept to
168.22 demonstrate completion of training requirements.

168.23 (b) Within 72 hours of beginning employment, all staff having direct patient contact
168.24 must be provided orientation on the following:

168.25 (1) specific license holder and staff responsibilities for patient confidentiality;

168.26 (2) standards governing the use of protective procedures;

168.27 (3) patient ethical boundaries and patient rights, including the rights of patients
168.28 admitted under chapter 253B;

168.29 (4) infection control procedures;

168.30 (5) mandatory reporting under sections 245A.65, 626.556, and 626.557, including
168.31 specific training covering the facility's policies concerning obtaining patient releases
168.32 of information;

168.33 (6) HIV minimum standards as required in section 245A.19;

168.34 (7) motivational counseling techniques and identifying stages of change; and

168.35 (8) eight hours of training on the program's protective procedures policy required in
168.36 section 245F.09, including:

- 169.1 (i) approved therapeutic holds;
- 169.2 (ii) protective procedures used to prevent patients from imminent danger of harming
- 169.3 self or others;
- 169.4 (iii) the emergency conditions under which the protective procedures may be used, if
- 169.5 any;
- 169.6 (iv) documentation standards for using protective procedures;
- 169.7 (v) how to monitor and respond to patient distress; and
- 169.8 (vi) person-centered planning and trauma-informed care.
- 169.9 (c) All staff having direct patient contact must be provided annual training on the
- 169.10 following:
- 169.11 (1) infection control procedures;
- 169.12 (2) mandatory reporting under sections 245A.65, 626.556, and 626.557, including
- 169.13 specific training covering the facility's policies concerning obtaining patient releases
- 169.14 of information;
- 169.15 (3) HIV minimum standards as required in section 245A.19; and
- 169.16 (4) motivational counseling techniques and identifying stages of change.
- 169.17 (d) All staff having direct patient contact must be provided training every two
- 169.18 years on the following:
- 169.19 (1) specific license holder and staff responsibilities for patient confidentiality;
- 169.20 (2) standards governing use of protective procedures, including:
- 169.21 (i) approved therapeutic holds;
- 169.22 (ii) protective procedures used to prevent patients from imminent danger of harming
- 169.23 self or others;
- 169.24 (iii) the emergency conditions under which the protective procedures may be used, if
- 169.25 any;
- 169.26 (iv) documentation standards for using protective procedures;
- 169.27 (v) how to monitor and respond to patient distress; and
- 169.28 (vi) person-centered planning and trauma-informed care; and
- 169.29 (3) patient ethical boundaries and patient rights, including the rights of patients
- 169.30 admitted under chapter 253B.
- 169.31 (e) Continuing education that is completed in areas outside of the required topics
- 169.32 must provide information to the staff person that is useful to the performance of the
- 169.33 individual staff person's duties.

169.34 Sec. 17. **[245F.17] PERSONNEL FILES.**

170.1 A license holder must maintain a separate personnel file for each staff member. At a
 170.2 minimum, the file must contain:

170.3 (1) a completed application for employment signed by the staff member that
 170.4 contains the staff member's qualifications for employment and documentation related to
 170.5 the applicant's background study data, as defined in chapter 245C;

170.6 (2) documentation of the staff member's current professional license or registration,
 170.7 if relevant;

170.8 (3) documentation of orientation and subsequent training;

170.9 (4) documentation of a statement of freedom from substance use problems; and

170.10 (5) an annual job performance evaluation.

170.11 **Sec. 18. [245F.18] POLICY AND PROCEDURES MANUAL.**

170.12 A license holder must develop a written policy and procedures manual that is
 170.13 alphabetically indexed and has a table of contents, so that staff have immediate access
 170.14 to all policies and procedures, and that consumers of the services, and other authorized
 170.15 parties have access to all policies and procedures. The manual must contain the following
 170.16 materials:

170.17 (1) a description of patient education services as required in section 245F.06;

170.18 (2) personnel policies that comply with section 245F.16;

170.19 (3) admission information and referral and discharge policies that comply with
 170.20 section 245F.05;

170.21 (4) a health monitoring plan that complies with section 245F.12;

170.22 (5) a protective procedures policy that complies with section 245F.09, if the program
 170.23 elects to use protective procedures;

170.24 (6) policies and procedures for assuring appropriate patient-to-staff ratios that
 170.25 comply with section 245F.14;

170.26 (7) policies and procedures for assessing and documenting the susceptibility for
 170.27 risk of abuse to the patient as the basis for the individual abuse prevention plan required
 170.28 by section 245A.65;

170.29 (8) procedures for mandatory reporting as required by sections 245A.65, 626.556,
 170.30 and 626.557;

170.31 (9) a medication control plan that complies with section 245F.13; and

170.32 (10) policies and procedures regarding HIV that meet the minimum standards
 170.33 under section 245A.19.

170.34 **Sec. 19. [245F.19] PATIENT RECORDS.**

171.1 Subdivision 1. **Patient records required.** A license holder must maintain a file of
171.2 current patient records on the program premises where the treatment is provided. Each
171.3 entry in each patient record must be signed and dated by the staff member making the
171.4 entry. Patient records must be protected against loss, tampering, or unauthorized disclosure
171.5 in compliance with chapter 13 and section 254A.09; Code of Federal Regulations, title 42,
171.6 sections 2.1 to 2.67; and title 45, parts 160 to 164.

171.7 Subd. 2. **Records retention.** A license holder must retain and store records as
171.8 required by section 245A.041, subdivisions 3 and 4.

171.9 Subd. 3. **Contents of records.** Patient records must include the following:

171.10 (1) documentation of the patient's presenting problem, any substance use screening,
171.11 the most recent assessment, and any updates;

171.12 (2) a stabilization plan and progress notes as required by section 245F.07,
171.13 subdivisions 1 and 2;

171.14 (3) a discharge summary as required by section 245F.07, subdivision 3;

171.15 (4) an individual abuse prevention plan that complies with section 245A.65, and
171.16 related rules;

171.17 (5) documentation of referrals made; and

171.18 (6) documentation of the monitoring and observations of the patient's medical needs.

171.19 **Sec. 20. [245F.20] DATA COLLECTION REQUIRED.**

171.20 The license holder must participate in the drug and alcohol abuse normative
171.21 evaluation system (DAANES) by submitting, in a format provided by the commissioner,
171.22 information concerning each patient admitted to the program. Staff submitting data must
171.23 be trained by the license holder with the DAANES Web manual.

171.24 **Sec. 21. [245F.21] PAYMENT METHODOLOGY.**

171.25 The commissioner shall develop a payment methodology for services provided
171.26 under this chapter or by an Indian Health Services facility or a facility owned and operated
171.27 by a tribe or tribal organization operating under Public Law 93-638 as a 638 facility. The
171.28 commissioner shall seek federal approval for the methodology. Upon federal approval, the
171.29 commissioner must seek and obtain legislative approval of the funding methodology to
171.30 support the service.

172.1 **ARTICLE 4**

172.2 **DIRECT CARE AND TREATMENT**

172.3 Section 1. Minnesota Statutes 2014, section 43A.241, is amended to read:

172.4 **43A.241 INSURANCE CONTRIBUTIONS; FORMER CORRECTIONS**
 172.5 **EMPLOYEES.**

172.6 (a) This section applies to a person who:

172.7 (1) ~~was employed by the commissioner of the Department of Corrections at a state~~
 172.8 ~~institution under control of the commissioner, and in that employment was a member~~
 172.9 ~~of the general plan of the Minnesota State Retirement System; or by the Department~~
 172.10 ~~of Human Services;~~

172.11 (2) was covered by the correctional employee retirement plan under section 352.91
 172.12 or the general state employees retirement plan of the Minnesota State Retirement System
 172.13 as defined in section 352.021;

172.14 (3) while employed under clause (1), was assaulted by:

172.15 ~~an inmate at a state institution under control of the commissioner of the Department~~
 172.16 ~~of Corrections~~ (i) a person under correctional supervision for a criminal offense; or

172.17 (ii) a client or patient at the Minnesota sex offender program, or at a state-operated
 172.18 forensic services program as defined in section 352.91, subdivision 3j, under the control of
 172.19 the commissioner of the Department of Human Services; and

172.20 ~~(3)~~ (4) as a direct result of the assault under clause (3), was determined to be
 172.21 totally and permanently physically disabled under laws governing the Minnesota State
 172.22 Retirement System.

172.23 (b) For a person to whom this section applies, the commissioner of the Department
 172.24 of Corrections or the commissioner of the Department of Human Services must continue
 172.25 to make the employer contribution for ~~hospital~~, medical, and dental benefits under the
 172.26 State Employee Group Insurance Program after the person terminates state service. If
 172.27 the person had dependent coverage at the time of terminating state service, employer
 172.28 contributions for dependent coverage also must continue under this section. The employer
 172.29 contributions must be in the amount of the employer contribution for active state
 172.30 employees at the time each payment is made. The employer contributions must continue
 172.31 until the person reaches age 65, provided the person makes the required employee
 172.32 contributions, in the amount required of an active state employee, at the time and in
 172.33 the manner specified by the commissioner.

173.1 **EFFECTIVE DATE.** This section is effective the day following final enactment
 173.2 and applies to a person assaulted by an inmate, client, or patient on or after that date.

173.3 Sec. 2. Minnesota Statutes 2014, section 246.54, subdivision 1, is amended to read:

173.4 Subdivision 1. **County portion for cost of care.** (a) Except for chemical
 173.5 dependency services provided under sections 254B.01 to 254B.09, the client's county
 173.6 shall pay to the state of Minnesota a portion of the cost of care provided in a regional
 173.7 treatment center or a state nursing facility to a client legally settled in that county. A
 173.8 county's payment shall be made from the county's own sources of revenue and payments
 173.9 shall equal a percentage of the cost of care, as determined by the commissioner, for each
 173.10 day, or the portion thereof, that the client spends at a regional treatment center or a state
 173.11 nursing facility according to the following schedule:

173.12 (1) zero percent for the first 30 days;

173.13 (2) 20 percent for days 31 ~~to 60~~ and over if the stay is determined to be clinically
 173.14 appropriate for the client; and

173.15 (3) ~~75 percent for any days over 60~~ 100 percent for each day during the stay,
 173.16 including the day of admission, when the facility determines that it is clinically appropriate
 173.17 for the client to be discharged.

173.18 ~~(b) The increase in the county portion for cost of care under paragraph (a), clause~~
 173.19 ~~(3), shall be imposed when the treatment facility has determined that it is clinically~~
 173.20 ~~appropriate for the client to be discharged.~~

173.21 ~~(e)~~ (b) If payments received by the state under sections 246.50 to 246.53 exceed
 173.22 80 percent of the cost of care for days over 31 to 60, or 25 percent for days over 60 for
 173.23 clients who meet the criteria in paragraph (a), clause (2), the county shall be responsible
 173.24 for paying the state only the remaining amount. The county shall not be entitled to
 173.25 reimbursement from the client, the client's estate, or from the client's relatives, except as
 173.26 provided in section 246.53.

173.27 ARTICLE 5

173.28 SIMPLIFICATION OF PUBLIC ASSISTANCE PROGRAMS

173.29 Section 1. Minnesota Statutes 2014, section 119B.011, subdivision 15, is amended to
 173.30 read:

173.31 Subd. 15. **Income.** "Income" means earned ~~or unearned~~ income received by all
 173.32 ~~family members, including~~ as defined under section 256P.01, subdivision 3, unearned
 173.33 income as defined under section 256P.01, subdivision 8, and public assistance cash benefits
 173.34 and, including the Minnesota family investment program, diversionary work program,

174.1 work benefit, Minnesota supplemental aid, general assistance, refugee cash assistance,
 174.2 at-home infant child care subsidy payments, unless specifically excluded and child support
 174.3 and maintenance distributed to the family under section 256.741, subdivision 15. The
 174.4 following are excluded deducted from income: funds used to pay for health insurance
 174.5 premiums for family members, Supplemental Security Income, scholarships, work-study
 174.6 income, and grants that cover costs or reimbursement for tuition, fees, books, and
 174.7 educational supplies; student loans for tuition, fees, books, supplies, and living expenses;
 174.8 state and federal earned income tax credits; assistance specifically excluded as income by
 174.9 law; in-kind income such as food support, energy assistance, foster care assistance, medical
 174.10 assistance, child care assistance, and housing subsidies; earned income of full-time or
 174.11 part-time students up to the age of 19, who have not earned a high school diploma or GED
 174.12 high school equivalency diploma including earnings from summer employment; grant
 174.13 awards under the family subsidy program; nonrecurring lump-sum income only to the
 174.14 extent that it is earmarked and used for the purpose for which it is paid; and any income
 174.15 assigned to the public authority according to section 256.741 and child or spousal support
 174.16 paid to or on behalf of a person or persons who live outside of the household. Income
 174.17 sources not included in this subdivision and section 256P.06, subdivision 3, are not counted.

174.18 Sec. 2. Minnesota Statutes 2014, section 119B.025, subdivision 1, is amended to read:

174.19 Subdivision 1. **Factors which must be verified.** (a) The county shall verify the
 174.20 following at all initial child care applications using the universal application:

174.21 (1) identity of adults;

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

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

174.25 (4) age;

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

174.27 (6) Social Security number, if given;

174.28 (7) income;

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

174.31 (9) residence; and

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

174.33 (b) If a family did not use the universal application or child care addendum to apply
 174.34 for child care assistance, the family must complete the universal application or child care
 174.35 addendum at its next eligibility redetermination and the county must verify the factors

175.1 listed in paragraph (a) as part of that redetermination. Once a family has completed a
175.2 universal application or child care addendum, the county shall use the redetermination
175.3 form described in paragraph (c) for that family's subsequent redeterminations. Eligibility
175.4 must be redetermined at least every six months. A family is considered to have met the
175.5 eligibility redetermination requirement if a complete redetermination form and all required
175.6 verifications are received within 30 days after the date the form was due. Assistance shall
175.7 be payable retroactively from the redetermination due date. For a family where at least
175.8 one parent is under the age of 21, does not have a high school or general equivalency
175.9 diploma, and is a student in a school district or another similar program that provides or
175.10 arranges for child care, as well as parenting, social services, career and employment
175.11 supports, and academic support to achieve high school graduation, the redetermination of
175.12 eligibility shall be deferred beyond six months, but not to exceed 12 months, to the end of
175.13 the student's school year. If a family reports a change in an eligibility factor before the
175.14 family's next regularly scheduled redetermination, the county must recalculate eligibility
175.15 without requiring verification of any eligibility factor that did not change. Changes must
175.16 be reported as required by section 256P.07. A change in income occurs on the day the
175.17 participant received the first payment reflecting the change in income.

175.18 (c) The commissioner shall develop a redetermination form to redetermine eligibility
175.19 and a change report form to report changes that minimize paperwork for the county and
175.20 the participant.

175.21 Sec. 3. Minnesota Statutes 2014, section 119B.035, subdivision 4, is amended to read:

175.22 Subd. 4. **Assistance.** (a) A family is limited to a lifetime total of 12 months of
175.23 assistance under subdivision 2. The maximum rate of assistance is equal to 68 percent
175.24 of the rate established under section 119B.13 for care of infants in licensed family child
175.25 care in the applicant's county of residence.

175.26 (b) A participating family must report income and other family changes as specified in
175.27 sections 256P.06 and 256P.07, and the county's plan under section 119B.08, subdivision 3.

175.28 (c) Persons who are admitted to the at-home infant child care program retain their
175.29 position in any basic sliding fee program. Persons leaving the at-home infant child care
175.30 program reenter the basic sliding fee program at the position they would have occupied.

175.31 (d) Assistance under this section does not establish an employer-employee
175.32 relationship between any member of the assisted family and the county or state.

175.33 Sec. 4. Minnesota Statutes 2014, section 119B.09, subdivision 4, is amended to read:

176.1 Subd. 4. **Eligibility; annual income; calculation.** Annual income of the applicant
176.2 family is the current monthly income of the family multiplied by 12 or the income for
176.3 the 12-month period immediately preceding the date of application, or income calculated
176.4 by the method which provides the most accurate assessment of income available to the
176.5 family. Self-employment income must be calculated based on gross receipts less operating
176.6 expenses. Income must be recalculated when the family's income changes, but no less
176.7 often than every six months. For a family where at least one parent is under the age of
176.8 21, does not have a high school or general equivalency diploma, and is a student in a
176.9 school district or another similar program that provides or arranges for child care, as well
176.10 as parenting, social services, career and employment supports, and academic support to
176.11 achieve high school graduation, income must be recalculated when the family's income
176.12 changes, but otherwise shall be deferred beyond six months, but not to exceed 12 months,
176.13 to the end of the student's school year. Included lump sums counted as income under
176.14 section 256P.06, subdivision 3, must be annualized over 12 months. Income must be
176.15 verified with documentary evidence. If the applicant does not have sufficient evidence of
176.16 income, verification must be obtained from the source of the income.

176.17 Sec. 5. Minnesota Statutes 2014, section 256D.01, subdivision 1a, is amended to read:

176.18 Subd. 1a. **Standards.** (a) A principal objective in providing general assistance is
176.19 to provide for single adults, childless couples, or children as defined in section 256D.02,
176.20 subdivision 6, ineligible for federal programs who are unable to provide for themselves.
176.21 The minimum standard of assistance determines the total amount of the general assistance
176.22 grant without separate standards for shelter, utilities, or other needs.

176.23 (b) The commissioner shall set the standard of assistance for an assistance unit
176.24 consisting of an adult recipient who is childless and unmarried or living apart from
176.25 children and spouse and who does not live with a parent or parents or a legal custodian.
176.26 When the other standards specified in this subdivision increase, this standard must also be
176.27 increased by the same percentage.

176.28 (c) For an assistance unit consisting of a single adult who lives with a parent or
176.29 parents, the general assistance standard of assistance is the amount that the aid to families
176.30 with dependent children standard of assistance, in effect on July 16, 1996, would increase
176.31 if the recipient were added as an additional minor child to an assistance unit consisting
176.32 of the recipient's parent and all of that parent's family members, except that the standard
176.33 may not exceed the standard for a general assistance recipient living alone. Benefits
176.34 received by a responsible relative of the assistance unit under the Supplemental Security
176.35 Income program, a workers' compensation program, the Minnesota supplemental aid

177.1 program, or any other program based on the responsible relative's disability, and any
 177.2 benefits received by a responsible relative of the assistance unit under the Social Security
 177.3 retirement program, may not be counted in the determination of eligibility or benefit
 177.4 level for the assistance unit. Except as provided below, the assistance unit is ineligible
 177.5 for general assistance if the available resources or the countable income of the assistance
 177.6 unit and the parent or parents with whom the assistance unit lives are such that a family
 177.7 consisting of the assistance unit's parent or parents, the parent or parents' other family
 177.8 members and the assistance unit as the only or additional minor child would be financially
 177.9 ineligible for general assistance. For the purposes of calculating the countable income
 177.10 of the assistance unit's parent or parents, the calculation methods, ~~income deductions,~~
 177.11 ~~exclusions, and disregards used when calculating the countable income for a single adult~~
 177.12 ~~or childless couple must be used~~ follow the provisions under section 256P.06.

177.13 (d) For an assistance unit consisting of a childless couple, the standards of assistance
 177.14 are the same as the first and second adult standards of the aid to families with dependent
 177.15 children program in effect on July 16, 1996. If one member of the couple is not included
 177.16 in the general assistance grant, the standard of assistance for the other is the second adult
 177.17 standard of the aid to families with dependent children program as of July 16, 1996.

177.18 Sec. 6. Minnesota Statutes 2014, section 256D.02, is amended by adding a subdivision
 177.19 to read:

177.20 Subd. 1a. **Assistance unit.** "Assistance unit" means an individual who is, or an
 177.21 eligible married couple who live together who are, applying for or receiving benefits
 177.22 under this chapter.

177.23 Sec. 7. Minnesota Statutes 2014, section 256D.02, is amended by adding a subdivision
 177.24 to read:

177.25 Subd. 1b. **Cash assistance benefit.** "Cash assistance benefit" means any payment
 177.26 received as a disability benefit, including veterans or workers' compensation; old age,
 177.27 survivors, and disability insurance; railroad retirement benefits; unemployment benefits;
 177.28 and benefits under any federally aided categorical assistance program, Supplemental
 177.29 Security Income, or other assistance program.

177.30 Sec. 8. Minnesota Statutes 2014, section 256D.02, subdivision 8, is amended to read:

177.31 Subd. 8. **Income.** "Income" means any form of income, including remuneration
 177.32 for services performed as an employee and earned income from rental income and
 177.33 self-employment earnings as described under section 256P.05 earned income as defined

178.1 under section 256P.01, subdivision 3, and unearned income as defined under section
 178.2 256P.01, subdivision 8.

178.3 ~~Income includes any payments received as an annuity, retirement, or disability~~
 178.4 ~~benefit, including veteran's or workers' compensation; old age, survivors, and disability~~
 178.5 ~~insurance; railroad retirement benefits; unemployment benefits; and benefits under any~~
 178.6 ~~federally aided categorical assistance program, supplementary security income, or other~~
 178.7 ~~assistance program; rents, dividends, interest and royalties; and support and maintenance~~
 178.8 ~~payments. Such payments may not be considered as available to meet the needs of any~~
 178.9 ~~person other than the person for whose benefit they are received, unless that person is~~
 178.10 ~~a family member or a spouse and the income is not excluded under section 256D.01,~~
 178.11 ~~subdivision 1a. Goods and services provided in lieu of cash payment shall be excluded~~
 178.12 ~~from the definition of income, except that payments made for room, board, tuition or~~
 178.13 ~~fees by a parent, on behalf of a child enrolled as a full-time student in a postsecondary~~
 178.14 ~~institution, and payments made on behalf of an applicant or participant which the applicant~~
 178.15 ~~or participant could legally demand to receive personally in cash, must be included as~~
 178.16 ~~income. Benefits of an applicant or participant, such as those administered by the Social~~
 178.17 ~~Security Administration, that are paid to a representative payee, and are spent on behalf of~~
 178.18 ~~the applicant or participant, are considered available income of the applicant or participant.~~

178.19 Sec. 9. Minnesota Statutes 2014, section 256D.06, subdivision 1, is amended to read:

178.20 Subdivision 1. **Eligibility; amount of assistance.** General assistance shall be
 178.21 granted in an amount that when added to the ~~nonexempt~~ countable income as determined
 178.22 to be actually available to the assistance unit under section 256P.06, the total amount
 178.23 equals the applicable standard of assistance for general assistance. In determining
 178.24 eligibility for and the amount of assistance for an individual or married couple, the agency
 178.25 shall apply the earned income disregard as determined in section 256P.03.

178.26 Sec. 10. Minnesota Statutes 2014, section 256D.405, subdivision 3, is amended to read:

178.27 Subd. 3. **Reports.** Participants must report changes in circumstances according to
 178.28 section 256P.07 that affect eligibility or assistance payment amounts within ten days of the
 178.29 change. Participants who do not receive SSI because of excess income must complete a
 178.30 monthly report form if they have earned income, if they have income deemed to them
 178.31 from a financially responsible relative with whom the participant resides, or if they have
 178.32 income deemed to them by a sponsor. If the report form is not received before the end of
 178.33 the month in which it is due, the county agency must terminate assistance. The termination
 178.34 shall be effective on the first day of the month following the month in which the report

179.1 was due. If a complete report is received within the month the assistance was terminated,
179.2 the assistance unit is considered to have continued its application for assistance, effective
179.3 the first day of the month the assistance was terminated.

179.4 Sec. 11. Minnesota Statutes 2014, section 256I.03, is amended by adding a subdivision
179.5 to read:

179.6 Subd. 1b. **Assistance unit.** "Assistance unit" means an individual who is applying
179.7 for or receiving benefits under this chapter.

179.8 Sec. 12. Minnesota Statutes 2014, section 256I.03, subdivision 7, is amended to read:

179.9 Subd. 7. **Countable income.** "Countable income" means all income received by an
179.10 applicant or recipient as described under section 256P.06, less any applicable exclusions
179.11 or disregards. For a recipient of any cash benefit from the SSI program, countable income
179.12 means the SSI benefit limit in effect at the time the person is in a GRH, less the medical
179.13 assistance personal needs allowance. If the SSI limit has been reduced for a person due to
179.14 events occurring prior to the persons entering the GRH setting, countable income means
179.15 actual income less any applicable exclusions and disregards.

179.16 Sec. 13. Minnesota Statutes 2014, section 256I.04, subdivision 1, is amended to read:

179.17 Subdivision 1. **Individual eligibility requirements.** An individual is eligible for
179.18 and entitled to a group residential housing payment to be made on the individual's behalf
179.19 if the agency has approved the individual's residence in a group residential housing setting
179.20 and the individual meets the requirements in paragraph (a) or (b).

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

179.30 (b) The individual meets a category of eligibility under section 256D.05, subdivision
179.31 1, paragraph (a), and the individual's resources are less than the standards specified by
179.32 section 256P.02, and the individual's countable income as determined under ~~sections~~
179.33 ~~256D.01 to 256D.21~~ section 256P.06, less the medical assistance personal needs allowance

180.1 under section 256B.35 is less than the monthly rate specified in the agency's agreement
180.2 with the provider of group residential housing in which the individual resides.

180.3 Sec. 14. Minnesota Statutes 2014, section 256I.06, subdivision 6, is amended to read:

180.4 Subd. 6. **Reports.** Recipients must report changes in circumstances according
180.5 to section 256P.07 that affect eligibility or group residential housing payment amounts
180.6 within ten days of the change. Recipients with countable earned income must complete
180.7 a monthly household report form. If the report form is not received before the end of
180.8 the month in which it is due, the county agency must terminate eligibility for group
180.9 residential housing payments. The termination shall be effective on the first day of the
180.10 month following the month in which the report was due. If a complete report is received
180.11 within the month eligibility was terminated, the individual is considered to have continued
180.12 an application for group residential housing payment effective the first day of the month
180.13 the eligibility was terminated.

180.14 Sec. 15. Minnesota Statutes 2014, section 256J.08, subdivision 26, is amended to read:

180.15 Subd. 26. **Earned income.** "~~Earned income~~" ~~means cash or in-kind income earned~~
180.16 ~~through the receipt of wages, salary, commissions, profit from employment activities, net~~
180.17 ~~profit from self-employment activities, payments made by an employer for regularly~~
180.18 ~~accrued vacation or sick leave, and any other profit from activity earned through effort or~~
180.19 ~~labor. The income must be in return for, or as a result of, legal activity~~ has the meaning
180.20 given in section 256P.01, subdivision 3.

180.21 Sec. 16. Minnesota Statutes 2014, section 256J.08, subdivision 86, is amended to read:

180.22 Subd. 86. **Unearned income.** "~~Unearned income~~" ~~means income received by~~
180.23 ~~a person that does not meet the definition of earned income. Unearned income includes~~
180.24 ~~income from a contract for deed, interest, dividends, unemployment benefits, disability~~
180.25 ~~insurance payments, veterans benefits, pension payments, return on capital investment,~~
180.26 ~~insurance payments or settlements, severance payments, child support and maintenance~~
180.27 ~~payments, and payments for illness or disability whether the premium payments are~~
180.28 ~~made in whole or in part by an employer or participant~~ has the meaning given in section
180.29 256P.01, subdivision 8.

180.30 Sec. 17. Minnesota Statutes 2014, section 256J.30, subdivision 1, is amended to read:

180.31 Subdivision 1. **Applicant reporting requirements.** An applicant must provide
180.32 information on an application form and supplemental forms about the applicant's

181.1 circumstances which affect MFIP eligibility or the assistance payment. An applicant must
 181.2 report changes identified in subdivision 9 while the application is pending. When an
 181.3 applicant does not accurately report information on an application, both an overpayment
 181.4 and a referral for a fraud investigation may result. When an applicant does not provide
 181.5 information or documentation, the receipt of the assistance payment may be delayed or the
 181.6 application may be denied depending on the type of information required and its effect on
 181.7 eligibility according to section 256P.07.

181.8 Sec. 18. Minnesota Statutes 2014, section 256J.30, subdivision 9, is amended to read:

181.9 Subd. 9. **Changes that must be reported.** A caregiver must report the changes or
 181.10 anticipated changes specified in clauses (1) to (15) within ten days of the date they occur,
 181.11 at the time of the periodic recertification of eligibility under section 256P.04, subdivisions
 181.12 8 and 9, or within eight calendar days of a reporting period as in subdivision 5, whichever
 181.13 occurs first. A caregiver must report other changes at the time of the periodic recertification
 181.14 of eligibility under section 256P.04, subdivisions 8 and 9, or at the end of a reporting period
 181.15 under subdivision 5, as applicable. A caregiver must make these reports in writing to the
 181.16 agency. When an agency could have reduced or terminated assistance for one or more
 181.17 payment months if a delay in reporting a change specified under clauses (1) to (14) had
 181.18 not occurred, the agency must determine whether a timely notice under section 256J.31,
 181.19 subdivision 4, could have been issued on the day that the change occurred. When a timely
 181.20 notice could have been issued, each month's overpayment subsequent to that notice must be
 181.21 considered a client error overpayment under section 256J.38. Calculation of overpayments
 181.22 for late reporting under clause (15) is specified in section 256J.09, subdivision 9. Changes
 181.23 in circumstances which must be reported within ten days must also be reported on the
 181.24 MFIP household report form for the reporting period in which those changes occurred.
 181.25 Within ten days, a caregiver must report: changes as specified under section 256P.07.

181.26 (1) a change in initial employment;

181.27 (2) a change in initial receipt of unearned income;

181.28 (3) a recurring change in unearned income;

181.29 (4) a nonrecurring change of unearned income that exceeds \$30;

181.30 (5) the receipt of a lump sum;

181.31 (6) an increase in assets that may cause the assistance unit to exceed asset limits;

181.32 (7) a change in the physical or mental status of an incapacitated member of the

181.33 assistance unit if the physical or mental status is the basis for reducing the hourly

181.34 participation requirements under section 256J.55, subdivision 1, or the type of activities

181.35 included in an employment plan under section 256J.521, subdivision 2;

- 182.1 ~~(8) a change in employment status;~~
 182.2 ~~(9) the marriage or divorce of an assistance unit member;~~
 182.3 ~~(10) the death of a parent, minor child, or financially responsible person;~~
 182.4 ~~(11) a change in address or living quarters of the assistance unit;~~
 182.5 ~~(12) the sale, purchase, or other transfer of property;~~
 182.6 ~~(13) a change in school attendance of a caregiver under age 20 or an employed child;~~
 182.7 ~~(14) filing a lawsuit, a workers' compensation claim, or a monetary claim against a~~
 182.8 ~~third party; and~~
 182.9 ~~(15) a change in household composition, including births, returns to and departures~~
 182.10 ~~from the home of assistance unit members and financially responsible persons, or a change~~
 182.11 ~~in the custody of a minor child.~~

182.12 Sec. 19. Minnesota Statutes 2014, section 256J.35, is amended to read:

182.13 **256J.35 AMOUNT OF ASSISTANCE PAYMENT.**

182.14 Except as provided in paragraphs (a) to (d), the amount of an assistance payment is
 182.15 equal to the difference between the MFIP standard of need or the Minnesota family wage
 182.16 level in section 256J.24 and countable income.

182.17 (a) Beginning July 1, 2015, MFIP assistance units are eligible for an MFIP housing
 182.18 assistance grant of \$110 per month, unless:

182.19 (1) the housing assistance unit is currently receiving public and assisted rental
 182.20 subsidies provided through the Department of Housing and Urban Development (HUD)
 182.21 and is subject to section 256J.37, subdivision 3a; or

182.22 (2) the assistance unit is a child-only case under section 256J.88.

182.23 (b) When MFIP eligibility exists for the month of application, the amount of the
 182.24 assistance payment for the month of application must be prorated from the date of
 182.25 application or the date all other eligibility factors are met for that applicant, whichever is
 182.26 later. This provision applies when an applicant loses at least one day of MFIP eligibility.

182.27 (c) MFIP overpayments to an assistance unit must be recouped according to section
 182.28 ~~256J.38, subdivision 4~~ 256P.08, subdivision 6.

182.29 (d) An initial assistance payment must not be made to an applicant who is not
 182.30 eligible on the date payment is made.

182.31 Sec. 20. Minnesota Statutes 2014, section 256J.40, is amended to read:

182.32 **256J.40 FAIR HEARINGS.**

182.33 Caregivers receiving a notice of intent to sanction or a notice of adverse action that
 182.34 includes a sanction, reduction in benefits, suspension of benefits, denial of benefits, or

183.1 termination of benefits may request a fair hearing. A request for a fair hearing must be
183.2 submitted in writing to the county agency or to the commissioner and must be mailed
183.3 within 30 days after a participant or former participant receives written notice of the
183.4 agency's action or within 90 days when a participant or former participant shows good
183.5 cause for not submitting the request within 30 days. A former participant who receives a
183.6 notice of adverse action due to an overpayment may appeal the adverse action according
183.7 to the requirements in this section. Issues that may be appealed are:

- 183.8 (1) the amount of the assistance payment;
- 183.9 (2) a suspension, reduction, denial, or termination of assistance;
- 183.10 (3) the basis for an overpayment, the calculated amount of an overpayment, and
183.11 the level of recoupment;
- 183.12 (4) the eligibility for an assistance payment; and
- 183.13 (5) the use of protective or vendor payments under section 256J.39, subdivision 2,
183.14 clauses (1) to (3).

183.15 Except for benefits issued under section 256J.95, a county agency must not reduce,
183.16 suspend, or terminate payment when an aggrieved participant requests a fair hearing
183.17 prior to the effective date of the adverse action or within ten days of the mailing of the
183.18 notice of adverse action, whichever is later, unless the participant requests in writing not
183.19 to receive continued assistance pending a hearing decision. An appeal request cannot
183.20 extend benefits for the diversionary work program under section 256J.95 beyond the
183.21 four-month time limit. Assistance issued pending a fair hearing is subject to recovery
183.22 under section ~~256J.38~~ 256P.08 when as a result of the fair hearing decision the participant
183.23 is determined ineligible for assistance or the amount of the assistance received. A county
183.24 agency may increase or reduce an assistance payment while an appeal is pending when the
183.25 circumstances of the participant change and are not related to the issue on appeal. The
183.26 commissioner's order is binding on a county agency. No additional notice is required to
183.27 enforce the commissioner's order.

183.28 A county agency shall reimburse appellants for reasonable and necessary expenses
183.29 of attendance at the hearing, such as child care and transportation costs and for the
183.30 transportation expenses of the appellant's witnesses and representatives to and from the
183.31 hearing. Reasonable and necessary expenses do not include legal fees. Fair hearings
183.32 must be conducted at a reasonable time and date by an impartial human services judge
183.33 employed by the department. The hearing may be conducted by telephone or at a site that
183.34 is readily accessible to persons with disabilities.

183.35 The appellant may introduce new or additional evidence relevant to the issues on
183.36 appeal. Recommendations of the human services judge and decisions of the commissioner

184.1 must be based on evidence in the hearing record and are not limited to a review of the
184.2 county agency action.

184.3 Sec. 21. Minnesota Statutes 2014, section 256J.95, subdivision 19, is amended to read:

184.4 Subd. 19. **DWP overpayments and underpayments.** DWP benefits are subject
184.5 to overpayments and underpayments. Anytime an overpayment or an underpayment is
184.6 determined for DWP, the correction shall be calculated using prospective budgeting.
184.7 Corrections shall be determined based on the policy in section 256J.34, subdivision 1,
184.8 paragraphs (a), (b), and (c). ATM errors must be recovered as specified in section ~~256J.38,~~
184.9 ~~subdivision 5~~ 256P.08, subdivision 7. Cross program recoupment of overpayments cannot
184.10 be assigned to or from DWP.

184.11 Sec. 22. Minnesota Statutes 2014, section 256P.001, is amended to read:

184.12 **256P.001 APPLICABILITY.**

184.13 General assistance and Minnesota supplemental aid under chapter 256D, child care
184.14 assistance programs under chapter 119B, and programs governed by chapter 256I or 256J
184.15 are subject to the requirements of this chapter, unless otherwise specified or exempted.

184.16 Sec. 23. Minnesota Statutes 2014, section 256P.01, is amended by adding a subdivision
184.17 to read:

184.18 Subd. 2a. **Assistance unit.** "Assistance unit" is defined by program area under
184.19 sections 119B.011, subdivision 13; 256D.02, subdivision 1a; 256D.35, subdivision 3a;
184.20 256I.03, subdivision 1b; and 256J.08, subdivision 7.

184.21 Sec. 24. Minnesota Statutes 2014, section 256P.01, subdivision 3, is amended to read:

184.22 Subd. 3. **Earned income.** "Earned income" means cash or in-kind income earned
184.23 through the receipt of wages, salary, commissions, bonuses, tips, gratuities, profit from
184.24 employment activities, net profit from self-employment activities, payments made by
184.25 an employer for regularly accrued vacation or sick leave, ~~and any~~ severance pay based
184.26 on accrued leave time, payments from training programs at a rate at or greater than the
184.27 state's minimum wage, royalties, honoraria, or other profit from activity earned through
184.28 effort that results from the client's work, service, effort, or labor. The income must be in
184.29 return for, or as a result of, legal activity.

184.30 Sec. 25. Minnesota Statutes 2014, section 256P.01, is amended by adding a subdivision
184.31 to read:

185.1 Subd. 8. **Unearned income.** "Unearned income" has the meaning given in section
185.2 256P.06, subdivision 3, clause (2).

185.3 Sec. 26. Minnesota Statutes 2014, section 256P.02, is amended by adding a subdivision
185.4 to read:

185.5 Subd. 1a. **Exemption.** Participants who qualify for child care assistance programs
185.6 under chapter 119B are exempt from this section.

185.7 Sec. 27. Minnesota Statutes 2014, section 256P.03, subdivision 1, is amended to read:

185.8 Subdivision 1. **Exempted programs.** Participants who qualify for child care
185.9 assistance programs under chapter 119B, Minnesota supplemental aid under chapter
185.10 256D₂ and for group residential housing under chapter 256I on the basis of eligibility for
185.11 Supplemental Security Income are exempt from this section.

185.12 Sec. 28. Minnesota Statutes 2014, section 256P.04, subdivision 1, is amended to read:

185.13 Subdivision 1. **Exemption.** Participants who receive Minnesota supplemental aid
185.14 and who maintain Supplemental Security Income eligibility under chapters 256D and 256I
185.15 are exempt from the reporting requirements of this section, except that the policies and
185.16 procedures for transfers of assets are those used by the medical assistance program under
185.17 section 256B.0595. Participants who receive child care assistance under chapter 119B are
185.18 exempt from the requirements of this section.

185.19 Sec. 29. Minnesota Statutes 2014, section 256P.04, subdivision 4, is amended to read:

185.20 Subd. 4. **Factors to be verified.** (a) The agency shall verify the following at
185.21 application:

185.22 (1) identity of adults;

185.23 (2) age, if necessary to determine eligibility;

185.24 (3) immigration status;

185.25 (4) income;

185.26 (5) spousal support and child support payments made to persons outside the
185.27 household;

185.28 (6) vehicles;

185.29 (7) checking and savings accounts;

185.30 (8) inconsistent information, if related to eligibility;

185.31 (9) residence; ~~and~~

185.32 (10) Social Security number; and

186.1 (11) use of nonrecurring income under section 256P.06, subdivision 3, clause (2),
186.2 item (ix), for the intended purpose for which it was given and received.

186.3 (b) Applicants who are qualified noncitizens and victims of domestic violence as
186.4 defined under section 256J.08, subdivision 73, clause (7), are not required to verify the
186.5 information in paragraph (a), clause (10). When a Social Security number is not provided
186.6 to the agency for verification, this requirement is satisfied when each member of the
186.7 assistance unit cooperates with the procedures for verification of Social Security numbers,
186.8 issuance of duplicate cards, and issuance of new numbers which have been established
186.9 jointly between the Social Security Administration and the commissioner.

186.10 Sec. 30. Minnesota Statutes 2014, section 256P.05, subdivision 1, is amended to read:

186.11 Subdivision 1. **Exempted programs.** Participants who qualify for child care
186.12 assistance programs under chapter 119B, Minnesota supplemental aid under chapter
186.13 256D₂ and for group residential housing under chapter 256I on the basis of eligibility for
186.14 Supplemental Security Income are exempt from this section.

186.15 Sec. 31. **[256P.06] INCOME CALCULATIONS.**

186.16 Subdivision 1. **Reporting of income.** To determine eligibility, the county agency
186.17 must evaluate income received by members of the assistance unit, or by other persons
186.18 whose income is considered available to the assistance unit, and only count income that
186.19 is available to the assistance unit. Income is available if the individual has legal access
186.20 to the income.

186.21 Subd. 2. **Exempted individuals.** The following members of an assistance unit
186.22 under chapters 119B and 256J are exempt from having their earned income count towards
186.23 the income of an assistance unit:

186.24 (1) children under six years old;

186.25 (2) caregivers under 20 years of age enrolled at least half-time in school; and

186.26 (3) minors enrolled in school full time.

186.27 Subd. 3. **Income inclusions.** The following must be included in determining the
186.28 income of an assistance unit:

186.29 (1) earned income; and

186.30 (2) unearned income, which includes:

186.31 (i) interest and dividends from investments and savings;

186.32 (ii) capital gains as defined by the Internal Revenue Service from any sale of real
186.33 property;

- 187.1 (iii) proceeds from rent and contract for deed payments in excess of the principal
 187.2 and interest portion owed on property;
 187.3 (iv) income from trusts, excluding special needs and supplemental needs trusts;
 187.4 (v) interest income from loans made by the participant or household;
 187.5 (vi) cash prizes and winnings;
 187.6 (vii) unemployment insurance income;
 187.7 (viii) retirement, survivors, and disability insurance payments;
 187.8 (ix) nonrecurring income over \$60 per quarter unless earmarked and used for the
 187.9 purpose for which it is intended. Income and use of this income is subject to verification
 187.10 requirements under section 256P.04;
 187.11 (x) retirement benefits;
 187.12 (xi) cash assistance benefits, as defined by each program in chapters 119B, 256D,
 187.13 256I, and 256J;
 187.14 (xii) tribal per capita payments unless excluded by federal and state law;
 187.15 (xiii) income and payments from service and rehabilitation programs that meet
 187.16 or exceed the state's minimum wage rate;
 187.17 (xiv) income from members of the United States armed forces unless excluded from
 187.18 income taxes according to federal or state law;
 187.19 (xv) all child support payments for programs under chapters 119B, 256D, and 256I;
 187.20 (xvi) the amount of current child support received that exceeds \$100 for assistance
 187.21 units with one child and \$200 for assistance units with two or more children for programs
 187.22 under chapter 256J; and
 187.23 (xvii) spousal support.

187.24 **Sec. 32. [256P.07] REPORTING OF INCOME AND CHANGES.**

187.25 Subdivision 1. **Exempted programs.** Participants who qualify for Minnesota
 187.26 supplemental aid under chapter 256D and for group residential housing under chapter 256I
 187.27 on the basis of eligibility for Supplemental Security Income are exempt from this section.

187.28 Subd. 2. **Reporting requirements.** An applicant or participant must provide
 187.29 information on an application and any subsequent reporting forms about the assistance
 187.30 unit's circumstances that affect eligibility or benefits. An applicant or assistance unit must
 187.31 report changes identified in subdivision 3. When information is not accurately reported,
 187.32 both an overpayment and a referral for a fraud investigation may result. When information
 187.33 or documentation is not provided, the receipt of any benefit may be delayed or denied,
 187.34 depending on the type of information required and its effect on eligibility.

188.1 Subd. 3. **Changes that must be reported.** An assistance unit must report the
 188.2 changes or anticipated changes specified in clauses (1) to (12) within ten days of the date
 188.3 they occur, at the time of recertification of eligibility under section 256P.04, subdivisions
 188.4 8 and 9, or within eight calendar days of a reporting period, whichever occurs first. An
 188.5 assistance unit must report other changes at the time of recertification of eligibility under
 188.6 section 256P.04, subdivisions 8 and 9, or at the end of a reporting period, as applicable.
 188.7 When an agency could have reduced or terminated assistance for one or more payment
 188.8 months if a delay in reporting a change specified under clauses (1) to (12) had not occurred,
 188.9 the agency must determine whether a timely notice could have been issued on the day
 188.10 that the change occurred. When a timely notice could have been issued, each month's
 188.11 overpayment subsequent to that notice must be considered a client error overpayment
 188.12 under section 119B.11, subdivision 2a, or 256P.08. Changes in circumstances that must
 188.13 be reported within ten days must also be reported for the reporting period in which those
 188.14 changes occurred. Within ten days, an assistance unit must report:

- 188.15 (1) a change in earned income of \$100 per month or greater;
- 188.16 (2) a change in unearned income of \$50 per month or greater;
- 188.17 (3) a change in employment status and hours;
- 188.18 (4) a change in address or residence;
- 188.19 (5) a change in household composition with the exception of programs under
 188.20 chapter 256I;
- 188.21 (6) a receipt of a lump-sum payment;
- 188.22 (7) an increase in assets if over \$9,000 with the exception of programs under chapter
 188.23 119B;
- 188.24 (8) a change in citizenship or immigration status;
- 188.25 (9) a change in family status with the exception of programs under chapter 256I;
- 188.26 (10) a change in disability status of a unit member, with the exception of programs
 188.27 under chapter 119B;
- 188.28 (11) a new rent subsidy or a change in rent subsidy; and
- 188.29 (12) a sale, purchase, or transfer of real property.

188.30 Subd. 4. **MFIP-specific reporting.** In addition to subdivision 3, an assistance unit
 188.31 under chapter 256J, within ten days of the change, must report:

- 188.32 (1) a pregnancy not resulting in birth when there are no other minor children; and
- 188.33 (2) a change in school attendance of a parent under 20 years of age or of an
 188.34 employed child.

189.1 Subd. 5. **DWP-specific reporting.** In addition to subdivisions 3 and 4, an assistance
189.2 unit participating in the diversionary work program under section 256J.95 must report
189.3 on an application:

189.4 (1) shelter expenses; and

189.5 (2) utility expenses.

189.6 Subd. 6. **Child care assistance programs-specific reporting.** In addition to
189.7 subdivision 3, an assistance unit under chapter 119B, within ten days of the change, must
189.8 report:

189.9 (1) a change in a parentally responsible individual's visitation schedule or custody
189.10 arrangement for any child receiving child care assistance program benefits; and

189.11 (2) a change in authorized activity status.

189.12 Subd. 7. **Minnesota supplemental aid-specific reporting.** In addition to
189.13 subdivision 3, an assistance unit participating in the Minnesota supplemental aid program
189.14 under section 256D.44, subdivision 5, paragraph (f), within ten days of the change, must
189.15 report shelter expenses.

189.16 Sec. 33. **[256P.08] CORRECTION OF OVERPAYMENTS AND**
189.17 **UNDERPAYMENTS.**

189.18 Subdivision 1. **Exempted programs.** Participants who qualify for child care
189.19 assistance programs under chapter 119B or group residential housing under chapter 256I
189.20 are exempt from this section.

189.21 Subd. 2. **Scope of overpayment.** (a) When a participant or former participant
189.22 receives an overpayment due to client or ATM error, or due to assistance received while
189.23 an appeal is pending and the participant or former participant is determined ineligible
189.24 for assistance or for less assistance than was received, except as provided for interim
189.25 assistance in section 256D.06, subdivision 5, the county agency must recoup or recover
189.26 the overpayment using the following methods:

189.27 (1) reconstruct each affected budget month and corresponding payment month;

189.28 (2) use the policies and procedures that were in effect for the payment month; and

189.29 (3) do not allow employment disregards in the calculation of the overpayment when
189.30 the unit has not reported within two calendar months following the end of the month in
189.31 which the income was received.

189.32 (b) Establishment of an overpayment is limited to six years prior to the month of
189.33 discovery due to client error or an intentional program violation determined under section
189.34 256.046.

190.1 (c) A participant or former participant is not responsible for overpayments due to
190.2 agency error, unless the amount of the overpayment is large enough that a reasonable
190.3 person would know it is an error.

190.4 Subd. 3. **Notice of overpayment.** When a county agency discovers that a participant
190.5 or former participant has received an overpayment for one or more months, the county
190.6 agency must notify the participant or former participant of the overpayment in writing.
190.7 A notice of overpayment must specify the reason for the overpayment, the authority for
190.8 citing the overpayment, the time period in which the overpayment occurred, the amount of
190.9 the overpayment, and the participant's or former participant's right to appeal. No limit
190.10 applies to the period in which the county agency is required to recoup or recover an
190.11 overpayment according to subdivisions 4, 5, and 6.

190.12 Subd. 4. **Recovering general assistance and Minnesota supplemental aid**
190.13 **overpayments.** (a) If an amount of assistance is paid to an assistance unit in excess of the
190.14 payment due, it shall be recoverable by the agency. The agency shall give written notice to
190.15 the participant of its intention to recover the overpayment.

190.16 (b) If the individual is no longer receiving assistance, the agency may request
190.17 voluntary repayment or pursue civil recovery.

190.18 (c) If the individual is receiving assistance, except as provided for interim assistance
190.19 in section 256D.06, subdivision 5, when an overpayment occurs the agency shall recover
190.20 the overpayment by withholding an amount equal to:

190.21 (1) three percent of the assistance unit's standard of need for all Minnesota
190.22 supplemental aid assistance units, and nonfraud cases for general assistance; and

190.23 (2) ten percent where fraud has occurred in general assistance cases; or

190.24 (3) the amount of the monthly general assistance or Minnesota supplemental aid
190.25 payment, whichever is less.

190.26 (d) In cases when there is both an overpayment and underpayment, the county
190.27 agency shall offset one against the other in correcting the payment.

190.28 (e) Overpayments may also be voluntarily repaid, in part or in full, by the individual,
190.29 in addition to the assistance reductions provided in this subdivision, to include further
190.30 voluntary reductions in the grant level agreed to in writing by the individual, until the
190.31 total amount of the overpayment is repaid.

190.32 (f) The county agency shall make reasonable efforts to recover overpayments to
190.33 individuals no longer on assistance. The agency need not attempt to recover overpayments
190.34 of less than \$35 paid to an individual no longer on assistance if the individual does not
190.35 receive assistance again within three years, unless the individual has been convicted of
190.36 violating section 256.98.

191.1 (g) Establishment of an overpayment is limited to 12 months prior to the month of
191.2 discovery due to agency error and six years prior to the month of discovery due to client
191.3 error or an intentional program violation determined under section 256.046.

191.4 (h) Residents of licensed residential facilities shall not have overpayments recovered
191.5 from their personal needs allowance.

191.6 (i) Overpayments by another maintenance benefit program shall not be recovered
191.7 from the general assistance or Minnesota supplemental aid grant.

191.8 Subd. 5. **Recovering MFIP overpayments.** A county agency must initiate efforts
191.9 to recover overpayments paid to a former participant or caregiver. Caregivers, both
191.10 parental and nonparental, and minor caregivers of an assistance unit at the time an
191.11 overpayment occurs, whether receiving assistance or not, are jointly and individually
191.12 liable for repayment of the overpayment. The county agency must request repayment
191.13 from the former participants and caregivers. When an agreement for repayment is
191.14 not completed within six months of the date of discovery or when there is a default on
191.15 an agreement for repayment after six months, the county agency must initiate recovery
191.16 consistent with chapter 270A or section 541.05. When a person has been disqualified
191.17 or convicted of fraud under section 256.98, recovery must be sought regardless of the
191.18 amount of overpayment. When an overpayment is less than \$35, and is not the result of a
191.19 fraud conviction under section 256.98, the county agency must not seek recovery under
191.20 this subdivision. The county agency must retain information about all overpayments
191.21 regardless of the amount. When an adult, adult caregiver, or minor caregiver reapplies for
191.22 assistance, the overpayment must be recouped under subdivision 6.

191.23 Subd. 6. **Recouping overpayments from MFIP participants.** A participant may
191.24 voluntarily repay, in part or in full, an overpayment even if assistance is reduced under this
191.25 subdivision, until the total amount of the overpayment is repaid. When an overpayment
191.26 occurs due to fraud, the county agency must recover from the overpaid assistance unit,
191.27 including child-only cases, ten percent of the applicable standard or the amount of the
191.28 monthly assistance payment, whichever is less. When a nonfraud overpayment occurs,
191.29 the county agency must recover from the overpaid assistance unit, including child-only
191.30 cases, three percent of the MFIP standard of need or the amount of the monthly assistance
191.31 payment, whichever is less.

191.32 Subd. 7. **Recovering automatic teller machine errors.** For recipients receiving
191.33 benefits by electronic benefit transfer, if the overpayment is a result of an ATM dispensing
191.34 funds in error to the recipient, the agency may recover the ATM error by immediately
191.35 withdrawing funds from the recipient's electronic benefit transfer account, up to the
191.36 amount of the error.

192.1 Subd. 8. **Scope of underpayments.** A county agency must issue a corrective
192.2 payment for underpayments made to a participant or to a person who would be a
192.3 participant if an agency or client error causing the underpayment had not occurred.
192.4 Corrective payments are limited to 12 months prior to the month of discovery. The county
192.5 agency must issue the corrective payment according to subdivision 10.

192.6 Subd. 9. **Identifying the underpayment.** An underpayment may be identified by
192.7 a county agency, participant, former participant, or person who would be a participant
192.8 except for agency or client error.

192.9 Subd. 10. **Issuing corrective payments.** A county agency must correct an
192.10 underpayment within seven calendar days after the underpayment has been identified,
192.11 by adding the corrective payment amount to the monthly assistance payment of the
192.12 participant, issuing a separate payment to a participant or former participant, or reducing
192.13 an existing overpayment balance. When an underpayment occurs in a payment month
192.14 and is not identified until the next payment month or later, the county agency must first
192.15 subtract the underpayment from any overpayment balance before issuing the corrective
192.16 payment. The county agency must not apply an underpayment in a current payment month
192.17 against an overpayment balance. When an underpayment in the current payment month
192.18 is identified, the corrective payment must be issued within seven calendar days after the
192.19 underpayment is identified. Corrective payments must be excluded when determining the
192.20 applicant's or participant's income and resources for the month of payment. The county
192.21 agency must correct underpayments using the following methods:

- 192.22 (1) reconstruct each affected budget month and corresponding payment month; and
192.23 (2) use the policies and procedures that were in effect for the payment month.

192.24 Subd. 11. **Appeals.** A participant may appeal an underpayment, an overpayment,
192.25 and a reduction in an assistance payment made to recoup the overpayment under
192.26 subdivisions 4 and 6. The participant's appeal of each issue must be timely under section
192.27 256.045. When an appeal based on the notice issued under subdivision 3 is not timely, the
192.28 fact or the amount of that overpayment must not be considered as a part of a later appeal,
192.29 including an appeal of a reduction in an assistance payment to recoup that overpayment.

192.30 Sec. 34. **REPEALER.**

192.31 (a) Minnesota Statutes 2014, sections 256D.0513; 256D.06, subdivision 8; 256D.09,
192.32 subdivision 6; 256D.49; and 256J.38, are repealed.

192.33 (b) Minnesota Rules, part 3400.0170, subparts 5, 6, 12, and 13, are repealed.

192.34 Sec. 35. **EFFECTIVE DATE.**

193.1 This article is effective August 1, 2016.

193.2 **ARTICLE 6**

193.3 **NURSING FACILITY PAYMENT REFORM AND WORKFORCE**
193.4 **DEVELOPMENT**

193.5 Section 1. **[144.1503] HOME AND COMMUNITY-BASED SERVICES**
193.6 **EMPLOYEE SCHOLARSHIP PROGRAM.**

193.7 Subdivision 1. **Creation.** The home and community-based services employee
193.8 scholarship grant program is established for the purpose of assisting qualified provider
193.9 applicants to fund employee scholarships for education in nursing and other health care
193.10 fields.

193.11 Subd. 2. **Provision of grants.** The commissioner shall make grants available
193.12 to qualified providers of older adult services. Grants must be used by home and
193.13 community-based service providers to recruit and train staff through the establishment of
193.14 an employee scholarship fund.

193.15 Subd. 3. **Eligibility.** (a) Eligible providers must primarily provide services to
193.16 individuals who are 65 years of age and older in home and community-based settings,
193.17 including housing with services establishments as defined in section 144D.01, subdivision
193.18 4; adult day care as defined in section 245A.02, subdivision 2a; and home care services as
193.19 defined in section 144A.43, subdivision 3.

193.20 (b) Qualifying providers must establish a home and community-based services
193.21 employee scholarship program, as specified in subdivision 4. Providers that receive
193.22 funding under this section must use the funds to award scholarships to employees who
193.23 work an average of at least 16 hours per week for the provider.

193.24 Subd. 4. **Home and community-based services employee scholarship program.**
193.25 Each qualifying provider under this section must propose a home and community-based
193.26 services employee scholarship program. Providers must establish criteria by which
193.27 funds are to be distributed among employees. At a minimum, the scholarship program
193.28 must cover employee costs related to a course of study that is expected to lead to career
193.29 advancement with the provider or in the field of long-term care, including home care,
193.30 care of persons with disabilities, or nursing.

193.31 Subd. 5. **Participating providers.** The commissioner shall publish a request for
193.32 proposals in the State Register, specifying provider eligibility requirements, criteria for
193.33 a qualifying employee scholarship program, provider selection criteria, documentation
193.34 required for program participation, maximum award amount, and methods of evaluation.

194.1 The commissioner must publish additional requests for proposals each year in which
194.2 funding is available for this purpose.

194.3 Subd. 6. **Application requirements.** Eligible providers seeking a grant shall submit
194.4 an application to the commissioner. Applications must contain a complete description of
194.5 the employee scholarship program being proposed by the applicant, including the need for
194.6 the organization to enhance the education of its workforce, the process for determining
194.7 which employees will be eligible for scholarships, any other sources of funding for
194.8 scholarships, the expected degrees or credentials eligible for scholarships, the amount of
194.9 funding sought for the scholarship program, a proposed budget detailing how funds will
194.10 be spent, and plans for retaining eligible employees after completion of their scholarship.

194.11 Subd. 7. **Selection process.** The commissioner shall determine a maximum
194.12 award for grants and make grant selections based on the information provided in the
194.13 grant application, including the demonstrated need for an applicant provider to enhance
194.14 the education of its workforce, the proposed employee scholarship selection process,
194.15 the applicant's proposed budget, and other criteria as determined by the commissioner.
194.16 Notwithstanding any law or rule to the contrary, funds awarded to grantees in a grant
194.17 agreement do not lapse until the grant agreement expires.

194.18 Subd. 8. **Reporting requirements.** Participating providers shall submit an invoice
194.19 for reimbursement and a report to the commissioner on a schedule determined by the
194.20 commissioner and on a form supplied by the commissioner. The report shall include
194.21 the amount spent on scholarships; the number of employees who received scholarships;
194.22 and, for each scholarship recipient, the name of the recipient, the current position of
194.23 the recipient, the amount awarded, the educational institution attended, the nature of
194.24 the educational program, and the expected or actual program completion date. During
194.25 the grant period, the commissioner may require and collect from grant recipients other
194.26 information necessary to evaluate the program.

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

194.28 Subd. 4a. **Exceptions for replacement beds.** It is in the best interest of the state
194.29 to ensure that nursing homes and boarding care homes continue to meet the physical
194.30 plant licensing and certification requirements by permitting certain construction projects.
194.31 Facilities should be maintained in condition to satisfy the physical and emotional needs
194.32 of residents while allowing the state to maintain control over nursing home expenditure
194.33 growth.

195.1 The commissioner of health in coordination with the commissioner of human
195.2 services, may approve the renovation, replacement, upgrading, or relocation of a nursing
195.3 home or boarding care home, under the following conditions:

195.4 (a) to license or certify beds in a new facility constructed to replace a facility or to
195.5 make repairs in an existing facility that was destroyed or damaged after June 30, 1987, by
195.6 fire, lightning, or other hazard provided:

195.7 (i) destruction was not caused by the intentional act of or at the direction of a
195.8 controlling person of the facility;

195.9 (ii) at the time the facility was destroyed or damaged the controlling persons of the
195.10 facility maintained insurance coverage for the type of hazard that occurred in an amount
195.11 that a reasonable person would conclude was adequate;

195.12 (iii) the net proceeds from an insurance settlement for the damages caused by the
195.13 hazard are applied to the cost of the new facility or repairs;

195.14 (iv) the number of licensed and certified beds in the new facility does not exceed the
195.15 number of licensed and certified beds in the destroyed facility; and

195.16 (v) the commissioner determines that the replacement beds are needed to prevent an
195.17 inadequate supply of beds.

195.18 Project construction costs incurred for repairs authorized under this clause shall not be
195.19 considered in the dollar threshold amount defined in subdivision 2;

195.20 (b) to license or certify beds that are moved from one location to another within a
195.21 nursing home facility, provided the total costs of remodeling performed in conjunction
195.22 with the relocation of beds does not exceed \$1,000,000;

195.23 (c) to license or certify beds in a project recommended for approval under section
195.24 144A.073;

195.25 (d) to license or certify beds that are moved from an existing state nursing home to
195.26 a different state facility, provided there is no net increase in the number of state nursing
195.27 home beds;

195.28 (e) to certify and license as nursing home beds boarding care beds in a certified
195.29 boarding care facility if the beds meet the standards for nursing home licensure, or in a
195.30 facility that was granted an exception to the moratorium under section 144A.073, and if
195.31 the cost of any remodeling of the facility does not exceed \$1,000,000. If boarding care
195.32 beds are licensed as nursing home beds, the number of boarding care beds in the facility
195.33 must not increase beyond the number remaining at the time of the upgrade in licensure.

195.34 The provisions contained in section 144A.073 regarding the upgrading of the facilities
195.35 do not apply to facilities that satisfy these requirements;

196.1 (f) to license and certify up to 40 beds transferred from an existing facility owned and
196.2 operated by the Amherst H. Wilder Foundation in the city of St. Paul to a new unit at the
196.3 same location as the existing facility that will serve persons with Alzheimer's disease and
196.4 other related disorders. The transfer of beds may occur gradually or in stages, provided
196.5 the total number of beds transferred does not exceed 40. At the time of licensure and
196.6 certification of a bed or beds in the new unit, the commissioner of health shall delicense
196.7 and decertify the same number of beds in the existing facility. As a condition of receiving
196.8 a license or certification under this clause, the facility must make a written commitment
196.9 to the commissioner of human services that it will not seek to receive an increase in its
196.10 property-related payment rate as a result of the transfers allowed under this paragraph;

196.11 (g) to license and certify nursing home beds to replace currently licensed and certified
196.12 boarding care beds which may be located either in a remodeled or renovated boarding care
196.13 or nursing home facility or in a remodeled, renovated, newly constructed, or replacement
196.14 nursing home facility within the identifiable complex of health care facilities in which the
196.15 currently licensed boarding care beds are presently located, provided that the number of
196.16 boarding care beds in the facility or complex are decreased by the number to be licensed
196.17 as nursing home beds and further provided that, if the total costs of new construction,
196.18 replacement, remodeling, or renovation exceed ten percent of the appraised value of
196.19 the facility or \$200,000, whichever is less, the facility makes a written commitment to
196.20 the commissioner of human services that it will not seek to receive an increase in its
196.21 property-related payment rate by reason of the new construction, replacement, remodeling,
196.22 or renovation. The provisions contained in section 144A.073 regarding the upgrading of
196.23 facilities do not apply to facilities that satisfy these requirements;

196.24 (h) to license as a nursing home and certify as a nursing facility a facility that is
196.25 licensed as a boarding care facility but not certified under the medical assistance program,
196.26 but only if the commissioner of human services certifies to the commissioner of health that
196.27 licensing the facility as a nursing home and certifying the facility as a nursing facility will
196.28 result in a net annual savings to the state general fund of \$200,000 or more;

196.29 (i) to certify, after September 30, 1992, and prior to July 1, 1993, existing nursing
196.30 home beds in a facility that was licensed and in operation prior to January 1, 1992;

196.31 (j) to license and certify new nursing home beds to replace beds in a facility acquired
196.32 by the Minneapolis Community Development Agency as part of redevelopment activities
196.33 in a city of the first class, provided the new facility is located within three miles of the site
196.34 of the old facility. Operating and property costs for the new facility must be determined
196.35 and allowed under section 256B.431 or 256B.434;

197.1 (k) to license and certify up to 20 new nursing home beds in a community-operated
197.2 hospital and attached convalescent and nursing care facility with 40 beds on April 21,
197.3 1991, that suspended operation of the hospital in April 1986. The commissioner of human
197.4 services shall provide the facility with the same per diem property-related payment rate
197.5 for each additional licensed and certified bed as it will receive for its existing 40 beds;

197.6 (l) to license or certify beds in renovation, replacement, or upgrading projects as
197.7 defined in section 144A.073, subdivision 1, so long as the cumulative total costs of the
197.8 facility's remodeling projects do not exceed \$1,000,000;

197.9 (m) to license and certify beds that are moved from one location to another for the
197.10 purposes of converting up to five four-bed wards to single or double occupancy rooms
197.11 in a nursing home that, as of January 1, 1993, was county-owned and had a licensed
197.12 capacity of 115 beds;

197.13 (n) to allow a facility that on April 16, 1993, was a 106-bed licensed and certified
197.14 nursing facility located in Minneapolis to layaway all of its licensed and certified nursing
197.15 home beds. These beds may be relicensed and recertified in a newly constructed teaching
197.16 nursing home facility affiliated with a teaching hospital upon approval by the legislature.
197.17 The proposal must be developed in consultation with the interagency committee on
197.18 long-term care planning. The beds on layaway status shall have the same status as
197.19 voluntarily delicensed and decertified beds, except that beds on layaway status remain
197.20 subject to the surcharge in section 256.9657. This layaway provision expires July 1, 1998;

197.21 (o) to allow a project which will be completed in conjunction with an approved
197.22 moratorium exception project for a nursing home in southern Cass County and which is
197.23 directly related to that portion of the facility that must be repaired, renovated, or replaced,
197.24 to correct an emergency plumbing problem for which a state correction order has been
197.25 issued and which must be corrected by August 31, 1993;

197.26 (p) to allow a facility that on April 16, 1993, was a 368-bed licensed and certified
197.27 nursing facility located in Minneapolis to layaway, upon 30 days prior written notice to
197.28 the commissioner, up to 30 of the facility's licensed and certified beds by converting
197.29 three-bed wards to single or double occupancy. Beds on layaway status shall have the
197.30 same status as voluntarily delicensed and decertified beds except that beds on layaway
197.31 status remain subject to the surcharge in section 256.9657, remain subject to the license
197.32 application and renewal fees under section 144A.07 and shall be subject to a \$100 per bed
197.33 reactivation fee. In addition, at any time within three years of the effective date of the
197.34 layaway, the beds on layaway status may be:

197.35 (1) relicensed and recertified upon relocation and reactivation of some or all of
197.36 the beds to an existing licensed and certified facility or facilities located in Pine River,

198.1 Brainerd, or International Falls; provided that the total project construction costs related to
198.2 the relocation of beds from layaway status for any facility receiving relocated beds may
198.3 not exceed the dollar threshold provided in subdivision 2 unless the construction project
198.4 has been approved through the moratorium exception process under section 144A.073;

198.5 (2) relicensed and recertified, upon reactivation of some or all of the beds within the
198.6 facility which placed the beds in layaway status, if the commissioner has determined a
198.7 need for the reactivation of the beds on layaway status.

198.8 The property-related payment rate of a facility placing beds on layaway status
198.9 must be adjusted by the incremental change in its rental per diem after recalculating the
198.10 rental per diem as provided in section 256B.431, subdivision 3a, paragraph (c). The
198.11 property-related payment rate for a facility relicensing and recertifying beds from layaway
198.12 status must be adjusted by the incremental change in its rental per diem after recalculating
198.13 its rental per diem using the number of beds after the relicensing to establish the facility's
198.14 capacity day divisor, which shall be effective the first day of the month following the
198.15 month in which the relicensing and recertification became effective. Any beds remaining
198.16 on layaway status more than three years after the date the layaway status became effective
198.17 must be removed from layaway status and immediately delicensed and decertified;

198.18 (q) to license and certify beds in a renovation and remodeling project to convert 12
198.19 four-bed wards into 24 two-bed rooms, expand space, and add improvements in a nursing
198.20 home that, as of January 1, 1994, met the following conditions: the nursing home was
198.21 located in Ramsey County; had a licensed capacity of 154 beds; and had been ranked
198.22 among the top 15 applicants by the 1993 moratorium exceptions advisory review panel.
198.23 The total project construction cost estimate for this project must not exceed the cost
198.24 estimate submitted in connection with the 1993 moratorium exception process;

198.25 (r) to license and certify up to 117 beds that are relocated from a licensed and certified
198.26 138-bed nursing facility located in St. Paul to a hospital with 130 licensed hospital beds
198.27 located in South St. Paul, provided that the nursing facility and hospital are owned by the
198.28 same or a related organization and that prior to the date the relocation is completed the
198.29 hospital ceases operation of its inpatient hospital services at that hospital. After relocation,
198.30 the nursing facility's status shall be the same as it was prior to relocation. The nursing
198.31 facility's property-related payment rate resulting from the project authorized in this
198.32 paragraph shall become effective no earlier than April 1, 1996. For purposes of calculating
198.33 the incremental change in the facility's rental per diem resulting from this project, the
198.34 allowable appraised value of the nursing facility portion of the existing health care facility
198.35 physical plant prior to the renovation and relocation may not exceed \$2,490,000;

199.1 (s) to license and certify two beds in a facility to replace beds that were voluntarily
199.2 delicensed and decertified on June 28, 1991;

199.3 (t) to allow 16 licensed and certified beds located on July 1, 1994, in a 142-bed
199.4 nursing home and 21-bed boarding care home facility in Minneapolis, notwithstanding
199.5 the licensure and certification after July 1, 1995, of the Minneapolis facility as a 147-bed
199.6 nursing home facility after completion of a construction project approved in 1993 under
199.7 section 144A.073, to be laid away upon 30 days' prior written notice to the commissioner.
199.8 Beds on layaway status shall have the same status as voluntarily delicensed or decertified
199.9 beds except that they shall remain subject to the surcharge in section 256.9657. The
199.10 16 beds on layaway status may be relicensed as nursing home beds and recertified at
199.11 any time within five years of the effective date of the layaway upon relocation of some
199.12 or all of the beds to a licensed and certified facility located in Watertown, provided that
199.13 the total project construction costs related to the relocation of beds from layaway status
199.14 for the Watertown facility may not exceed the dollar threshold provided in subdivision
199.15 2 unless the construction project has been approved through the moratorium exception
199.16 process under section 144A.073.

199.17 The property-related payment rate of the facility placing beds on layaway status must
199.18 be adjusted by the incremental change in its rental per diem after recalculating the rental per
199.19 diem as provided in section 256B.431, subdivision 3a, paragraph (c). The property-related
199.20 payment rate for the facility relicensing and recertifying beds from layaway status must be
199.21 adjusted by the incremental change in its rental per diem after recalculating its rental per
199.22 diem using the number of beds after the relicensing to establish the facility's capacity day
199.23 divisor, which shall be effective the first day of the month following the month in which
199.24 the relicensing and recertification became effective. Any beds remaining on layaway
199.25 status more than five years after the date the layaway status became effective must be
199.26 removed from layaway status and immediately delicensed and decertified;

199.27 (u) to license and certify beds that are moved within an existing area of a facility or
199.28 to a newly constructed addition which is built for the purpose of eliminating three- and
199.29 four-bed rooms and adding space for dining, lounge areas, bathing rooms, and ancillary
199.30 service areas in a nursing home that, as of January 1, 1995, was located in Fridley and had
199.31 a licensed capacity of 129 beds;

199.32 (v) to relocate 36 beds in Crow Wing County and four beds from Hennepin County
199.33 to a 160-bed facility in Crow Wing County, provided all the affected beds are under
199.34 common ownership;

199.35 (w) to license and certify a total replacement project of up to 49 beds located in
199.36 Norman County that are relocated from a nursing home destroyed by flood and whose

200.1 residents were relocated to other nursing homes. The operating cost payment rates for
200.2 the new nursing facility shall be determined based on the interim and settle-up payment
200.3 provisions of Minnesota Rules, part 9549.0057, and the reimbursement provisions of
200.4 section 256B.431. Property-related reimbursement rates shall be determined under section
200.5 256B.431, taking into account any federal or state flood-related loans or grants provided
200.6 to the facility;

200.7 (x) to license and certify ~~a total~~ to the licensee of a nursing home in Polk County
200.8 that was destroyed by flood in 1997 replacement project projects with a total of up to 129
200.9 beds, with at least 25 beds to be located in Polk County that are relocated from a nursing
200.10 home destroyed by flood and whose residents were relocated to other nursing homes. and
200.11 up to 104 beds distributed among up to three other counties. These beds may only be
200.12 distributed to counties with fewer than the median number of age intensity adjusted beds
200.13 per thousand, as most recently published by the commissioner of human services. If the
200.14 licensee chooses to distribute beds outside of Polk County under this paragraph, prior to
200.15 distributing the beds, the commissioner of health must approve the location in which the
200.16 licensee plans to distribute the beds. The commissioner of health shall consult with the
200.17 commissioner of human services prior to approving the location of the proposed beds.
200.18 The licensee may combine these beds with beds relocated from other nursing facilities
200.19 as provided in section 144A.073, subdivision 3c. The operating cost payment rates for
200.20 the new nursing facility facilities shall be determined based on the interim and settle-up
200.21 payment provisions of section 256B.431, 256B.434, or 256B.441 or Minnesota Rules, part
200.22 9549.0057, and the reimbursement provisions of section 256B.431, except that subdivision
200.23 26, paragraphs (a) and (b), shall not apply until the second rate year after the settle-up cost
200.24 report is filed. Property-related reimbursement rates shall be determined under section
200.25 256B.431, taking into account any federal or state flood-related loans or grants provided to
200.26 the facility; parts 9549.0010 to 9549.0080. Property-related reimbursement rates shall
200.27 be determined under section 256B.431, 256B.434, or 256B.441. If the replacement beds
200.28 permitted under this paragraph are combined with beds from other nursing facilities, the
200.29 rates shall be calculated as the weighted average of rates determined as provided in this
200.30 paragraph and section 256B.441, subdivision 60;

200.31 (y) to license and certify beds in a renovation and remodeling project to convert 13
200.32 three-bed wards into 13 two-bed rooms and 13 single-bed rooms, expand space, and
200.33 add improvements in a nursing home that, as of January 1, 1994, met the following
200.34 conditions: the nursing home was located in Ramsey County, was not owned by a hospital
200.35 corporation, had a licensed capacity of 64 beds, and had been ranked among the top 15
200.36 applicants by the 1993 moratorium exceptions advisory review panel. The total project

201.1 construction cost estimate for this project must not exceed the cost estimate submitted in
201.2 connection with the 1993 moratorium exception process;

201.3 (z) to license and certify up to 150 nursing home beds to replace an existing 285
201.4 bed nursing facility located in St. Paul. The replacement project shall include both the
201.5 renovation of existing buildings and the construction of new facilities at the existing
201.6 site. The reduction in the licensed capacity of the existing facility shall occur during the
201.7 construction project as beds are taken out of service due to the construction process. Prior
201.8 to the start of the construction process, the facility shall provide written information to the
201.9 commissioner of health describing the process for bed reduction, plans for the relocation
201.10 of residents, and the estimated construction schedule. The relocation of residents shall be
201.11 in accordance with the provisions of law and rule;

201.12 (aa) to allow the commissioner of human services to license an additional 36 beds
201.13 to provide residential services for the physically disabled under Minnesota Rules, parts
201.14 9570.2000 to 9570.3400, in a 198-bed nursing home located in Red Wing, provided that
201.15 the total number of licensed and certified beds at the facility does not increase;

201.16 (bb) to license and certify a new facility in St. Louis County with 44 beds
201.17 constructed to replace an existing facility in St. Louis County with 31 beds, which has
201.18 resident rooms on two separate floors and an antiquated elevator that creates safety
201.19 concerns for residents and prevents nonambulatory residents from residing on the second
201.20 floor. The project shall include the elimination of three- and four-bed rooms;

201.21 (cc) to license and certify four beds in a 16-bed certified boarding care home in
201.22 Minneapolis to replace beds that were voluntarily delicensed and decertified on or
201.23 before March 31, 1992. The licensure and certification is conditional upon the facility
201.24 periodically assessing and adjusting its resident mix and other factors which may
201.25 contribute to a potential institution for mental disease declaration. The commissioner of
201.26 human services shall retain the authority to audit the facility at any time and shall require
201.27 the facility to comply with any requirements necessary to prevent an institution for mental
201.28 disease declaration, including delicensure and decertification of beds, if necessary;

201.29 (dd) to license and certify 72 beds in an existing facility in Mille Lacs County with
201.30 80 beds as part of a renovation project. The renovation must include construction of
201.31 an addition to accommodate ten residents with beginning and midstage dementia in a
201.32 self-contained living unit; creation of three resident households where dining, activities,
201.33 and support spaces are located near resident living quarters; designation of four beds
201.34 for rehabilitation in a self-contained area; designation of 30 private rooms; and other
201.35 improvements;

202.1 (ee) to license and certify beds in a facility that has undergone replacement or
202.2 remodeling as part of a planned closure under section 256B.437;

202.3 (ff) to license and certify a total replacement project of up to 124 beds located
202.4 in Wilkin County that are in need of relocation from a nursing home significantly
202.5 damaged by flood. The operating cost payment rates for the new nursing facility shall be
202.6 determined based on the interim and settle-up payment provisions of Minnesota Rules,
202.7 part 9549.0057, and the reimbursement provisions of section 256B.431. Property-related
202.8 reimbursement rates shall be determined under section 256B.431, taking into account any
202.9 federal or state flood-related loans or grants provided to the facility;

202.10 (gg) to allow the commissioner of human services to license an additional nine beds
202.11 to provide residential services for the physically disabled under Minnesota Rules, parts
202.12 9570.2000 to 9570.3400, in a 240-bed nursing home located in Duluth, provided that the
202.13 total number of licensed and certified beds at the facility does not increase;

202.14 (hh) to license and certify up to 120 new nursing facility beds to replace beds in a
202.15 facility in Anoka County, which was licensed for 98 beds as of July 1, 2000, provided the
202.16 new facility is located within four miles of the existing facility and is in Anoka County.
202.17 Operating and property rates shall be determined and allowed under section 256B.431 and
202.18 Minnesota Rules, parts 9549.0010 to 9549.0080, or section 256B.434 or 256B.441; or

202.19 (ii) to transfer up to 98 beds of a 129-licensed bed facility located in Anoka County
202.20 that, as of March 25, 2001, is in the active process of closing, to a 122-licensed bed nonprofit
202.21 nursing facility located in the city of Columbia Heights or its affiliate. The transfer is
202.22 effective when the receiving facility notifies the commissioner in writing of the number of
202.23 beds accepted. The commissioner shall place all transferred beds on layaway status held in
202.24 the name of the receiving facility. The layaway adjustment provisions of section 256B.431,
202.25 subdivision 30, do not apply to this layaway. The receiving facility may only remove the
202.26 beds from layaway for recertification and relicensure at the receiving facility's current
202.27 site, or at a newly constructed facility located in Anoka County. The receiving facility
202.28 must receive statutory authorization before removing these beds from layaway status, or
202.29 may remove these beds from layaway status if removal from layaway status is part of a
202.30 moratorium exception project approved by the commissioner under section 144A.073.

202.31 Sec. 3. Minnesota Statutes 2014, section 256B.0913, subdivision 4, is amended to read:

202.32 Subd. 4. **Eligibility for funding for services for nonmedical assistance recipients.**

202.33 (a) Funding for services under the alternative care program is available to persons who
202.34 meet the following criteria:

203.1 (1) the person has been determined by a community assessment under section
203.2 256B.0911 to be a person who would require the level of care provided in a nursing
203.3 facility, as determined under section 256B.0911, subdivision 4e, but for the provision of
203.4 services under the alternative care program;

203.5 (2) the person is age 65 or older;

203.6 (3) the person would be eligible for medical assistance within 135 days of admission
203.7 to a nursing facility;

203.8 (4) the person is not ineligible for the payment of long-term care services by the
203.9 medical assistance program due to an asset transfer penalty under section 256B.0595 or
203.10 equity interest in the home exceeding \$500,000 as stated in section 256B.056;

203.11 (5) the person needs long-term care services that are not funded through other
203.12 state or federal funding, or other health insurance or other third-party insurance such as
203.13 long-term care insurance;

203.14 (6) except for individuals described in clause (7), the monthly cost of the alternative
203.15 care services funded by the program for this person does not exceed 75 percent of the
203.16 monthly limit described under section 256B.0915, subdivision 3a. This monthly limit
203.17 does not prohibit the alternative care client from payment for additional services, but in no
203.18 case may the cost of additional services purchased under this section exceed the difference
203.19 between the client's monthly service limit defined under section 256B.0915, subdivision
203.20 3, and the alternative care program monthly service limit defined in this paragraph. If
203.21 care-related supplies and equipment or environmental modifications and adaptations are or
203.22 will be purchased for an alternative care services recipient, the costs may be prorated on a
203.23 monthly basis for up to 12 consecutive months beginning with the month of purchase.
203.24 If the monthly cost of a recipient's other alternative care services exceeds the monthly
203.25 limit established in this paragraph, the annual cost of the alternative care services shall be
203.26 determined. In this event, the annual cost of alternative care services shall not exceed 12
203.27 times the monthly limit described in this paragraph;

203.28 (7) for individuals assigned a case mix classification A as described under section
203.29 256B.0915, subdivision 3a, paragraph (a), with (i) no dependencies in activities of daily
203.30 living, or (ii) up to two dependencies in bathing, dressing, grooming, walking, and eating
203.31 when the dependency score in eating is three or greater as determined by an assessment
203.32 performed under section 256B.0911, the monthly cost of alternative care services funded
203.33 by the program cannot exceed \$593 per month for all new participants enrolled in
203.34 the program on or after July 1, 2011. This monthly limit shall be applied to all other
203.35 participants who meet this criteria at reassessment. This monthly limit shall be increased
203.36 annually as described in section 256B.0915, subdivision 3a, ~~paragraph~~ paragraphs (a) and

204.1 (e). This monthly limit does not prohibit the alternative care client from payment for
204.2 additional services, but in no case may the cost of additional services purchased exceed the
204.3 difference between the client's monthly service limit defined in this clause and the limit
204.4 described in clause (6) for case mix classification A; and

204.5 (8) the person is making timely payments of the assessed monthly fee.

204.6 A person is ineligible if payment of the fee is over 60 days past due, unless the person
204.7 agrees to:

204.8 (i) the appointment of a representative payee;

204.9 (ii) automatic payment from a financial account;

204.10 (iii) the establishment of greater family involvement in the financial management of
204.11 payments; or

204.12 (iv) another method acceptable to the lead agency to ensure prompt fee payments.

204.13 The lead agency may extend the client's eligibility as necessary while making
204.14 arrangements to facilitate payment of past-due amounts and future premium payments.
204.15 Following disenrollment due to nonpayment of a monthly fee, eligibility shall not be
204.16 reinstated for a period of 30 days.

204.17 (b) Alternative care funding under this subdivision is not available for a person who
204.18 is a medical assistance recipient or who would be eligible for medical assistance without a
204.19 spenddown or waiver obligation. A person whose initial application for medical assistance
204.20 and the elderly waiver program is being processed may be served under the alternative care
204.21 program for a period up to 60 days. If the individual is found to be eligible for medical
204.22 assistance, medical assistance must be billed for services payable under the federally
204.23 approved elderly waiver plan and delivered from the date the individual was found eligible
204.24 for the federally approved elderly waiver plan. Notwithstanding this provision, alternative
204.25 care funds may not be used to pay for any service the cost of which: (i) is payable by
204.26 medical assistance; (ii) is used by a recipient to meet a waiver obligation; or (iii) is used to
204.27 pay a medical assistance income spenddown for a person who is eligible to participate in the
204.28 federally approved elderly waiver program under the special income standard provision.

204.29 (c) Alternative care funding is not available for a person who resides in a licensed
204.30 nursing home, certified boarding care home, hospital, or intermediate care facility, except
204.31 for case management services which are provided in support of the discharge planning
204.32 process for a nursing home resident or certified boarding care home resident to assist with
204.33 a relocation process to a community-based setting.

204.34 (d) Alternative care funding is not available for a person whose income is greater
204.35 than the maintenance needs allowance under section 256B.0915, subdivision 1d, but equal
204.36 to or less than 120 percent of the federal poverty guideline effective July 1 in the fiscal

205.1 year for which alternative care eligibility is determined, who would be eligible for the
205.2 elderly waiver with a waiver obligation.

205.3 Sec. 4. Minnesota Statutes 2014, section 256B.0915, subdivision 3a, is amended to read:

205.4 Subd. 3a. **Elderly waiver cost limits.** (a) ~~The monthly limit for the cost of~~
205.5 ~~waivered services to an individual elderly waiver client except for individuals described~~
205.6 ~~in paragraphs (b) and (d) shall be the weighted average monthly nursing facility rate of~~
205.7 ~~the case mix resident class to which the elderly waiver client would be assigned under~~
205.8 ~~Minnesota Rules, parts 9549.0050 to 9549.0059, less the recipient's maintenance needs~~
205.9 ~~allowance as described in subdivision 1d, paragraph (a), until the first day of the state~~
205.10 ~~fiscal year in which the resident assessment system as described in section 256B.438 for~~
205.11 ~~nursing home rate determination is implemented. Effective on the first day of the state~~
205.12 ~~fiscal year in which the resident assessment system as described in section 256B.438 for~~
205.13 ~~nursing home rate determination is implemented and the first day of each subsequent state~~
205.14 ~~fiscal year, the monthly limit for the cost of waived services to an individual elderly~~
205.15 ~~waiver client shall be the rate monthly limit of the case mix resident class to which the~~
205.16 ~~waiver client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, in~~
205.17 ~~effect on the last day of the previous state fiscal year, adjusted by any legislatively adopted~~
205.18 ~~home and community-based services percentage rate adjustment.~~

205.19 (b) The monthly limit for the cost of waived services under paragraph (a) to an
205.20 individual elderly waiver client assigned to a case mix classification A ~~under paragraph~~
205.21 ~~(a)~~ with:

205.22 (1) no dependencies in activities of daily living; or

205.23 (2) up to two dependencies in bathing, dressing, grooming, walking, and eating
205.24 when the dependency score in eating is three or greater as determined by an assessment
205.25 performed under section 256B.0911 shall be \$1,750 per month effective on July 1, 2011,
205.26 for all new participants enrolled in the program on or after July 1, 2011. This monthly
205.27 limit shall be applied to all other participants who meet this criteria at reassessment. This
205.28 monthly limit shall be increased annually as described in ~~paragraph~~ paragraphs (a) and (e).

205.29 (c) If extended medical supplies and equipment or environmental modifications are
205.30 or will be purchased for an elderly waiver client, the costs may be prorated for up to
205.31 12 consecutive months beginning with the month of purchase. If the monthly cost of a
205.32 recipient's waived services exceeds the monthly limit established in paragraph (a) ~~or~~
205.33 ~~(b), (d), or (e),~~ the annual cost of all waived services shall be determined. In this event,
205.34 the annual cost of all waived services shall not exceed 12 times the monthly limit of
205.35 waived services as described in paragraph (a) ~~or~~ (b), (d), or (e).

206.1 (d) Effective July 1, 2013, the monthly cost limit of waiver services, including
206.2 any necessary home care services described in section 256B.0651, subdivision 2, for
206.3 individuals who meet the criteria as ventilator-dependent given in section 256B.0651,
206.4 subdivision 1, paragraph (g), shall be the average of the monthly medical assistance
206.5 amount established for home care services as described in section 256B.0652, subdivision
206.6 7, and the annual average contracted amount established by the commissioner for nursing
206.7 facility services for ventilator-dependent individuals. This monthly limit shall be increased
206.8 annually as described in ~~paragraph~~ paragraphs (a) and (e).

206.9 (e) Effective July 1, 2016, and each July 1 thereafter, the monthly cost limits for
206.10 elderly waiver services in effect on the previous June 30 shall be increased by the
206.11 difference between any legislatively adopted home and community-based provider rate
206.12 increases effective on July 1 or since the previous July 1 and the average statewide
206.13 percentage increase in nursing facility operating payment rates under sections 256B.431,
206.14 256B.434, and 256B.441, effective the previous January 1. This paragraph shall only
206.15 apply if the average statewide percentage increase in nursing facility operating payment
206.16 rates is greater than any legislatively adopted home and community-based provider rate
206.17 increases effective on July 1, or occurring since the previous July 1.

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

206.19 Sec. 5. Minnesota Statutes 2014, section 256B.0915, subdivision 3e, is amended to read:

206.20 Subd. 3e. **Customized living service rate.** (a) Payment for customized living
206.21 services shall be a monthly rate authorized by the lead agency within the parameters
206.22 established by the commissioner. The payment agreement must delineate the amount of
206.23 each component service included in the recipient's customized living service plan. The
206.24 lead agency, with input from the provider of customized living services, shall ensure that
206.25 there is a documented need within the parameters established by the commissioner for all
206.26 component customized living services authorized.

206.27 (b) The payment rate must be based on the amount of component services to be
206.28 provided utilizing component rates established by the commissioner. Counties and tribes
206.29 shall use tools issued by the commissioner to develop and document customized living
206.30 service plans and rates.

206.31 (c) Component service rates must not exceed payment rates for comparable elderly
206.32 waiver or medical assistance services and must reflect economies of scale. Customized
206.33 living services must not include rent or raw food costs.

206.34 (d) With the exception of individuals described in subdivision 3a, paragraph (b), the
206.35 individualized monthly authorized payment for the customized living service plan shall not

207.1 exceed 50 percent of the greater of either the statewide or any of the geographic groups'
207.2 weighted average monthly nursing facility rate of the case mix resident class to which the
207.3 elderly waiver eligible client would be assigned under Minnesota Rules, parts 9549.0050 to
207.4 9549.0059, less the maintenance needs allowance as described in subdivision 1d, paragraph
207.5 (a), ~~until the July 1 of the state fiscal year in which the resident assessment system as~~
207.6 ~~described in section 256B.438 for nursing home rate determination is implemented.~~
207.7 Effective on July 1 of the state fiscal year in which the resident assessment system as
207.8 described in section 256B.438 for nursing home rate determination is implemented and
207.9 July 1 of each subsequent state fiscal year, the individualized monthly authorized payment
207.10 for the services described in this clause shall not exceed the limit which was in effect on
207.11 June 30 of the previous state fiscal year updated annually based on legislatively adopted
207.12 changes to all service rate maximums for home and community-based service providers.

207.13 (e) Effective July 1, 2011, the individualized monthly payment for the customized
207.14 living service plan for individuals described in subdivision 3a, paragraph (b), must be the
207.15 monthly authorized payment limit for customized living for individuals classified as case
207.16 mix A, reduced by 25 percent. This rate limit must be applied to all new participants
207.17 enrolled in the program on or after July 1, 2011, who meet the criteria described in
207.18 subdivision 3a, paragraph (b). This monthly limit also applies to all other participants who
207.19 meet the criteria described in subdivision 3a, paragraph (b), at reassessment.

207.20 (f) Customized living services are delivered by a provider licensed by the
207.21 Department of Health as a class A or class F home care provider and provided in a
207.22 building that is registered as a housing with services establishment under chapter 144D.
207.23 Licensed home care providers are subject to section 256B.0651, subdivision 14.

207.24 (g) A provider may not bill or otherwise charge an elderly waiver participant or their
207.25 family for additional units of any allowable component service beyond those available
207.26 under the service rate limits described in paragraph (d), nor for additional units of any
207.27 allowable component service beyond those approved in the service plan by the lead agency.

207.28 (h) Effective July 1, 2016, and each July 1 thereafter, individualized service rate
207.29 limits for customized living services under this subdivision shall be increased by the
207.30 difference between any legislatively adopted home and community-based provider rate
207.31 increases effective on July 1 or since the previous July 1 and the average statewide
207.32 percentage increase in nursing facility operating payment rates under sections 256B.431,
207.33 256B.434, and 256B.441, effective the previous January 1. This paragraph shall only
207.34 apply if the average statewide percentage increase in nursing facility operating payment
207.35 rates is greater than any legislatively adopted home and community-based provider rate
207.36 increases effective on July 1, or occurring since the previous July 1.

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

208.2 Sec. 6. Minnesota Statutes 2014, section 256B.0915, subdivision 3h, is amended to read:

208.3 Subd. 3h. **Service rate limits; 24-hour customized living services.** (a) The
208.4 payment rate for 24-hour customized living services is a monthly rate authorized by the
208.5 lead agency within the parameters established by the commissioner of human services.
208.6 The payment agreement must delineate the amount of each component service included
208.7 in each recipient's customized living service plan. The lead agency, with input from
208.8 the provider of customized living services, shall ensure that there is a documented need
208.9 within the parameters established by the commissioner for all component customized
208.10 living services authorized. The lead agency shall not authorize 24-hour customized living
208.11 services unless there is a documented need for 24-hour supervision.

208.12 (b) For purposes of this section, "24-hour supervision" means that the recipient
208.13 requires assistance due to needs related to one or more of the following:

208.14 (1) intermittent assistance with toileting, positioning, or transferring;

208.15 (2) cognitive or behavioral issues;

208.16 (3) a medical condition that requires clinical monitoring; or

208.17 (4) for all new participants enrolled in the program on or after July 1, 2011, and

208.18 all other participants at their first reassessment after July 1, 2011, dependency in at
208.19 least three of the following activities of daily living as determined by assessment under
208.20 section 256B.0911: bathing; dressing; grooming; walking; or eating when the dependency
208.21 score in eating is three or greater; and needs medication management and at least 50
208.22 hours of service per month. The lead agency shall ensure that the frequency and mode
208.23 of supervision of the recipient and the qualifications of staff providing supervision are
208.24 described and meet the needs of the recipient.

208.25 (c) The payment rate for 24-hour customized living services must be based on the
208.26 amount of component services to be provided utilizing component rates established by the
208.27 commissioner. Counties and tribes will use tools issued by the commissioner to develop
208.28 and document customized living plans and authorize rates.

208.29 (d) Component service rates must not exceed payment rates for comparable elderly
208.30 waiver or medical assistance services and must reflect economies of scale.

208.31 (e) The individually authorized 24-hour customized living payments, in combination
208.32 with the payment for other elderly waiver services, including case management, must not
208.33 exceed the recipient's community budget cap specified in subdivision 3a. Customized
208.34 living services must not include rent or raw food costs.

209.1 (f) The individually authorized 24-hour customized living payment rates shall not
209.2 exceed the 95 percentile of statewide monthly authorizations for 24-hour customized
209.3 living services in effect and in the Medicaid management information systems on March
209.4 31, 2009, for each case mix resident class under Minnesota Rules, parts 9549.0050
209.5 to 9549.0059, to which elderly waiver service clients are assigned. When there are
209.6 fewer than 50 authorizations in effect in the case mix resident class, the commissioner
209.7 shall multiply the calculated service payment rate maximum for the A classification by
209.8 the standard weight for that classification under Minnesota Rules, parts 9549.0050 to
209.9 9549.0059, to determine the applicable payment rate maximum. Service payment rate
209.10 maximums shall be updated annually based on legislatively adopted changes to all service
209.11 rates for home and community-based service providers.

209.12 (g) Notwithstanding the requirements of paragraphs (d) and (f), the commissioner
209.13 may establish alternative payment rate systems for 24-hour customized living services in
209.14 housing with services establishments which are freestanding buildings with a capacity of
209.15 16 or fewer, by applying a single hourly rate for covered component services provided
209.16 in either:

209.17 (1) licensed corporate adult foster homes; or

209.18 (2) specialized dementia care units which meet the requirements of section 144D.065
209.19 and in which:

209.20 (i) each resident is offered the option of having their own apartment; or

209.21 (ii) the units are licensed as board and lodge establishments with maximum capacity
209.22 of eight residents, and which meet the requirements of Minnesota Rules, part 9555.6205,
209.23 subparts 1, 2, 3, and 4, item A.

209.24 (h) Twenty-four-hour customized living services are delivered by a provider licensed
209.25 by the Department of Health as a class A or class F home care provider and provided in a
209.26 building that is registered as a housing with services establishment under chapter 144D.
209.27 Licensed home care providers are subject to section 256B.0651, subdivision 14.

209.28 (i) A provider may not bill or otherwise charge an elderly waiver participant or their
209.29 family for additional units of any allowable component service beyond those available
209.30 under the service rate limits described in paragraph (e), nor for additional units of any
209.31 allowable component service beyond those approved in the service plan by the lead agency.

209.32 (j) Effective July 1, 2016, and each July 1 thereafter, individualized service rate
209.33 limits for 24-hour customized living services under this subdivision shall be increased by
209.34 the difference between any legislatively adopted home and community-based provider
209.35 rate increases effective on July 1 or since the previous July 1 and the average statewide
209.36 percentage increase in nursing facility operating payment rates under sections 256B.431,

210.1 256B.434, and 256B.441, effective the previous January 1. This paragraph shall only
210.2 apply if the average statewide percentage increase in nursing facility operating payment
210.3 rates is greater than any legislatively adopted home and community-based provider rate
210.4 increases effective on July 1, or occurring since the previous July 1.

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

210.6 Sec. 7. Minnesota Statutes 2014, section 256B.431, subdivision 2b, is amended to read:

210.7 Subd. 2b. **Operating costs after July 1, 1985.** (a) For rate years beginning on or
210.8 after July 1, 1985, the commissioner shall establish procedures for determining per diem
210.9 reimbursement for operating costs.

210.10 (b) The commissioner shall contract with an econometric firm with recognized
210.11 expertise in and access to national economic change indices that can be applied to the
210.12 appropriate cost categories when determining the operating cost payment rate.

210.13 (c) The commissioner shall analyze and evaluate each nursing facility's cost report
210.14 of allowable operating costs incurred by the nursing facility during the reporting year
210.15 immediately preceding the rate year for which the payment rate becomes effective.

210.16 (d) The commissioner shall establish limits on actual allowable historical operating
210.17 cost per diems based on cost reports of allowable operating costs for the reporting year
210.18 that begins October 1, 1983, taking into consideration relevant factors including resident
210.19 needs, geographic location, and size of the nursing facility. In developing the geographic
210.20 groups for purposes of reimbursement under this section, the commissioner shall ensure
210.21 that nursing facilities in any county contiguous to the Minneapolis-St. Paul seven-county
210.22 metropolitan area are included in the same geographic group. The limits established by
210.23 the commissioner shall not be less, in the aggregate, than the 60th percentile of total
210.24 actual allowable historical operating cost per diems for each group of nursing facilities
210.25 established under subdivision 1 based on cost reports of allowable operating costs in the
210.26 previous reporting year. For rate years beginning on or after July 1, 1989, facilities located
210.27 in geographic group I as described in Minnesota Rules, part 9549.0052, on January 1,
210.28 1989, may choose to have the commissioner apply either the care related limits or the
210.29 other operating cost limits calculated for facilities located in geographic group II, or
210.30 both, if either of the limits calculated for the group II facilities is higher. The efficiency
210.31 incentive for geographic group I nursing facilities must be calculated based on geographic
210.32 group I limits. The phase-in must be established utilizing the chosen limits. For purposes
210.33 of these exceptions to the geographic grouping requirements, the definitions in Minnesota
210.34 Rules, parts 9549.0050 to 9549.0059 (Emergency), and 9549.0010 to 9549.0080, apply.
210.35 The limits established under this paragraph remain in effect until the commissioner

211.1 establishes a new base period. Until the new base period is established, the commissioner
211.2 shall adjust the limits annually using the appropriate economic change indices established
211.3 in paragraph (e). In determining allowable historical operating cost per diems for purposes
211.4 of setting limits and nursing facility payment rates, the commissioner shall divide the
211.5 allowable historical operating costs by the actual number of resident days, except that
211.6 where a nursing facility is occupied at less than 90 percent of licensed capacity days, the
211.7 commissioner may establish procedures to adjust the computation of the per diem to
211.8 an imputed occupancy level at or below 90 percent. The commissioner shall establish
211.9 efficiency incentives as appropriate. The commissioner may establish efficiency incentives
211.10 for different operating cost categories. The commissioner shall consider establishing
211.11 efficiency incentives in care related cost categories. The commissioner may combine one
211.12 or more operating cost categories and may use different methods for calculating payment
211.13 rates for each operating cost category or combination of operating cost categories. For the
211.14 rate year beginning on July 1, 1985, the commissioner shall:

211.15 (1) allow nursing facilities that have an average length of stay of 180 days or less in
211.16 their skilled nursing level of care, 125 percent of the care related limit and 105 percent
211.17 of the other operating cost limit established by rule; and

211.18 (2) exempt nursing facilities licensed on July 1, 1983, by the commissioner to
211.19 provide residential services for the physically disabled under Minnesota Rules, parts
211.20 9570.2000 to 9570.3600, from the care related limits and allow 105 percent of the other
211.21 operating cost limit established by rule.

211.22 For the purpose of calculating the other operating cost efficiency incentive for
211.23 nursing facilities referred to in clause (1) or (2), the commissioner shall use the other
211.24 operating cost limit established by rule before application of the 105 percent.

211.25 (e) The commissioner shall establish a composite index or indices by determining
211.26 the appropriate economic change indicators to be applied to specific operating cost
211.27 categories or combination of operating cost categories.

211.28 (f) Each nursing facility shall receive an operating cost payment rate equal to the sum
211.29 of the nursing facility's operating cost payment rates for each operating cost category. The
211.30 operating cost payment rate for an operating cost category shall be the lesser of the nursing
211.31 facility's historical operating cost in the category increased by the appropriate index
211.32 established in paragraph (e) for the operating cost category plus an efficiency incentive
211.33 established pursuant to paragraph (d) or the limit for the operating cost category increased
211.34 by the same index. If a nursing facility's actual historic operating costs are greater than the
211.35 prospective payment rate for that rate year, there shall be no retroactive cost settle up. In

212.1 establishing payment rates for one or more operating cost categories, the commissioner may
212.2 establish separate rates for different classes of residents based on their relative care needs.

212.3 (g) The commissioner shall include the reported actual real estate tax liability or
212.4 payments in lieu of real estate tax of each nursing facility as an operating cost of that
212.5 nursing facility. Allowable costs under this subdivision for payments made by a nonprofit
212.6 nursing facility that are in lieu of real estate taxes shall not exceed the amount which the
212.7 nursing facility would have paid to a city or township and county for fire, police, sanitation
212.8 services, and road maintenance costs had real estate taxes been levied on that property
212.9 for those purposes. For rate years beginning on or after July 1, 1987, the reported actual
212.10 real estate tax liability or payments in lieu of real estate tax of nursing facilities shall be
212.11 adjusted to include an amount equal to one-half of the dollar change in real estate taxes
212.12 from the prior year. The commissioner shall include a reported actual special assessment,
212.13 and reported actual license fees required by the Minnesota Department of Health, for each
212.14 nursing facility as an operating cost of that nursing facility. For rate years beginning
212.15 on or after July 1, 1989, the commissioner shall include a nursing facility's reported
212.16 Public Employee Retirement Act contribution for the reporting year as apportioned to the
212.17 care-related operating cost categories and other operating cost categories multiplied by
212.18 the appropriate composite index or indices established pursuant to paragraph (e) as costs
212.19 under this paragraph. Total adjusted real estate tax liability, payments in lieu of real
212.20 estate tax, actual special assessments paid, the indexed Public Employee Retirement Act
212.21 contribution, and license fees paid as required by the Minnesota Department of Health,
212.22 for each nursing facility (1) shall be divided by actual resident days in order to compute
212.23 the operating cost payment rate for this operating cost category, (2) shall not be used to
212.24 compute the care-related operating cost limits or other operating cost limits established
212.25 by the commissioner, and (3) shall not be increased by the composite index or indices
212.26 established pursuant to paragraph (e), unless otherwise indicated in this paragraph.

212.27 ~~(h) For rate years beginning on or after July 1, 1987, the commissioner shall adjust~~
212.28 ~~the rates of a nursing facility that meets the criteria for the special dietary needs of its~~
212.29 ~~residents and the requirements in section 31.651. The adjustment for raw food cost shall~~
212.30 ~~be the difference between the nursing facility's allowable historical raw food cost per~~
212.31 ~~diem and 115 percent of the median historical allowable raw food cost per diem of the~~
212.32 ~~corresponding geographic group.~~

212.33 ~~The rate adjustment shall be reduced by the applicable phase-in percentage as~~
212.34 ~~provided under subdivision 2h.~~

212.35 Sec. 8. Minnesota Statutes 2014, section 256B.431, subdivision 36, is amended to read:

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

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

213.10 (i) scholarships are available to all employees who work an average of at least ~~20~~
 213.11 ten hours per week at the facility except the administrator, ~~department supervisors, and~~
 213.12 registered nurses and to reimburse student loan expenses for newly hired and recently
 213.13 graduated registered nurses and licensed practical nurses, and training expenses for
 213.14 nursing assistants as defined in section 144A.611, subdivision 2, who are newly hired and
 213.15 have graduated within the last 12 months; and

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

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

213.19 (b) ~~A facility receiving~~ All facilities may annually request a rate adjustment under
 213.20 this subdivision ~~may submit~~ by submitting information to the commissioner on a schedule
 213.21 ~~determined by the commissioner and on~~ in a form supplied by the commissioner a
 213.22 ~~calculation of the scholarship per diem, including: the amount received from this rate~~
 213.23 ~~adjustment; the amount used for training in English as a second language; the number of~~
 213.24 ~~persons receiving the training; the name of the person or entity providing the training;~~
 213.25 ~~and for each scholarship recipient, the name of the recipient, the amount awarded, the~~
 213.26 ~~educational institution attended, the nature of the educational program, the program~~
 213.27 ~~completion date, and a determination of the per diem amount of these costs based on~~
 213.28 ~~actual resident days.~~ The commissioner shall allow a scholarship payment rate equal to
 213.29 the reported and allowable costs divided by resident days.

213.30 (c) ~~On July 1, 2003, the commissioner shall remove the 25-cent scholarship per diem~~
 213.31 ~~from the total operating payment rate of each facility.~~

213.32 (d) ~~For rate years beginning after June 30, 2003, the commissioner shall provide to~~
 213.33 ~~each facility the scholarship per diem determined in paragraph (b).~~ In calculating the per
 213.34 diem under paragraph (b), the commissioner shall allow ~~only~~ costs related to tuition and,
 213.35 direct educational expenses, and reasonable costs as defined by the commissioner for child
 213.36 care costs and transportation expenses related to direct educational expenses.

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

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

214.8 Sec. 9. Minnesota Statutes 2014, section 256B.434, subdivision 4, is amended to read:

214.9 Subd. 4. **Alternate rates for nursing facilities.** ~~(a) For nursing facilities which~~
 214.10 ~~have their payment rates determined under this section rather than section 256B.431, the~~
 214.11 ~~commissioner shall establish a rate under this subdivision. The nursing facility must enter~~
 214.12 ~~into a written contract with the commissioner.~~

214.13 ~~(b) A nursing facility's case mix payment rate for the first rate year of a facility's~~
 214.14 ~~contract under this section is the payment rate the facility would have received under~~
 214.15 ~~section 256B.431.~~

214.16 ~~(c)~~ (e) A nursing facility's case mix payment rates for the second and subsequent years
 214.17 of a facility's contract under this section are the previous rate year's contract payment rates
 214.18 plus an inflation adjustment and, for facilities reimbursed under this section or section
 214.19 256B.431, an adjustment to include the cost of any increase in Health Department licensing
 214.20 fees for the facility taking effect on or after July 1, 2001. The index for the inflation
 214.21 adjustment must be based on the change in the Consumer Price Index-All Items (United
 214.22 States City average) (CPI-U) forecasted by the commissioner of management and budget's
 214.23 national economic consultant, as forecasted in the fourth quarter of the calendar year
 214.24 preceding the rate year. The inflation adjustment must be based on the 12-month period
 214.25 from the midpoint of the previous rate year to the midpoint of the rate year for which the
 214.26 rate is being determined. For the rate years beginning on July 1, 1999, July 1, 2000, July
 214.27 1, 2001, July 1, 2002, July 1, 2003, July 1, 2004, July 1, 2005, July 1, 2006, July 1, 2007,
 214.28 July 1, 2008, October 1, 2009, and October 1, 2010, this paragraph shall apply only to the
 214.29 property-related payment rate. For the rate years beginning on October 1, 2011, October 1,
 214.30 2012, October 1, 2013, October 1, 2014, October 1, 2015, ~~and October~~ January 1, 2016, and
 214.31 January 1, 2017, the rate adjustment under this paragraph shall be suspended. Beginning
 214.32 in 2005, adjustment to the property payment rate under this section and section 256B.431
 214.33 shall be effective on October 1. In determining the amount of the property-related payment
 214.34 rate adjustment under this paragraph, the commissioner shall determine the proportion of
 214.35 the facility's rates that are property-related based on the facility's most recent cost report.

215.1 ~~(d) The commissioner shall develop additional incentive-based payments of up to~~
215.2 ~~five percent above a facility's operating payment rate for achieving outcomes specified~~
215.3 ~~in a contract. The commissioner may solicit contract amendments and implement those~~
215.4 ~~which, on a competitive basis, best meet the state's policy objectives. The commissioner~~
215.5 ~~shall limit the amount of any incentive payment and the number of contract amendments~~
215.6 ~~under this paragraph to operate the incentive payments within funds appropriated for this~~
215.7 ~~purpose. The contract amendments may specify various levels of payment for various~~
215.8 ~~levels of performance. Incentive payments to facilities under this paragraph may be in the~~
215.9 ~~form of time-limited rate adjustments or onetime supplemental payments. In establishing~~
215.10 ~~the specified outcomes and related criteria, the commissioner shall consider the following~~
215.11 ~~state policy objectives:~~

215.12 ~~(1) successful diversion or discharge of residents to the residents' prior home or other~~
215.13 ~~community-based alternatives;~~

215.14 ~~(2) adoption of new technology to improve quality or efficiency;~~

215.15 ~~(3) improved quality as measured in the Nursing Home Report Card;~~

215.16 ~~(4) reduced acute care costs; and~~

215.17 ~~(5) any additional outcomes proposed by a nursing facility that the commissioner~~
215.18 ~~finds desirable.~~

215.19 ~~(e) Notwithstanding the threshold in section 256B.431, subdivision 16, facilities that~~
215.20 ~~take action to come into compliance with existing or pending requirements of the life~~
215.21 ~~safety code provisions or federal regulations governing sprinkler systems must receive~~
215.22 ~~reimbursement for the costs associated with compliance if all of the following conditions~~
215.23 ~~are met:~~

215.24 ~~(1) the expenses associated with compliance occurred on or after January 1, 2005,~~
215.25 ~~and before December 31, 2008;~~

215.26 ~~(2) the costs were not otherwise reimbursed under subdivision 4f or section~~
215.27 ~~144A.071 or 144A.073; and~~

215.28 ~~(3) the total allowable costs reported under this paragraph are less than the minimum~~
215.29 ~~threshold established under section 256B.431, subdivision 15, paragraph (c), and~~
215.30 ~~subdivision 16.~~

215.31 ~~The commissioner shall use money appropriated for this purpose to provide to qualifying~~
215.32 ~~nursing facilities a rate adjustment beginning October 1, 2007, and ending September 30,~~
215.33 ~~2008. Nursing facilities that have spent money or anticipate the need to spend money~~
215.34 ~~to satisfy the most recent life safety code requirements by (1) installing a sprinkler~~
215.35 ~~system or (2) replacing all or portions of an existing sprinkler system may submit to the~~
215.36 ~~commissioner by June 30, 2007, on a form provided by the commissioner the actual~~

216.1 costs of a completed project or the estimated costs, based on a project bid, of a planned
 216.2 project. The commissioner shall calculate a rate adjustment equal to the allowable
 216.3 costs of the project divided by the resident days reported for the report year ending
 216.4 September 30, 2006. If the costs from all projects exceed the appropriation for this
 216.5 purpose, the commissioner shall allocate the money appropriated on a pro rata basis to the
 216.6 qualifying facilities by reducing the rate adjustment determined for each facility by an
 216.7 equal percentage. Facilities that used estimated costs when requesting the rate adjustment
 216.8 shall report to the commissioner by January 31, 2009, on the use of this money on a
 216.9 form provided by the commissioner. If the nursing facility fails to provide the report, the
 216.10 commissioner shall recoup the money paid to the facility for this purpose. If the facility
 216.11 reports expenditures allowable under this subdivision that are less than the amount received
 216.12 in the facility's annualized rate adjustment, the commissioner shall recoup the difference.

216.13 Sec. 10. Minnesota Statutes 2014, section 256B.434, is amended by adding a
 216.14 subdivision to read:

216.15 Subd. 4i. **Construction project rate adjustments for certain nursing facilities.**

216.16 (a) This subdivision applies to nursing facilities with at least 120 active beds as of January
 216.17 1, 2015, that have projects approved in 2015 under the nursing facility moratorium
 216.18 exception process in section 144A.073. When each facility's moratorium exception
 216.19 construction project is completed, the facility must receive the rate adjustment allowed
 216.20 under subdivision 4f. In addition to that rate adjustment, facilities with at least 120
 216.21 active beds, but not more than 149 active beds, as of January 1, 2015, must have their
 216.22 construction project rate adjustment increased by an additional \$4; and facilities with at
 216.23 least 150 active beds, but not more than 160 active beds, as of January 1, 2015, must have
 216.24 their construction project rate adjustment increased by an additional \$12.50.

216.25 (b) Notwithstanding any other law to the contrary, money available under section
 216.26 144A.073, subdivision 11, after the completion of the moratorium exception approval
 216.27 process in 2015 under section 144A.073, subdivision 3, shall be used to reduce the fiscal
 216.28 impact to the medical assistance budget for the increases allowed in this subdivision.

216.29 Sec. 11. Minnesota Statutes 2014, section 256B.441, subdivision 1, is amended to read:

216.30 Subdivision 1. **Rebasing Calculation of nursing facility operating payment**
 216.31 **rates.** (a) The commissioner shall rebase nursing facility operating payment rates to align
 216.32 payments to facilities with the cost of providing care. The rebased calculate operating
 216.33 payment rates shall be calculated using the statistical and cost report filed by each nursing
 216.34 facility for the report period ending one year 15 months prior to the rate year.

217.1 (b) The new operating payment rates based on this section shall take effect beginning
 217.2 with the rate year beginning ~~October 1, 2008, and shall be phased in over eight rate years~~
 217.3 ~~through October 1, 2015.~~ For each year of the phase-in, the operating payment rates shall
 217.4 be calculated using the statistical and cost report filed by each nursing facility for the
 217.5 report period ending one year prior to the rate year January 1, 2016.

217.6 (e) ~~Operating payment rates shall be rebased on October 1, 2016, and every two~~
 217.7 ~~years after that date.~~

217.8 (d) (c) Each cost reporting year shall begin on October 1 and end on the following
 217.9 September 30. ~~Beginning in 2014,~~ A statistical and cost report shall be filed by each
 217.10 nursing facility by February 1 in a form and manner specified by the commissioner.
 217.11 Notice of rates shall be distributed by ~~August~~ November 15 and the rates shall go into
 217.12 effect on ~~October~~ January 1 for one year.

217.13 (e) ~~Effective October 1, 2014, property rates shall be rebased in accordance with~~
 217.14 ~~section 256B.431 and Minnesota Rules, chapter 9549. The commissioner shall determine~~
 217.15 ~~what the property payment rate for a nursing facility would be had the facility not had its~~
 217.16 ~~property rate determined under section 256B.434. The commissioner shall allow nursing~~
 217.17 ~~facilities to provide information affecting this rate determination that would have been~~
 217.18 ~~filed annually under Minnesota Rules, chapter 9549, and nursing facilities shall report~~
 217.19 ~~information necessary to determine allowable debt. The commissioner shall use this~~
 217.20 ~~information to determine the property payment rate.~~

217.21 Sec. 12. Minnesota Statutes 2014, section 256B.441, subdivision 5, is amended to read:

217.22 Subd. 5. **Administrative costs.** "Administrative costs" means the direct costs for
 217.23 administering the overall activities of the nursing home. These costs include salaries and
 217.24 wages of the administrator, assistant administrator, business office employees, security
 217.25 guards, and associated fringe benefits and payroll taxes, fees, contracts, or purchases
 217.26 related to business office functions, licenses, and permits except as provided in the
 217.27 external fixed costs category, employee recognition, travel including meals and lodging,
 217.28 all training except as specified in subdivision 11, voice and data communication or
 217.29 transmission, office supplies, property and liability insurance and other forms of insurance
 217.30 not designated to other areas, personnel recruitment, legal services, accounting services,
 217.31 management or business consultants, data processing, information technology, Web
 217.32 site, central or home office costs, business meetings and seminars, postage, fees for
 217.33 professional organizations, subscriptions, security services, advertising, board of director's
 217.34 fees, working capital interest expense, and bad debts and bad debt collection fees.

218.1 Sec. 13. Minnesota Statutes 2014, section 256B.441, subdivision 6, is amended to read:

218.2 Subd. 6. **Allowed costs.** (a) "Allowed costs" means the amounts reported by the
218.3 facility which are necessary for the operation of the facility and the care of residents
218.4 and which are reviewed by the department for accuracy; reasonableness, in accordance
218.5 with the requirements set forth in title XVIII of the federal Social Security Act and the
218.6 interpretations in the provider reimbursement manual; and compliance with this section
218.7 and generally accepted accounting principles. All references to costs in this section shall
218.8 be assumed to refer to allowed costs.

218.9 (b) For facilities where employees are represented by collective bargaining agents,
218.10 costs related to the salaries and wages, payroll taxes, and employer's share of fringe benefit
218.11 costs, except employer health insurance costs, for facility employees who are members of
218.12 the bargaining unit are allowed costs only if:

218.13 (1) these costs are incurred pursuant to a collective bargaining agreement. The
218.14 commissioner shall allow until March 1 following the date on which the cost report was
218.15 required to be submitted for a collective bargaining agent to notify the commissioner if
218.16 a collective bargaining agreement, effective on the last day of the cost reporting year,
218.17 was not in effect; or

218.18 (2) the collective bargaining agent notifies the commissioner by October 1 following
218.19 the date on which the cost report was required to be submitted that these costs are
218.20 incurred pursuant to an agreement or understanding between the facility and the collective
218.21 bargaining agent.

218.22 (c) In any year when a portion of a facility's reported costs are not allowed costs
218.23 under paragraph (b), when calculating the operating payment rate for the facility, the
218.24 commissioner shall use the facility's allowed costs from the facility's second most recent
218.25 cost report in place of the nonallowed costs. For the purpose of setting the price for other
218.26 operating costs under subdivision 51, the price shall be reduced by the difference between
218.27 the nonallowed costs and the allowed costs from the facility's second most recent cost
218.28 report.

218.29 Sec. 14. Minnesota Statutes 2014, section 256B.441, is amended by adding a
218.30 subdivision to read:

218.31 Subd. 11a. **Employer health insurance costs.** "Employer health insurance costs"
218.32 means premium expenses for group coverage and reinsurance, actual expenses incurred
218.33 for self-insured plans, and employer contributions to employee health reimbursement and
218.34 health savings accounts. Premium and expense costs and contributions are allowable for

219.1 employees who meet the definition of full-time employees and their spouse and dependents
 219.2 under the federal Affordable Care Act, Public Law 111-148, and part-time employees.

219.3 Sec. 15. Minnesota Statutes 2014, section 256B.441, subdivision 13, is amended to read:

219.4 Subd. 13. **External fixed costs.** "External fixed costs" means costs related to the
 219.5 nursing home surcharge under section 256.9657, subdivision 1; licensure fees under
 219.6 section 144.122; ~~until September 30, 2013, long-term care consultation fees under~~
 219.7 ~~section 256B.0911, subdivision 6;~~ family advisory council fee under section 144A.33;
 219.8 scholarships under section 256B.431, subdivision 36; planned closure rate adjustments
 219.9 under section 256B.437; ~~or~~ single bed room incentives under section 256B.431,
 219.10 subdivision 42; property taxes and property insurance, assessments, and payments in
 219.11 lieu of taxes; employer health insurance costs; quality improvement incentive payment
 219.12 rate adjustments under subdivision 46c; performance-based incentive payments under
 219.13 subdivision 46d; special dietary needs under subdivision 51b; and PERA.

219.14 Sec. 16. Minnesota Statutes 2014, section 256B.441, subdivision 14, is amended to read:

219.15 Subd. 14. **Facility average case mix index.** "Facility average case mix index"
 219.16 or "CMI" means a numerical value score that describes the relative resource use for
 219.17 all residents within the groups under the resource utilization group ~~(RUG-III)~~ (RUG)
 219.18 classification system prescribed by the commissioner based on an assessment of each
 219.19 resident. The facility average CMI shall be computed as the standardized days divided by
 219.20 total days for all residents in the facility. The RUG's weights used ~~in this section shall be~~
 219.21 ~~as follows for each RUG's class: SE3 1.605; SE2 1.247; SE1 1.081; RAD 1.509; RAC~~
 219.22 ~~1.259; RAB 1.109; RAA 0.957; SSC 1.453; SSB 1.224; SSA 1.047; CC2 1.292; CC1~~
 219.23 ~~1.200; CB2 1.086; CB1 1.017; CA2 0.908; CA1 0.834; IB2 0.877; IB1 0.817; IA2 0.720;~~
 219.24 ~~IA1 0.676; BB2 0.956; BB1 0.885; BA2 0.716; BA1 0.673; PE2 1.199; PE1 1.104; PD2~~
 219.25 ~~1.023; PD1 0.948; PC2 0.926; PC1 0.860; PB2 0.786; PB1 0.734; PA2 0.691; PA1 0.651;~~
 219.26 ~~BC1 0.651; and DDF 1.000~~ shall be based on the system prescribed in section 256B.438.

219.27 Sec. 17. Minnesota Statutes 2014, section 256B.441, subdivision 17, is amended to read:

219.28 Subd. 17. **Fringe benefit costs.** "Fringe benefit costs" means the costs for group life,
 219.29 ~~health;~~ dental, workers' compensation, and other employee insurances and pension, except
 219.30 for the Public Employees Retirement Association and employer health insurance costs;
 219.31 profit sharing; and retirement plans for which the employer pays all or a portion of the costs.

219.32 Sec. 18. Minnesota Statutes 2014, section 256B.441, subdivision 30, is amended to read:

220.1 Subd. 30. **Peer groups Median total care-related cost per diem and other**
 220.2 **operating per diem determined.** ~~Facilities shall be classified into three groups by county.~~
 220.3 ~~The groups shall consist of:~~

220.4 (1) ~~group one: facilities in Anoka, Benton, Carlton, Carver, Chisago, Dakota,~~
 220.5 ~~Dodge, Goodhue, Hennepin, Isanti, Mille Laes, Morrison, Olmsted, Ramsey, Rice, Scott,~~
 220.6 ~~Sherburne, St. Louis, Stearns, Steele, Wabasha, Washington, Winona, or Wright County;~~

220.7 (2) ~~group two: facilities in Aitkin, Beltrami, Blue Earth, Brown, Cass, Clay,~~
 220.8 ~~Cook, Crow Wing, Faribault, Fillmore, Freeborn, Houston, Hubbard, Itasea, Kanabee,~~
 220.9 ~~Koochiching, Lake, Lake of the Woods, Le Sueur, Martin, MeLeod, Meeker, Mower,~~
 220.10 ~~Nicollet, Norman, Pine, Roseau, Sibley, Todd, Wadena, Waseca, Watonwan, or Wilkin~~
 220.11 ~~County; and~~

220.12 (3) ~~group three: facilities in all other counties~~ (a) The commissioner shall determine
 220.13 the median total care-related per diem to be used in subdivision 50 and the median other
 220.14 operating per diem to be used in subdivision 51 using the cost reports from nursing
 220.15 facilities in Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington Counties.

220.16 (b) The median total care-related per diem shall be equal to the median direct care
 220.17 cost for a RUG's weight of 1.00 for facilities located in the counties listed in paragraph (a).

220.18 (c) The median other operating per diem shall be equal to the median other
 220.19 operating per diem for facilities located in the counties listed in paragraph (a). The other
 220.20 operating per diem shall be the sum of each facility's administrative costs, dietary costs,
 220.21 housekeeping costs, laundry costs, and maintenance and plant operations costs divided
 220.22 by each facility's resident days.

220.23 Sec. 19. Minnesota Statutes 2014, section 256B.441, subdivision 31, is amended to read:

220.24 Subd. 31. **Prior system operating cost payment rate.** "Prior system operating cost
 220.25 payment rate" means the operating cost payment rate in effect on ~~September 30, 2008~~
 220.26 December 31, 2015, under Minnesota Rules and Minnesota Statutes, ~~not including planned~~
 220.27 ~~closure rate adjustments under section 256B.437 or single bed room incentives under~~
 220.28 ~~section 256B.431, subdivision 42 inclusive of health insurance plus property insurance~~
 220.29 costs from external fixed, but not including rate increases allowed under subdivision 55a.

220.30 Sec. 20. Minnesota Statutes 2014, section 256B.441, subdivision 33, is amended to read:

220.31 Subd. 33. **Rate year.** "Rate year" means the 12-month period beginning on ~~October~~
 220.32 January 1 following the second most recent reporting year.

220.33 Sec. 21. Minnesota Statutes 2014, section 256B.441, subdivision 35, is amended to read:

221.1 Subd. 35. **Reporting period.** "Reporting period" means the one-year period
 221.2 beginning on October 1 and ending on the following September 30 during which incurred
 221.3 costs are accumulated and then reported on the statistical and cost report. If a facility is
 221.4 reporting for an interim or settle-up period, the reporting period beginning date may be a
 221.5 date other than October 1. An interim or settle-up report must cover at least five months,
 221.6 but no more than 17 months, and must always end on September 30.

221.7 Sec. 22. Minnesota Statutes 2014, section 256B.441, subdivision 40, is amended to read:

221.8 Subd. 40. **Standardized days.** "Standardized days" means the sum of resident days
 221.9 by case mix category multiplied by the RUG index for each category. When a facility has
 221.10 resident days at a penalty classification, these days shall be reported as resident days at the
 221.11 RUG class established immediately after the penalty period, if available, and otherwise, at
 221.12 the RUG class in effect before the penalty began.

221.13 Sec. 23. Minnesota Statutes 2014, section 256B.441, subdivision 44, is amended to read:

221.14 Subd. 44. **Calculation of a quality score.** (a) The commissioner shall determine
 221.15 a quality score for each nursing facility using quality measures established in section
 221.16 256B.439, according to methods determined by the commissioner in consultation with
 221.17 stakeholders and experts, and using the most recently available data as provided in
 221.18 the Minnesota Nursing Home Report Card. These methods shall be exempt from the
 221.19 rulemaking requirements under chapter 14.

221.20 (b) For each quality measure, a score shall be determined with ~~a maximum~~ the number
 221.21 ~~of points available and number of points~~ assigned as determined by the commissioner
 221.22 using the methodology established according to this subdivision. ~~The scores determined~~
 221.23 ~~for all quality measures shall be totaled.~~ The determination of the quality measures to be
 221.24 used and the methods of calculating scores may be revised annually by the commissioner.

221.25 (c) ~~For the initial rate year under the new payment system, the quality measures~~
 221.26 ~~shall include:~~

221.27 (1) ~~staff turnover;~~

221.28 (2) ~~staff retention;~~

221.29 (3) ~~use of pool staff;~~

221.30 (4) ~~quality indicators from the minimum data set; and~~

221.31 (5) ~~survey deficiencies.~~

221.32 (d) ~~Beginning July 1, 2013~~ January 1, 2016, the quality score shall be a value
 221.33 ~~between zero and 100, using data as provided in the Minnesota nursing home report~~
 221.34 ~~card, with~~ include up to 50 percent derived from points related to the Minnesota quality

222.1 indicators score, up to 40 percent derived from points related to the resident quality of life
 222.2 score, and up to ten percent derived from points related to the state inspection results score.

222.3 ~~(e)~~ (d) The commissioner, in cooperation with the commissioner of health, may
 222.4 adjust the formula in paragraph ~~(d)~~ (c), or the methodology for computing the total quality
 222.5 score, effective July 1 of any year beginning in ~~2014~~ 2017, with five months advance
 222.6 public notice. In changing the formula, the commissioner shall consider quality measure
 222.7 priorities registered by report card users, advice of stakeholders, and available research.

222.8 Sec. 24. Minnesota Statutes 2014, section 256B.441, subdivision 46c, is amended to
 222.9 read:

222.10 Subd. 46c. **Quality improvement incentive system beginning October 1, 2015.**
 222.11 The commissioner shall develop a quality improvement incentive program in consultation
 222.12 with stakeholders. The annual funding pool available for quality improvement incentive
 222.13 payments shall be equal to 0.8 percent of all operating payments, not including any rate
 222.14 components resulting from equitable cost-sharing for publicly owned nursing facility
 222.15 program participation under subdivision 55a, critical access nursing facility program
 222.16 participation under subdivision 63, or performance-based incentive payment program
 222.17 participation under section 256B.434, subdivision 4, paragraph (d). For the period from
 222.18 October 1, 2015, to December 31, 2016, rate adjustments provided under this subdivision
 222.19 shall be effective for 15 months. Beginning ~~October 1, 2015~~ January 1, 2017, annual
 222.20 rate adjustments provided under this subdivision shall be effective for one year, starting
 222.21 ~~October~~ January 1 and ending the following ~~September 30~~ December 31. The increase in
 222.22 this subdivision shall be included in the external fixed payment rate under subdivisions
 222.23 13 and 53.

222.24 Sec. 25. Minnesota Statutes 2014, section 256B.441, is amended by adding a
 222.25 subdivision to read:

222.26 Subd. 46d. **Performance-based incentive payments.** The commissioner shall
 222.27 develop additional incentive-based payments of up to five percent above a facility's
 222.28 operating payment rate for achieving outcomes specified in a contract. The commissioner
 222.29 may solicit proposals and select those which, on a competitive basis, best meet the state's
 222.30 policy objectives. The commissioner shall limit the amount of any incentive payment
 222.31 and the number of contract amendments under this subdivision to operate the incentive
 222.32 payments within funds appropriated for this purpose. The commissioner shall approve
 222.33 proposals through a memorandum of understanding which shall specify various levels of
 222.34 payment for various levels of performance. Incentive payments to facilities under this

223.1 subdivision shall be in the form of time-limited rate adjustments which shall be included
 223.2 in the external fixed payment rate under subdivisions 13 and 53. In establishing the
 223.3 specified outcomes and related criteria, the commissioner shall consider the following
 223.4 state policy objectives:

223.5 (1) successful diversion or discharge of residents to the residents' prior home or other
 223.6 community-based alternatives;

223.7 (2) adoption of new technology to improve quality or efficiency;

223.8 (3) improved quality as measured in the Minnesota Nursing Home Report Card;

223.9 (4) reduced acute care costs; and

223.10 (5) any additional outcomes proposed by a nursing facility that the commissioner
 223.11 finds desirable.

223.12 Sec. 26. Minnesota Statutes 2014, section 256B.441, subdivision 48, is amended to read:

223.13 Subd. 48. **Calculation of operating care-related per diems.** The direct care per
 223.14 diem for each facility shall be the facility's direct care costs divided by its standardized
 223.15 days. The other care-related per diem shall be the sum of the facility's activities costs,
 223.16 other direct care costs, raw food costs, therapy costs, and social services costs, divided by
 223.17 the facility's resident days. ~~The other operating per diem shall be the sum of the facility's~~
 223.18 ~~administrative costs, dietary costs, housekeeping costs, laundry costs, and maintenance~~
 223.19 ~~and plant operations costs divided by the facility's resident days.~~

223.20 Sec. 27. Minnesota Statutes 2014, section 256B.441, subdivision 50, is amended to read:

223.21 Subd. 50. **Determination of total care-related limit.** (a) ~~The limit on the median~~
 223.22 ~~total care-related per diem shall be determined for each peer group and facility type group~~
 223.23 ~~combination. A facility's total care-related per diems shall be limited to 120 percent of the~~
 223.24 ~~median for the facility's peer and facility type group. The facility-specific direct care costs~~
 223.25 ~~used in making this comparison and in the calculation of the median shall be based on a~~
 223.26 ~~RUG's weight of 1.00. A facility that is above that limit shall have its total care-related per~~
 223.27 ~~diem reduced to the limit. If a reduction of the total care-related per diem is necessary~~
 223.28 ~~because of this limit, the reduction shall be made proportionally to both the direct care per~~
 223.29 ~~diem and the other care-related per diem according to subdivision 30.~~

223.30 (b) ~~Beginning with rates determined for October 1, 2016, the~~ A facility's total
 223.31 care-related limit shall be a variable amount based on each facility's quality score, as
 223.32 determined under subdivision 44, in accordance with clauses (1) to ~~(4)~~ (3):

223.33 (1) ~~for each facility, the commissioner shall determine the quality score, subtract 40,~~
 223.34 ~~divide by 40, and convert to a percentage~~ the quality score shall be multiplied by 0.5625;

224.1 (2) if the value determined in clause (1) is less than zero, the total care-related limit
 224.2 shall be 105 percent of the median for the facility's peer and facility type group add 89.375
 224.3 to the amount determined in clause (1), and divide the total by 100; and

224.4 (3) if the value determined in clause (1) is greater than 100 percent, the total
 224.5 care-related limit shall be 125 percent of the median for the facility's peer and facility type
 224.6 group; and multiply the amount determined in clause (2) by the median total care-related
 224.7 per diem determined in subdivision 30, paragraph (b).

224.8 (4) if the value determined in clause (1) is greater than zero and less than 100
 224.9 percent, the total care-related limit shall be 105 percent of the median for the facility's peer
 224.10 and facility type group plus one-fifth of the percentage determined in clause (1).

224.11 (c) A RUG's weight of 1.00 shall be used in the calculation of the median total
 224.12 care-related per diem, and in comparisons of facility-specific direct care costs to the median.

224.13 (d) A facility that is above its total care-related limit as determined according to
 224.14 paragraph (b) shall have its total care-related per diem reduced to its limit. If a reduction
 224.15 of the total care-related per diem is necessary due to this limit, the reduction shall be made
 224.16 proportionally to both the direct care per diem and the other care-related per diem.

224.17 Sec. 28. Minnesota Statutes 2014, section 256B.441, subdivision 51, is amended to read:

224.18 Subd. 51. **Determination of other operating limit price.** The limit on the A price
 224.19 for other operating per diem costs shall be determined for each peer group. A facility's
 224.20 other operating per diem shall be limited to The price shall be calculated as 105 percent
 224.21 of the median for its peer group other operating per diem described in subdivision 30,
 224.22 paragraph (c). A facility that is above that limit shall have its other operating per diem
 224.23 reduced to the limit.

224.24 Sec. 29. Minnesota Statutes 2014, section 256B.441, subdivision 51a, is amended to
 224.25 read:

224.26 Subd. 51a. **Exception allowing contracting for specialized care facilities.** (a)
 224.27 For rate years beginning on or after ~~October~~ January 1, 2016, the commissioner may
 224.28 negotiate increases to the care-related limit for nursing facilities that provide specialized
 224.29 care, at a cost to the general fund not to exceed \$600,000 per year. The commissioner
 224.30 shall publish a request for proposals annually, and may negotiate increases to the limits
 224.31 that shall apply for either one or two years before the increase shall be subject to a new
 224.32 proposal and negotiation. the care-related limit may for specialized care facilities shall
 224.33 be increased by up to 50 percent.

225.1 ~~(b) In selecting facilities with which to negotiate, the commissioner shall consider:~~
 225.2 "Specialized care facilities" are defined as a facility having a program licensed under
 225.3 chapter 245A and Minnesota Rules, chapter 9570, or a facility with 96 beds on January 1,
 225.4 2015, located in Robbinsdale that specializes in the treatment of Huntington's Disease.

225.5 ~~(1) the diagnoses or other circumstances of residents in the specialized program that~~
 225.6 ~~require care that costs substantially more than the RUG's rates associated with those~~
 225.7 ~~residents;~~

225.8 ~~(2) the nature of the specialized program or programs offered to meet the needs~~
 225.9 ~~of these individuals; and~~

225.10 ~~(3) outcomes achieved by the specialized program.~~

225.11 Sec. 30. Minnesota Statutes 2014, section 256B.441, is amended by adding a
 225.12 subdivision to read:

225.13 Subd. 51b. **Special dietary needs.** The commissioner shall adjust the rates of
 225.14 a nursing facility that meets the criteria for the special dietary needs of its residents and
 225.15 the requirements in section 31.651 or 31.658. The adjustment for raw food cost shall be
 225.16 the difference between the nursing facility's most recently reported allowable raw food
 225.17 cost per diem and 115 percent of the median allowable raw food cost per diem. For rate
 225.18 years beginning on or after January 1, 2016, this amount shall be removed from allowable
 225.19 raw food per diem costs under operating costs and included in the external fixed per
 225.20 diem rate under subdivisions 13 and 53.

225.21 Sec. 31. Minnesota Statutes 2014, section 256B.441, subdivision 53, is amended to read:

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

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

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

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

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

226.1 (d) ~~Until September 30, 2013, the portion related to long-term care consultation shall~~
 226.2 ~~be determined according to section 256B.0911, subdivision 6.~~

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

226.5 ~~(f)~~ (e) The portion related to planned closure rate adjustments shall be as determined
 226.6 under section 256B.437, subdivision 6, and Minnesota Statutes 2010, section 256B.436.
 226.7 ~~Planned closure rate adjustments that take effect before October 1, 2014, shall no longer~~
 226.8 ~~be included in the payment rate for external fixed costs beginning October 1, 2016.~~
 226.9 ~~Planned closure rate adjustments that take effect on or after October 1, 2014, shall no~~
 226.10 ~~longer be included in the payment rate for external fixed costs beginning on October 1 of~~
 226.11 ~~the first year not less than two years after their effective date.~~

226.12 (f) The single bed room incentives shall be as determined under section 256B.431,
 226.13 subdivision 42.

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

226.17 (h) The portion related to employer health insurance costs shall be the allowable
 226.18 costs divided by resident days.

226.19 (i) The portion related to the Public Employees Retirement Association shall be
 226.20 actual costs divided by resident days.

226.21 ~~(i) The single bed room incentives shall be as determined under section 256B.431,~~
 226.22 ~~subdivision 42. Single bed room incentives that take effect before October 1, 2014, shall~~
 226.23 ~~no longer be included in the payment rate for external fixed costs beginning October 1,~~
 226.24 ~~2016. Single bed room incentives that take effect on or after October 1, 2014, shall no~~
 226.25 ~~longer be included in the payment rate for external fixed costs beginning on October 1 of~~
 226.26 ~~the first year not less than two years after their effective date.~~

226.27 (j) The portion related to quality improvement incentive payment rate adjustments
 226.28 shall be as determined under subdivision 46c.

226.29 (k) The portion related to performance-based incentive payments shall be as
 226.30 determined under subdivision 46d.

226.31 (l) The portion related to special dietary needs shall be the per diem amount
 226.32 determined under subdivision 51b.

226.33 ~~(j)~~ (m) The payment rate for external fixed costs shall be the sum of the amounts in
 226.34 paragraphs (a) to ~~(j)~~ (l).

226.35 Sec. 32. Minnesota Statutes 2014, section 256B.441, subdivision 54, is amended to read:

227.1 Subd. 54. **Determination of total payment rates.** ~~In rate years when rates are~~
 227.2 ~~rebased,~~ The total care-related per diem, other operating price, and external fixed per
 227.3 diem for each facility shall be converted to payment rates. The total payment rate for
 227.4 a RUG's weight of 1.00 shall be the sum of the total care-related payment rate, other
 227.5 operating payment rate, ~~efficiency incentive,~~ external fixed cost rate, and the property rate
 227.6 determined under section 256B.434. To determine a total payment rate for each RUG's
 227.7 level, the total care-related payment rate shall be divided into the direct care payment rate
 227.8 and the other care-related payment rate, and the direct care payment rate multiplied by the
 227.9 RUG's weight for each RUG's level ~~using the weights in subdivision 14.~~

227.10 Sec. 33. Minnesota Statutes 2014, section 256B.441, subdivision 55a, is amended to
 227.11 read:

227.12 Subd. 55a. **Alternative to phase-in for publicly owned nursing facilities.** (a) For
 227.13 operating payment rates implemented between October 1, 2011, and the day before ~~the~~
 227.14 ~~phase-in under subdivision 55 is complete~~ operating payment rates are determined under
 227.15 this section, the commissioner shall allow nursing facilities whose physical plant is owned
 227.16 or whose license is held by a city, county, or hospital district to apply for a higher payment
 227.17 rate under this section if the local governmental entity agrees to pay a specified portion
 227.18 of the nonfederal share of medical assistance costs. Nursing facilities that apply shall be
 227.19 eligible to select an operating payment rate, with a weight of 1.00, up to the rate calculated
 227.20 in subdivision 54, without application of the phase-in under subdivision 55. The rates for
 227.21 the other RUGs shall be computed as provided under subdivision 54.

227.22 (b) For operating payment rates implemented beginning the day when the ~~phase-in~~
 227.23 ~~under subdivision 55 is complete~~ operating payment rates are determined under this
 227.24 section, the commissioner shall allow nursing facilities whose physical plant is owned or
 227.25 whose license is held by a city, county, or hospital district to apply for a higher payment
 227.26 rate under this section if the local governmental entity agrees to pay a specified portion of
 227.27 the nonfederal share of medical assistance costs. Nursing facilities that apply are eligible
 227.28 to select an operating payment rate with a weight of 1.00, up to an amount determined by
 227.29 the commissioner to be allowable under the Medicare upper payment limit test. The rates
 227.30 for the other RUGs shall be computed under subdivision 54. The rate increase allowed in
 227.31 this paragraph shall take effect only upon federal approval.

227.32 (c) Rates determined under this subdivision shall take effect ~~beginning October 1,~~
 227.33 ~~2011, based on cost reports for the reporting year ending September 30, 2010, and in~~
 227.34 ~~future rate years, rates determined for nursing facilities participating under this subdivision~~

228.1 ~~shall take effect on October 1 of each year~~ in accordance with the rate year in subdivision
228.2 33, based on the most recent available cost report.

228.3 (d) Eligible nursing facilities that wish to participate under this subdivision shall
228.4 make an application to the commissioner by August 31, 2011, or by ~~June~~ September 30
228.5 of any subsequent year.

228.6 (e) For each participating nursing facility, the public entity that owns the physical
228.7 plant or is the license holder of the nursing facility shall pay to the state the entire
228.8 nonfederal share of medical assistance payments received as a result of the difference
228.9 between the nursing facility's payment rate under paragraph (a) or (b), and the rates that
228.10 the nursing facility would otherwise be paid without application of this subdivision under
228.11 subdivision 54 ~~or 55~~ as determined by the commissioner.

228.12 (f) The commissioner may, at any time, reduce the payments under this subdivision
228.13 based on the commissioner's determination that the payments shall cause nursing facility
228.14 rates to exceed the state's Medicare upper payment limit or any other federal limitation. If
228.15 the commissioner determines a reduction is necessary, the commissioner shall reduce all
228.16 payment rates for participating nursing facilities by a percentage applied to the amount of
228.17 increase they would otherwise receive under this subdivision and shall notify participating
228.18 facilities of the reductions. If payments to a nursing facility are reduced, payments under
228.19 section 256B.19, subdivision 1e, shall be reduced accordingly.

228.20 Sec. 34. Minnesota Statutes 2014, section 256B.441, subdivision 56, is amended to read:

228.21 Subd. 56. **Hold harmless.** (a) For the rate years beginning October 1, 2008, to
228.22 October on or after January 1, 2016, no nursing facility shall receive an operating a cost
228.23 payment rate, including the property insurance portion of operating costs plus the health
228.24 insurance component of external fixed, less than its operating prior system cost payment
228.25 rate under section 256B.434. For rate years beginning between October 1, 2009, and
228.26 October 1, 2015, no nursing facility shall receive an operating payment rate less than its
228.27 operating payment rate in effect on September 30, 2009, which included operating costs
228.28 inclusive of health insurance costs plus the property insurance component of external
228.29 fixed. The comparison of operating payment rates under this section shall be made for a
228.30 RUG's rate with a weight of 1.00.

228.31 (b) For rate years beginning on or after January 1, 2016, no facility shall be subject
228.32 to a care-related payment rate limit reduction greater than five percent of the median
228.33 determined in subdivision 30.

228.34 Sec. 35. Minnesota Statutes 2014, section 256B.441, subdivision 63, is amended to read:

229.1 Subd. 63. **Critical access nursing facilities.** (a) The commissioner, in consultation
229.2 with the commissioner of health, may designate certain nursing facilities as critical access
229.3 nursing facilities. The designation shall be granted on a competitive basis, within the
229.4 limits of funds appropriated for this purpose.

229.5 (b) The commissioner shall request proposals from nursing facilities every
229.6 two years. Proposals must be submitted in the form and according to the timelines
229.7 established by the commissioner. In selecting applicants to designate, the commissioner,
229.8 in consultation with the commissioner of health, and with input from stakeholders, shall
229.9 develop criteria designed to preserve access to nursing facility services in isolated areas,
229.10 rebalance long-term care, and improve quality. Beginning in fiscal year 2015, to the
229.11 extent practicable, the commissioner shall ensure an even distribution of designations
229.12 across the state.

229.13 (c) The commissioner shall allow the benefits in clauses (1) to (5) for nursing
229.14 facilities designated as critical access nursing facilities:

229.15 (1) partial rebasing, with the commissioner allowing a designated facility operating
229.16 payment rates being the sum of up to 60 percent of the operating payment rate determined
229.17 in accordance with subdivision 54 and at least 40 percent, with the sum of the two portions
229.18 being equal to 100 percent, of the operating payment rate that would have been allowed
229.19 had the facility not been designated. The commissioner may adjust these percentages by
229.20 up to 20 percent and may approve a request for less than the amount allowed;

229.21 (2) enhanced payments for leave days. Notwithstanding section 256B.431,
229.22 subdivision 2r, upon designation as a critical access nursing facility, the commissioner
229.23 shall limit payment for leave days to 60 percent of that nursing facility's total payment rate
229.24 for the involved resident, and shall allow this payment only when the occupancy of the
229.25 nursing facility, inclusive of bed hold days, is equal to or greater than 90 percent;

229.26 (3) two designated critical access nursing facilities, with up to 100 beds in active
229.27 service, may jointly apply to the commissioner of health for a waiver of Minnesota
229.28 Rules, part 4658.0500, subpart 2, in order to jointly employ a director of nursing. The
229.29 commissioner of health will consider each waiver request independently based on the
229.30 criteria under Minnesota Rules, part 4658.0040;

229.31 (4) the minimum threshold under section 256B.431, subdivision 15, paragraph (e),
229.32 shall be 40 percent of the amount that would otherwise apply; and

229.33 (5) ~~notwithstanding subdivision 58, beginning October 1, 2014,~~ the quality-based
229.34 rate limits under subdivision 50 shall apply to designated critical access nursing facilities.

230.1 (d) Designation of a critical access nursing facility shall be for a period of two
230.2 years, after which the benefits allowed under paragraph (c) shall be removed. Designated
230.3 facilities may apply for continued designation.

230.4 (e) This subdivision is suspended and no state or federal funding shall be
230.5 appropriated or allocated for the purposes of this subdivision from January 1, 2016, to
230.6 December 31, 2017.

230.7 Sec. 36. Minnesota Statutes 2014, section 256B.441, is amended by adding a
230.8 subdivision to read:

230.9 Subd. 65. **Nursing facility in Golden Valley.** Effective for the rate year beginning
230.10 January 1, 2016, and all subsequent rate years, the operating payment rate for a facility
230.11 located in the city of Golden Valley at 3915 Golden Valley Road with 44 licensed
230.12 rehabilitation beds as of January 7, 2015, must be calculated without the application of
230.13 subdivisions 50 and 51.

230.14 Sec. 37. Minnesota Statutes 2014, section 256B.441, is amended by adding a
230.15 subdivision to read:

230.16 Subd. 66. **Nursing facilities in border cities.** Effective for the rate year beginning
230.17 January 1, 2016, and annually thereafter, operating payment rates of a nonprofit nursing
230.18 facility that exists on January 1, 2015, is located anywhere within the boundaries of the
230.19 city of Breckenridge, and is reimbursed under this section, section 256B.431, or section
230.20 256B.434, shall be adjusted to be equal to the median RUG's rates, including comparable
230.21 rate components as determined by the commissioner, for the equivalent RUG's weight of
230.22 the nonprofit nursing facility or facilities located in an adjacent city in another state and
230.23 in cities contiguous to the adjacent city. The Minnesota facility's operating payment rate
230.24 with a weight of 1.0 shall be computed by dividing the adjacent city's nursing facilities
230.25 median operating payment rate with a weight of 1.02 by 1.02. If the adjustments under
230.26 this subdivision result in a rate that exceeds the limits in subdivisions 50 and 51 in a given
230.27 rate year, the facility's rate shall not be subject to those limits for that rate year. This
230.28 subdivision shall apply only if it results in a higher operating payment rate than would
230.29 otherwise be determined under this section, section 256B.431, or section 256B.434.

230.30 Sec. 38. Minnesota Statutes 2014, section 256B.441, is amended by adding a
230.31 subdivision to read:

230.32 Subd. 67. **Nursing facility; contract with insurance provider.** Within the projected
230.33 cost of nursing facility payment reform under this section, for a facility that did not provide

231.1 employee health insurance coverage as of May 1, 2015, if the facility has a signed contract
 231.2 with a health insurance provider to begin providing employee health insurance coverage
 231.3 by January 1, 2016, the facility shall be paid for the employer health insurance costs
 231.4 portion of external fixed costs under subdivisions 13 and 53 beginning January 1, 2016.

231.5 Sec. 39. Minnesota Statutes 2014, section 256B.50, subdivision 1, is amended to read:

231.6 Subdivision 1. **Scope.** A provider may appeal from a determination of a payment
 231.7 rate established pursuant to this chapter or allowed costs under section 256B.441 and
 231.8 reimbursement rules of the commissioner if the appeal, if successful, would result in
 231.9 a change to the provider's payment rate or to the calculation of maximum charges to
 231.10 therapy vendors as provided by section 256B.433, subdivision 3. Appeals must be filed
 231.11 in accordance with procedures in this section. This section does not apply to a request
 231.12 from a resident or long-term care facility for reconsideration of the classification of a
 231.13 resident under section 144.0722.

231.14 **EFFECTIVE DATE.** This section is effective July 1, 2015, and applies to appeals
 231.15 filed on or after that date.

231.16 Sec. 40. Minnesota Statutes 2014, section 256I.05, subdivision 2, is amended to read:

231.17 Subd. 2. **Monthly rates; exemptions.** This subdivision applies to a residence
 231.18 that on August 1, 1984, was licensed by the commissioner of health only as a boarding
 231.19 care home, certified by the commissioner of health as an intermediate care facility, and
 231.20 licensed by the commissioner of human services under Minnesota Rules, parts 9520.0500
 231.21 to 9520.0690. Notwithstanding the provisions of subdivision 1c, the rate paid to a
 231.22 facility reimbursed under this subdivision shall be determined under section 256B.431,
 231.23 ~~or under section 256B.434,~~ or 256B.441, if the facility is accepted by the commissioner
 231.24 for participation in the alternative payment demonstration project. The rate paid to this
 231.25 facility shall also include adjustments to the group residential housing rate according to
 231.26 subdivision 1, and any adjustments applicable to supplemental service rates statewide.

231.27 Sec. 41. **DIRECTION TO COMMISSIONER; NURSING FACILITY PAYMENT**
 231.28 **REFORM REPORT.**

231.29 By January 1, 2017, the commissioner of human services shall evaluate and report to
 231.30 the house of representatives and senate committees and divisions with jurisdiction over
 231.31 nursing facility payment rates on:

231.32 (1) the impact of using cost report data to set rates without accounting for cost
 231.33 report to rate year inflation;

- 232.1 (2) the impact of the quality adjusted care limits;
 232.2 (3) the ability of nursing facilities to attract and retain employees, including how rate
 232.3 increases are being passed through to employees, under the new payment system;
 232.4 (4) the efficacy of the critical access nursing facility program under Minnesota
 232.5 Statutes, section 256B.441, subdivision 63, given the new nursing facility payment system;
 232.6 (5) creating a process for the commissioner to designate certain facilities as
 232.7 specialized care facilities for difficult-to-serve populations; and
 232.8 (6) limiting the hold harmless in Minnesota Statutes, section 256B.441, subdivision
 232.9 56.

232.10 Sec. 42. **PROPERTY RATE SETTING.**

232.11 The commissioner shall conduct a study, in consultation with stakeholders and
 232.12 experts, of property rate setting, based on a rental value or other approach for Minnesota
 232.13 nursing facilities, and shall report the findings to the house of representatives and senate
 232.14 committees and divisions with jurisdiction over nursing facility payment rates by March 1,
 232.15 2016, for a system implementation date of January 1, 2017. The commissioner shall:

232.16 (1) contract with at least two firms to conduct appraisals of all nursing facilities in
 232.17 the medical assistance program. Each firm shall conduct appraisals of approximately
 232.18 equal portions of all nursing facilities assigned to them at random. The appraisals shall
 232.19 determine the value of the land, building, and equipment of each nursing facility, taking
 232.20 into account the quality of construction and current condition of the building;

232.21 (2) use the information from the appraisals to complete the design of a rental value
 232.22 or other system and calculate a replacement value and an effective age for each nursing
 232.23 facility. Nursing facilities may request an appraisal by a second firm which shall be
 232.24 assigned randomly by the commissioner. The commissioner shall use the findings of
 232.25 the second appraisal. If the second firm increases the appraisal value by more than five
 232.26 percent, the state shall pay for the second appraisal. Otherwise, the nursing facility shall
 232.27 pay the cost of the appraisal. Results of appraisals are not otherwise subject to appeal
 232.28 under section 256B.50; and

232.29 (3) include in the report required under this section the following items:

232.30 (i) a description of the proposed rental value or other system;

232.31 (ii) options for adjusting the system parameters that vary the cost of implementing
 232.32 the new property rate system and an analysis of individual nursing facilities under the
 232.33 current property payment rate and the rates under various approaches to calculating rates
 232.34 under the rental value or other system;

232.35 (iii) recommended steps for transition to the rental value or other system;

233.1 (iv) an analysis of the expected long-term incentives of the rental value or other
 233.2 system for nursing facilities to maintain and replace buildings, including how the current
 233.3 exceptions to the moratorium process under Minnesota Statutes, section 144A.073, may
 233.4 be adapted; and

233.5 (v) bill language for implementation of the rental value or other system.

233.6 Sec. 43. **REVISOR'S INSTRUCTION.**

233.7 The revisor of statutes, in consultation with the House Research Department, Office
 233.8 of Senate Counsel, Research, and Fiscal Analysis, Department of Human Services, and
 233.9 stakeholders, shall prepare legislation for the 2016 legislative session to recodify laws
 233.10 governing nursing home payments and rates in Minnesota Statutes, chapter 256B, and in
 233.11 Minnesota Rules, chapter 9549.

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

233.13 Sec. 44. **REPEALER.**

233.14 Minnesota Statutes 2014, sections 256B.434, subdivision 19b; and 256B.441,
 233.15 subdivisions 14a, 19, 50a, 52, 55, 58, and 62, are repealed.

233.16 ARTICLE 7

233.17 CONTINUING CARE

233.18 Section 1. Minnesota Statutes 2014, section 13.461, is amended by adding a
 233.19 subdivision to read:

233.20 Subd. 32. **ABLE accounts and designated beneficiaries.** Data on ABLE accounts
 233.21 and designated beneficiaries of ABLE accounts are classified under section 256Q.05,
 233.22 subdivision 7.

233.23 Sec. 2. Minnesota Statutes 2014, section 144.057, subdivision 1, is amended to read:

233.24 Subdivision 1. **Background studies required.** The commissioner of health shall
 233.25 contract with the commissioner of human services to conduct background studies of:

233.26 (1) individuals providing services which have direct contact, as defined under
 233.27 section 245C.02, subdivision 11, with patients and residents in hospitals, boarding care
 233.28 homes, outpatient surgical centers licensed under sections 144.50 to 144.58; nursing
 233.29 homes and home care agencies licensed under chapter 144A; residential care homes
 233.30 licensed under chapter 144B, and board and lodging establishments that are registered to
 233.31 provide supportive or health supervision services under section 157.17;

234.1 (2) individuals specified in section 245C.03, subdivision 1, who perform direct
234.2 contact services in a nursing home or a home care agency licensed under chapter 144A
234.3 or a boarding care home licensed under sections 144.50 to 144.58, ~~and~~. If the individual
234.4 under study resides outside Minnesota, the study must ~~be at least as comprehensive as~~
234.5 ~~that of a Minnesota resident and include a search of information from the criminal justice~~
234.6 ~~data communications network in the state where the subject of the study resides~~ include a
234.7 check for substantiated findings of maltreatment of adults and children in the individual's
234.8 state of residence when the information is made available by that state, and must include a
234.9 check of the National Crime Information Center database;

234.10 (3) beginning July 1, 1999, all other employees in nursing homes licensed under
234.11 chapter 144A, and boarding care homes licensed under sections 144.50 to 144.58. A
234.12 disqualification of an individual in this section shall disqualify the individual from
234.13 positions allowing direct contact or access to patients or residents receiving services.
234.14 "Access" means physical access to a client or the client's personal property without
234.15 continuous, direct supervision as defined in section 245C.02, subdivision 8, when the
234.16 employee's employment responsibilities do not include providing direct contact services;

234.17 (4) individuals employed by a supplemental nursing services agency, as defined
234.18 under section 144A.70, who are providing services in health care facilities; and

234.19 (5) controlling persons of a supplemental nursing services agency, as defined under
234.20 section 144A.70.

234.21 If a facility or program is licensed by the Department of Human Services and
234.22 subject to the background study provisions of chapter 245C and is also licensed by the
234.23 Department of Health, the Department of Human Services is solely responsible for the
234.24 background studies of individuals in the jointly licensed programs.

234.25 Sec. 3. Minnesota Statutes 2014, section 245A.06, is amended by adding a subdivision
234.26 to read:

234.27 Subd. 1a. **Correction orders and conditional licenses for programs licensed as**
234.28 **home and community-based services.** (a) For programs licensed under both this chapter
234.29 and chapter 245D, if the license holder operates more than one service site under a single
234.30 license governed by chapter 245D, the order issued under this section shall be specific to
234.31 the service site or sites at which the violations of applicable law or rules occurred. The
234.32 order shall not apply to other service sites governed by chapter 245D and operated by the
234.33 same license holder unless the commissioner has included in the order the articulable basis
234.34 for applying the order to another service site.

235.1 (b) If the commissioner has issued more than one license to the license holder under
235.2 this chapter, the conditions imposed under this section shall be specific to the license for
235.3 the program at which the violations of applicable law or rules occurred and shall not apply
235.4 to other licenses held by the same license holder if those programs are being operated in
235.5 substantial compliance with applicable law and rules.

235.6 Sec. 4. **[245A.081] SETTLEMENT AGREEMENT.**

235.7 (a) A license holder who has made a timely appeal pursuant to section 245A.06,
235.8 subdivision 4, or 245A.07, subdivision 3, or the commissioner may initiate a discussion
235.9 about a possible settlement agreement related to the licensing sanction. For the purposes
235.10 of this section, the following conditions apply to a settlement agreement reached by the
235.11 parties:

235.12 (1) if the parties enter into a settlement agreement, the effect of the agreement shall
235.13 be that the appeal is withdrawn and the agreement shall constitute the full agreement
235.14 between the commissioner and the party who filed the appeal; and

235.15 (2) the settlement agreement must identify the agreed upon actions the license holder
235.16 has taken and will take in order to achieve and maintain compliance with the licensing
235.17 requirements that the commissioner determined the license holder had violated.

235.18 (b) Neither the license holder nor the commissioner is required to initiate a
235.19 settlement discussion under this section.

235.20 (c) If a settlement discussion is initiated by the license holder, the commissioner
235.21 shall respond to the license holder within 14 calendar days of receipt of the license
235.22 holder's submission.

235.23 (d) If the commissioner agrees to engage in settlement discussions, the commissioner
235.24 may decide at any time not to continue settlement discussions with a license holder.

235.25 Sec. 5. Minnesota Statutes 2014, section 245A.155, subdivision 1, is amended to read:

235.26 Subdivision 1. **Licensed foster care and respite care.** This section applies to
235.27 foster care agencies and licensed foster care providers who place, supervise, or care for
235.28 individuals who rely on medical monitoring equipment to sustain life or monitor a medical
235.29 condition that could become life-threatening without proper use of the medical equipment
235.30 in respite care or foster care.

235.31 Sec. 6. Minnesota Statutes 2014, section 245A.155, subdivision 2, is amended to read:

235.32 Subd. 2. **Foster care agency requirements.** In order for an agency to place an
235.33 individual who relies on medical equipment to sustain life or monitor a medical condition

236.1 that could become life-threatening without proper use of the medical equipment with a
236.2 foster care provider, the agency must ensure that the foster care provider has received the
236.3 training to operate such equipment as observed and confirmed by a qualified source,
236.4 and that the provider:

236.5 (1) is currently caring for an individual who is using the same equipment in the
236.6 foster home; or

236.7 (2) has written documentation that the foster care provider has cared for an
236.8 individual who relied on such equipment within the past six months; or

236.9 (3) has successfully completed training with the individual being placed with the
236.10 provider.

236.11 Sec. 7. Minnesota Statutes 2014, section 245A.65, subdivision 2, is amended to read:

236.12 Subd. 2. **Abuse prevention plans.** All license holders shall establish and enforce
236.13 ongoing written program abuse prevention plans and individual abuse prevention plans as
236.14 required under section 626.557, subdivision 14.

236.15 (a) The scope of the program abuse prevention plan is limited to the population,
236.16 physical plant, and environment within the control of the license holder and the location
236.17 where licensed services are provided. In addition to the requirements in section 626.557,
236.18 subdivision 14, the program abuse prevention plan shall meet the requirements in clauses
236.19 (1) to (5).

236.20 (1) The assessment of the population shall include an evaluation of the following
236.21 factors: age, gender, mental functioning, physical and emotional health or behavior of the
236.22 client; the need for specialized programs of care for clients; the need for training of staff to
236.23 meet identified individual needs; and the knowledge a license holder may have regarding
236.24 previous abuse that is relevant to minimizing risk of abuse for clients.

236.25 (2) The assessment of the physical plant where the licensed services are provided
236.26 shall include an evaluation of the following factors: the condition and design of the
236.27 building as it relates to the safety of the clients; and the existence of areas in the building
236.28 which are difficult to supervise.

236.29 (3) The assessment of the environment for each facility and for each site when living
236.30 arrangements are provided by the agency shall include an evaluation of the following
236.31 factors: the location of the program in a particular neighborhood or community; the type
236.32 of grounds and terrain surrounding the building; the type of internal programming; and
236.33 the program's staffing patterns.

236.34 (4) The license holder shall provide an orientation to the program abuse prevention
236.35 plan for clients receiving services. If applicable, the client's legal representative must be

237.1 notified of the orientation. The license holder shall provide this orientation for each new
237.2 person within 24 hours of admission, or for persons who would benefit more from a later
237.3 orientation, the orientation may take place within 72 hours.

237.4 (5) The license holder's governing body or the governing body's delegated
237.5 representative shall review the plan at least annually using the assessment factors in the
237.6 plan and any substantiated maltreatment findings that occurred since the last review. The
237.7 governing body or the governing body's delegated representative shall revise the plan,
237.8 if necessary, to reflect the review results.

237.9 (6) A copy of the program abuse prevention plan shall be posted in a prominent
237.10 location in the program and be available upon request to mandated reporters, persons
237.11 receiving services, and legal representatives.

237.12 (b) In addition to the requirements in section 626.557, subdivision 14, the individual
237.13 abuse prevention plan shall meet the requirements in clauses (1) and (2).

237.14 (1) The plan shall include a statement of measures that will be taken to minimize the
237.15 risk of abuse to the vulnerable adult when the individual assessment required in section
237.16 626.557, subdivision 14, paragraph (b), indicates the need for measures in addition to the
237.17 specific measures identified in the program abuse prevention plan. The measures shall
237.18 include the specific actions the program will take to minimize the risk of abuse within
237.19 the scope of the licensed services, and will identify referrals made when the vulnerable
237.20 adult is susceptible to abuse outside the scope or control of the licensed services. When
237.21 the assessment indicates that the vulnerable adult does not need specific risk reduction
237.22 measures in addition to those identified in the program abuse prevention plan, the
237.23 individual abuse prevention plan shall document this determination.

237.24 (2) An individual abuse prevention plan shall be developed for each new person as
237.25 part of the initial individual program plan or service plan required under the applicable
237.26 licensing rule. The review and evaluation of the individual abuse prevention plan shall
237.27 be done as part of the review of the program plan or service plan. The person receiving
237.28 services shall participate in the development of the individual abuse prevention plan to the
237.29 full extent of the person's abilities. If applicable, the person's legal representative shall be
237.30 given the opportunity to participate with or for the person in the development of the plan.
237.31 The interdisciplinary team shall document the review of all abuse prevention plans at least
237.32 annually, using the individual assessment and any reports of abuse relating to the person.
237.33 The plan shall be revised to reflect the results of this review.

237.34 Sec. 8. Minnesota Statutes 2014, section 245C.08, subdivision 1, is amended to read:

238.1 Subdivision 1. **Background studies conducted by Department of Human**

238.2 **Services.** (a) For a background study conducted by the Department of Human Services,
238.3 the commissioner shall review:

238.4 (1) information related to names of substantiated perpetrators of maltreatment of
238.5 vulnerable adults that has been received by the commissioner as required under section
238.6 626.557, subdivision 9c, paragraph (j);

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

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

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

238.15 (5) except as provided in clause (6), information from the national crime information
238.16 system when the commissioner has reasonable cause as defined under section 245C.05,
238.17 subdivision 5, or as required under section 144.057, subdivision 1, clause (2); and

238.18 (6) for a background study related to a child foster care application for licensure, a
238.19 transfer of permanent legal and physical custody of a child under sections 260C.503 to
238.20 260C.515, or adoptions, the commissioner shall also review:

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

238.23 (ii) information from national crime information databases, when the background
238.24 study subject is 18 years of age or older.

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

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

238.33 (d) When the commissioner has reasonable cause to believe that the identity of
238.34 a background study subject is uncertain, the commissioner may require the subject to
238.35 provide a set of classifiable fingerprints for purposes of completing a fingerprint-based
238.36 record check with the Bureau of Criminal Apprehension. Fingerprints collected under this

239.1 paragraph shall not be saved by the commissioner after they have been used to verify the
239.2 identity of the background study subject against the particular criminal record in question.

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

239.5 Sec. 9. Minnesota Statutes 2014, section 245C.12, is amended to read:

239.6 **245C.12 BACKGROUND STUDY; TRIBAL ORGANIZATIONS.**

239.7 (a) For the purposes of background studies completed by tribal organizations
239.8 performing licensing activities otherwise required of the commissioner under this chapter,
239.9 after obtaining consent from the background study subject, tribal licensing agencies shall
239.10 have access to criminal history data in the same manner as county licensing agencies and
239.11 private licensing agencies under this chapter.

239.12 (b) Tribal organizations may contract with the commissioner to obtain background
239.13 study data on individuals under tribal jurisdiction related to adoptions according to
239.14 section 245C.34. Tribal organizations may also contract with the commissioner to obtain
239.15 background study data on individuals under tribal jurisdiction related to child foster care
239.16 according to section 245C.34.

239.17 (c) For the purposes of background studies completed to comply with a tribal
239.18 organization's licensing requirements for individuals affiliated with a tribally licensed
239.19 nursing facility, the commissioner shall obtain criminal history data from the National
239.20 Criminal Records Repository in accordance with section 245C.32.

239.21 Sec. 10. Minnesota Statutes 2014, section 245D.02, is amended by adding a
239.22 subdivision to read:

239.23 Subd. 37. **Working day.** "Working day" means Monday, Tuesday, Wednesday,
239.24 Thursday, or Friday, excluding any legal holiday.

239.25 Sec. 11. Minnesota Statutes 2014, section 245D.05, subdivision 1, is amended to read:

239.26 Subdivision 1. **Health needs.** (a) The license holder is responsible for meeting
239.27 health service needs assigned in the coordinated service and support plan or the
239.28 coordinated service and support plan addendum, consistent with the person's health needs.
239.29 Unless directed otherwise in the coordinated service and support plan or the coordinated
239.30 service and support plan addendum, the license holder is responsible for promptly
239.31 notifying the person's legal representative, if any, and the case manager of changes in a
239.32 person's physical and mental health needs affecting health service needs assigned to the
239.33 license holder in the coordinated service and support plan or the coordinated service

240.1 and support plan addendum, when discovered by the license holder, unless the license
240.2 holder has reason to know the change has already been reported. The license holder
240.3 must document when the notice is provided.

240.4 (b) If responsibility for meeting the person's health service needs has been assigned
240.5 to the license holder in the coordinated service and support plan or the coordinated service
240.6 and support plan addendum, the license holder must maintain documentation on how the
240.7 person's health needs will be met, including a description of the procedures the license
240.8 holder will follow in order to:

240.9 (1) provide medication setup, assistance, or administration according to this chapter.
240.10 Unlicensed staff responsible for medication setup or medication administration under this
240.11 section must complete training according to section 245D.09, subdivision 4a, paragraph (d);

240.12 (2) monitor health conditions according to written instructions from a licensed
240.13 health professional;

240.14 (3) assist with or coordinate medical, dental, and other health service appointments; or

240.15 (4) use medical equipment, devices, or adaptive aides or technology safely and
240.16 correctly according to written instructions from a licensed health professional.

240.17 Sec. 12. Minnesota Statutes 2014, section 245D.05, subdivision 2, is amended to read:

240.18 Subd. 2. **Medication administration.** (a) For purposes of this subdivision,
240.19 "medication administration" means:

240.20 (1) checking the person's medication record;

240.21 (2) preparing the medication as necessary;

240.22 (3) administering the medication or treatment to the person;

240.23 (4) documenting the administration of the medication or treatment or the reason for
240.24 not administering the medication or treatment; and

240.25 (5) reporting to the prescriber or a nurse any concerns about the medication or
240.26 treatment, including side effects, effectiveness, or a pattern of the person refusing to
240.27 take the medication or treatment as prescribed. Adverse reactions must be immediately
240.28 reported to the prescriber or a nurse.

240.29 (b)(1) If responsibility for medication administration is assigned to the license holder
240.30 in the coordinated service and support plan or the coordinated service and support plan
240.31 addendum, the license holder must implement medication administration procedures to
240.32 ensure a person takes medications and treatments as prescribed. The license holder must
240.33 ensure that the requirements in clauses (2) and (3) have been met before administering
240.34 medication or treatment.

241.1 (2) The license holder must obtain written authorization from the person or the
241.2 person's legal representative to administer medication or treatment ~~and must obtain~~
241.3 ~~reauthorization annually as needed~~. This authorization shall remain in effect unless it is
241.4 withdrawn in writing and may be withdrawn at any time. If the person or the person's
241.5 legal representative refuses to authorize the license holder to administer medication, the
241.6 medication must not be administered. The refusal to authorize medication administration
241.7 must be reported to the prescriber as expeditiously as possible.

241.8 (3) For a license holder providing intensive support services, the medication or
241.9 treatment must be administered according to the license holder's medication administration
241.10 policy and procedures as required under section 245D.11, subdivision 2, clause (3).

241.11 (c) The license holder must ensure the following information is documented in the
241.12 person's medication administration record:

241.13 (1) the information on the current prescription label or the prescriber's current
241.14 written or electronically recorded order or prescription that includes the person's name,
241.15 description of the medication or treatment to be provided, and the frequency and other
241.16 information needed to safely and correctly administer the medication or treatment to
241.17 ensure effectiveness;

241.18 (2) information on any risks or other side effects that are reasonable to expect, and
241.19 any contraindications to its use. This information must be readily available to all staff
241.20 administering the medication;

241.21 (3) the possible consequences if the medication or treatment is not taken or
241.22 administered as directed;

241.23 (4) instruction on when and to whom to report the following:

241.24 (i) if a dose of medication is not administered or treatment is not performed as
241.25 prescribed, whether by error by the staff or the person or by refusal by the person; and

241.26 (ii) the occurrence of possible adverse reactions to the medication or treatment;

241.27 (5) notation of any occurrence of a dose of medication not being administered or
241.28 treatment not performed as prescribed, whether by error by the staff or the person or by
241.29 refusal by the person, or of adverse reactions, and when and to whom the report was
241.30 made; and

241.31 (6) notation of when a medication or treatment is started, administered, changed, or
241.32 discontinued.

241.33 Sec. 13. Minnesota Statutes 2014, section 245D.06, subdivision 1, is amended to read:

242.1 Subdivision 1. **Incident response and reporting.** (a) The license holder must
242.2 respond to incidents under section 245D.02, subdivision 11, that occur while providing
242.3 services to protect the health and safety of and minimize risk of harm to the person.

242.4 (b) The license holder must maintain information about and report incidents to the
242.5 person's legal representative or designated emergency contact and case manager within
242.6 24 hours of an incident occurring while services are being provided, within 24 hours of
242.7 discovery or receipt of information that an incident occurred, unless the license holder
242.8 has reason to know that the incident has already been reported, or as otherwise directed
242.9 in a person's coordinated service and support plan or coordinated service and support
242.10 plan addendum. An incident of suspected or alleged maltreatment must be reported as
242.11 required under paragraph (d), and an incident of serious injury or death must be reported
242.12 as required under paragraph (e).

242.13 (c) When the incident involves more than one person, the license holder must not
242.14 disclose personally identifiable information about any other person when making the report
242.15 to each person and case manager unless the license holder has the consent of the person.

242.16 (d) Within 24 hours of reporting maltreatment as required under section 626.556
242.17 or 626.557, the license holder must inform the case manager of the report unless there is
242.18 reason to believe that the case manager is involved in the suspected maltreatment. The
242.19 license holder must disclose the nature of the activity or occurrence reported and the
242.20 agency that received the report.

242.21 (e) The license holder must report the death or serious injury of the person as
242.22 required in paragraph (b) and to the Department of Human Services Licensing Division,
242.23 and the Office of Ombudsman for Mental Health and Developmental Disabilities as
242.24 required under section 245.94, subdivision 2a, within 24 hours of the death or serious
242.25 injury, or receipt of information that the death or serious injury occurred, unless the license
242.26 holder has reason to know that the death or serious injury has already been reported.

242.27 (f) When a death or serious injury occurs in a facility certified as an intermediate
242.28 care facility for persons with developmental disabilities, the death or serious injury must
242.29 be reported to the Department of Health, Office of Health Facility Complaints, and the
242.30 Office of Ombudsman for Mental Health and Developmental Disabilities, as required
242.31 under sections 245.91 and 245.94, subdivision 2a, unless the license holder has reason to
242.32 know that the death or serious injury has already been reported.

242.33 (g) The license holder must conduct an internal review of incident reports of deaths
242.34 and serious injuries that occurred while services were being provided and that were not
242.35 reported by the program as alleged or suspected maltreatment, for identification of incident
242.36 patterns, and implementation of corrective action as necessary to reduce occurrences.

243.1 The review must include an evaluation of whether related policies and procedures were
243.2 followed, whether the policies and procedures were adequate, whether there is a need for
243.3 additional staff training, whether the reported event is similar to past events with the
243.4 persons or the services involved, and whether there is a need for corrective action by the
243.5 license holder to protect the health and safety of persons receiving services. Based on
243.6 the results of this review, the license holder must develop, document, and implement a
243.7 corrective action plan designed to correct current lapses and prevent future lapses in
243.8 performance by staff or the license holder, if any.

243.9 (h) The license holder must verbally report the emergency use of manual restraint
243.10 of a person as required in paragraph (b) within 24 hours of the occurrence. The license
243.11 holder must ensure the written report and internal review of all incident reports of the
243.12 emergency use of manual restraints are completed according to the requirements in section
243.13 245D.061 or successor provisions.

243.14 Sec. 14. Minnesota Statutes 2014, section 245D.06, subdivision 2, is amended to read:

243.15 Subd. 2. **Environment and safety.** The license holder must:

243.16 (1) ensure the following when the license holder is the owner, lessor, or tenant
243.17 of the service site:

243.18 (i) the service site is a safe and hazard-free environment;

243.19 (ii) that toxic substances or dangerous items are inaccessible to persons served by
243.20 the program only to protect the safety of a person receiving services when a known safety
243.21 threat exists and not as a substitute for staff supervision or interactions with a person who
243.22 is receiving services. If toxic substances or dangerous items are made inaccessible, the
243.23 license holder must document an assessment of the physical plant, its environment, and its
243.24 population identifying the risk factors which require toxic substances or dangerous items
243.25 to be inaccessible and a statement of specific measures to be taken to minimize the safety
243.26 risk to persons receiving services and to restore accessibility to all persons receiving
243.27 services at the service site;

243.28 (iii) doors are locked from the inside to prevent a person from exiting only when
243.29 necessary to protect the safety of a person receiving services and not as a substitute for
243.30 staff supervision or interactions with the person. If doors are locked from the inside, the
243.31 license holder must document an assessment of the physical plant, the environment and
243.32 the population served, identifying the risk factors which require the use of locked doors,
243.33 and a statement of specific measures to be taken to minimize the safety risk to persons
243.34 receiving services at the service site; and

- 244.1 (iv) a staff person is available at the service site who is trained in basic first aid and,
244.2 when required in a person's coordinated service and support plan or coordinated service
244.3 and support plan addendum, cardiopulmonary resuscitation (CPR) whenever persons are
244.4 present and staff are required to be at the site to provide direct support service. The CPR
244.5 training must include ~~in-person~~ instruction, hands-on practice, and an observed skills
244.6 assessment under the direct supervision of a CPR instructor;
- 244.7 (2) maintain equipment, vehicles, supplies, and materials owned or leased by the
244.8 license holder in good condition when used to provide services;
- 244.9 (3) follow procedures to ensure safe transportation, handling, and transfers of the
244.10 person and any equipment used by the person, when the license holder is responsible for
244.11 transportation of a person or a person's equipment;
- 244.12 (4) be prepared for emergencies and follow emergency response procedures to
244.13 ensure the person's safety in an emergency; and
- 244.14 (5) follow universal precautions and sanitary practices, including hand washing, for
244.15 infection prevention and control, and to prevent communicable diseases.

244.16 Sec. 15. Minnesota Statutes 2014, section 245D.06, subdivision 7, is amended to read:

244.17 Subd. 7. **Permitted actions and procedures.** (a) Use of the instructional techniques
244.18 and intervention procedures as identified in paragraphs (b) and (c) is permitted when used
244.19 on an intermittent or continuous basis. When used on a continuous basis, it must be
244.20 addressed in a person's coordinated service and support plan addendum as identified in
244.21 sections 245D.07 and 245D.071. For purposes of this chapter, the requirements of this
244.22 subdivision supersede the requirements identified in Minnesota Rules, part 9525.2720.

244.23 (b) Physical contact or instructional techniques must use the least restrictive
244.24 alternative possible to meet the needs of the person and may be used:

244.25 (1) to calm or comfort a person by holding that person with no resistance from
244.26 that person;

244.27 (2) to protect a person known to be at risk of injury due to frequent falls as a result
244.28 of a medical condition;

244.29 (3) to facilitate the person's completion of a task or response when the person does
244.30 not resist or the person's resistance is minimal in intensity and duration;

244.31 (4) to block or redirect a person's limbs or body without holding the person or
244.32 limiting the person's movement to interrupt the person's behavior that may result in injury
244.33 to self or others with less than 60 seconds of physical contact by staff; or

245.1 (5) to redirect a person's behavior when the behavior does not pose a serious threat
245.2 to the person or others and the behavior is effectively redirected with less than 60 seconds
245.3 of physical contact by staff.

245.4 (c) Restraint may be used as an intervention procedure to:

245.5 (1) allow a licensed health care professional to safely conduct a medical examination
245.6 or to provide medical treatment ordered by a licensed health care professional ~~to a person~~
245.7 ~~necessary to promote healing or recovery from an acute, meaning short-term, medical~~
245.8 ~~condition;~~

245.9 (2) assist in the safe evacuation or redirection of a person in the event of an
245.10 emergency and the person is at imminent risk of harm; or

245.11 (3) position a person with physical disabilities in a manner specified in the person's
245.12 coordinated service and support plan addendum.

245.13 Any use of manual restraint as allowed in this paragraph must comply with the restrictions
245.14 identified in subdivision 6, paragraph (b).

245.15 (d) Use of adaptive aids or equipment, orthotic devices, or other medical equipment
245.16 ordered by a licensed health professional to treat a diagnosed medical condition do not in
245.17 and of themselves constitute the use of mechanical restraint.

245.18 Sec. 16. Minnesota Statutes 2014, section 245D.07, subdivision 2, is amended to read:

245.19 Subd. 2. **Service planning requirements for basic support services.** (a) License
245.20 holders providing basic support services must meet the requirements of this subdivision.

245.21 (b) Within 15 calendar days of service initiation the license holder must complete
245.22 a preliminary coordinated service and support plan addendum based on the coordinated
245.23 service and support plan.

245.24 (c) Within 60 calendar days of service initiation the license holder must review
245.25 and revise as needed the preliminary coordinated service and support plan addendum to
245.26 document the services that will be provided including how, when, and by whom services
245.27 will be provided, and the person responsible for overseeing the delivery and coordination
245.28 of services.

245.29 (d) The license holder must participate in service planning and support team
245.30 meetings for the person following stated timelines established in the person's coordinated
245.31 service and support plan or as requested by the person or the person's legal representative,
245.32 the support team or the expanded support team.

245.33 Sec. 17. Minnesota Statutes 2014, section 245D.071, subdivision 5, is amended to read:

246.1 Subd. 5. **Service plan review and evaluation.** (a) The license holder must give the
246.2 person or the person's legal representative and case manager an opportunity to participate
246.3 in the ongoing review and development of the service plan and the methods used to support
246.4 the person and accomplish outcomes identified in subdivisions 3 and 4. The license holder,
246.5 in coordination with the person's support team or expanded support team, must meet
246.6 with the person, the person's legal representative, and the case manager, and participate
246.7 in service plan review meetings following stated timelines established in the person's
246.8 coordinated service and support plan or coordinated service and support plan addendum or
246.9 within 30 days of a written request by the person, the person's legal representative, or the
246.10 case manager, at a minimum of once per year. The purpose of the service plan review
246.11 is to determine whether changes are needed to the service plan based on the assessment
246.12 information, the license holder's evaluation of progress towards accomplishing outcomes,
246.13 or other information provided by the support team or expanded support team.

246.14 (b) The license holder must summarize the person's status and progress toward
246.15 achieving the identified outcomes and make recommendations and identify the rationale
246.16 for changing, continuing, or discontinuing implementation of supports and methods
246.17 identified in subdivision 4 in a ~~written report sent to the person or the person's legal~~
246.18 ~~representative and case manager five working days prior to the review meeting, unless the~~
246.19 ~~person, the person's legal representative, or the case manager requests to receive the report~~
246.20 available at the time of the progress review meeting. The report must be sent at least
246.21 five working days prior to the progress review meeting if requested by the team in the
246.22 coordinated service and support plan or coordinated service and support plan addendum.

246.23 (c) The license holder must send the coordinated service and support plan addendum
246.24 to the person, the person's legal representative, and the case manager by mail within ten
246.25 working days of the progress review meeting. Within ten working days of the ~~progress~~
246.26 ~~review meeting mailing of the coordinated service and support plan addendum,~~ the license
246.27 holder must obtain dated signatures from the person or the person's legal representative
246.28 and the case manager to document approval of any changes to the coordinated service and
246.29 support plan addendum.

246.30 (d) If, within ten working days of submitting changes to the coordinated service
246.31 and support plan and coordinated service and support plan addendum, the person or the
246.32 person's legal representative or case manager has not signed and returned to the license
246.33 holder the coordinated service and support plan or coordinated service and support plan
246.34 addendum or has not proposed written modifications to the license holder's submission, the
246.35 submission is deemed approved and the coordinated service and support plan addendum

247.1 becomes effective and remains in effect until the legal representative or case manager
247.2 submits a written request to revise the coordinated service and support plan addendum.

247.3 Sec. 18. Minnesota Statutes 2014, section 245D.09, subdivision 3, is amended to read:

247.4 Subd. 3. **Staff qualifications.** (a) The license holder must ensure that staff providing
247.5 direct support, or staff who have responsibilities related to supervising or managing the
247.6 provision of direct support service, are competent as demonstrated through skills and
247.7 knowledge training, experience, and education relevant to the primary disability of the
247.8 person and to meet the person's needs and additional requirements as written in the
247.9 coordinated service and support plan or coordinated service and support plan addendum,
247.10 or when otherwise required by the case manager or the federal waiver plan. The license
247.11 holder must verify and maintain evidence of staff competency, including documentation of:

247.12 (1) education and experience qualifications relevant to the job responsibilities
247.13 assigned to the staff and to the primary disability of persons served by the program,
247.14 including a valid degree and transcript, or a current license, registration, or certification,
247.15 when a degree or licensure, registration, or certification is required by this chapter or in the
247.16 coordinated service and support plan or coordinated service and support plan addendum;

247.17 (2) demonstrated competency in the orientation and training areas required under
247.18 this chapter, and when applicable, completion of continuing education required to
247.19 maintain professional licensure, registration, or certification requirements. Competency in
247.20 these areas is determined by the license holder through knowledge testing or observed
247.21 skill assessment conducted by the trainer or instructor or by an individual who has been
247.22 previously deemed competent by the trainer or instructor in the area being assessed; and

247.23 (3) except for a license holder who is the sole direct support staff, periodic
247.24 performance evaluations completed by the license holder of the direct support staff
247.25 person's ability to perform the job functions based on direct observation.

247.26 (b) Staff under 18 years of age may not perform overnight duties or administer
247.27 medication.

247.28 Sec. 19. Minnesota Statutes 2014, section 245D.09, subdivision 5, is amended to read:

247.29 Subd. 5. **Annual training.** A license holder must provide annual training to direct
247.30 support staff on the topics identified in subdivision 4, clauses (3) to (10). If the direct
247.31 support staff has a first aid certification, annual training under subdivision 4, clause (9), is
247.32 not required as long as the certification remains current. A license holder must provide a
247.33 minimum of 24 hours of annual training to direct service staff providing intensive services
247.34 and having fewer than five years of documented experience and 12 hours of annual

248.1 training to direct service staff providing intensive services and having five or more years
248.2 of documented experience in topics described in subdivisions 4 and 4a, paragraphs (a) to
248.3 (f). Training on relevant topics received from sources other than the license holder may
248.4 count toward training requirements. A license holder must provide a minimum of 12 hours
248.5 of annual training to direct service staff providing basic services and having fewer than
248.6 five years of documented experience and six hours of annual training to direct service staff
248.7 providing basic services and having five or more years of documented experience.

248.8 Sec. 20. Minnesota Statutes 2014, section 245D.22, subdivision 4, is amended to read:

248.9 Subd. 4. **First aid must be available on site.** (a) A staff person trained in first
248.10 aid must be available on site and, when required in a person's coordinated service and
248.11 support plan or coordinated service and support plan addendum, be able to provide
248.12 cardiopulmonary resuscitation, whenever persons are present and staff are required to be
248.13 at the site to provide direct service. The CPR training must include ~~in-person~~ instruction,
248.14 hands-on practice, and an observed skills assessment under the direct supervision of a
248.15 CPR instructor.

248.16 (b) A facility must have first aid kits readily available for use by, and that meet
248.17 the needs of, persons receiving services and staff. At a minimum, the first aid kit must
248.18 be equipped with accessible first aid supplies including bandages, sterile compresses,
248.19 scissors, an ice bag or cold pack, an oral or surface thermometer, mild liquid soap,
248.20 adhesive tape, and first aid manual.

248.21 Sec. 21. Minnesota Statutes 2014, section 245D.31, subdivision 3, is amended to read:

248.22 Subd. 3. **Staff ratio requirement for each person receiving services.** The case
248.23 manager, in consultation with the interdisciplinary team, must determine at least once each
248.24 year which of the ratios in subdivisions 4, 5, and 6 is appropriate for each person receiving
248.25 services on the basis of the characteristics described in subdivisions 4, 5, and 6. The ratio
248.26 assigned each person and the documentation of how the ratio was arrived at must be kept
248.27 in each person's individual service plan. Documentation must include an assessment of the
248.28 person with respect to the characteristics in subdivisions 4, 5, and 6 ~~recorded on a standard~~
248.29 ~~assessment form required by the commissioner.~~

248.30 Sec. 22. Minnesota Statutes 2014, section 245D.31, subdivision 4, is amended to read:

248.31 Subd. 4. **Person requiring staff ratio of one to four.** A person must be assigned a
248.32 staff ratio requirement of one to four if:

249.1 (1) on a daily basis the person requires total care and monitoring or constant
 249.2 hand-over-hand physical guidance to successfully complete at least three of the following
 249.3 activities: toileting, communicating basic needs, eating, or ambulating; ~~or is not capable~~
 249.4 ~~of taking appropriate action for self-preservation under emergency conditions;~~ or

249.5 (2) the person engages in conduct that poses an imminent risk of physical harm to
 249.6 self or others at a documented level of frequency, intensity, or duration requiring frequent
 249.7 daily ongoing intervention and monitoring as established in the person's coordinated
 249.8 service and support plan or coordinated service and support plan addendum.

249.9 Sec. 23. Minnesota Statutes 2014, section 245D.31, subdivision 5, is amended to read:

249.10 Subd. 5. **Person requiring staff ratio of one to eight.** A person must be assigned a
 249.11 staff ratio requirement of one to eight if:

249.12 (1) the person does not meet the requirements in subdivision 4; and

249.13 (2) on a daily basis the person requires verbal prompts or spot checks and minimal
 249.14 or no physical assistance to successfully complete at least ~~four~~ three of the following
 249.15 activities: toileting, communicating basic needs, eating, or ambulating, ~~or taking~~
 249.16 ~~appropriate action for self-preservation under emergency conditions.~~

249.17 Sec. 24. Minnesota Statutes 2014, section 252.27, subdivision 2a, is amended to read:

249.18 Subd. 2a. **Contribution amount.** (a) The natural or adoptive parents of a minor
 249.19 child, including a child determined eligible for medical assistance without consideration of
 249.20 parental income, must contribute to the cost of services used by making monthly payments
 249.21 on a sliding scale based on income, unless the child is married or has been married, parental
 249.22 rights have been terminated, or the child's adoption is subsidized according to chapter
 249.23 259A or through title IV-E of the Social Security Act. The parental contribution is a partial
 249.24 or full payment for medical services provided for diagnostic, therapeutic, curing, treating,
 249.25 mitigating, rehabilitation, maintenance, and personal care services as defined in United
 249.26 States Code, title 26, section 213, needed by the child with a chronic illness or disability.

249.27 (b) For households with adjusted gross income equal to or greater than 275 percent
 249.28 of federal poverty guidelines, the parental contribution shall be computed by applying the
 249.29 following schedule of rates to the adjusted gross income of the natural or adoptive parents:

249.30 (1) if the adjusted gross income is equal to or greater than 275 percent of federal
 249.31 poverty guidelines and less than or equal to 545 percent of federal poverty guidelines,
 249.32 the parental contribution shall be determined using a sliding fee scale established by the
 249.33 commissioner of human services which begins at ~~2.48~~ 2.23 percent of adjusted gross
 249.34 income at 275 percent of federal poverty guidelines and increases to ~~6.75~~ 6.08 percent of

250.1 adjusted gross income for those with adjusted gross income up to 545 percent of federal
250.2 poverty guidelines;

250.3 (2) if the adjusted gross income is greater than 545 percent of federal poverty
250.4 guidelines and less than 675 percent of federal poverty guidelines, the parental
250.5 contribution shall be ~~6.75~~ 6.08 percent of adjusted gross income;

250.6 (3) if the adjusted gross income is equal to or greater than 675 percent of federal
250.7 poverty guidelines and less than 975 percent of federal poverty guidelines, the parental
250.8 contribution shall be determined using a sliding fee scale established by the commissioner
250.9 of human services which begins at ~~6.75~~ 6.08 percent of adjusted gross income at 675 percent
250.10 of federal poverty guidelines and increases to ~~nine~~ 8.1 percent of adjusted gross income
250.11 for those with adjusted gross income up to 975 percent of federal poverty guidelines; and

250.12 (4) if the adjusted gross income is equal to or greater than 975 percent of federal
250.13 poverty guidelines, the parental contribution shall be ~~11.25~~ 10.13 percent of adjusted
250.14 gross income.

250.15 If the child lives with the parent, the annual adjusted gross income is reduced by
250.16 \$2,400 prior to calculating the parental contribution. If the child resides in an institution
250.17 specified in section 256B.35, the parent is responsible for the personal needs allowance
250.18 specified under that section in addition to the parental contribution determined under this
250.19 section. The parental contribution is reduced by any amount required to be paid directly to
250.20 the child pursuant to a court order, but only if actually paid.

250.21 (c) The household size to be used in determining the amount of contribution under
250.22 paragraph (b) includes natural and adoptive parents and their dependents, including the
250.23 child receiving services. Adjustments in the contribution amount due to annual changes
250.24 in the federal poverty guidelines shall be implemented on the first day of July following
250.25 publication of the changes.

250.26 (d) For purposes of paragraph (b), "income" means the adjusted gross income of the
250.27 natural or adoptive parents determined according to the previous year's federal tax form,
250.28 except, effective retroactive to July 1, 2003, taxable capital gains to the extent the funds
250.29 have been used to purchase a home shall not be counted as income.

250.30 (e) The contribution shall be explained in writing to the parents at the time eligibility
250.31 for services is being determined. The contribution shall be made on a monthly basis
250.32 effective with the first month in which the child receives services. Annually upon
250.33 redetermination or at termination of eligibility, if the contribution exceeded the cost of
250.34 services provided, the local agency or the state shall reimburse that excess amount to
250.35 the parents, either by direct reimbursement if the parent is no longer required to pay a
250.36 contribution, or by a reduction in or waiver of parental fees until the excess amount is

251.1 exhausted. All reimbursements must include a notice that the amount reimbursed may be
251.2 taxable income if the parent paid for the parent's fees through an employer's health care
251.3 flexible spending account under the Internal Revenue Code, section 125, and that the
251.4 parent is responsible for paying the taxes owed on the amount reimbursed.

251.5 (f) The monthly contribution amount must be reviewed at least every 12 months;
251.6 when there is a change in household size; and when there is a loss of or gain in income
251.7 from one month to another in excess of ten percent. The local agency shall mail a written
251.8 notice 30 days in advance of the effective date of a change in the contribution amount.
251.9 A decrease in the contribution amount is effective in the month that the parent verifies a
251.10 reduction in income or change in household size.

251.11 (g) Parents of a minor child who do not live with each other shall each pay the
251.12 contribution required under paragraph (a). An amount equal to the annual court-ordered
251.13 child support payment actually paid on behalf of the child receiving services shall be
251.14 deducted from the adjusted gross income of the parent making the payment prior to
251.15 calculating the parental contribution under paragraph (b).

251.16 (h) The contribution under paragraph (b) shall be increased by an additional five
251.17 percent if the local agency determines that insurance coverage is available but not
251.18 obtained for the child. For purposes of this section, "available" means the insurance is a
251.19 benefit of employment for a family member at an annual cost of no more than five percent
251.20 of the family's annual income. For purposes of this section, "insurance" means health
251.21 and accident insurance coverage, enrollment in a nonprofit health service plan, health
251.22 maintenance organization, self-insured plan, or preferred provider organization.

251.23 Parents who have more than one child receiving services shall not be required
251.24 to pay more than the amount for the child with the highest expenditures. There shall
251.25 be no resource contribution from the parents. The parent shall not be required to pay
251.26 a contribution in excess of the cost of the services provided to the child, not counting
251.27 payments made to school districts for education-related services. Notice of an increase in
251.28 fee payment must be given at least 30 days before the increased fee is due.

251.29 (i) The contribution under paragraph (b) shall be reduced by \$300 per fiscal year if,
251.30 in the 12 months prior to July 1:

251.31 (1) the parent applied for insurance for the child;

251.32 (2) the insurer denied insurance;

251.33 (3) the parents submitted a complaint or appeal, in writing to the insurer, submitted
251.34 a complaint or appeal, in writing, to the commissioner of health or the commissioner of
251.35 commerce, or litigated the complaint or appeal; and

251.36 (4) as a result of the dispute, the insurer reversed its decision and granted insurance.

252.1 For purposes of this section, "insurance" has the meaning given in paragraph (h).

252.2 A parent who has requested a reduction in the contribution amount under this
 252.3 paragraph shall submit proof in the form and manner prescribed by the commissioner or
 252.4 county agency, including, but not limited to, the insurer's denial of insurance, the written
 252.5 letter or complaint of the parents, court documents, and the written response of the insurer
 252.6 approving insurance. The determinations of the commissioner or county agency under this
 252.7 paragraph are not rules subject to chapter 14.

252.8 Sec. 25. Minnesota Statutes 2014, section 256.478, is amended to read:

252.9 **256.478 HOME AND COMMUNITY-BASED SERVICES TRANSITIONS**
 252.10 **GRANTS.**

252.11 (a) The commissioner shall make available home and community-based services
 252.12 transition grants to serve individuals who do not meet eligibility criteria for the medical
 252.13 assistance program under section 256B.056 or 256B.057, but who otherwise meet the
 252.14 criteria under section 256B.092, subdivision 13, or 256B.49, subdivision 24.

252.15 ~~(b) For the purposes of this section, the commissioner has the authority to transfer~~
 252.16 ~~funds between the medical assistance account and the home and community-based~~
 252.17 ~~services transitions grants account.~~

252.18 Sec. 26. Minnesota Statutes 2014, section 256.975, is amended by adding a subdivision
 252.19 to read:

252.20 Subd. 11. **Regional and local dementia grants.** (a) The Minnesota Board on
 252.21 Aging shall award competitive grants to eligible applicants for regional and local projects
 252.22 and initiatives targeted to a designated community, which may consist of a specific
 252.23 geographic area or population, to increase awareness of Alzheimer's disease and other
 252.24 dementias, increase the rate of cognitive testing in the population at risk for dementias,
 252.25 promote the benefits of early diagnosis of dementias, or connect caregivers of persons
 252.26 with dementia to education and resources.

252.27 (b) The project areas for grants include:

252.28 (1) local or community-based initiatives to promote the benefits of physician
 252.29 consultations for all individuals who suspect a memory or cognitive problem;

252.30 (2) local or community-based initiatives to promote the benefits of early diagnosis of
 252.31 Alzheimer's disease and other dementias; and

252.32 (3) local or community-based initiatives to provide informational materials and
 252.33 other resources to caregivers of persons with dementia.

253.1 (c) Eligible applicants for local and regional grants may include, but are not limited
253.2 to, community health boards, school districts, colleges and universities, community
253.3 clinics, tribal communities, nonprofit organizations, and other health care organizations.

253.4 (d) Applicants must:

253.5 (1) describe the proposed initiative, including the targeted community and how the
253.6 initiative meets the requirements of this subdivision; and

253.7 (2) identify the proposed outcomes of the initiative and the evaluation process to be
253.8 used to measure these outcomes.

253.9 (e) In awarding the regional and local dementia grants, the Minnesota Board on
253.10 Aging must give priority to applicants who demonstrate that the proposed project:

253.11 (1) is supported by and appropriately targeted to the community the applicant serves;

253.12 (2) is designed to coordinate with other community activities related to other health
253.13 initiatives, particularly those initiatives targeted at the elderly;

253.14 (3) is conducted by an applicant able to demonstrate expertise in the project areas;

253.15 (4) utilizes and enhances existing activities and resources or involves innovative
253.16 approaches to achieve success in the project areas; and

253.17 (5) strengthens community relationships and partnerships in order to achieve the
253.18 project areas.

253.19 (f) The board shall divide the state into specific geographic regions and allocate a
253.20 percentage of the money available for the local and regional dementia grants to projects or
253.21 initiatives aimed at each geographic region.

253.22 (g) The board shall award any available grants by January 1, 2016, and each July 1
253.23 thereafter.

253.24 (h) Each grant recipient shall report to the board on the progress of the initiative at
253.25 least once during the grant period, and within two months of the end of the grant period
253.26 shall submit a final report to the board that includes the outcome results.

253.27 (i) The Minnesota Board on Aging shall:

253.28 (1) develop the criteria and procedures to allocate the grants under this subdivision,
253.29 evaluate all applicants on a competitive basis and award the grants, and select qualified
253.30 providers to offer technical assistance to grant applicants and grantees. The selected
253.31 provider shall provide applicants and grantees assistance with project design, evaluation
253.32 methods, materials, and training; and

253.33 (2) submit by January 15, 2017, and on each January 15 thereafter, a progress
253.34 report on the dementia grants programs under this subdivision to the chairs and ranking
253.35 minority members of the senate and house of representatives committees and divisions
253.36 with jurisdiction over health finance and policy. The report shall include:

- 254.1 (i) information on each grant recipient;
 254.2 (ii) a summary of all projects or initiatives undertaken with each grant;
 254.3 (iii) the measurable outcomes established by each grantee, an explanation of the
 254.4 evaluation process used to determine whether the outcomes were met, and the results of
 254.5 the evaluation; and
 254.6 (iv) an accounting of how the grant funds were spent.

254.7 **EFFECTIVE DATE.** This section is effective July 1, 2015.

254.8 Sec. 27. Minnesota Statutes 2014, section 256B.056, subdivision 5c, is amended to read:

254.9 Subd. 5c. **Excess income standard.** (a) The excess income standard for parents
 254.10 and caretaker relatives, pregnant women, infants, and children ages two through 20 is the
 254.11 standard specified in subdivision 4, paragraph (b).

254.12 (b) The excess income standard for a person whose eligibility is based on blindness,
 254.13 disability, or age of 65 or more years shall equal ~~75~~ 80 percent of the federal poverty
 254.14 guidelines.

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

254.16 Sec. 28. Minnesota Statutes 2014, section 256B.057, subdivision 9, is amended to read:

254.17 Subd. 9. **Employed persons with disabilities.** (a) Medical assistance may be paid
 254.18 for a person who is employed and who:

254.19 (1) but for excess earnings or assets, meets the definition of disabled under the
 254.20 Supplemental Security Income program;

254.21 (2) meets the asset limits in paragraph (d); and

254.22 (3) pays a premium and other obligations under paragraph (e).

254.23 (b) For purposes of eligibility, there is a \$65 earned income disregard. To be eligible
 254.24 for medical assistance under this subdivision, a person must have more than \$65 of earned
 254.25 income. Earned income must have Medicare, Social Security, and applicable state and
 254.26 federal taxes withheld. The person must document earned income tax withholding. Any
 254.27 spousal income or assets shall be disregarded for purposes of eligibility and premium
 254.28 determinations.

254.29 (c) After the month of enrollment, a person enrolled in medical assistance under
 254.30 this subdivision who:

254.31 (1) is temporarily unable to work and without receipt of earned income due to a
 254.32 medical condition, as verified by a physician; or

255.1 (2) loses employment for reasons not attributable to the enrollee, and is without
255.2 receipt of earned income may retain eligibility for up to four consecutive months after the
255.3 month of job loss. To receive a four-month extension, enrollees must verify the medical
255.4 condition or provide notification of job loss. All other eligibility requirements must be met
255.5 and the enrollee must pay all calculated premium costs for continued eligibility.

255.6 (d) For purposes of determining eligibility under this subdivision, a person's assets
255.7 must not exceed \$20,000, excluding:

255.8 (1) all assets excluded under section 256B.056;

255.9 (2) retirement accounts, including individual accounts, 401(k) plans, 403(b) plans,
255.10 Keogh plans, and pension plans;

255.11 (3) medical expense accounts set up through the person's employer; and

255.12 (4) spousal assets, including spouse's share of jointly held assets.

255.13 (e) All enrollees must pay a premium to be eligible for medical assistance under this
255.14 subdivision, except as provided under clause (5).

255.15 (1) An enrollee must pay the greater of a ~~\$65~~ \$35 premium or the premium calculated
255.16 based on the person's gross earned and unearned income and the applicable family size
255.17 using a sliding fee scale established by the commissioner, which begins at one percent of
255.18 income at 100 percent of the federal poverty guidelines and increases to 7.5 percent of
255.19 income for those with incomes at or above 300 percent of the federal poverty guidelines.

255.20 (2) Annual adjustments in the premium schedule based upon changes in the federal
255.21 poverty guidelines shall be effective for premiums due in July of each year.

255.22 (3) All enrollees who receive unearned income must pay ~~five~~ one-half of one percent
255.23 of unearned income in addition to the premium amount, except as provided under clause (5).

255.24 (4) Increases in benefits under title II of the Social Security Act shall not be counted
255.25 as income for purposes of this subdivision until July 1 of each year.

255.26 (5) Effective July 1, 2009, American Indians are exempt from paying premiums as
255.27 required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public
255.28 Law 111-5. For purposes of this clause, an American Indian is any person who meets the
255.29 definition of Indian according to Code of Federal Regulations, title 42, section 447.50.

255.30 (f) A person's eligibility and premium shall be determined by the local county
255.31 agency. Premiums must be paid to the commissioner. All premiums are dedicated to
255.32 the commissioner.

255.33 (g) Any required premium shall be determined at application and redetermined at
255.34 the enrollee's six-month income review or when a change in income or household size is
255.35 reported. Enrollees must report any change in income or household size within ten days
255.36 of when the change occurs. A decreased premium resulting from a reported change in

256.1 income or household size shall be effective the first day of the next available billing month
 256.2 after the change is reported. Except for changes occurring from annual cost-of-living
 256.3 increases, a change resulting in an increased premium shall not affect the premium amount
 256.4 until the next six-month review.

256.5 (h) Premium payment is due upon notification from the commissioner of the
 256.6 premium amount required. Premiums may be paid in installments at the discretion of
 256.7 the commissioner.

256.8 (i) Nonpayment of the premium shall result in denial or termination of medical
 256.9 assistance unless the person demonstrates good cause for nonpayment. Good cause exists
 256.10 if the requirements specified in Minnesota Rules, part 9506.0040, subpart 7, items B to
 256.11 D, are met. Except when an installment agreement is accepted by the commissioner, all
 256.12 persons disenrolled for nonpayment of a premium must pay any past due premiums as well
 256.13 as current premiums due prior to being reenrolled. Nonpayment shall include payment with
 256.14 a returned, refused, or dishonored instrument. The commissioner may require a guaranteed
 256.15 form of payment as the only means to replace a returned, refused, or dishonored instrument.

256.16 (j) For enrollees whose income does not exceed 200 percent of the federal poverty
 256.17 guidelines and who are also enrolled in Medicare, the commissioner shall reimburse
 256.18 the enrollee for Medicare part B premiums under section 256B.0625, subdivision 15,
 256.19 paragraph (a).

256.20 **EFFECTIVE DATE.** This section is effective September 1, 2015.

256.21 Sec. 29. Minnesota Statutes 2014, section 256B.059, subdivision 5, is amended to read:

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

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

256.28 (i) \$14,148;

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

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

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

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

256.33 July 1, 1994, the greater of:

256.34 (i) \$20,000;

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

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

257.2 The value of assets transferred for the sole benefit of the community spouse under section
257.3 256B.0595, subdivision 4, in combination with other assets available to the community
257.4 spouse under this section, cannot exceed the limit for the community spouse asset
257.5 allowance determined under subdivision 3 or 4. Assets that exceed this allowance shall be
257.6 considered available to the institutionalized spouse ~~whether or not converted to income~~. If
257.7 the community spouse asset allowance has been increased under subdivision 4, then the
257.8 assets considered available to the institutionalized spouse under this subdivision shall be
257.9 further reduced by the value of additional amounts allowed under subdivision 4.

257.10 (b) An institutionalized spouse may be found eligible for medical assistance even
257.11 though assets in excess of the allowable amount are found to be available under paragraph
257.12 (a) if the assets are owned jointly or individually by the community spouse, and the
257.13 institutionalized spouse cannot use those assets to pay for the cost of care without the
257.14 consent of the community spouse, and if: (i) the institutionalized spouse assigns to the
257.15 commissioner the right to support from the community spouse under section 256B.14,
257.16 subdivision 3; (ii) the institutionalized spouse lacks the ability to execute an assignment
257.17 due to a physical or mental impairment; or (iii) the denial of eligibility would cause an
257.18 imminent threat to the institutionalized spouse's health and well-being.

257.19 (c) After the month in which the institutionalized spouse is determined eligible for
257.20 medical assistance, during the continuous period of institutionalization, no assets of the
257.21 community spouse are considered available to the institutionalized spouse, unless the
257.22 institutionalized spouse has been found eligible under paragraph (b).

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

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

257.27 Sec. 30. Minnesota Statutes 2014, section 256B.0916, subdivision 2, is amended to read:

257.28 Subd. 2. **Distribution of funds; partnerships.** (a) Beginning with fiscal year 2000,
257.29 the commissioner shall distribute all funding available for home and community-based
257.30 waiver services for persons with developmental disabilities to individual counties or to
257.31 groups of counties that form partnerships to jointly plan, administer, and authorize funding
257.32 for eligible individuals. The commissioner shall encourage counties to form partnerships
257.33 that have a sufficient number of recipients and funding to adequately manage the risk
257.34 and maximize use of available resources.

258.1 (b) Counties must submit a request for funds and a plan for administering the
258.2 program as required by the commissioner. The plan must identify the number of clients to
258.3 be served, their ages, and their priority listing based on:

258.4 (1) requirements in Minnesota Rules, part 9525.1880; and

258.5 (2) statewide priorities identified in section 256B.092, subdivision 12.

258.6 The plan must also identify changes made to improve services to eligible persons and to
258.7 improve program management.

258.8 (c) In allocating resources to counties, priority must be given to groups of counties
258.9 that form partnerships to jointly plan, administer, and authorize funding for eligible
258.10 individuals and to counties determined by the commissioner to have sufficient waiver
258.11 capacity to maximize resource use.

258.12 (d) Within 30 days after receiving the county request for funds and plans, the
258.13 commissioner shall provide a written response to the plan that includes the level of
258.14 resources available to serve additional persons.

258.15 (e) Counties are eligible to receive medical assistance administrative reimbursement
258.16 for administrative costs under criteria established by the commissioner.

258.17 (f) The commissioner shall manage waiver allocations in such a manner as to fully
258.18 use available state and federal waiver appropriations.

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

258.20 Sec. 31. Minnesota Statutes 2014, section 256B.0916, subdivision 11, is amended to
258.21 read:

258.22 Subd. 11. **Excess spending.** County and tribal agencies are responsible for spending
258.23 in excess of the allocation made by the commissioner. In the event a county or tribal agency
258.24 spends in excess of the allocation made by the commissioner for a given allocation period,
258.25 they must submit a corrective action plan to the commissioner for approval. The plan must
258.26 state the actions the agency will take to correct their overspending for the year two years
258.27 following the period when the overspending occurred. ~~Failure to correct overspending~~
258.28 ~~shall result in recoupment of spending in excess of the allocation.~~ The commissioner
258.29 shall recoup spending in excess of the allocation only in cases where statewide spending
258.30 exceeds the appropriation designated for the home and community-based services waivers.
258.31 Nothing in this subdivision shall be construed as reducing the county's responsibility to
258.32 offer and make available feasible home and community-based options to eligible waiver
258.33 recipients within the resources allocated to them for that purpose.

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

259.1 Sec. 32. Minnesota Statutes 2014, section 256B.0916, is amended by adding a
259.2 subdivision to read:

259.3 Subd. 12. Use of waiver allocations. County and tribal agencies are responsible
259.4 for spending the annual allocation made by the commissioner. In the event a county or
259.5 tribal agency spends less than 97 percent of the allocation, while maintaining a list of
259.6 persons waiting for waiver services, the county or tribal agency must submit a corrective
259.7 action plan to the commissioner for approval. The commissioner may determine a plan
259.8 is unnecessary given the size of the allocation and capacity for new enrollment. The
259.9 plan must state the actions the agency will take to assure reasonable and timely access
259.10 to home and community-based waiver services for persons waiting for services. If a
259.11 county or tribe does not submit a plan when required or implement the changes required,
259.12 the commissioner shall assure access to waiver services within the county's or tribe's
259.13 available allocation and take other actions needed to assure that all waiver participants in
259.14 that county or tribe are receiving appropriate waiver services to meet their needs.

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

259.16 Sec. 33. Minnesota Statutes 2014, section 256B.49, subdivision 26, is amended to read:

259.17 Subd. 26. **Excess allocations.** (a) Effective through June 30, 2018, county and
259.18 tribal agencies will be responsible for authorizations in excess of the annual allocation
259.19 made by the commissioner. In the event a county or tribal agency authorizes in excess
259.20 of the allocation made by the commissioner for a given allocation period, the county or
259.21 tribal agency must submit a corrective action plan to the commissioner for approval.
259.22 The plan must state the actions the agency will take to correct their overspending for
259.23 the year ~~two years~~ following the period when the overspending occurred. ~~Failure to~~
259.24 ~~correct overauthorizations shall result in recoupment of authorizations in excess of the~~
259.25 ~~allocation.~~ The commissioner shall recoup funds spent in excess of the allocation only
259.26 in cases where statewide spending exceeds the appropriation designated for the home
259.27 and community-based services waivers. Nothing in this subdivision shall be construed
259.28 as reducing the county's responsibility to offer and make available feasible home and
259.29 community-based options to eligible waiver recipients within the resources allocated
259.30 to them for that purpose.

259.31 (b) Effective July 1, 2018, county and tribal agencies will be responsible for
259.32 spending in excess of the annual allocation made by the commissioner. In the event a
259.33 county or tribal agency spends in excess of the allocation made by the commissioner for a
259.34 given allocation period, the county or tribal agency must submit a corrective action plan to
259.35 the commissioner for approval. The plan must state the actions the agency will take to

260.1 correct its overspending for the two years following the period when the overspending
260.2 occurred. The commissioner shall recoup funds spent in excess of the allocation only in
260.3 cases when statewide spending exceeds the appropriation designated for the home and
260.4 community-based services waivers. Nothing in this subdivision shall be construed as
260.5 reducing the county or tribe's responsibility to offer and make available feasible home and
260.6 community-based options to eligible waiver recipients within the resources allocated to
260.7 it for that purpose.

260.8 Sec. 34. Minnesota Statutes 2014, section 256B.49, is amended by adding a
260.9 subdivision to read:

260.10 Subd. 27. **Use of waiver allocations.** (a) Effective until June 30, 2018, county
260.11 and tribal agencies are responsible for authorizing the annual allocation made by the
260.12 commissioner. In the event a county or tribal agency authorizes less than 97 percent of
260.13 the allocation, while maintaining a list of persons waiting for waiver services, the county
260.14 or tribal agency must submit a corrective action plan to the commissioner for approval.
260.15 The commissioner may determine a plan is unnecessary given the size of the allocation
260.16 and capacity for new enrollment. The plan must state the actions the agency will take
260.17 to assure reasonable and timely access to home and community-based waiver services
260.18 for persons waiting for services.

260.19 (b) Effective July 1, 2018, county and tribal agencies are responsible for spending
260.20 the annual allocation made by the commissioner. In the event a county or tribal agency
260.21 spends less than 97 percent of the allocation, while maintaining a list of persons waiting
260.22 for waiver services, the county or tribal agency must submit a corrective action plan to the
260.23 commissioner for approval. The commissioner may determine a plan is unnecessary given
260.24 the size of the allocation and capacity for new enrollment. The plan must state the actions
260.25 the agency will take to assure reasonable and timely access to home and community-based
260.26 waiver services for persons waiting for services.

260.27 (c) If a county or tribe does not submit a plan when required or implement the
260.28 changes required, the commissioner shall assure access to waiver services within the
260.29 county or tribe's available allocation, and take other actions needed to assure that all
260.30 waiver participants in that county or tribe are receiving appropriate waiver services
260.31 to meet their needs.

260.32 Sec. 35. Minnesota Statutes 2014, section 256B.4913, subdivision 4a, is amended to
260.33 read:

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

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

261.10 (1) for a day service recipient who was not authorized to receive these waiver
261.11 services prior to January 1, 2014; added a new service or services on or after January 1,
261.12 2014; or changed providers on or after January 1, 2014, the historical rate must be the
261.13 authorized rate for the provider in the county of service, effective December 1, 2013; or

261.14 (2) for a unit-based service with programming or a unit-based service without
261.15 programming recipient who was not authorized to receive these waiver services prior to
261.16 January 1, 2014; added a new service or services on or after January 1, 2014; or changed
261.17 providers on or after January 1, 2014, the historical rate must be the weighted average
261.18 authorized rate for each provider number in the county of service, effective December 1,
261.19 2013; or

261.20 (3) for residential service recipients who change providers on or after January 1,
261.21 2014, the historical rate must be set by each lead agency within their county aggregate
261.22 budget using their respective methodology for residential services effective December 1,
261.23 2013, for determining the provider rate for a similarly situated recipient being served by
261.24 that provider.

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

261.27 (1) 0.5 percent from the historical rate for the implementation period;

261.28 (2) 0.5 percent from the rate in effect in clause (1), for the 12-month period
261.29 immediately following the time period of clause (1);

261.30 (3) ~~1.0~~ 0.5 percent from the rate in effect in clause (2), for the 12-month period
261.31 immediately following the time period of clause (2);

261.32 (4) 1.0 percent from the rate in effect in clause (3), for the 12-month period
261.33 immediately following the time period of clause (3); ~~and~~

261.34 (5) 1.0 percent from the rate in effect in clause (4), for the 12-month period
261.35 immediately following the time period of clause (4); and

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

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

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

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

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

262.17 (2) calculating a service rate under section 256B.4914, subdivision 6, 7, 8, or
 262.18 9, for the individual with variables reflecting the updated level of service at the time
 262.19 of application; and

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

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

262.25 Sec. 36. Minnesota Statutes 2014, section 256B.4913, subdivision 5, is amended to read:

262.26 Subd. 5. **Stakeholder consultation and county training.** (a) The commissioner
 262.27 shall continue consultation on regular intervals with the existing stakeholder group
 262.28 established as part of the rate-setting methodology process and others, to gather input,
 262.29 concerns, and data, to assist in the full implementation of the new rate payment system and
 262.30 to make pertinent information available to the public through the department's Web site.

262.31 (b) The commissioner shall offer training at least annually for county personnel
 262.32 responsible for administering the rate-setting framework in a manner consistent with this
 262.33 section and section 256B.4914.

262.34 (c) The commissioner shall maintain an online instruction manual explaining the
 262.35 rate-setting framework. The manual shall be consistent with this section and section

263.1 256B.4914, and shall be accessible to all stakeholders including recipients, representatives
263.2 of recipients, county or tribal agencies, and license holders.

263.3 (d) The commissioner shall not defer to the county or tribal agency on matters of
263.4 technical application of the rate-setting framework, and a county or tribal agency shall not
263.5 set rates in a manner that conflicts with this section or section 256B.4914.

263.6 Sec. 37. Minnesota Statutes 2014, section 256B.4914, subdivision 2, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

264.19 (2) for day services under subdivision 7:

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

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

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

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

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

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

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

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

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

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

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

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

265.6 Sec. 38. Minnesota Statutes 2014, section 256B.4914, subdivision 6, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

266.14 ~~(d) The commissioner shall establish a Monitoring Technology Review Panel to~~
266.15 ~~annually review and approve the plans, safeguards, and rates that include residential~~
266.16 ~~direct care provided remotely through monitoring technology. Lead agencies shall submit~~
266.17 ~~individual service plans that include supervision using monitoring technology to the~~
266.18 ~~Monitoring Technology Review Panel for approval. Individual service plans that include~~
266.19 ~~supervision using monitoring technology as of December 31, 2013, shall be submitted to~~
266.20 ~~the Monitoring Technology Review Panel, but the plans are not subject to approval.~~

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

266.29 ~~(f)~~ (e) The number of days authorized for all individuals enrolling after January 1,
266.30 2014, in residential services must include every day that services start and end.

266.31 Sec. 39. Minnesota Statutes 2014, section 256B.4914, subdivision 8, is amended to read:

266.32 Subd. 8. **Payments for unit-based services with programming.** Payments for
266.33 unit-based ~~with program~~ services with programming, including behavior programming,
266.34 housing access coordination, in-home family support, independent living skills training,
266.35 hourly supported living services, and supported employment provided to an individual

267.1 outside of any day or residential service plan must be calculated as follows, unless the
267.2 services are authorized separately under subdivision 6 or 7:

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

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

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

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

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

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

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

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

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

267.23 (10) this is the subtotal rate;

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

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

267.28 (13) for supported employment provided in a shared manner, divide the total
267.29 payment amount in clause (12) by the number of service recipients, not to exceed three.

267.30 For independent living skills training provided in a shared manner, divide the total
267.31 payment amount in clause (12) by the number of service recipients, not to exceed two; and

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

267.34 Sec. 40. Minnesota Statutes 2014, section 256B.4914, subdivision 10, is amended to
267.35 read:

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

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

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

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

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

268.15 (c) Using a statistically valid set of rates management system data, the commissioner,
268.16 in consultation with stakeholders, shall analyze for each service the average difference
268.17 in the rate on December 31, 2013, and the framework rate at the individual, provider,
268.18 lead agency, and state levels. The commissioner shall issue semiannual reports to the
268.19 stakeholders on the difference in rates by service and by county during the banding period
268.20 under section 256B.4913, subdivision 4a. The commissioner shall issue the first report
268.21 by October 1, 2014.

268.22 (d) No later than July 1, 2014, the commissioner, in consultation with stakeholders,
268.23 shall begin the review and evaluation of the following values already in subdivisions 6 to
268.24 9, or issues that impact all services, including, but not limited to:

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

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

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

268.28 (4) values for indirect services;

268.29 (5) values for nursing;

268.30 (6) component values for independent living skills;

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

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

268.33 (9) remote monitoring technology for nonresidential services;

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

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

269.1 (12) values for workers' compensation as part of employee-related expenses;
269.2 (13) values for unemployment insurance as part of employee-related expenses;
269.3 (14) a component value to reflect costs for individuals with rates previously adjusted
269.4 for the inclusion of group residential housing rate 3 costs, only for any individual enrolled
269.5 as of December 31, 2013; and

269.6 (15) any changes in state or federal law with an impact on the underlying cost of
269.7 providing home and community-based services.

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

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

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

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

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

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

269.23 (g) The commissioner shall implement a regional adjustment factor to all rate
269.24 calculations in subdivisions 6 to 9, effective no later than January 1, 2015. Prior to
269.25 implementation, the commissioner shall consult with stakeholders on the methodology to
269.26 calculate the adjustment.

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

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

269.32 (2) service utilization;

269.33 (3) county and tribal allocation changes; and

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

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

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

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

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

270.14 Sec. 41. Minnesota Statutes 2014, section 256B.4914, subdivision 14, is amended to
 270.15 read:

270.16 Subd. 14. **Exceptions.** (a) In a format prescribed by the commissioner, lead
 270.17 agencies must identify individuals with exceptional needs that cannot be met under the
 270.18 disability waiver rate system. The commissioner shall use that information to evaluate
 270.19 and, if necessary, approve an alternative payment rate for those individuals. Whether
 270.20 granted, denied, or modified, the commissioner shall respond to all exception requests in
 270.21 writing. The commissioner shall include in the written response the basis for the action
 270.22 and provide notification of the right to appeal under paragraph (h).

270.23 (b) Lead agencies must act on an exception request within 30 days and notify the
 270.24 initiator of the request of their recommendation in writing. A lead agency shall submit all
 270.25 exception requests along with its recommendation to the state commissioner.

270.26 (c) An application for a rate exception may be submitted for the following criteria:

270.27 (1) an individual has service needs that cannot be met through additional units
 270.28 of service; ~~or~~

270.29 (2) an individual's rate determined under subdivisions 6, 7, 8, and 9 results is so
 270.30 insufficient that it has resulted in an individual being discharged receiving a notice of
 270.31 discharge from the individual's provider; or

270.32 (3) an individual's service needs, including behavioral changes, require a level of
 270.33 service which necessitates a change in provider or which requires the current provider to
 270.34 propose service changes beyond those currently authorized.

270.35 (d) Exception requests must include the following information:

271.1 (1) the service needs required by each individual that are not accounted for in
271.2 subdivisions 6, 7, 8, and 9;

271.3 (2) the service rate requested and the difference from the rate determined in
271.4 subdivisions 6, 7, 8, and 9;

271.5 (3) a basis for the underlying costs used for the rate exception and any accompanying
271.6 documentation; and

271.7 (4) ~~the duration of the rate exception; and~~

271.8 ~~(5) any contingencies for approval.~~

271.9 (e) Approved rate exceptions shall be managed within lead agency allocations under
271.10 sections 256B.092 and 256B.49.

271.11 (f) Individual disability waiver recipients, an interested party, or the license holder
271.12 that would receive the rate exception increase may request that a lead agency submit an
271.13 exception request. A lead agency that denies such a request shall notify the individual
271.14 waiver recipient, interested party, or license holder of its decision and the reasons for
271.15 denying the request in writing no later than 30 days after the ~~individual's~~ request has been
271.16 made and shall submit its denial to the commissioner in accordance with paragraph (b).
271.17 The reasons for the denial must be based on the failure to meet the criteria in paragraph (c).

271.18 (g) The commissioner shall determine whether to approve or deny an exception
271.19 request no more than 30 days after receiving the request. If the commissioner denies the
271.20 request, the commissioner shall notify the lead agency and the individual disability waiver
271.21 recipient, the interested party, and the license holder in writing of the reasons for the denial.

271.22 (h) The individual disability waiver recipient may appeal any denial of an exception
271.23 request by either the lead agency or the commissioner, pursuant to sections 256.045 and
271.24 256.0451. When the denial of an exception request results in the proposed demission of a
271.25 waiver recipient from a residential or day habilitation program, the commissioner shall
271.26 issue a temporary stay of demission, when requested by the disability waiver recipient,
271.27 consistent with the provisions of section 256.045, subdivisions 4a and 6, paragraph (c).
271.28 The temporary stay shall remain in effect until the lead agency can provide an informed
271.29 choice of appropriate, alternative services to the disability waiver.

271.30 (i) Providers may petition lead agencies to update values that were entered
271.31 incorrectly or erroneously into the rate management system, based on past service level
271.32 discussions and determination in subdivision 4, without applying for a rate exception.

271.33 (j) The starting date for the rate exception will be the later of the date of the
271.34 recipient's change in support or the date of the request to the lead agency for an exception.

271.35 (k) The commissioner shall track all exception requests received and their
271.36 dispositions. The commissioner shall issue quarterly public exceptions statistical reports,

272.1 including the number of exception requests received and the numbers granted, denied,
 272.2 withdrawn, and pending. The report shall include the average amount of time required to
 272.3 process exceptions.

272.4 (l) No later than January 15, 2016, the commissioner shall provide research
 272.5 findings on the estimated fiscal impact, the primary cost drivers, and common population
 272.6 characteristics of recipients with needs that cannot be met by the framework rates.

272.7 (m) No later than July 1, 2016, the commissioner shall develop and implement,
 272.8 in consultation with stakeholders, a process to determine eligibility for rate exceptions
 272.9 for individuals with rates determined under the methodology in section 256B.4913,
 272.10 subdivision 4a. Determination of eligibility for an exception will occur as annual service
 272.11 renewals are completed.

272.12 (n) Approved rate exceptions will be implemented at such time that the individual's
 272.13 rate is no longer banded and remain in effect in all cases until an individual's needs change
 272.14 as defined in paragraph (c).

272.15 Sec. 42. Minnesota Statutes 2014, section 256B.4914, subdivision 15, is amended to
 272.16 read:

272.17 Subd. 15. **County or tribal allocations.** (a) Upon implementation of the disability
 272.18 waiver rates management system on January 1, 2014, the commissioner shall establish
 272.19 a method of tracking and reporting the fiscal impact of the disability waiver rates
 272.20 management system on individual lead agencies.

272.21 (b) Beginning January 1, 2014, the commissioner shall make annual adjustments to
 272.22 lead agencies' home and community-based waived service budget allocations to adjust
 272.23 for rate differences and the resulting impact on county allocations upon implementation of
 272.24 the disability waiver rates system.

272.25 (c) ~~During the first two years of implementation under section 256B.4913, Lead~~
 272.26 ~~agencies exceeding their allocations shall be subject to the provisions under sections~~
 272.27 ~~256B.092 256B.0916, subdivision 11, and 256B.49 shall only be held liable for spending~~
 272.28 ~~in excess of their allocations after a reallocation of resources by the commissioner under~~
 272.29 ~~paragraph (b). The commissioner shall reallocate resources under sections 256B.092,~~
 272.30 ~~subdivision 12, and 256B.49, subdivision 11a. The commissioner shall notify lead~~
 272.31 ~~agencies of this process by July 1, 2014 256B.49, subdivision 26.~~

272.32 Sec. 43. Minnesota Statutes 2014, section 256B.492, is amended to read:

272.33 **256B.492 HOME AND COMMUNITY-BASED SETTINGS FOR PEOPLE**
 272.34 **WITH DISABILITIES.**

273.1 (a) Individuals receiving services under a home and community-based waiver under
273.2 section 256B.092 or 256B.49 may receive services in the following settings:

273.3 (1) ~~an individual's own home or family home~~ and community-based settings that
273.4 comply with all requirements identified by the federal Centers for Medicare and Medicaid
273.5 Services in the Code of Federal Regulations, title 42, section 441.301(c), and with the
273.6 requirements of the federally approved transition plan and waiver plans for each home
273.7 and community-based services waiver; and

273.8 (2) ~~a licensed adult foster care or child foster care setting of up to five people or~~
273.9 ~~community residential setting of up to five people; and~~ settings required by the Housing
273.10 Opportunities for Persons with AIDS Program.

273.11 (3) ~~community living settings as defined in section 256B.49, subdivision 23, where~~
273.12 ~~individuals with disabilities may reside in all of the units in a building of four or fewer units,~~
273.13 ~~and who receive services under a home and community-based waiver occupy no more~~
273.14 ~~than the greater of four or 25 percent of the units in a multifamily building of more than~~
273.15 ~~four units, unless required by the Housing Opportunities for Persons with AIDS Program.~~

273.16 (b) The settings in paragraph (a) must not:

273.17 (1) ~~be located in a building that is a publicly or privately operated facility that~~
273.18 ~~provides institutional treatment or custodial care;~~

273.19 (2) ~~be located in a building on the grounds of or adjacent to a public or private~~
273.20 ~~institution;~~

273.21 (3) ~~be a housing complex designed expressly around an individual's diagnosis or~~
273.22 ~~disability, unless required by the Housing Opportunities for Persons with AIDS Program;~~

273.23 (4) ~~be segregated based on a disability, either physically or because of setting~~
273.24 ~~characteristics, from the larger community; and~~

273.25 (5) have the qualities of an institution which include, but are not limited to:
273.26 regimented meal and sleep times, limitations on visitors, and lack of privacy. Restrictions
273.27 agreed to and documented in the person's individual service plan shall not result in a
273.28 residence having the qualities of an institution as long as the restrictions for the person are
273.29 not imposed upon others in the same residence and are the least restrictive alternative,
273.30 imposed for the shortest possible time to meet the person's needs.

273.31 (c) ~~The provisions of paragraphs (a) and (b) do not apply to any setting in which~~
273.32 ~~individuals receive services under a home and community-based waiver as of July 1,~~
273.33 ~~2012, and the setting does not meet the criteria of this section.~~

273.34 (d) ~~Notwithstanding paragraph (c), a program in Hennepin County established as~~
273.35 ~~part of a Hennepin County demonstration project is qualified for the exception allowed~~
273.36 ~~under paragraph (c).~~

274.1 ~~(e) Notwithstanding paragraphs (a) and (b), a program in Hennepin County, located~~
274.2 ~~in the city of Golden Valley, within the city of Golden Valley's Highway 55 West~~
274.3 ~~redevelopment area, that is not a provider-owned or controlled home and community-based~~
274.4 ~~setting, and is scheduled to open by July 1, 2016, is exempt from the restrictions in~~
274.5 ~~paragraphs (a) and (b). If the program fails to comply with the Centers for Medicare and~~
274.6 ~~Medicaid Services rules for home and community-based settings, the exemption is void.~~

274.7 ~~(f) The commissioner shall submit an amendment to the waiver plan no later than~~
274.8 ~~December 31, 2012.~~

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

274.10 Sec. 44. **[256Q.01] PLAN ESTABLISHED.**

274.11 A savings plan known as the Minnesota ABLE plan is established. In establishing
274.12 this plan, the legislature seeks to encourage and assist individuals and families in saving
274.13 private funds for the purpose of supporting individuals with disabilities to maintain health,
274.14 independence, and quality of life, and to provide secure funding for disability-related
274.15 expenses on behalf of designated beneficiaries with disabilities that will supplement, but
274.16 not supplant, benefits provided through private insurance, the Medicaid program under
274.17 title XIX of the Social Security Act, the Supplemental Security Income program under
274.18 title XVI of the Social Security Act, the beneficiary's employment, and other sources.

274.19 Sec. 45. **[256Q.02] CITATION.**

274.20 This chapter may be cited as the "Minnesota Achieving a Better Life Experience
274.21 Act" or "Minnesota ABLE Act."

274.22 Sec. 46. **[256Q.03] DEFINITIONS.**

274.23 Subdivision 1. **Scope.** For the purposes of this chapter, the terms defined in this
274.24 section have the meanings given them.

274.25 Subd. 2. **ABLE account.** "ABLE account" has the meaning given in section
274.26 529A(e)(6) of the Internal Revenue Code.

274.27 Subd. 3. **ABLE plan or plan.** "ABLE plan" or "plan" means the qualified ABLE
274.28 program, as defined in section 529A(b) of the Internal Revenue Code, provided for
274.29 in this chapter.

274.30 Subd. 4. **Account.** "Account" means the formal record of transactions relating to an
274.31 ABLE plan beneficiary.

274.32 Subd. 5. **Account owner.** "Account owner" means the designated beneficiary
274.33 of the account.

275.1 Subd. 6. **Annual contribution limit.** "Annual contribution limit" has the meaning
275.2 given in section 529A(b)(2) of the Internal Revenue Code.

275.3 Subd. 7. **Application.** "Application" means the form executed by a prospective
275.4 account owner to enter into a participation agreement and open an account in the plan.
275.5 The application incorporates by reference the participation agreement.

275.6 Subd. 8. **Board.** "Board" means the State Board of Investment.

275.7 Subd. 9. **Commissioner.** "Commissioner" means the commissioner of human
275.8 services.

275.9 Subd. 10. **Contribution.** "Contribution" means a payment directly allocated to
275.10 an account for the benefit of a beneficiary.

275.11 Subd. 11. **Department.** "Department" means the Department of Human Services.

275.12 Subd. 12. **Designated beneficiary or beneficiary.** "Designated beneficiary" or
275.13 "beneficiary" has the meaning given in section 529A(e)(3) of the Internal Revenue Code
275.14 and further defined through regulations issued under that section.

275.15 Subd. 13. **Earnings.** "Earnings" means the total account balance minus the
275.16 investment in the account.

275.17 Subd. 14. **Eligible individual.** "Eligible individual" has the meaning given in
275.18 section 529A(e)(1) of the Internal Revenue Code and further defined through regulations
275.19 issued under that section.

275.20 Subd. 15. **Executive director.** "Executive director" means the executive director of
275.21 the State Board of Investment.

275.22 Subd. 16. **Internal Revenue Code.** "Internal Revenue Code" means the Internal
275.23 Revenue Code of 1986, as amended.

275.24 Subd. 17. **Investment in the account.** "Investment in the account" means the sum
275.25 of all contributions made to an account by a particular date minus the aggregate amount
275.26 of contributions included in distributions or rollover distributions, if any, made from the
275.27 account as of that date.

275.28 Subd. 18. **Member of the family.** "Member of the family" has the meaning given in
275.29 section 529A(e)(4) of the Internal Revenue Code.

275.30 Subd. 19. **Participation agreement.** "Participation agreement" means an agreement
275.31 to participate in the Minnesota ABLE plan between an account owner and the state
275.32 through its agencies, the commissioner, and the board.

275.33 Subd. 20. **Person.** "Person" means an individual, trust, estate, partnership,
275.34 association, company, corporation, or the state.

276.1 Subd. 21. **Plan administrator.** "Plan administrator" means the person selected by
276.2 the commissioner and the board to administer the daily operations of the ABLE plan and
276.3 provide record keeping, investment management, and other services for the plan.

276.4 Subd. 22. **Qualified disability expense.** "Qualified disability expense" has the
276.5 meaning given in section 529A(e)(5) of the Internal Revenue Code and further defined
276.6 through regulations issued under that section.

276.7 Subd. 23. **Qualified distribution.** "Qualified distribution" means a withdrawal from
276.8 an ABLE account to pay the qualified disability expenses of the beneficiary of the account.
276.9 A qualified withdrawal may be made by the beneficiary, by an agent of the beneficiary
276.10 who has the power of attorney, or by the beneficiary's legal guardian.

276.11 Subd. 24. **Rollover distribution.** "Rollover distribution" means a transfer of funds
276.12 made:

276.13 (1) from one account in another state's qualified ABLE program to an account for
276.14 the benefit of the same designated beneficiary or an eligible individual who is a family
276.15 member of the former designated beneficiary; or

276.16 (2) from one account to another account for the benefit of an eligible individual who
276.17 is a family member of the former designated beneficiary.

276.18 Subd. 25. **Total account balance.** "Total account balance" means the amount in an
276.19 account on a particular date or the fair market value of an account on a particular date.

276.20 **Sec. 47. [256Q.04] ABLE PLAN REQUIREMENTS.**

276.21 Subdivision 1. **State residency requirement.** The designated beneficiary of an
276.22 ABLE account must be a resident of Minnesota, or the resident of a state that has entered
276.23 into a contract with Minnesota to provide its residents access to the Minnesota ABLE plan.

276.24 Subd. 2. **Single account requirement.** No more than one ABLE account shall be
276.25 established per beneficiary, except as permitted under section 529A(c)(4) of the Internal
276.26 Revenue Code.

276.27 Subd. 3. **Accounts-type plan.** The plan must be operated as an accounts-type
276.28 plan. A separate account must be maintained for each designated beneficiary for whom
276.29 contributions are made.

276.30 Subd. 4. **Contribution and account requirements.** Contributions to an ABLE
276.31 account are subject to the requirements of section 529A(b)(2) of the Internal Revenue
276.32 Code prohibiting noncash contributions and contributions in excess of the annual
276.33 contribution limit. The total account balance may not exceed the maximum account
276.34 balance limit imposed under section 136G.09, subdivision 8.

277.1 Subd. 5. **Limited investment direction.** Designated beneficiaries may not direct
277.2 the investment of assets in their accounts more than twice in any calendar year.

277.3 Subd. 6. **Security for loans.** An interest in an account must not be used as security
277.4 for a loan.

277.5 Sec. 48. **[256Q.05] ABLE PLAN ADMINISTRATION.**

277.6 Subdivision 1. **Plan to comply with federal law.** The commissioner shall ensure
277.7 that the plan meets the requirements for an ABLE account under section 529A of the
277.8 Internal Revenue Code, including any regulations released after the effective date of this
277.9 section. The commissioner may request a private letter ruling or rulings from the Internal
277.10 Revenue Service or Secretary of Health and Human Services and must take any necessary
277.11 steps to ensure that the plan qualifies under relevant provisions of federal law.

277.12 Subd. 2. **Plan rules and procedures.** (a) The commissioner shall establish the
277.13 rules, terms, and conditions for the plan, subject to the requirements of this chapter and
277.14 section 529A of the Internal Revenue Code.

277.15 (b) The commissioner shall prescribe the application forms, procedures, and other
277.16 requirements that apply to the plan.

277.17 Subd. 3. **Consultation with other state agencies; annual fee.** In designing and
277.18 establishing the plan's requirements and in negotiating or entering into contracts with third
277.19 parties under subdivision 4, the commissioner shall consult with the executive director of
277.20 the board and the commissioner of the Office of Higher Education. The commissioner and
277.21 the executive director shall establish an annual fee, equal to a percentage of the average
277.22 daily net assets of the plan, to be imposed on account owners to recover the costs of
277.23 administration, record keeping, and investment management as provided in subdivision 5.

277.24 Subd. 4. **Administration.** The commissioner shall administer the plan, including
277.25 accepting and processing applications, verifying state residency, verifying eligibility,
277.26 maintaining account records, making payments, and undertaking any other necessary
277.27 tasks to administer the plan. Notwithstanding other requirements of this chapter, the
277.28 commissioner shall adopt rules for purposes of implementing and administering the plan.
277.29 The commissioner may contract with one or more third parties to carry out some or all of
277.30 these administrative duties, including providing incentives. The commissioner and the
277.31 board may jointly contract with third-party providers, if the commissioner and board
277.32 determine that it is desirable to contract with the same entity or entities for administration
277.33 and investment management.

277.34 Subd. 5. **Authority to impose fees.** The commissioner, or the commissioner's
277.35 designee, may impose annual fees, as provided in subdivision 3, on account owners to

278.1 recover the costs of administration. The commissioner must keep the fees as low as
278.2 possible, consistent with efficient administration, so that the returns on savings invested in
278.3 the plan are as high as possible.

278.4 Subd. 6. **Federally mandated reporting.** (a) As required under section 529A(d) of
278.5 the Internal Revenue Code, the commissioner or the commissioner's designee shall submit
278.6 a notice to the Secretary of the Treasury upon the establishment of each ABLE account.
278.7 The notice must contain the name and state of residence of the designated beneficiary and
278.8 other information as the secretary may require.

278.9 (b) As required under section 529A(d) of the Internal Revenue Code, the
278.10 commissioner or the commissioner's designee shall submit electronically on a monthly
278.11 basis to the Commissioner of Social Security, in a manner specified by the Commissioner
278.12 of Social Security, statements on relevant distributions and account balances from all
278.13 ABLE accounts.

278.14 Subd. 7. **Data.** (a) Data on ABLE accounts and designated beneficiaries of ABLE
278.15 accounts are private data on individuals or nonpublic data as defined in section 13.02.

278.16 (b) The commissioner may share or disseminate data classified as private or
278.17 nonpublic in this subdivision as follows:

278.18 (1) with other state or federal agencies, only to the extent necessary to verify
278.19 identity of, determine the eligibility of, or process applications for an eligible individual
278.20 participating in the Minnesota ABLE plan; and

278.21 (2) with a nongovernmental person, only to the extent necessary to carry out the
278.22 functions of the Minnesota ABLE plan, provided the commissioner has entered into
278.23 a data-sharing agreement with the person, as provided in section 13.05, subdivision 6,
278.24 prior to sharing data under this clause or a contract with that person that complies with
278.25 section 13.05, subdivision 11, as applicable.

278.26 Sec. 49. **[256Q.06] PLAN ACCOUNTS.**

278.27 Subdivision 1. **Contributions to an account.** Any person may make contributions
278.28 to an ABLE account on behalf of a designated beneficiary. Contributions to an account
278.29 made by persons other than the account owner become the property of the account owner.
278.30 A person does not acquire an interest in an ABLE account by making contributions to
278.31 an account. Contributions to an account must be made in cash, by check, or by other
278.32 commercially acceptable means, as permitted by the Internal Revenue Service and
278.33 approved by the plan administrator in cooperation with the commissioner and the board.

278.34 Subd. 2. **Contribution and account limitations.** Contributions to an ABLE
278.35 account are subject to the requirements of section 529A(b) of the Internal Revenue Code.

279.1 The total account balance of an ABLE account may not exceed the maximum account
 279.2 balance limit imposed under section 136G.09, subdivision 8. The plan administrator must
 279.3 reject any portion of a contribution to an account that exceeds the annual contribution limit
 279.4 or that would cause the total account balance to exceed the maximum account balance
 279.5 limit imposed under section 136G.09, subdivision 8.

279.6 Subd. 3. **Authority of account owner.** An account owner is the only person
 279.7 entitled to:

279.8 (1) request distributions;

279.9 (2) request rollover distributions; or

279.10 (3) change the beneficiary of an ABLE account to a member of the family of the
 279.11 current beneficiary, but only if the beneficiary to whom the ABLE account is transferred
 279.12 is an eligible individual.

279.13 Subd. 4. **Effect of plan changes on participation agreement.** Amendments to
 279.14 this chapter automatically amend the participation agreement. Any amendments to the
 279.15 operating procedures and policies of the plan automatically amend the participation
 279.16 agreement after adoption by the commissioner or the board.

279.17 Subd. 5. **Special account to hold plan assets in trust.** All assets of the plan,
 279.18 including contributions to accounts, are held in trust for the exclusive benefit of account
 279.19 owners. Assets must be held in a separate account in the state treasury to be known as
 279.20 the Minnesota ABLE plan account or in accounts with the third-party provider selected
 279.21 pursuant to section 256Q.05, subdivision 4. Plan assets are not subject to claims by creditors
 279.22 of the state, are not part of the general fund, and are not subject to appropriation by the
 279.23 state. Payments from the Minnesota ABLE plan account shall be made under this chapter.

279.24 Sec. 50. **[256Q.07] INVESTMENT OF ABLE ACCOUNTS.**

279.25 Subdivision 1. **State Board of Investment to invest.** The State Board of Investment
 279.26 shall invest the money deposited in accounts in the plan.

279.27 Subd. 2. **Permitted investments.** The board may invest the accounts in any
 279.28 permitted investment under section 11A.24, except that the accounts may be invested
 279.29 without limit in investment options from open-ended investment companies registered
 279.30 under the federal Investment Company Act of 1940, United States Code, title 15, sections
 279.31 80a-1 to 80a-64.

279.32 Subd. 3. **Contracting authority.** The board may contract with one or more third
 279.33 parties for investment management, record keeping, or other services in connection with
 279.34 investing the accounts. The board and commissioner may jointly contract with third-party

280.1 providers, if the commissioner and board determine that it is desirable to contract with the
280.2 same entity or entities for administration and investment management.

280.3 **Sec. 51. [256Q.08] ACCOUNT DISTRIBUTIONS.**

280.4 **Subdivision 1. Qualified distribution methods.** (a) Qualified distributions may
280.5 be made:

280.6 (1) directly to participating providers of goods and services that are qualified
280.7 disability expenses, if purchased for a beneficiary;

280.8 (2) in the form of a check payable to both the beneficiary and provider of goods or
280.9 services that are qualified disability expenses; or

280.10 (3) directly to the beneficiary, if the beneficiary has already paid qualified disability
280.11 expenses.

280.12 (b) Qualified distributions must be withdrawn proportionally from contributions and
280.13 earnings in an account owner's account on the date of distribution as provided in section
280.14 529A of the Internal Revenue Code.

280.15 **Subd. 2. Distributions upon death of a beneficiary.** Upon the death of a
280.16 beneficiary, the amount remaining in the beneficiary's account must be distributed pursuant
280.17 to section 529A(f) of the Internal Revenue Code.

280.18 **Subd. 3. Nonqualified distribution.** An account owner may request a nonqualified
280.19 distribution from an account at any time. Nonqualified distributions are based on the total
280.20 account balances in an account owner's account and must be withdrawn proportionally
280.21 from contributions and earnings as provided in section 529A of the Internal Revenue
280.22 Code. The earnings portion of a nonqualified distribution is subject to a federal additional
280.23 tax pursuant to section 529A of the Internal Revenue Code. For purposes of this
280.24 subdivision, "earnings portion" means the ratio of the earnings in the account to the total
280.25 account balance, immediately prior to the distribution, multiplied by the distribution.

280.26 **Sec. 52. INDIVIDUAL PROVIDERS OF DIRECT SUPPORT SERVICES.**

280.27 The labor agreement between the state of Minnesota and the Service Employees
280.28 International Union Healthcare Minnesota, submitted to the Legislative Coordinating
280.29 Commission on March 2, 2015, is ratified.

280.30 **EFFECTIVE DATE.** This section is effective July 1, 2015.

280.31 **Sec. 53. RATE INCREASE FOR DIRECT SUPPORT SERVICES PROVIDERS**
280.32 **WORKFORCE NEGOTIATIONS.**

281.1 (a) If the labor agreement between the state of Minnesota and the Service Employees
281.2 International Union Healthcare Minnesota under Minnesota Statutes, section 179A.54, is
281.3 approved pursuant to Minnesota Statutes, sections 3.855 and 179A.22, the commissioner
281.4 of human services shall increase reimbursement rates, individual budgets, grants, or
281.5 allocations by 1.53 percent for services provided on or after July 1, 2015, and by an
281.6 additional 0.2 percent for services provided on or after July 1, 2016, to implement the
281.7 minimum hourly wage and paid time off provisions of that agreement.

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

281.11 **Sec. 54. CONSUMER-DIRECTED COMMUNITY SUPPORTS BUDGET**
281.12 **METHODOLOGY EXCEPTION.**

281.13 (a) No later than September 30, 2015, if necessary, the commissioner of human
281.14 services shall submit an amendment to the Centers for Medicare and Medicaid Services
281.15 for the home and community-based services waivers authorized under Minnesota Statutes,
281.16 sections 256B.092 and 256B.49, to establish an exception to the consumer-directed
281.17 community supports budget methodology to provide up to 20 percent more funds for:

281.18 (1) consumer-directed community supports participants who have graduated
281.19 from high school and have a coordinated service and support plan which identifies the
281.20 need for more services under consumer-directed community supports, either prior to
281.21 graduation or in order to increase the amount of time a person works or to improve their
281.22 employment opportunities, than the amount they are eligible to receive under the current
281.23 consumer-directed community supports budget methodology; and

281.24 (2) home and community-based waiver participants who are currently using licensed
281.25 services for employment supports or services during the day which cost more annually
281.26 than the person would spend under a consumer-directed community supports plan for
281.27 individualized employment supports or services during the day.

281.28 (b) The exception under paragraph (a) is limited to those persons who can
281.29 demonstrate either that they will have to leave consumer-directed community supports and
281.30 use other waiver services because their need for day or employment supports cannot be
281.31 met within the consumer-directed community supports budget limits or they will move
281.32 to consumer-directed community supports and their services will cost less than services
281.33 currently being used.

282.1 **EFFECTIVE DATE.** The exception under this section is effective October 1, 2015,
282.2 or upon federal approval, whichever is later. The commissioner of human services shall
282.3 notify the revisor of statutes when this occurs.

282.4 Sec. 55. **HOME AND COMMUNITY-BASED SERVICES INCENTIVE POOL.**

282.5 The commissioner of human services shall develop an initiative to provide
282.6 incentives for innovation in achieving integrated competitive employment, living in
282.7 the most integrated setting, and other outcomes determined by the commissioner. The
282.8 commissioner shall seek requests for proposals and shall contract with one or more entities
282.9 to provide incentive payments for meeting identified outcomes. The initial requests for
282.10 proposals must be issued by October 1, 2016.

282.11 Sec. 56. **DIRECTION TO COMMISSIONER; REPORTS REQUIRED.**

282.12 The commissioner of human services shall develop and submit reports to the chairs
282.13 and ranking minority members of the house of representatives and senate committees and
282.14 divisions with jurisdiction over health and human services policy and finance on the
282.15 implementation of Minnesota Statutes, sections 256B.0916, subdivisions 2, 11, and 12,
282.16 and 256B.49, subdivisions 26 and 27. The commissioner shall submit two reports, one by
282.17 February 15, 2018, and the second by February 15, 2019.

282.18 Sec. 57. **INSTRUCTIONS TO THE COMMISSIONER.**

282.19 The commissioner shall determine the number of individuals who were determined
282.20 to be ineligible to receive community first services and supports because they did not
282.21 require constant supervision and cuing in order to accomplish activities of daily living.
282.22 The commissioner shall issue a report with these findings to the chairs and ranking
282.23 minority members of the house and senate committees with jurisdiction over human
282.24 services programs.

282.25 Sec. 58. **REPEALER.**

282.26 Laws 2012, chapter 247, article 4, section 47, as amended by Laws 2014, chapter
282.27 312, article 27, section 72, is repealed upon the effective date of section 54.

282.28 **ARTICLE 8**

282.29 **HEALTH DEPARTMENT AND PUBLIC HEALTH**

282.30 Section 1. Minnesota Statutes 2014, section 16A.724, subdivision 2, is amended to read:

283.1 Subd. 2. **Transfers.** (a) Notwithstanding section 295.581, to the extent available
 283.2 resources in the health care access fund exceed expenditures in that fund, effective for
 283.3 the biennium beginning July 1, 2007, the commissioner of management and budget shall
 283.4 transfer the excess funds from the health care access fund to the general fund on June 30
 283.5 of each year, provided that the amount transferred in any fiscal biennium shall not exceed
 283.6 \$96,000,000. The purpose of this transfer is to meet the rate increase required under Laws
 283.7 2003, First Special Session chapter 14, article 13C, section 2, subdivision 6.

283.8 (b) For fiscal years 2006 to 2011, MinnesotaCare shall be a forecasted program, and,
 283.9 if necessary, the commissioner shall reduce these transfers from the health care access
 283.10 fund to the general fund to meet annual MinnesotaCare expenditures or, if necessary,
 283.11 transfer sufficient funds from the general fund to the health care access fund to meet
 283.12 annual MinnesotaCare expenditures.

283.13 ~~(c) Notwithstanding section 295.581, to the extent available resources in the health~~
 283.14 ~~care access fund exceed expenditures in that fund after the transfer required in paragraph~~
 283.15 ~~(a), effective for the biennium beginning July 1, 2013, the commissioner of management~~
 283.16 ~~and budget shall transfer \$1,000,000 each fiscal year from the health access fund to~~
 283.17 ~~the medical education and research costs fund established under section 62J.692, for~~
 283.18 ~~distribution under section 62J.692, subdivision 4, paragraph (c).~~

283.19 Sec. 2. Minnesota Statutes 2014, section 62J.498, is amended to read:

283.20 **62J.498 HEALTH INFORMATION EXCHANGE.**

283.21 Subdivision 1. **Definitions.** The following definitions apply to sections 62J.498 to
 283.22 62J.4982:

283.23 (a) "Clinical data repository" means a real time database that consolidates data from
 283.24 a variety of clinical sources to present a unified view of a single patient and is used by a
 283.25 state-certified health information exchange service provider to enable health information
 283.26 exchange among health care providers that are not related health care entities as defined in
 283.27 section 144.291, subdivision 2, paragraph (j). This does not include clinical data that are
 283.28 submitted to the commissioner for public health purposes required or permitted by law,
 283.29 including any rules adopted by the commissioner.

283.30 ~~(a)~~ (b) "Clinical transaction" means any meaningful use transaction or other health
 283.31 information exchange transaction that is not covered by section 62J.536.

283.32 ~~(b)~~ (c) "Commissioner" means the commissioner of health.

283.33 ~~(c) "Direct health information exchange" means the electronic transmission of~~
 283.34 ~~health-related information through a direct connection between the electronic health~~
 283.35 ~~record systems of health care providers without the use of a health data intermediary.~~

284.1 (d) "Health care provider" or "provider" means a health care provider or provider as
284.2 defined in section 62J.03, subdivision 8.

284.3 (e) "Health data intermediary" means an entity that provides the ~~infrastructure~~
284.4 technical capabilities or related products and services to connect computer systems or
284.5 ~~other electronic devices used by health care providers, laboratories, pharmacies, health~~
284.6 ~~plans, third-party administrators, or pharmacy benefit managers to facilitate the secure~~
284.7 ~~transmission of health information, including~~ enable health information exchange among
284.8 health care providers that are not related health care entities as defined in section 144.291,
284.9 subdivision 2, paragraph (j). This includes but is not limited to: health information service
284.10 providers (HISP), electronic health record vendors, and pharmaceutical electronic data
284.11 intermediaries as defined in section 62J.495. ~~This does not include health care providers~~
284.12 ~~engaged in direct health information exchange.~~

284.13 (f) "Health information exchange" means the electronic transmission of health-related
284.14 information between organizations according to nationally recognized standards.

284.15 (g) "Health information exchange service provider" means a health data intermediary
284.16 or health information organization ~~that has been issued a certificate of authority by the~~
284.17 ~~commissioner under section 62J.4981.~~

284.18 (h) "Health information organization" means an organization that oversees, governs,
284.19 and facilitates ~~the health information exchange of health-related information among~~
284.20 ~~organizations according to nationally recognized standards~~ health care providers that are
284.21 not related health care entities as defined in section 144.291, subdivision 2, paragraph (j),
284.22 to improve coordination of patient care and the efficiency of health care delivery.

284.23 (i) "HITECH Act" means the Health Information Technology for Economic and
284.24 Clinical Health Act as defined in section 62J.495.

284.25 (j) "Major participating entity" means:

284.26 (1) a participating entity that receives compensation for services that is greater
284.27 than 30 percent of the health information organization's gross annual revenues from the
284.28 health information exchange service provider;

284.29 (2) a participating entity providing administrative, financial, or management services
284.30 to the health information organization, if the total payment for all services provided by the
284.31 participating entity exceeds three percent of the gross revenue of the health information
284.32 organization; and

284.33 (3) a participating entity that nominates or appoints 30 percent or more of the board
284.34 of directors or equivalent governing body of the health information organization.

284.35 (k) "Master patient index" means an electronic database that holds unique identifiers
284.36 of patients registered at a care facility and is used by a state-certified health information

285.1 exchange service provider to enable health information exchange among health care
 285.2 providers that are not related health care entities as defined in section 144.291, subdivision
 285.3 2, paragraph (j). This does not include data that are submitted to the commissioner for
 285.4 public health purposes required or permitted by law, including any rules adopted by the
 285.5 commissioner.

285.6 ~~(k)~~ (l) "Meaningful use" means use of certified electronic health record technology
 285.7 ~~that includes e-prescribing, and is connected in a manner that provides for the electronic~~
 285.8 ~~exchange of health information and used for the submission of clinical quality measures~~
 285.9 ~~to improve quality, safety, and efficiency and reduce health disparities; engage patients~~
 285.10 ~~and families; improve care coordination and population and public health; and maintain~~
 285.11 ~~privacy and security of patient health information as established by the Center for~~
 285.12 ~~Medicare and Medicaid Services and the Minnesota Department of Human Services~~
 285.13 ~~pursuant to sections 4101, 4102, and 4201 of the HITECH Act.~~

285.14 ~~(h)~~ (m) "Meaningful use transaction" means an electronic transaction that a health
 285.15 care provider must exchange to receive Medicare or Medicaid incentives or avoid
 285.16 Medicare penalties pursuant to sections 4101, 4102, and 4201 of the HITECH Act.

285.17 ~~(m)~~ (n) "Participating entity" means any of the following persons, health care
 285.18 providers, companies, or other organizations with which a health information organization
 285.19 or health data intermediary has contracts or other agreements for the provision of health
 285.20 information exchange ~~service providers~~ services:

285.21 (1) a health care facility licensed under sections 144.50 to 144.56, a nursing home
 285.22 licensed under sections 144A.02 to 144A.10, and any other health care facility otherwise
 285.23 licensed under the laws of this state or registered with the commissioner;

285.24 (2) a health care provider, and any other health care professional otherwise licensed
 285.25 under the laws of this state or registered with the commissioner;

285.26 (3) a group, professional corporation, or other organization that provides the
 285.27 services of individuals or entities identified in clause (2), including but not limited to a
 285.28 medical clinic, a medical group, a home health care agency, an urgent care center, and
 285.29 an emergent care center;

285.30 (4) a health plan as defined in section 62A.011, subdivision 3; and

285.31 (5) a state agency as defined in section 13.02, subdivision 17.

285.32 ~~(n)~~ (o) "Reciprocal agreement" means an arrangement in which two or more health
 285.33 information exchange service providers agree to share in-kind services and resources to
 285.34 allow for the pass-through of ~~meaningful use~~ clinical transactions.

285.35 ~~(o)~~ (p) "State-certified health data intermediary" means a health data intermediary
 285.36 ~~that~~ has been issued a certificate of authority to operate in Minnesota.

286.1 ~~(1) provides a subset of the meaningful use transaction capabilities necessary for~~
 286.2 ~~hospitals and providers to achieve meaningful use of electronic health records;~~

286.3 ~~(2) is not exclusively engaged in the exchange of meaningful use transactions~~
 286.4 ~~covered by section 62J.536; and~~

286.5 ~~(3) has been issued a certificate of authority to operate in Minnesota.~~

286.6 ~~(p)~~ (q) "State-certified health information organization" means a nonprofit health
 286.7 information organization that provides transaction capabilities necessary to fully support
 286.8 clinical transactions required for meaningful use of electronic health records that has been
 286.9 issued a certificate of authority to operate in Minnesota.

286.10 Subd. 2. **Health information exchange oversight.** (a) The commissioner shall
 286.11 protect the public interest on matters pertaining to health information exchange. The
 286.12 commissioner shall:

286.13 (1) review and act on applications from health data intermediaries and health
 286.14 information organizations for certificates of authority to operate in Minnesota;

286.15 (2) provide ongoing monitoring to ensure compliance with criteria established under
 286.16 sections 62J.498 to 62J.4982;

286.17 (3) respond to public complaints related to health information exchange services;

286.18 (4) take enforcement actions as necessary, including the imposition of fines,
 286.19 suspension, or revocation of certificates of authority as outlined in section 62J.4982;

286.20 (5) provide a biennial report on the status of health information exchange services
 286.21 that includes but is not limited to:

286.22 (i) recommendations on actions necessary to ensure that health information exchange
 286.23 services are adequate to meet the needs of Minnesota citizens and providers statewide;

286.24 (ii) recommendations on enforcement actions to ensure that health information
 286.25 exchange service providers act in the public interest without causing disruption in health
 286.26 information exchange services;

286.27 (iii) recommendations on updates to criteria for obtaining certificates of authority
 286.28 under this section; and

286.29 (iv) recommendations on standard operating procedures for health information
 286.30 exchange, including but not limited to the management of consumer preferences; and

286.31 (6) other duties necessary to protect the public interest.

286.32 (b) As part of the application review process for certification under paragraph (a),
 286.33 prior to issuing a certificate of authority, the commissioner shall:

286.34 (1) ~~hold public hearings that provide an adequate opportunity for participating~~
 286.35 ~~entities and consumers to provide feedback and recommendations on the application under~~
 286.36 ~~consideration. The commissioner shall make all portions of the application classified as~~

287.1 public data available to the public for at least ten days in advance of the hearing while
 287.2 an application is under consideration. At the request of the commissioner, the applicant
 287.3 shall participate in the a public hearing by presenting an overview of their application and
 287.4 responding to questions from interested parties; and

287.5 (2) ~~make available all feedback and recommendations gathered at the hearing~~
 287.6 ~~available to the public prior to issuing a certificate of authority; and~~

287.7 (3) ~~consult with hospitals, physicians, and other professionals eligible to receive~~
 287.8 ~~meaningful use incentive payments or subject to penalties as established in the HITECH~~
 287.9 ~~Act, and their respective statewide associations, providers prior to issuing a certificate of~~
 287.10 ~~authority.~~

287.11 (c) When the commissioner is actively considering a suspension or revocation of a
 287.12 certificate of authority as described in section 62J.4982, subdivision 3, all investigatory
 287.13 data that are collected, created, or maintained related to the suspension or revocation
 287.14 are classified as confidential data on individuals and as protected nonpublic data in the
 287.15 case of data not on individuals.

287.16 (d) The commissioner may disclose data classified as protected nonpublic or
 287.17 confidential under paragraph (c) if disclosing the data will protect the health or safety of
 287.18 patients.

287.19 (e) After the commissioner makes a final determination regarding a suspension or
 287.20 revocation of a certificate of authority, all minutes, orders for hearing, findings of fact,
 287.21 conclusions of law, and the specification of the final disciplinary action, are classified
 287.22 as public data.

287.23 Sec. 3. Minnesota Statutes 2014, section 62J.4981, is amended to read:

287.24 **62J.4981 CERTIFICATE OF AUTHORITY TO PROVIDE HEALTH**
 287.25 **INFORMATION EXCHANGE SERVICES.**

287.26 Subdivision 1. **Authority to require organizations to apply.** The commissioner
 287.27 shall require ~~an entity providing health information exchange services~~ a health data
 287.28 intermediary or a health information organization to apply for a certificate of authority
 287.29 under this section. An applicant may continue to operate until the commissioner acts
 287.30 on the application. If the application is denied, the applicant is considered a health
 287.31 information ~~organization~~ exchange service provider whose certificate of authority has
 287.32 been revoked under section 62J.4982, subdivision 2, paragraph (d).

287.33 Subd. 2. **Certificate of authority for health data intermediaries.** (a) A health
 287.34 data intermediary ~~that provides health information exchange services for the transmission~~
 287.35 ~~of one or more clinical transactions necessary for hospitals, providers, or eligible~~

288.1 ~~professionals to achieve meaningful use~~ must be registered with certified by the state and
 288.2 comply with requirements established in this section.

288.3 (b) Notwithstanding any law to the contrary, any corporation organized to do so
 288.4 may apply to the commissioner for a certificate of authority to establish and operate as
 288.5 a health data intermediary in compliance with this section. No person shall establish or
 288.6 operate a health data intermediary in this state, nor sell or offer to sell, or solicit offers
 288.7 to purchase or receive advance or periodic consideration in conjunction with a health
 288.8 data intermediary contract unless the organization has a certificate of authority or has an
 288.9 application under active consideration under this section.

288.10 (c) In issuing the certificate of authority, the commissioner shall determine whether
 288.11 the applicant for the certificate of authority has demonstrated that the applicant meets
 288.12 the following minimum criteria:

288.13 ~~(1) interoperate with at least one state-certified health information organization;~~

288.14 ~~(2) provide an option for Minnesota entities to connect to their services through at
 288.15 least one state-certified health information organization;~~

288.16 ~~(3) have a record locator service as defined in section 144.291, subdivision 2,
 288.17 paragraph (i), that is compliant with the requirements of section 144.293, subdivision 8,
 288.18 when conducting meaningful use transactions; and~~

288.19 ~~(4) (1) hold reciprocal agreements with at least one state-certified health information
 288.20 organization to enable access to record locator services to find patient data, and for the
 288.21 transmission and receipt of meaningful use clinical transactions consistent with the
 288.22 format and content required by national standards established by Centers for Medicare
 288.23 and Medicaid Services. Reciprocal agreements must meet the requirements established in
 288.24 subdivision 5; and~~

288.25 (2) participate in statewide shared health information exchange services as defined
 288.26 by the commissioner to support interoperability between state-certified health information
 288.27 organizations and state-certified health data intermediaries.

288.28 **Subd. 3. Certificate of authority for health information organizations.**

288.29 (a) A health information organization ~~that provides all electronic capabilities for the~~
 288.30 ~~transmission of clinical transactions necessary for meaningful use of electronic health~~
 288.31 ~~records~~ must obtain a certificate of authority from the commissioner and demonstrate
 288.32 compliance with the criteria in paragraph (c).

288.33 (b) Notwithstanding any law to the contrary, ~~a nonprofit corporation organized to~~
 288.34 ~~do so~~ an organization may apply for a certificate of authority to establish and operate a
 288.35 health information organization under this section. No person shall establish or operate a
 288.36 health information organization in this state, nor sell or offer to sell, or solicit offers

289.1 to purchase or receive advance or periodic consideration in conjunction with a health
289.2 information organization or health information contract unless the organization has a
289.3 certificate of authority under this section.

289.4 (c) In issuing the certificate of authority, the commissioner shall determine whether
289.5 the applicant for the certificate of authority has demonstrated that the applicant meets
289.6 the following minimum criteria:

289.7 (1) the entity is a legally established, ~~nonprofit~~ organization;

289.8 (2) appropriate insurance, including liability insurance, for the operation of the
289.9 health information organization is in place and sufficient to protect the interest of the
289.10 public and participating entities;

289.11 (3) strategic and operational plans ~~clearly~~ address governance, technical
289.12 infrastructure, legal and policy issues, finance, and business operations in regard to how
289.13 the organization will expand technical capacity of the health information organization
289.14 to support providers in achieving meaningful use of electronic health records health
289.15 information exchange goals over time;

289.16 (4) the entity addresses the parameters to be used with participating entities and
289.17 other health information ~~organizations~~ exchange service providers for ~~meaningful use~~
289.18 clinical transactions, compliance with Minnesota law, and interstate health information
289.19 exchange ~~in~~ trust agreements;

289.20 (5) the entity's board of directors or equivalent governing body is composed of
289.21 members that broadly represent the health information organization's participating entities
289.22 and consumers;

289.23 (6) the entity maintains a professional staff responsible to the board of directors or
289.24 equivalent governing body with the capacity to ensure accountability to the organization's
289.25 mission;

289.26 (7) the organization is compliant with ~~criteria established under the Health~~
289.27 ~~Information Exchange Accreditation Program of the Electronic Healthcare Network~~
289.28 ~~Accreditation Commission (EHNAC) or equivalent criteria established~~ national
289.29 certification and accreditation programs designated by the commissioner;

289.30 (8) the entity maintains a the capability to query for patient information based on
289.31 national standards. The query capability may utilize a master patient index, clinical
289.32 data repository, or record locator service as defined in section 144.291, subdivision 2,
289.33 paragraph (i), that is. The entity must be compliant with the requirements of section
289.34 144.293, subdivision 8, when conducting ~~meaningful use~~ clinical transactions;

289.35 (9) the organization demonstrates interoperability with all other state-certified health
289.36 information organizations using nationally recognized standards;

290.1 (10) the organization demonstrates compliance with all privacy and security
290.2 requirements required by state and federal law; and

290.3 (11) the organization uses financial policies and procedures consistent with generally
290.4 accepted accounting principles and has an independent audit of the organization's
290.5 financials on an annual basis.

290.6 (d) Health information organizations that have obtained a certificate of authority must:

290.7 (1) meet the requirements established for connecting to the ~~Nationwide Health~~
290.8 ~~Information Network (NHIN) within the federally mandated timeline or within a time~~
290.9 ~~frame established by the commissioner and published in the State Register. If the state~~
290.10 ~~timeline for implementation varies from the federal timeline, the State Register notice~~
290.11 ~~shall include an explanation for the variation~~ National eHealth Exchange;

290.12 (2) annually submit strategic and operational plans for review by the commissioner
290.13 that address:

290.14 ~~(i) increasing adoption rates to include a sufficient number of participating entities to~~
290.15 ~~achieve financial sustainability; and~~

290.16 ~~(ii) (i) progress in achieving objectives included in previously submitted strategic~~
290.17 ~~and operational plans across the following domains: business and technical operations,~~
290.18 ~~technical infrastructure, legal and policy issues, finance, and organizational governance;~~

290.19 ~~(3) develop and maintain a business plan that addresses:~~

290.20 ~~(i) (ii) plans for ensuring the necessary capacity to support meaningful use~~ clinical
290.21 transactions;

290.22 ~~(ii) (iii) approach for attaining financial sustainability, including public and private~~
290.23 ~~financing strategies, and rate structures;~~

290.24 ~~(iii) (iv) rates of adoption, utilization, and transaction volume, and mechanisms to~~
290.25 ~~support health information exchange; and~~

290.26 ~~(iv) (v) an explanation of methods employed to address the needs of community~~
290.27 ~~clinics, critical access hospitals, and free clinics in accessing health information exchange~~
290.28 ~~services;~~

290.29 ~~(4) annually submit a rate plan to the commissioner outlining fee structures for health~~
290.30 ~~information exchange services for approval by the commissioner. The commissioner~~
290.31 ~~shall approve the rate plan if it:~~

290.32 ~~(i) distributes costs equitably among users of health information services;~~

290.33 ~~(ii) provides predictable costs for participating entities;~~

290.34 ~~(iii) covers all costs associated with conducting the full range of meaningful use~~
290.35 ~~clinical transactions, including access to health information retrieved through other~~
290.36 ~~state-certified health information exchange service providers; and~~

291.1 ~~(iv) provides for a predictable revenue stream for the health information organization~~
 291.2 ~~and generates sufficient resources to maintain operating costs and develop technical~~
 291.3 ~~infrastructure necessary to serve the public interest;~~

291.4 ~~(5) (3) enter into reciprocal agreements with all other state-certified health~~
 291.5 ~~information organizations and state-certified health data intermediaries to enable access~~
 291.6 ~~to record locator services to find patient data, and for the transmission and receipt of~~
 291.7 ~~meaningful use clinical transactions consistent with the format and content required by~~
 291.8 ~~national standards established by Centers for Medicare and Medicaid Services. Reciprocal~~
 291.9 ~~agreements must meet the requirements in subdivision 5; and~~

291.10 ~~(4) participate in statewide shared health information exchange services as defined~~
 291.11 ~~by the commissioner to support interoperability between state-certified health information~~
 291.12 ~~organizations and state-certified health data intermediaries; and~~

291.13 ~~(6) (5) comply with additional requirements for the certification or recertification of~~
 291.14 ~~health information organizations that may be established by the commissioner.~~

291.15 **Subd. 4. Application for certificate of authority for health information exchange**
 291.16 **service providers.** (a) Each application for a certificate of authority shall be in a form
 291.17 prescribed by the commissioner and verified by an officer or authorized representative
 291.18 of the applicant. Each application shall include the following in addition to information
 291.19 described in the criteria in subdivisions 2 and 3:

291.20 (1) for health information organizations only, a copy of the basic organizational
 291.21 document, if any, of the applicant and of each major participating entity, such as the
 291.22 articles of incorporation, or other applicable documents, and all amendments to it;

291.23 (2) for health information organizations only, a list of the names, addresses, and
 291.24 official positions of the following:

291.25 (i) all members of the board of directors or equivalent governing body, and the
 291.26 principal officers and, if applicable, shareholders of the applicant organization; and

291.27 (ii) all members of the board of directors or equivalent governing body, and the
 291.28 principal officers of each major participating entity and, if applicable, each shareholder
 291.29 beneficially owning more than ten percent of any voting stock of the major participating
 291.30 entity;

291.31 (3) for health information organizations only, the name and address of each
 291.32 participating entity and the agreed-upon duration of each contract or agreement if
 291.33 applicable;

291.34 (4) a copy of each standard agreement or contract intended to bind the participating
 291.35 entities and the health information ~~organization~~ exchange service provider. Contractual
 291.36 provisions shall be consistent with the purposes of this section, in regard to the services to

292.1 be performed under the standard agreement or contract, the manner in which payment for
 292.2 services is determined, the nature and extent of responsibilities to be retained by the health
 292.3 information organization, and contractual termination provisions;

292.4 ~~(5) a copy of each contract intended to bind major participating entities and the~~
 292.5 ~~health information organization. Contract information filed with the commissioner under~~
 292.6 ~~this section shall be nonpublic as defined in section 13.02, subdivision 9;~~

292.7 ~~(6)~~ (5) a statement generally describing the health information ~~organization~~ exchange
 292.8 service provider, its health information exchange contracts, facilities, and personnel,
 292.9 including a statement describing the manner in which the applicant proposes to provide
 292.10 participants with comprehensive health information exchange services;

292.11 ~~(7) financial statements showing the applicant's assets, liabilities, and sources~~
 292.12 ~~of financial support, including a copy of the applicant's most recent certified financial~~
 292.13 ~~statement;~~

292.14 ~~(8) strategic and operational plans that specifically address how the organization~~
 292.15 ~~will expand technical capacity of the health information organization to support providers~~
 292.16 ~~in achieving meaningful use of electronic health records over time, a description of~~
 292.17 ~~the proposed method of marketing the services, a schedule of proposed charges, and a~~
 292.18 ~~financial plan that includes a three-year projection of the expenses and income and other~~
 292.19 ~~sources of future capital;~~

292.20 ~~(9)~~ (6) a statement reasonably describing the geographic area or areas to be served
 292.21 and the type or types of participants to be served;

292.22 ~~(10)~~ (7) a description of the complaint procedures to be used as required under
 292.23 this section;

292.24 ~~(11)~~ (8) a description of the mechanism by which participating entities will have an
 292.25 opportunity to participate in matters of policy and operation;

292.26 ~~(12)~~ (9) a copy of any pertinent agreements between the health information
 292.27 organization and insurers, including liability insurers, demonstrating coverage is in place;

292.28 ~~(13)~~ (10) a copy of the conflict of interest policy that applies to all members of the
 292.29 board of directors or equivalent governing body and the principal officers of the health
 292.30 information organization; and

292.31 ~~(14)~~ (11) other information as the commissioner may reasonably require to be
 292.32 provided.

292.33 (b) Within ~~30~~ 45 days after the receipt of the application for a certificate of authority,
 292.34 the commissioner shall determine whether or not the application submitted meets the
 292.35 requirements for completion in paragraph (a), and notify the applicant of any further
 292.36 information required for the application to be processed.

293.1 (c) Within 90 days after the receipt of a complete application for a certificate of
 293.2 authority, the commissioner shall issue a certificate of authority to the applicant if the
 293.3 commissioner determines that the applicant meets the minimum criteria requirements
 293.4 of subdivision 2 for health data intermediaries or subdivision 3 for health information
 293.5 organizations. If the commissioner determines that the applicant is not qualified, the
 293.6 commissioner shall notify the applicant and specify the reasons for disqualification.

293.7 (d) Upon being granted a certificate of authority to operate as a state-certified health
 293.8 information organization or state-certified health data intermediary, the organization must
 293.9 operate in compliance with the provisions of this section. Noncompliance may result in
 293.10 the imposition of a fine or the suspension or revocation of the certificate of authority
 293.11 according to section 62J.4982.

293.12 **Subd. 5. Reciprocal agreements between health information exchange entities.**

293.13 (a) Reciprocal agreements between two health information organizations or between a
 293.14 health information organization and a health data intermediary must include a fair and
 293.15 equitable model for charges between the entities that:

293.16 (1) does not impede the secure transmission of clinical transactions ~~necessary to~~
 293.17 ~~achieve meaningful use~~;

293.18 (2) does not charge a fee for the exchange of meaningful use transactions transmitted
 293.19 according to nationally recognized standards where no additional value-added service
 293.20 is rendered to the sending or receiving health information organization or health data
 293.21 intermediary either directly or on behalf of the client;

293.22 (3) is consistent with fair market value and proportionately reflects the value-added
 293.23 services accessed as a result of the agreement; and

293.24 (4) prevents health care stakeholders from being charged multiple times for the
 293.25 same service.

293.26 (b) Reciprocal agreements must include comparable quality of service standards that
 293.27 ensure equitable levels of services.

293.28 (c) Reciprocal agreements are subject to review and approval by the commissioner.

293.29 (d) Nothing in this section precludes a state-certified health information organization
 293.30 or state-certified health data intermediary from entering into contractual agreements for
 293.31 the provision of value-added services beyond meaningful use transactions.

293.32 ~~(e) The commissioner of human services or health, when providing access to data or~~
 293.33 ~~services through a certified health information organization, must offer the same data or~~
 293.34 ~~services directly through any certified health information organization at the same pricing,~~
 293.35 ~~if the health information organization pays for all connection costs to the state data or~~
 293.36 ~~service. For all external connectivity to the respective agencies through existing or future~~

294.1 ~~information exchange implementations, the respective agency shall establish the required~~
 294.2 ~~connectivity methods as well as protocol standards to be utilized.~~

294.3 ~~Subd. 6. **State participation in health information exchange.** A state agency that~~
 294.4 ~~connects to a health information exchange service provider for the purpose of exchanging~~
 294.5 ~~meaningful use transactions must ensure that the contracted health information exchange~~
 294.6 ~~service provider has reciprocal agreements in place as required by this section. The~~
 294.7 ~~reciprocal agreements must provide equal access to information supplied by the agency as~~
 294.8 ~~necessary for meaningful use by the participating entities of the other health information~~
 294.9 ~~service providers.~~

294.10 Sec. 4. Minnesota Statutes 2014, section 62J.4982, subdivision 4, is amended to read:

294.11 Subd. 4. **Coordination.** (a) The commissioner shall, to the extent possible, seek
 294.12 the advice of the Minnesota e-Health Advisory Committee, in the review and update of
 294.13 criteria for the certification and recertification of health information exchange service
 294.14 providers when implementing sections 62J.498 to 62J.4982.

294.15 ~~(b) By January 1, 2011, the commissioner shall report to the governor and the chairs~~
 294.16 ~~of the senate and house of representatives committees having jurisdiction over health~~
 294.17 ~~information policy issues on the status of health information exchange in Minnesota, and~~
 294.18 ~~provide recommendations on further action necessary to facilitate the secure electronic~~
 294.19 ~~movement of health information among health providers that will enable Minnesota~~
 294.20 ~~providers and hospitals to meet meaningful use exchange requirements.~~

294.21 Sec. 5. Minnesota Statutes 2014, section 62J.4982, subdivision 5, is amended to read:

294.22 Subd. 5. **Fees and monetary penalties.** (a) The commissioner shall assess fees
 294.23 on every health information exchange service provider subject to sections 62J.4981 and
 294.24 62J.4982 as follows:

294.25 (1) filing an application for certificate of authority to operate as a health information
 294.26 organization, ~~\$10,500~~ \$7,000;

294.27 (2) filing an application for certificate of authority to operate as a health data
 294.28 intermediary, \$7,000;

294.29 (3) annual health information organization certificate fee, ~~\$14,000~~ \$7,000; and

294.30 (4) annual health data intermediary certificate fee, \$7,000; and

294.31 (5) fees for other filings, as specified by rule.

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

295.1 ~~(b)~~ (c) Administrative monetary penalties imposed under this subdivision shall
295.2 be credited to an account in the special revenue fund and are appropriated to the
295.3 commissioner for the purposes of sections 62J.498 to 62J.4982.

295.4 Sec. 6. Minnesota Statutes 2014, section 62J.692, subdivision 4, is amended to read:

295.5 Subd. 4. **Distribution of funds.** (a) The commissioner shall annually distribute the
295.6 available medical education funds to all qualifying applicants based on a public program
295.7 volume factor, which is determined by the total volume of public program revenue
295.8 received by each training site as a percentage of all public program revenue received by
295.9 all training sites in the fund pool.

295.10 Public program revenue for the distribution formula includes revenue from medical
295.11 assistance, prepaid medical assistance, general assistance medical care, and prepaid
295.12 general assistance medical care. Training sites that receive no public program revenue
295.13 are ineligible for funds available under this subdivision. For purposes of determining
295.14 training-site level grants to be distributed under this paragraph, total statewide average
295.15 costs per trainee for medical residents is based on audited clinical training costs per trainee
295.16 in primary care clinical medical education programs for medical residents. Total statewide
295.17 average costs per trainee for dental residents is based on audited clinical training costs
295.18 per trainee in clinical medical education programs for dental students. Total statewide
295.19 average costs per trainee for pharmacy residents is based on audited clinical training
295.20 costs per trainee in clinical medical education programs for pharmacy students. Training
295.21 sites whose training site level grant is less than \$5,000, based on the formula described
295.22 in this paragraph, or that train fewer than 0.1 FTE eligible trainees, are ineligible for
295.23 funds available under this subdivision. No training sites shall receive a grant per FTE
295.24 trainee that is in excess of the 95th percentile grant per FTE across all eligible training
295.25 sites; grants in excess of this amount will be redistributed to other eligible sites based on
295.26 the formula described in this paragraph.

295.27 (b) For funds distributed in fiscal years 2014 and 2015, the distribution formula shall
295.28 include a supplemental public program volume factor, which is determined by providing
295.29 a supplemental payment to training sites whose public program revenue accounted for
295.30 at least 0.98 percent of the total public program revenue received by all eligible training
295.31 sites. The supplemental public program volume factor shall be equal to ten percent of each
295.32 training site's grant for funds distributed in fiscal year 2014 and for funds distributed in
295.33 fiscal year 2015. Grants to training sites whose public program revenue accounted for less
295.34 than 0.98 percent of the total public program revenue received by all eligible training sites
295.35 shall be reduced by an amount equal to the total value of the supplemental payment. For

296.1 fiscal year 2016 and beyond, the distribution of funds shall be based solely on the public
296.2 program volume factor as described in paragraph (a).

296.3 ~~(c) Of available medical education funds, \$1,000,000 shall be distributed each~~
296.4 ~~year for grants to family medicine residency programs located outside the seven-county~~
296.5 ~~metropolitan area, as defined in section 473.121, subdivision 4, focused on education and~~
296.6 ~~training of family medicine physicians to serve communities outside the metropolitan area.~~
296.7 ~~To be eligible for a grant under this paragraph, a family medicine residency program must~~
296.8 ~~demonstrate that over the most recent three calendar years, at least 25 percent of its residents~~
296.9 ~~practice in Minnesota communities outside the metropolitan area. Grant funds must be~~
296.10 ~~allocated proportionally based on the number of residents per eligible residency program.~~

296.11 ~~(d)~~ Funds distributed shall not be used to displace current funding appropriations
296.12 from federal or state sources.

296.13 ~~(e)~~ (d) Funds shall be distributed to the sponsoring institutions indicating the amount
296.14 to be distributed to each of the sponsor's clinical medical education programs based on the
296.15 criteria in this subdivision and in accordance with the commissioner's approval letter. Each
296.16 clinical medical education program must distribute funds allocated under paragraphs (a)
296.17 and (b) to the training sites as specified in the commissioner's approval letter. Sponsoring
296.18 institutions, which are accredited through an organization recognized by the Department
296.19 of Education or the Centers for Medicare and Medicaid Services, may contract directly
296.20 with training sites to provide clinical training. To ensure the quality of clinical training,
296.21 those accredited sponsoring institutions must:

296.22 (1) develop contracts specifying the terms, expectations, and outcomes of the clinical
296.23 training conducted at sites; and

296.24 (2) take necessary action if the contract requirements are not met. Action may include
296.25 the withholding of payments under this section or the removal of students from the site.

296.26 ~~(f)~~ (e) Use of funds is limited to expenses related to clinical training program costs
296.27 for eligible programs.

296.28 ~~(g)~~ (f) Any funds not distributed in accordance with the commissioner's approval
296.29 letter must be returned to the medical education and research fund within 30 days of
296.30 receiving notice from the commissioner. The commissioner shall distribute returned funds
296.31 to the appropriate training sites in accordance with the commissioner's approval letter.

296.32 ~~(h)~~ (g) A maximum of \$150,000 of the funds dedicated to the commissioner
296.33 under section 297F.10, subdivision 1, clause (2), may be used by the commissioner for
296.34 administrative expenses associated with implementing this section.

296.35 Sec. 7. Minnesota Statutes 2014, section 62Q.37, subdivision 2, is amended to read:

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

297.3 (a) "Commissioner" means the commissioner of health for purposes of regulating
297.4 health maintenance organizations and community integrated service networks, the
297.5 commissioner of commerce for purposes of regulating nonprofit health service plan
297.6 corporations, or the commissioner of human services for the purpose of contracting with
297.7 managed care organizations serving persons enrolled in programs under chapter 256B,
297.8 256D, or 256L.

297.9 (b) "Health plan company" means (i) a nonprofit health service plan corporation
297.10 operating under chapter 62C; (ii) a health maintenance organization operating under
297.11 chapter 62D; (iii) a community integrated service network operating under chapter 62N;
297.12 or (iv) a managed care organization operating under chapter 256B, 256D, or 256L.

297.13 (c) "Nationally recognized independent organization" means (i) an organization
297.14 that sets specific national standards governing health care quality assurance processes,
297.15 utilization review, provider credentialing, marketing, and other topics covered by
297.16 this chapter and other chapters and audits and provides accreditation to those health
297.17 plan companies that meet those standards. The American Accreditation Health Care
297.18 Commission (URAC), the National Committee for Quality Assurance (NCQA), ~~and~~
297.19 the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the
297.20 Accreditation Association for Ambulatory Health Care (AAAHC) are, at a minimum,
297.21 defined as nationally recognized independent organizations; and (ii) the Centers for
297.22 Medicare and Medicaid Services for purposes of reviews or audits conducted of health
297.23 plan companies under Part C of Title XVIII of the Social Security Act or under section
297.24 1876 of the Social Security Act.

297.25 (d) "Performance standard" means those standards relating to quality management
297.26 and improvement, access and availability of service, utilization review, provider selection,
297.27 provider credentialing, marketing, member rights and responsibilities, complaints, appeals,
297.28 grievance systems, enrollee information and materials, enrollment and disenrollment,
297.29 subcontractual relationships and delegation, confidentiality, continuity and coordination of
297.30 care, assurance of adequate capacity and services, coverage and authorization of services,
297.31 practice guidelines, health information systems, and financial solvency.

297.32 Sec. 8. Minnesota Statutes 2014, section 62U.04, subdivision 11, is amended to read:

297.33 Subd. 11. **Restricted uses of the all-payer claims data.** (a) Notwithstanding
297.34 subdivision 4, paragraph (b), and subdivision 5, paragraph (b), the commissioner or the

298.1 commissioner's designee shall only use the data submitted under subdivisions 4 and 5 for
298.2 the following purposes:

298.3 (1) to evaluate the performance of the health care home program as authorized under
298.4 sections 256B.0751, subdivision 6, and 256B.0752, subdivision 2;

298.5 (2) to study, in collaboration with the reducing avoidable readmissions effectively
298.6 (RARE) campaign, hospital readmission trends and rates;

298.7 (3) to analyze variations in health care costs, quality, utilization, and illness burden
298.8 based on geographical areas or populations; ~~and~~

298.9 (4) to evaluate the state innovation model (SIM) testing grant received by the
298.10 Departments of Health and Human Services, including the analysis of health care cost,
298.11 quality, and utilization baseline and trend information for targeted populations and
298.12 communities; and

298.13 (5) to compile one or more public use files of summary data or tables that must:

298.14 (i) be available to the public for no or minimal cost by March 1, 2016, and available
298.15 by Web-based electronic data download by June 30, 2019;

298.16 (ii) not identify individual patients, payers, or providers;

298.17 (iii) be updated by the commissioner, at least annually, with the most current data
298.18 available;

298.19 (iv) contain clear and conspicuous explanations of the characteristics of the data,
298.20 such as the dates of the data contained in the files, the absence of costs of care for uninsured
298.21 patients or nonresidents, and other disclaimers that provide appropriate context; and

298.22 (v) not lead to the collection of additional data elements beyond what is authorized
298.23 under this section as of June 30, 2015.

298.24 (b) The commissioner may publish the results of the authorized uses identified
298.25 in paragraph (a) so long as the data released publicly do not contain information or
298.26 descriptions in which the identity of individual hospitals, clinics, or other providers may
298.27 be discerned.

298.28 (c) Nothing in this subdivision shall be construed to prohibit the commissioner from
298.29 using the data collected under subdivision 4 to complete the state-based risk adjustment
298.30 system assessment due to the legislature on October 1, 2015.

298.31 (d) The commissioner or the commissioner's designee may use the data submitted
298.32 under subdivisions 4 and 5 for the purpose described in paragraph (a), clause (3), until
298.33 July 1, 2016.

298.34 (e) The commissioner shall consult with the all-payer claims database work group
298.35 established under subdivision 12 regarding the technical considerations necessary to create
298.36 the public use files of summary data described in paragraph (a), clause (5).

299.1 Sec. 9. Minnesota Statutes 2014, section 62U.10, is amended by adding a subdivision
299.2 to read:

299.3 Subd. 6. **Projected spending baseline.** Beginning February 15, 2016, and each
299.4 February 15 thereafter, the commissioner of health shall report the projected impact on
299.5 spending from specified health indicators related to various preventable illnesses and
299.6 death. The impacts shall be reported over a ten-year time frame using a baseline forecast
299.7 of private and public health care and long-term care spending for residents of this state,
299.8 beginning with calendar year 2009 projected estimates of costs, and updated annually
299.9 for each of the following health indicators:

299.10 (1) costs related to rates of obesity, including obesity-related cancers, coronary
299.11 heart disease, stroke, and arthritis;

299.12 (2) costs related to the utilization of tobacco products;

299.13 (3) costs related to hypertension;

299.14 (4) costs related to diabetes or prediabetes; and

299.15 (5) costs related to dementia and chronic disease among an elderly population over
299.16 60, including additional long-term care costs.

299.17 Sec. 10. Minnesota Statutes 2014, section 62U.10, is amended by adding a subdivision
299.18 to read:

299.19 Subd. 7. **Outcomes reporting; savings determination.** (a) Beginning November 1,
299.20 2016, and each November 1 thereafter, the commissioner of health shall determine the
299.21 actual total private and public health care and long-term care spending for Minnesota
299.22 residents related to each health indicator projected in subdivision 6 for the most recent
299.23 calendar year available. The commissioner shall determine the difference between the
299.24 projected and actual spending for each health indicator and for each year, and determine
299.25 the savings attributable to changes in these health indicators. The assumptions and
299.26 research methods used to calculate actual spending must be determined to be appropriate
299.27 by an independent actuarial consultant. If the actual spending is less than the projected
299.28 spending, the commissioner, in consultation with the commissioners of human services
299.29 and management and budget, shall use the proportion of spending for state-administered
299.30 health care programs to total private and public health care spending for each health
299.31 indicator for the calendar year two years before the current calendar year to determine
299.32 the percentage of the calculated aggregate savings amount accruing to state-administered
299.33 health care programs.

300.1 (b) The commissioner may use the data submitted under section 62U.04, subdivisions
 300.2 4 and 5, to complete the activities required under this section, but may only report publicly
 300.3 on regional data aggregated to granularity of 25,000 lives or greater for this purpose.

300.4 Sec. 11. Minnesota Statutes 2014, section 62U.10, is amended by adding a subdivision
 300.5 to read:

300.6 Subd. 8. **Transfers.** When accumulated annual savings accruing to
 300.7 state-administered health care programs, as calculated under subdivision 7, meet or
 300.8 exceed \$50,000,000 for all health indicators in aggregate statewide, the commissioner of
 300.9 health shall certify that event to the commissioner of management and budget, no later
 300.10 than December 15 of each year. In the next fiscal year following the certification, the
 300.11 commissioner of management and budget shall transfer \$50,000,000 from the general
 300.12 fund to the health care access fund. This transfer shall repeat in each fiscal year following
 300.13 subsequent certifications of additional cumulative savings, up to \$50,000,000 per year.
 300.14 The amount necessary to make the transfer is appropriated from the general fund to the
 300.15 commissioner of management and budget.

300.16 Sec. 12. Minnesota Statutes 2014, section 144.1501, subdivision 1, is amended to read:

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

300.19 (b) "Advanced dental therapist" means an individual who is licensed as a dental
 300.20 therapist under section 150A.06, and who is certified as an advanced dental therapist
 300.21 under section 150A.106.

300.22 (c) "Dental therapist" means an individual who is licensed as a dental therapist
 300.23 under section 150A.06.

300.24 ~~(b)~~ (d) "Dentist" means an individual who is licensed to practice dentistry.

300.25 ~~(e)~~ (e) "Designated rural area" means a statutory and home rule charter city or
 300.26 township that is:

300.27 ~~(1)~~ (1) outside the seven-county metropolitan area as defined in section 473.121,
 300.28 subdivision 2; ~~and~~, excluding the cities of Duluth, Mankato, Moorhead, Rochester, and
 300.29 St. Cloud.

300.30 ~~(2)~~ (2) has a population under 15,000.

300.31 ~~(d)~~ (f) "Emergency circumstances" means those conditions that make it impossible
 300.32 for the participant to fulfill the service commitment, including death, total and permanent
 300.33 disability, or temporary disability lasting more than two years.

301.1 (g) "Mental health professional" means an individual providing clinical services in
301.2 the treatment of mental illness who is qualified in at least one of the ways specified in
301.3 section 245.462, subdivision 18.

301.4 ~~(e)~~ (h) "Medical resident" means an individual participating in a medical residency
301.5 in family practice, internal medicine, obstetrics and gynecology, pediatrics, or psychiatry.

301.6 ~~(f)~~ (i) "Midlevel practitioner" means a nurse practitioner, nurse-midwife, nurse
301.7 anesthetist, advanced clinical nurse specialist, or physician assistant.

301.8 ~~(g)~~ (j) "Nurse" means an individual who has completed training and received
301.9 all licensing or certification necessary to perform duties as a licensed practical nurse
301.10 or registered nurse.

301.11 ~~(h)~~ (k) "Nurse-midwife" means a registered nurse who has graduated from a program
301.12 of study designed to prepare registered nurses for advanced practice as nurse-midwives.

301.13 ~~(i)~~ (l) "Nurse practitioner" means a registered nurse who has graduated from a
301.14 program of study designed to prepare registered nurses for advanced practice as nurse
301.15 practitioners.

301.16 ~~(j)~~ (m) "Pharmacist" means an individual with a valid license issued under chapter
301.17 151.

301.18 ~~(k)~~ (n) "Physician" means an individual who is licensed to practice medicine in
301.19 the areas of family practice, internal medicine, obstetrics and gynecology, pediatrics,
301.20 or psychiatry.

301.21 ~~(l)~~ (o) "Physician assistant" means a person licensed under chapter 147A.

301.22 (p) "Public health nurse" means a registered nurse licensed in Minnesota who has
301.23 obtained a registration certificate as a public health nurse from the Board of Nursing in
301.24 accordance with Minnesota Rules, chapter 6316.

301.25 ~~(m)~~ (q) "Qualified educational loan" means a government, commercial, or foundation
301.26 loan for actual costs paid for tuition, reasonable education expenses, and reasonable living
301.27 expenses related to the graduate or undergraduate education of a health care professional.

301.28 ~~(n)~~ (r) "Underserved urban community" means a Minnesota urban area or population
301.29 included in the list of designated primary medical care health professional shortage areas
301.30 (HPSAs), medically underserved areas (MUAs), or medically underserved populations
301.31 (MUPs) maintained and updated by the United States Department of Health and Human
301.32 Services.

301.33 Sec. 13. Minnesota Statutes 2014, section 144.1501, subdivision 2, is amended to read:

302.1 Subd. 2. **Creation of account.** (a) A health professional education loan forgiveness
302.2 program account is established. The commissioner of health shall use money from the
302.3 account to establish a loan forgiveness program:

302.4 (1) for medical residents and mental health professionals agreeing to practice
302.5 in designated rural areas or underserved urban communities or specializing in the area
302.6 of pediatric psychiatry;

302.7 (2) for midlevel practitioners agreeing to practice in designated rural areas or to
302.8 teach at least 12 credit hours, or 720 hours per year in the nursing field in a postsecondary
302.9 program at the undergraduate level or the equivalent at the graduate level;

302.10 (3) for nurses who agree to practice in a Minnesota nursing home ~~or~~; an intermediate
302.11 care facility for persons with developmental disability; or a hospital if the hospital owns
302.12 and operates a Minnesota nursing home and a minimum of 50 percent of the hours worked
302.13 by the nurse is in the nursing home; or agree to teach at least 12 credit hours, or 720 hours
302.14 per year in the nursing field in a postsecondary program at the undergraduate level or the
302.15 equivalent at the graduate level;

302.16 (4) for other health care technicians agreeing to teach at least 12 credit hours, or 720
302.17 hours per year in their designated field in a postsecondary program at the undergraduate
302.18 level or the equivalent at the graduate level. The commissioner, in consultation with
302.19 the Healthcare Education-Industry Partnership, shall determine the health care fields
302.20 where the need is the greatest, including, but not limited to, respiratory therapy, clinical
302.21 laboratory technology, radiologic technology, and surgical technology;

302.22 (5) for pharmacists, advanced dental therapists, dental therapists, and public health
302.23 nurses who agree to practice in designated rural areas; and

302.24 (6) for dentists agreeing to deliver at least 25 percent of the dentist's yearly patient
302.25 encounters to state public program enrollees or patients receiving sliding fee schedule
302.26 discounts through a formal sliding fee schedule meeting the standards established by
302.27 the United States Department of Health and Human Services under Code of Federal
302.28 Regulations, title 42, section 51, chapter 303.

302.29 (b) Appropriations made to the account do not cancel and are available until
302.30 expended, except that at the end of each biennium, any remaining balance in the account
302.31 that is not committed by contract and not needed to fulfill existing commitments shall
302.32 cancel to the fund.

302.33 Sec. 14. Minnesota Statutes 2014, section 144.1501, subdivision 3, is amended to read:

302.34 Subd. 3. **Eligibility.** (a) To be eligible to participate in the loan forgiveness program,
302.35 an individual must:

303.1 (1) be a medical or dental resident; a licensed pharmacist; or be enrolled in a training
303.2 or education program to become a dentist, dental therapist, advanced dental therapist,
303.3 mental health professional, pharmacist, public health nurse, midlevel practitioner,
303.4 registered nurse, or a licensed practical nurse training program. The commissioner may
303.5 also consider applications submitted by graduates in eligible professions who are licensed
303.6 and in practice; and

303.7 (2) submit an application to the commissioner of health. ~~If fewer applications are~~
303.8 ~~submitted by dental students or residents than there are dentist participant slots available,~~
303.9 ~~the commissioner may consider applications submitted by dental program graduates~~
303.10 ~~who are licensed dentists.~~

303.11 (b) An applicant selected to participate must sign a contract to agree to serve a
303.12 minimum three-year full-time service obligation according to subdivision 2, which
303.13 shall begin no later than March 31 following completion of required training, with the
303.14 exception of a nurse, who must agree to serve a minimum two-year full-time service
303.15 obligation according to subdivision 2, which shall begin no later than March 31 following
303.16 completion of required training.

303.17 Sec. 15. Minnesota Statutes 2014, section 144.1501, subdivision 4, is amended to read:

303.18 Subd. 4. **Loan forgiveness.** The commissioner of health may select applicants
303.19 each year for participation in the loan forgiveness program, within the limits of available
303.20 funding. In considering applications, the commissioner shall give preference to applicants
303.21 who document diverse cultural competencies. The commissioner shall distribute available
303.22 funds for loan forgiveness proportionally among the eligible professions according to the
303.23 vacancy rate for each profession in the required geographic area, facility type, teaching
303.24 area, patient group, or specialty type specified in subdivision 2. The commissioner shall
303.25 allocate funds for physician loan forgiveness so that 75 percent of the funds available are
303.26 used for rural physician loan forgiveness and 25 percent of the funds available are used
303.27 for underserved urban communities and pediatric psychiatry loan forgiveness. If the
303.28 commissioner does not receive enough qualified applicants each year to use the entire
303.29 allocation of funds for any eligible profession, the remaining funds may be allocated
303.30 proportionally among the other eligible professions according to the vacancy rate for
303.31 each profession in the required geographic area, patient group, or facility type specified
303.32 in subdivision 2. Applicants are responsible for securing their own qualified educational
303.33 loans. The commissioner shall select participants based on their suitability for practice
303.34 serving the required geographic area or facility type specified in subdivision 2, as indicated
303.35 by experience or training. The commissioner shall give preference to applicants closest to

304.1 completing their training. For each year that a participant meets the service obligation
 304.2 required under subdivision 3, up to a maximum of four years, the commissioner shall make
 304.3 annual disbursements directly to the participant equivalent to 15 percent of the average
 304.4 educational debt for indebted graduates in their profession in the year closest to the
 304.5 applicant's selection for which information is available, not to exceed the balance of the
 304.6 participant's qualifying educational loans. Before receiving loan repayment disbursements
 304.7 and as requested, the participant must complete and return to the commissioner a
 304.8 confirmation of practice form provided by the commissioner verifying that the participant
 304.9 is practicing as required under subdivisions 2 and 3. The participant must provide the
 304.10 commissioner with verification that the full amount of loan repayment disbursement
 304.11 received by the participant has been applied toward the designated loans. After each
 304.12 disbursement, verification must be received by the commissioner and approved before the
 304.13 next loan repayment disbursement is made. Participants who move their practice remain
 304.14 eligible for loan repayment as long as they practice as required under subdivision 2.

304.15 Sec. 16. **[144.1506] PRIMARY CARE RESIDENCY EXPANSION GRANT**
 304.16 **PROGRAM.**

304.17 Subdivision 1. **Definitions.** For purposes of this section, the following definitions
 304.18 apply:

304.19 (1) "eligible primary care residency program" means a program that meets the
 304.20 following criteria:

304.21 (i) is located in Minnesota;

304.22 (ii) trains medical residents in the specialties of family medicine, general internal
 304.23 medicine, general pediatrics, psychiatry, geriatrics, or general surgery; and

304.24 (iii) is accredited by the Accreditation Council for Graduate Medical Education or
 304.25 presents a credible plan to obtain accreditation;

304.26 (2) "eligible project" means a project to establish a new eligible primary care
 304.27 residency program or create at least one new residency slot in an existing eligible primary
 304.28 care residency program; and

304.29 (3) "new residency slot" means the creation of a new residency position and the
 304.30 execution of a contract with a new resident in a residency program.

304.31 Subd. 2. **Expansion grant program.** (a) The commissioner of health shall award
 304.32 primary care residency expansion grants to eligible primary care residency programs to
 304.33 plan and implement new residency slots. A planning grant shall not exceed \$75,000, and a
 304.34 training grant shall not exceed \$150,000 per new residency slot for the first year, \$100,000
 304.35 for the second year, and \$50,000 for the third year of the new residency slot.

305.1 (b) Funds may be spent to cover the costs of:
305.2 (1) planning related to establishing an accredited primary care residency program;
305.3 (2) obtaining accreditation by the Accreditation Council for Graduate Medical
305.4 Education or another national body that accredits residency programs;
305.5 (3) establishing new residency programs or new resident training slots;
305.6 (4) recruitment, training, and retention of new residents and faculty;
305.7 (5) travel and lodging for new residents;
305.8 (6) faculty, new resident, and preceptor salaries related to new residency slots;
305.9 (7) training site improvements, fees, equipment, and supplies required for new
305.10 primary care resident training slots; and
305.11 (8) supporting clinical education in which trainees are part of a primary care team
305.12 model.

305.13 Subd. 3. **Applications for expansion grants.** Eligible primary care residency
305.14 programs seeking a grant shall apply to the commissioner. Applications must include the
305.15 number of new primary care residency slots planned or under contract; attestation that
305.16 funding will be used to support an increase in the number of available residency slots;
305.17 a description of the training to be received by the new residents, including the location
305.18 of training; a description of the project, including all costs associated with the project;
305.19 all sources of funds for the project; detailed uses of all funds for the project; the results
305.20 expected; and a plan to maintain the new residency slot after the grant period. The
305.21 applicant must describe achievable objectives, a timetable, and roles and capabilities of
305.22 responsible individuals in the organization.

305.23 Subd. 4. **Consideration of expansion grant applications.** The commissioner shall
305.24 review each application to determine whether or not the residency program application
305.25 is complete and whether the proposed new residency program and any new residency
305.26 slots are eligible for a grant. The commissioner shall award grants to support up to six
305.27 family medicine, general internal medicine, or general pediatrics residents; four psychiatry
305.28 residents; two geriatrics residents; and two general surgery residents. If insufficient
305.29 applications are received from any eligible specialty, funds may be redistributed to
305.30 applications from other eligible specialties.

305.31 Subd. 5. **Program oversight.** During the grant period, the commissioner may
305.32 require and collect from grantees any information necessary to evaluate the program.
305.33 Appropriations made to the program do not cancel and are available until expended.

305.34 Sec. 17. **[144.1911] INTERNATIONAL MEDICAL GRADUATES ASSISTANCE**
305.35 **PROGRAM.**

306.1 Subdivision 1. **Establishment.** The international medical graduates assistance
306.2 program is established to address barriers to practice and facilitate pathways to assist
306.3 immigrant international medical graduates to integrate into the Minnesota health
306.4 care delivery system, with the goal of increasing access to primary care in rural and
306.5 underserved areas of the state.

306.6 Subd. 2. **Definitions.** (a) For the purposes of this section, the following terms
306.7 have the meanings given.

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

306.9 (c) "Immigrant international medical graduate" means an international medical
306.10 graduate who was born outside the United States, now resides permanently in the United
306.11 States, and who did not enter the United States on a J1 or similar nonimmigrant visa
306.12 following acceptance into a United States medical residency or fellowship program.

306.13 (d) "International medical graduate" means a physician who received a basic medical
306.14 degree or qualification from a medical school located outside the United States and Canada.

306.15 (e) "Minnesota immigrant international medical graduate" means an immigrant
306.16 international medical graduate who has lived in Minnesota for at least two years.

306.17 (f) "Rural community" means a statutory and home rule charter city or township that
306.18 is outside the seven-county metropolitan area as defined in section 473.121, subdivision 2,
306.19 excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud.

306.20 (g) "Underserved community" means a Minnesota area or population included in
306.21 the list of designated primary medical care health professional shortage areas, medically
306.22 underserved areas, or medically underserved populations (MUPs) maintained and updated
306.23 by the United States Department of Health and Human Services.

306.24 Subd. 3. **Program administration.** (a) In administering the international medical
306.25 graduates assistance program, the commissioner shall:

306.26 (1) provide overall coordination for the planning, development, and implementation
306.27 of a comprehensive system for integrating qualified immigrant international medical
306.28 graduates into the Minnesota health care delivery system, particularly those willing to
306.29 serve in rural or underserved communities of the state;

306.30 (2) develop and maintain, in partnership with community organizations working
306.31 with international medical graduates, a voluntary roster of immigrant international medical
306.32 graduates interested in entering the Minnesota health workforce to assist in planning
306.33 and program administration, including making available summary reports that show the
306.34 aggregate number and distribution, by geography and specialty, of immigrant international
306.35 medical graduates in Minnesota;

307.1 (3) work with graduate clinical medical training programs to address barriers
307.2 faced by immigrant international medical graduates in securing residency positions in
307.3 Minnesota, including the requirement that applicants for residency positions be recent
307.4 graduates of medical school. The annual report required in subdivision 10 shall include
307.5 any progress in addressing these barriers;

307.6 (4) develop a system to assess and certify the clinical readiness of eligible immigrant
307.7 international medical graduates to serve in a residency program. The system shall
307.8 include assessment methods, an operating plan, and a budget. Initially, the commissioner
307.9 may develop assessments for clinical readiness for practice of one or more primary
307.10 care specialties, and shall add additional assessments as resources are available. The
307.11 commissioner may contract with an independent entity or another state agency to conduct
307.12 the assessments. In order to be assessed for clinical readiness for residency, an eligible
307.13 international medical graduate must have obtained a certification from the Educational
307.14 Commission of Foreign Medical Graduates. The commissioner shall issue a Minnesota
307.15 certificate of clinical readiness for residency to those who pass the assessment;

307.16 (5) explore and facilitate more streamlined pathways for immigrant international
307.17 medical graduates to serve in nonphysician professions in the Minnesota workforce; and

307.18 (6) study, in consultation with the Board of Medical Practice and other stakeholders,
307.19 changes necessary in health professional licensure and regulation to ensure full utilization
307.20 of immigrant international medical graduates in the Minnesota health care delivery
307.21 system. The commissioner shall include recommendations in the annual report required
307.22 under subdivision 10, due January 15, 2017.

307.23 Subd. 4. **Career guidance and support services.** (a) The commissioner shall
307.24 award grants to eligible nonprofit organizations to provide career guidance and support
307.25 services to immigrant international medical graduates seeking to enter the Minnesota
307.26 health workforce. Eligible grant activities include the following:

307.27 (1) educational and career navigation, including information on training and
307.28 licensing requirements for physician and nonphysician health care professions, and
307.29 guidance in determining which pathway is best suited for an individual international
307.30 medical graduate based on the graduate's skills, experience, resources, and interests;

307.31 (2) support in becoming proficient in medical English;

307.32 (3) support in becoming proficient in the use of information technology, including
307.33 computer skills and use of electronic health record technology;

307.34 (4) support for increasing knowledge of and familiarity with the United States
307.35 health care system;

307.36 (5) support for other foundational skills identified by the commissioner;

308.1 (6) support for immigrant international medical graduates in becoming certified
308.2 by the Educational Commission on Foreign Medical Graduates, including help with
308.3 preparation for required licensing examinations and financial assistance for fees; and

308.4 (7) assistance to international medical graduates in registering with the program's
308.5 Minnesota international medical graduate roster.

308.6 (b) The commissioner shall award the initial grants under this subdivision by
308.7 December 31, 2015.

308.8 Subd. 5. **Clinical preparation.** (a) The commissioner shall award grants to support
308.9 clinical preparation for Minnesota international medical graduates needing additional
308.10 clinical preparation or experience to qualify for residency. The grant program shall include:

308.11 (1) proposed training curricula;

308.12 (2) associated policies and procedures for clinical training sites, which must be part
308.13 of existing clinical medical education programs in Minnesota; and

308.14 (3) monthly stipends for international medical graduate participants. Priority shall
308.15 be given to primary care sites in rural or underserved areas of the state, and international
308.16 medical graduate participants must commit to serving at least five years in a rural or
308.17 underserved community of the state.

308.18 (b) The policies and procedures for the clinical preparation grants must be developed
308.19 by December 31, 2015, including an implementation schedule that begins awarding grants
308.20 to clinical preparation programs beginning in June of 2016.

308.21 Subd. 6. **International medical graduate primary care residency grant program**
308.22 **and revolving account.** (a) The commissioner shall award grants to support primary
308.23 care residency positions designated for Minnesota immigrant physicians who are willing
308.24 to serve in rural or underserved areas of the state. No grant shall exceed \$150,000 per
308.25 residency position per year. Eligible primary care residency grant recipients include
308.26 accredited family medicine, internal medicine, obstetrics and gynecology, psychiatry, and
308.27 pediatric residency programs. Eligible primary care residency programs shall apply to the
308.28 commissioner. Applications must include the number of anticipated residents to be funded
308.29 using grant funds and a budget. Notwithstanding any law to the contrary, funds awarded
308.30 to grantees in a grant agreement do not lapse until the grant agreement expires. Before any
308.31 funds are distributed, a grant recipient shall provide the commissioner with the following:

308.32 (1) a copy of the signed contract between the primary care residency program and
308.33 the participating international medical graduate;

308.34 (2) certification that the participating international medical graduate has lived in
308.35 Minnesota for at least two years and is certified by the Educational Commission on
308.36 Foreign Medical Graduates. Residency programs may also require that participating

309.1 international medical graduates hold a Minnesota certificate of clinical readiness for
309.2 residency, once the certificates become available; and

309.3 (3) verification that the participating international medical graduate has executed a
309.4 participant agreement pursuant to paragraph (b).

309.5 (b) Upon acceptance by a participating residency program, international medical
309.6 graduates shall enter into an agreement with the commissioner to provide primary
309.7 care for at least five years in a rural or underserved area of Minnesota after graduating
309.8 from the residency program and make payments to the revolving international medical
309.9 graduate residency account for five years beginning in their second year of postresidency
309.10 employment. Participants shall pay \$15,000 or ten percent of their annual compensation
309.11 each year, whichever is less.

309.12 (c) A revolving international medical graduate residency account is established
309.13 as an account in the special revenue fund in the state treasury. The commissioner of
309.14 management and budget shall credit to the account appropriations, payments, and
309.15 transfers to the account. Earnings, such as interest, dividends, and any other earnings
309.16 arising from fund assets, must be credited to the account. Funds in the account are
309.17 appropriated annually to the commissioner to award grants and administer the grant
309.18 program established in paragraph (a). Notwithstanding any law to the contrary, any funds
309.19 deposited in the account do not expire. The commissioner may accept contributions to the
309.20 account from private sector entities subject to the following provisions:

309.21 (1) the contributing entity may not specify the recipient or recipients of any grant
309.22 issued under this subdivision;

309.23 (2) the commissioner shall make public the identity of any private contributor to the
309.24 account, as well as the amount of the contribution provided; and

309.25 (3) a contributing entity may not specify that the recipient or recipients of any funds
309.26 use specific products or services, nor may the contributing entity imply that a contribution
309.27 is an endorsement of any specific product or service.

309.28 Subd. 7. **Voluntary hospital programs.** A hospital may establish residency
309.29 programs for foreign-trained physicians to become candidates for licensure to practice
309.30 medicine in the state of Minnesota. A hospital may partner with organizations, such as
309.31 the New Americans Alliance for Development, to screen for and identify foreign-trained
309.32 physicians eligible for a hospital's particular residency program.

309.33 Subd. 8. **Board of Medical Practice.** Nothing in this section alters the authority of
309.34 the Board of Medical Practice to regulate the practice of medicine.

310.1 Subd. 9. Consultation with stakeholders. The commissioner shall administer the
 310.2 international medical graduates assistance program, including the grant programs described
 310.3 under subdivisions 4, 5, and 6, in consultation with representatives of the following sectors:

310.4 (1) state agencies:

310.5 (i) Board of Medical Practice;

310.6 (ii) Office of Higher Education; and

310.7 (iii) Department of Employment and Economic Development;

310.8 (2) health care industry:

310.9 (i) a health care employer in a rural or underserved area of Minnesota;

310.10 (ii) a health plan company;

310.11 (iii) the Minnesota Medical Association;

310.12 (iv) licensed physicians experienced in working with international medical

310.13 graduates; and

310.14 (v) the Minnesota Academy of Physician Assistants;

310.15 (3) community-based organizations:

310.16 (i) organizations serving immigrant and refugee communities of Minnesota;

310.17 (ii) organizations serving the international medical graduate community, such as the

310.18 New Americans Alliance for Development and Women's Initiative for Self Empowerment;

310.19 and

310.20 (iii) the Minnesota Association of Community Health Centers;

310.21 (4) higher education:

310.22 (i) University of Minnesota;

310.23 (ii) Mayo Clinic School of Health Professions;

310.24 (iii) graduate medical education programs not located at the University of Minnesota

310.25 or Mayo Clinic School of Health Professions; and

310.26 (iv) Minnesota physician assistant education program; and

310.27 (5) two international medical graduates.

310.28 Subd. 10. Report. The commissioner shall submit an annual report to the chairs and

310.29 ranking minority members of the legislative committees with jurisdiction over health care

310.30 and higher education on the progress of the integration of international medical graduates

310.31 into the Minnesota health care delivery system. The report shall include recommendations

310.32 on actions needed for continued progress integrating international medical graduates. The

310.33 report shall be submitted by January 15 each year, beginning January 15, 2016.

310.34 Sec. 18. Minnesota Statutes 2014, section 144.291, subdivision 2, is amended to read:

311.1 Subd. 2. **Definitions.** For the purposes of sections 144.291 to 144.298, the following
311.2 terms have the meanings given.

311.3 (a) "Group purchaser" has the meaning given in section 62J.03, subdivision 6.

311.4 (b) "Health information exchange" means a legal arrangement between health care
311.5 providers and group purchasers to enable and oversee the business and legal issues
311.6 involved in the electronic exchange of health records between the entities for the delivery
311.7 of patient care.

311.8 (c) "Health record" means any information, whether oral or recorded in any form or
311.9 medium, that relates to the past, present, or future physical or mental health or condition of
311.10 a patient; the provision of health care to a patient; or the past, present, or future payment
311.11 for the provision of health care to a patient.

311.12 (d) "Identifying information" means the patient's name, address, date of birth,
311.13 gender, parent's or guardian's name regardless of the age of the patient, and other
311.14 nonclinical data which can be used to uniquely identify a patient.

311.15 (e) "Individually identifiable form" means a form in which the patient is or can be
311.16 identified as the subject of the health records.

311.17 (f) "Medical emergency" means medically necessary care which is immediately
311.18 needed to preserve life, prevent serious impairment to bodily functions, organs, or parts,
311.19 or prevent placing the physical or mental health of the patient in serious jeopardy.

311.20 (g) "Patient" means a natural person who has received health care services from a
311.21 provider for treatment or examination of a medical, psychiatric, or mental condition, the
311.22 surviving spouse and parents of a deceased patient, or a person the patient appoints in
311.23 writing as a representative, including a health care agent acting according to chapter 145C,
311.24 unless the authority of the agent has been limited by the principal in the principal's health
311.25 care directive. Except for minors who have received health care services under sections
311.26 144.341 to 144.347, in the case of a minor, patient includes a parent or guardian, or a
311.27 person acting as a parent or guardian in the absence of a parent or guardian.

311.28 (h) "Patient information service" means a service providing the following query
311.29 options: a record locator service as defined in section 144.291, subdivision 2, paragraph
311.30 (i), or a master patient index or clinical data repository as defined in section 62J.498,
311.31 subdivision 1.

311.32 ~~(h)~~ (i) "Provider" means:

311.33 (1) any person who furnishes health care services and is regulated to furnish the
311.34 services under chapter 147, 147A, 147B, 147C, 147D, 148, 148B, 148D, 148F, 150A,
311.35 151, 153, or 153A;

311.36 (2) a home care provider licensed under section ~~144A.46~~ 144A.471;

312.1 (3) a health care facility licensed under this chapter or chapter 144A; and

312.2 (4) a physician assistant registered under chapter 147A.

312.3 (†) (j) "Record locator service" means an electronic index of patient identifying
312.4 information that directs providers in a health information exchange to the location of
312.5 patient health records held by providers and group purchasers.

312.6 (†) (k) "Related health care entity" means an affiliate, as defined in section 144.6521,
312.7 subdivision 3, paragraph (b), of the provider releasing the health records.

312.8 Sec. 19. Minnesota Statutes 2014, section 144.293, subdivision 5, is amended to read:

312.9 Subd. 5. **Exceptions to consent requirement.** (a) This section does not prohibit the
312.10 release of health records:

312.11 (1) for a medical emergency when the provider is unable to obtain the patient's
312.12 consent due to the patient's condition or the nature of the medical emergency;

312.13 (2) to other providers within related health care entities when necessary for the
312.14 current treatment of the patient; or

312.15 (3) to a health care facility licensed by this chapter, chapter 144A, or to the same
312.16 types of health care facilities licensed by this chapter and chapter 144A that are licensed
312.17 in another state when a patient:

312.18 (i) is returning to the health care facility and unable to provide consent; or

312.19 (ii) who resides in the health care facility, has services provided by an outside
312.20 resource under Code of Federal Regulations, title 42, section 483.75(h), and is unable
312.21 to provide consent.

312.22 (b) A provider may release a deceased patient's health care records to another provider
312.23 for the purposes of diagnosing or treating the deceased patient's surviving adult child.

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

312.25 Sec. 20. Minnesota Statutes 2014, section 144.293, subdivision 8, is amended to read:

312.26 Subd. 8. **Record locator or patient information service.** (a) A provider or group
312.27 purchaser may release patient identifying information and information about the location

312.28 of the patient's health records to a record locator or patient information service without
312.29 consent from the patient, unless the patient has elected to be excluded from the service

312.30 under paragraph (d). The Department of Health may not access the record locator or
312.31 patient information service or receive data from the ~~record locator~~ service. Only a

312.32 provider may have access to patient identifying information in a record locator or patient
312.33 information service. Except in the case of a medical emergency, a provider participating in

312.34 a health information exchange using a record locator or patient information service does

313.1 not have access to patient identifying information and information about the location of
 313.2 the patient's health records unless the patient specifically consents to the access. A consent
 313.3 does not expire but may be revoked by the patient at any time by providing written notice
 313.4 of the revocation to the provider.

313.5 (b) A health information exchange maintaining a record locator or patient
 313.6 information service must maintain an audit log of providers accessing information in a
 313.7 ~~record locator~~ the service that at least contains information on:

- 313.8 (1) the identity of the provider accessing the information;
- 313.9 (2) the identity of the patient whose information was accessed by the provider; and
- 313.10 (3) the date the information was accessed.

313.11 (c) No group purchaser may in any way require a provider to participate in a record
 313.12 locator or patient information service as a condition of payment or participation.

313.13 (d) A provider or an entity operating a record locator or patient information service
 313.14 must provide a mechanism under which patients may exclude their identifying information
 313.15 and information about the location of their health records from a record locator or patient
 313.16 information service. At a minimum, a consent form that permits a provider to access
 313.17 a record locator or patient information service must include a conspicuous check-box
 313.18 option that allows a patient to exclude all of the patient's information from the ~~record~~
 313.19 ~~locator~~ service. A provider participating in a health information exchange with a record
 313.20 locator or patient information service who receives a patient's request to exclude all of the
 313.21 patient's information from the ~~record locator~~ service or to have a specific provider contact
 313.22 excluded from the ~~record locator~~ service is responsible for removing that information
 313.23 from the ~~record locator~~ service.

313.24 Sec. 21. Minnesota Statutes 2014, section 144.298, subdivision 2, is amended to read:

313.25 Subd. 2. **Liability of provider or other person.** A person who does any of the
 313.26 following is liable to the patient for compensatory damages caused by an unauthorized
 313.27 release or an intentional, unauthorized access, plus costs and reasonable attorney fees:

313.28 (1) negligently or intentionally requests or releases a health record in violation
 313.29 of sections 144.291 to 144.297;

313.30 (2) forges a signature on a consent form or materially alters the consent form of
 313.31 another person without the person's consent;

313.32 (3) obtains a consent form or the health records of another person under false
 313.33 pretenses; or

313.34 (4) intentionally violates sections 144.291 to 144.297 by intentionally accessing a
 313.35 record locator or patient information service without authorization.

314.1 Sec. 22. Minnesota Statutes 2014, section 144.298, subdivision 3, is amended to read:

314.2 Subd. 3. **Liability for record locator or patient information service.** A patient
314.3 is entitled to receive compensatory damages plus costs and reasonable attorney fees
314.4 if a health information exchange maintaining a record locator or patient information
314.5 service, or an entity maintaining a record locator or patient information service for a
314.6 health information exchange, negligently or intentionally violates the provisions of section
314.7 144.293, subdivision 8.

314.8 Sec. 23. **[144.3875] EARLY DENTAL PREVENTION INITIATIVE.**

314.9 (a) The commissioner of health, in collaboration with the commissioner of human
314.10 services, shall implement a statewide initiative to increase awareness among communities
314.11 of color and recent immigrants on the importance of early preventive dental intervention
314.12 for infants and toddlers before and after primary teeth appear.

314.13 (b) The commissioner shall develop educational materials and information for
314.14 expectant and new parents within the targeted communities that include the importance
314.15 of early dental care to prevent early cavities, including proper cleaning techniques and
314.16 feeding habits, before and after primary teeth appear.

314.17 (c) The commissioner shall develop a distribution plan to ensure that the materials
314.18 are distributed to expectant and new parents within the targeted communities, including,
314.19 but not limited to, making the materials available to health care providers, community
314.20 clinics, WIC sites, and other relevant sites within the targeted communities.

314.21 (d) In developing these materials and distribution plan, the commissioner shall work
314.22 collaboratively with members of the targeted communities, dental providers, pediatricians,
314.23 child care providers, and home visiting nurses.

314.24 (e) The commissioner shall, with input from stakeholders listed in paragraph (d),
314.25 develop and pilot incentives to encourage early dental care within one year of an infant's
314.26 teeth erupting.

314.27 Sec. 24. **[144.4961] MINNESOTA RADON LICENSING ACT.**

314.28 Subdivision 1. **Citation.** This section may be cited as the "Minnesota Radon
314.29 Licensing Act."

314.30 Subd. 2. **Definitions.** (a) As used in this section, the following terms have the
314.31 meanings given them.

314.32 (b) "Mitigation" means the act of repairing or altering a building or building design
314.33 for the purpose in whole or in part of reducing the concentration of radon in the indoor
314.34 atmosphere.

315.1 (c) "Radon" means both the radioactive, gaseous element produced by the
315.2 disintegration of radium, and the short-lived radionuclides that are decay products of radon.

315.3 Subd. 3. **Rulemaking.** The commissioner of health shall adopt rules for licensure
315.4 and enforcement of applicable laws and rules relating to indoor radon in dwellings and
315.5 other buildings, with the exception of newly constructed Minnesota homes according
315.6 to section 326B.106, subdivision 6. The commissioner shall coordinate, oversee, and
315.7 implement all state functions in matters concerning the presence, effects, measurement,
315.8 and mitigation of risks of radon in dwellings and other buildings.

315.9 Subd. 4. **System tag.** All radon mitigation systems installed in Minnesota on or after
315.10 October 1, 2017, must have a radon mitigation system tag provided by the commissioner.
315.11 A radon mitigation professional must attach the tag to the radon mitigation system in
315.12 a visible location.

315.13 Subd. 5. **License required annually.** A license is required annually for every
315.14 person, firm, or corporation that sells a device or performs a service for compensation
315.15 to detect the presence of radon in the indoor atmosphere, performs laboratory analysis,
315.16 or performs a service to mitigate radon in the indoor atmosphere. This section does not
315.17 apply to retail stores that only sell or distribute radon sampling but are not engaged in the
315.18 manufacture of radon sampling devices.

315.19 Subd. 6. **Exemptions.** Radon systems installed in newly constructed Minnesota
315.20 homes according to section 326B.106, subdivision 6, prior to the issuance of a certificate
315.21 of occupancy are not required to follow the requirements of this section.

315.22 Subd. 7. **License applications and other reports.** The professionals, companies,
315.23 and laboratories listed in subdivision 8 must submit applications for licenses, system
315.24 tags, and any other reporting required under this section and Minnesota Rules on forms
315.25 prescribed by the commissioner.

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

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

316.1 (2) Each mitigation professional license, \$500 per year. "Mitigation professional"
 316.2 means an individual who performs radon mitigation in a building they do not own or
 316.3 lease; provides professional or expert advice on radon mitigation or radon entry routes;
 316.4 or provides on-site supervision of radon mitigation and mitigation technicians; or makes
 316.5 representations of doing any of these activities. This license also permits the licensee to
 316.6 perform the activities of a measurement professional described in clause (1).

316.7 (3) Each mitigation company license, \$500 per year. "Mitigation company" means
 316.8 any business or government entity that performs or authorizes employees to perform radon
 316.9 mitigation. This fee is waived if the company is a sole proprietorship.

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

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

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

316.20 Subd. 9. **Enforcement.** The commissioner shall enforce this section under the
 316.21 provisions of sections 144.989 to 144.993.

316.22 **EFFECTIVE DATE.** This section is effective July 1, 2015, except subdivisions 4
 316.23 and 5, which are effective October 1, 2017.

316.24 Sec. 25. **[144.566] VIOLENCE AGAINST HEALTH CARE WORKERS.**

316.25 Subdivision 1. **Definitions.** (a) The following definitions apply to this section and
 316.26 have the meanings given.

316.27 (b) "Act of violence" means an act by a patient or visitor against a health care
 316.28 worker that includes kicking, scratching, urinating, sexually harassing, or any act defined
 316.29 in sections 609.221 to 609.2241.

316.30 (c) "Commissioner" means the commissioner of health.

316.31 (d) "Health care worker" means any person, whether licensed or unlicensed,
 316.32 employed by, volunteering in, or under contract with a hospital, who has direct contact
 316.33 with a patient of the hospital for purposes of either medical care or emergency response to
 316.34 situations potentially involving violence.

316.35 (e) "Hospital" means any facility licensed as a hospital under section 144.55.

317.1 (f) "Incident response" means the actions taken by hospital administration and health
317.2 care workers during and following an act of violence.

317.3 (g) "Interfere" means to prevent, impede, discourage, or delay a health care worker's
317.4 ability to report acts of violence, including by retaliating or threatening to retaliate against
317.5 a health care worker.

317.6 (h) "Preparedness" means the actions taken by hospital administration and health
317.7 care workers to prevent a single act of violence or acts of violence generally.

317.8 (i) "Retaliate" means to discharge, discipline, threaten, otherwise discriminate
317.9 against, or penalize a health care worker regarding the health care worker's compensation,
317.10 terms, conditions, location, or privileges of employment.

317.11 Subd. 2. **Hospital duties.** (a) All hospitals must design and implement preparedness
317.12 and incident response action plans to acts of violence by January 15, 2016, and review the
317.13 plan at least annually thereafter.

317.14 (b) A hospital shall designate a committee of representatives of health care workers
317.15 employed by the hospital, including nonmanagerial health care workers, nonclinical
317.16 staff, administrators, patient safety experts, and other appropriate personnel to develop
317.17 preparedness and incident response action plans to acts of violence. The hospital shall, in
317.18 consultation with the designated committee, implement the plans under paragraph (a).
317.19 Nothing in this paragraph shall require the establishment of a separate committee solely
317.20 for the purpose required by this subdivision.

317.21 (c) A hospital shall provide training to all health care workers employed or
317.22 contracted with the hospital on safety during acts of violence. Each health care worker
317.23 must receive safety training annually and upon hire. Training must, at a minimum, include:

317.24 (1) safety guidelines for response to and de-escalation of an act of violence;

317.25 (2) ways to identify potentially violent or abusive situations; and

317.26 (3) the hospital's incident response reaction plan and violence prevention plan.

317.27 (d) As part of its annual review required under paragraph (a), the hospital must
317.28 review with the designated committee:

317.29 (1) the effectiveness of its preparedness and incident response action plans;

317.30 (2) the most recent gap analysis as provided by the commissioner; and

317.31 (3) the number of acts of violence that occurred in the hospital during the previous
317.32 year, including injuries sustained, if any, and the unit in which the incident occurred.

317.33 (e) A hospital shall make its action plans and the information listed in paragraph
317.34 (d) available to local law enforcement and, if any of its workers are represented by a
317.35 collective bargaining unit, to the exclusive bargaining representatives of those collective
317.36 bargaining units.

318.1 (f) A hospital, including any individual, partner, association, or any person or group
318.2 of persons acting directly or indirectly in the interest of the hospital, shall not interfere
318.3 with or discourage a health care worker if the health care worker wishes to contact law
318.4 enforcement or the commissioner regarding an act of violence.

318.5 (g) The commissioner may impose an administrative fine of up to \$250 for failure to
318.6 comply with the requirements of subdivision 2.

318.7 **Sec. 26. [144.586] REQUIREMENTS FOR CERTAIN NOTICES AND**
318.8 **DISCHARGE PLANNING.**

318.9 Subdivision 1. **Observation stay notice.** (a) Each hospital, as defined under
318.10 section 144.50, subdivision 2, shall provide oral and written notice to each patient that
318.11 the hospital places in observation status of such placement not later than 24 hours after
318.12 such placement. The oral and written notices must include:

318.13 (1) a statement that the patient is not admitted to the hospital but is under observation
318.14 status;

318.15 (2) a statement that observation status may affect the patient's Medicare coverage for:

318.16 (i) hospital services, including medications and pharmaceutical supplies; or

318.17 (ii) home or community-based care or care at a skilled nursing facility upon the
318.18 patient's discharge; and

318.19 (3) a recommendation that the patient contact the patient's health insurance provider
318.20 or the Office of the Ombudsman for Long-Term Care or Office of the Ombudsman for
318.21 State Managed Health Care Programs or the Beneficiary and Family Centered Care
318.22 Quality Improvement Organization to better understand the implications of placement in
318.23 observation status.

318.24 (b) The hospital shall document the date in the patient's record that the notice
318.25 required in paragraph (a) was provided to the patient, the patient's designated
318.26 representative such as the patient's health care agent, legal guardian, conservator, or
318.27 another person acting as the patient's representative.

318.28 Subd. 2. **Postacute care discharge planning.** Each hospital, including hospitals
318.29 designated as critical access hospitals, must comply with the federal hospital requirements
318.30 for discharge planning which include:

318.31 (1) conducting a discharge planning evaluation that includes an evaluation of:

318.32 (i) the likelihood of the patient needing posthospital services and of the availability
318.33 of those services; and

318.34 (ii) the patient's capacity for self-care or the possibility of the patient being cared for
318.35 in the environment from which the patient entered the hospital;

319.1 (2) timely completion of the discharge planning evaluation under clause (1) by
 319.2 hospital personnel so that appropriate arrangements for posthospital care are made before
 319.3 discharge, and to avoid unnecessary delays in discharge;

319.4 (3) including the discharge planning evaluation under clause (1) in the patient's
 319.5 medical record for use in establishing an appropriate discharge plan. The hospital must
 319.6 discuss the results of the evaluation with the patient or individual acting on behalf of the
 319.7 patient. The hospital must reassess the patient's discharge plan if the hospital determines
 319.8 that there are factors that may affect continuing care needs or the appropriateness of
 319.9 the discharge plan; and

319.10 (4) providing counseling, as needed, for the patient and family members or interested
 319.11 persons to prepare them for posthospital care. The hospital must provide a list of available
 319.12 Medicare-eligible home care agencies or skilled nursing facilities that serve the patient's
 319.13 geographic area, or other area requested by the patient if such care or placement is
 319.14 indicated and appropriate. Once the patient has designated their preferred providers, the
 319.15 hospital will assist the patient in securing care covered by their health plan or within the
 319.16 care network. The hospital must not specify or otherwise limit the qualified providers that
 319.17 are available to the patient. The hospital must document in the patient's record that the list
 319.18 was presented to the patient or to the individual acting on the patient's behalf.

319.19 Sec. 27. Minnesota Statutes 2014, section 144.9501, subdivision 6d, is amended to read:

319.20 Subd. 6d. **Certified lead firm.** "Certified lead firm" means a person that employs
 319.21 individuals to perform regulated lead work, with the exception of renovation, and ~~that~~
 319.22 is certified by the commissioner under section 144.9505.

319.23 Sec. 28. Minnesota Statutes 2014, section 144.9501, is amended by adding a
 319.24 subdivision to read:

319.25 Subd. 6e. **Certified renovation firm.** "Certified renovation firm" means a person
 319.26 that employs individuals to perform renovation and is certified by the commissioner
 319.27 under section 144.9505.

319.28 Sec. 29. Minnesota Statutes 2014, section 144.9501, subdivision 22b, is amended to
 319.29 read:

319.30 Subd. 22b. **Lead sampling technician.** "Lead sampling technician" means an
 319.31 individual who performs clearance inspections for renovation sites and lead dust sampling
 319.32 for nonabatement sites, ~~and who is registered with the commissioner under section~~
 319.33 ~~144.9505.~~

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

320.2 Sec. 30. Minnesota Statutes 2014, section 144.9501, subdivision 26b, is amended to
320.3 read:

320.4 Subd. 26b. **Renovation.** "Renovation" means the modification of any pre-1978
320.5 affected property that results in the disturbance of known or presumed lead-containing
320.6 painted surfaces defined under section 144.9508, unless that activity is performed as an
320.7 abatement lead hazard reduction. A renovation performed for the purpose of converting a
320.8 building or part of a building into an affected property is a renovation under this subdivision.

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

320.10 Sec. 31. Minnesota Statutes 2014, section 144.9501, is amended by adding a
320.11 subdivision to read:

320.12 Subd. 26c. **Lead renovator.** "Lead renovator" means an individual who directs
320.13 individuals who perform renovations. A lead renovator also performs renovation, surface
320.14 coating testing, and cleaning verification.

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

320.16 Sec. 32. Minnesota Statutes 2014, section 144.9505, is amended to read:

320.17 **144.9505 LICENSING CREDENTIALING OF LEAD FIRMS AND**
320.18 **PROFESSIONALS.**

320.19 Subdivision 1. **Licensing and, certification; generally, and permitting.** (a) ~~All~~
320.20 ~~Fees received shall be paid~~ collected under this section shall be deposited into the state
320.21 treasury and credited to the ~~lead abatement licensing and certification account and are~~
320.22 ~~appropriated to the commissioner to cover costs incurred under this section and section~~
320.23 ~~144.9508~~ state government special revenue fund.

320.24 (b) Persons shall not advertise or otherwise present themselves as lead supervisors,
320.25 lead workers, lead inspectors, lead risk assessors, lead sampling technicians, lead project
320.26 designers, ~~or renovation firms, or lead firms~~ unless they have licenses or certificates issued
320.27 ~~by or are registered with~~ the commissioner under this section.

320.28 (c) The fees required in this section for inspectors, risk assessors, and certified lead
320.29 firms are waived for state or local government employees performing services for or
320.30 as an assessing agency.

320.31 (d) An individual who is the owner of property on which regulated lead work is to be
320.32 performed or an adult individual who is related to the property owner, as defined under

321.1 section 245A.02, subdivision 13, is exempt from the requirements to obtain a license and
321.2 pay a fee according to this section.

321.3 (e) A person that employs individuals to perform regulated lead work outside of the
321.4 person's property must obtain certification as a certified lead firm. An individual who
321.5 performs ~~regulated lead work~~ lead hazard reduction, lead hazard screens, lead inspections,
321.6 lead risk assessments, clearance inspections, lead project designer services, lead sampling
321.7 technician services, swab team services, and activities performed to comply with lead
321.8 orders must be employed by a certified lead firm, unless the individual is a sole proprietor
321.9 and does not employ any other ~~individual who performs regulated lead work~~ individuals,
321.10 the individual is employed by a person that does not perform regulated lead work outside
321.11 of the person's property, or the individual is employed by an assessing agency.

321.12 Subd. 1a. **Lead worker license.** Before an individual performs regulated lead work
321.13 as a worker, the individual shall first obtain a license from the commissioner. No license
321.14 shall be issued unless the individual shows evidence of successfully completing a training
321.15 course in lead hazard control. The commissioner shall specify the course of training and
321.16 testing requirements and shall charge a \$50 fee annually for the license. License fees are
321.17 nonrefundable and must be submitted with each application. The license must be carried
321.18 by the individual and be readily available for review by the commissioner and other public
321.19 health officials charged with the health, safety, and welfare of the state's citizens.

321.20 Subd. 1b. **Lead supervisor license.** Before an individual performs regulated lead
321.21 work as a supervisor, the individual shall first obtain a license from the commissioner. No
321.22 license shall be issued unless the individual shows evidence of experience and successful
321.23 completion of a training course in lead hazard control. The commissioner shall specify
321.24 the course of training, experience, and testing requirements and shall charge a \$50 fee
321.25 annually for the license. License fees are nonrefundable and must be submitted with
321.26 each application. The license must be carried by the individual and be readily available
321.27 for review by the commissioner and other public health officials charged with the health,
321.28 safety, and welfare of the state's citizens.

321.29 Subd. 1c. **Lead inspector license.** Before an individual performs lead inspection
321.30 services, the individual shall first obtain a license from the commissioner. No license shall
321.31 be issued unless the individual shows evidence of successfully completing a training
321.32 course in lead inspection. The commissioner shall specify the course of training and
321.33 testing requirements and shall charge a \$50 fee annually for the license. License fees are
321.34 nonrefundable and must be submitted with each application. The license must be carried
321.35 by the individual and be readily available for review by the commissioner and other public
321.36 health officials charged with the health, safety, and welfare of the state's citizens.

322.1 Subd. 1d. **Lead risk assessor license.** Before an individual performs lead risk
322.2 assessor services, the individual shall first obtain a license from the commissioner. No
322.3 license shall be issued unless the individual shows evidence of experience and successful
322.4 completion of a training course in lead risk assessment. The commissioner shall specify
322.5 the course of training, experience, and testing requirements and shall charge a \$100 fee
322.6 annually for the license. License fees are nonrefundable and must be submitted with
322.7 each application. The license must be carried by the individual and be readily available
322.8 for review by the commissioner and other public health officials charged with the health,
322.9 safety, and welfare of the state's citizens.

322.10 Subd. 1e. **Lead project designer license.** Before an individual performs lead
322.11 project designer services, the individual shall first obtain a license from the commissioner.
322.12 No license shall be issued unless the individual shows evidence of experience and
322.13 successful completion of a training course in lead project design. The commissioner shall
322.14 specify the course of training, experience, and testing requirements and shall charge a
322.15 \$100 fee annually for the license. License fees are nonrefundable and must be submitted
322.16 with each application. The license must be carried by the individual and be readily
322.17 available for review by the commissioner and other public health officials charged with
322.18 the health, safety, and welfare of the state's citizens.

322.19 ~~Subd. 1f. **Lead sampling technician.** An individual performing lead sampling~~
322.20 ~~technician services shall first register with the commissioner. The commissioner shall not~~
322.21 ~~register an individual unless the individual shows evidence of successfully completing a~~
322.22 ~~training course in lead sampling. The commissioner shall specify the course of training~~
322.23 ~~and testing requirements. Proof of registration must be carried by the individual and be~~
322.24 ~~readily available for review by the commissioner and other public health officials charged~~
322.25 ~~with the health, safety, and welfare of the state's citizens.~~

322.26 Subd. 1g. **Certified lead firm.** A person who employs individuals to perform
322.27 regulated lead work, with the exception of renovation, outside of the person's property
322.28 must obtain certification as a lead firm. The certificate must be in writing, contain an
322.29 expiration date, be signed by the commissioner, and give the name and address of the
322.30 person to whom it is issued. A lead firm certificate is valid for one year. The certification
322.31 fee is \$100, is nonrefundable, and must be submitted with each application. The lead firm
322.32 certificate or a copy of the certificate must be readily available at the worksite for review
322.33 by the contracting entity, the commissioner, and other public health officials charged with
322.34 the health, safety, and welfare of the state's citizens.

322.35 Subd. 1h. **Certified renovation firm.** A person who employs individuals to
322.36 perform renovation activities outside of the person's property must obtain certification

323.1 as a renovation firm. The certificate must be in writing, contain an expiration date, be
323.2 signed by the commissioner, and give the name and address of the person to whom it is
323.3 issued. A renovation firm certificate is valid for two years. The certification fee is \$100,
323.4 is nonrefundable, and must be submitted with each application. The renovation firm
323.5 certificate or a copy of the certificate must be readily available at the worksite for review
323.6 by the contracting entity, the commissioner, and other public health officials charged with
323.7 the health, safety, and welfare of the state's citizens.

323.8 Subd. 1i. **Lead training course.** Before a person provides training to lead
323.9 workers, lead supervisors, lead inspectors, lead risk assessors, lead project designers, lead
323.10 sampling technicians, and lead renovators, the person shall first obtain a permit from the
323.11 commissioner. The permit must be in writing, contain an expiration date, be signed by
323.12 the commissioner, and give the name and address of the person to whom it is issued.
323.13 A training course permit is valid for two years. Training course permit fees shall be
323.14 nonrefundable and must be submitted with each application in the amount of \$500 for an
323.15 initial training course, \$250 for renewal of a permit for an initial training course, \$250 for
323.16 a refresher training course, and \$125 for renewal of a permit of a refresher training course.

323.17 Subd. 3. **Licensed building contractor; information.** The commissioner shall
323.18 provide health and safety information on lead abatement and lead hazard reduction to all
323.19 residential building contractors licensed under section 326B.805. The information must
323.20 include the lead-safe practices and any other materials describing ways to protect the
323.21 health and safety of both employees and residents.

323.22 Subd. 4. **Notice of regulated lead work.** (a) At least five working days before
323.23 starting work at each regulated lead worksite, the person performing the regulated lead
323.24 work shall give written notice to the commissioner and the appropriate board of health.

323.25 (b) This provision does not apply to lead hazard screen, lead inspection, lead risk
323.26 assessment, lead sampling technician, renovation, or lead project design activities.

323.27 Subd. 6. **Duties of contracting entity.** A contracting entity intending to have
323.28 regulated lead work performed for its benefit shall include in the specifications and
323.29 contracts for the work a requirement that the work be performed by contractors and
323.30 subcontractors licensed by the commissioner under sections 144.9501 to 144.9512 and
323.31 according to rules adopted by the commissioner related to regulated lead work. No
323.32 contracting entity shall allow regulated lead work to be performed for its benefit unless the
323.33 contracting entity has seen that the person has a valid license or certificate. A contracting
323.34 entity's failure to comply with this subdivision does not relieve a person from any
323.35 responsibility under sections 144.9501 to 144.9512.

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

324.1 Sec. 33. Minnesota Statutes 2014, section 144.9508, is amended to read:

324.2 **144.9508 RULES.**

324.3 Subdivision 1. **Sampling and analysis.** The commissioner shall adopt, by rule,
324.4 methods for:

324.5 (1) lead inspections, lead hazard screens, lead risk assessments, and clearance
324.6 inspections;

324.7 (2) environmental surveys of lead in paint, soil, dust, and drinking water to determine
324.8 areas at high risk for toxic lead exposure;

324.9 (3) soil sampling for soil used as replacement soil;

324.10 (4) drinking water sampling, which shall be done in accordance with lab certification
324.11 requirements and analytical techniques specified by Code of Federal Regulations, title
324.12 40, section 141.89; and

324.13 (5) sampling to determine whether at least 25 percent of the soil samples collected
324.14 from a census tract within a standard metropolitan statistical area contain lead in
324.15 concentrations that exceed 100 parts per million.

324.16 Subd. 2. **Regulated lead work standards and methods.** (a) The commissioner shall
324.17 adopt rules establishing regulated lead work standards and methods in accordance with the
324.18 provisions of this section, for lead in paint, dust, drinking water, and soil in a manner that
324.19 protects public health and the environment for all residences, including residences also
324.20 used for a commercial purpose, child care facilities, playgrounds, and schools.

324.21 (b) In the rules required by this section, the commissioner shall require lead hazard
324.22 reduction of intact paint only if the commissioner finds that the intact paint is on a
324.23 chewable or lead-dust producing surface that is a known source of actual lead exposure to
324.24 a specific individual. The commissioner shall prohibit methods that disperse lead dust into
324.25 the air that could accumulate to a level that would exceed the lead dust standard specified
324.26 under this section. The commissioner shall work cooperatively with the commissioner
324.27 of administration to determine which lead hazard reduction methods adopted under this
324.28 section may be used for lead-safe practices including prohibited practices, preparation,
324.29 disposal, and cleanup. The commissioner shall work cooperatively with the commissioner
324.30 of the Pollution Control Agency to develop disposal procedures. In adopting rules under
324.31 this section, the commissioner shall require the best available technology for regulated
324.32 lead work methods, paint stabilization, and repainting.

324.33 (c) The commissioner of health shall adopt regulated lead work standards and
324.34 methods for lead in bare soil in a manner to protect public health and the environment.
324.35 The commissioner shall adopt a maximum standard of 100 parts of lead per million in
324.36 bare soil. The commissioner shall set a soil replacement standard not to exceed 25 parts

325.1 of lead per million. Soil lead hazard reduction methods shall focus on erosion control
325.2 and covering of bare soil.

325.3 (d) The commissioner shall adopt regulated lead work standards and methods for lead
325.4 in dust in a manner to protect the public health and environment. Dust standards shall use
325.5 a weight of lead per area measure and include dust on the floor, on the window sills, and
325.6 on window wells. Lead hazard reduction methods for dust shall focus on dust removal and
325.7 other practices which minimize the formation of lead dust from paint, soil, or other sources.

325.8 (e) The commissioner shall adopt lead hazard reduction standards and methods for
325.9 lead in drinking water both at the tap and public water supply system or private well
325.10 in a manner to protect the public health and the environment. The commissioner may
325.11 adopt the rules for controlling lead in drinking water as contained in Code of Federal
325.12 Regulations, title 40, part 141. Drinking water lead hazard reduction methods may include
325.13 an educational approach of minimizing lead exposure from lead in drinking water.

325.14 (f) The commissioner of the Pollution Control Agency shall adopt rules to ensure that
325.15 removal of exterior lead-based coatings from residences and steel structures by abrasive
325.16 blasting methods is conducted in a manner that protects health and the environment.

325.17 (g) All regulated lead work standards shall provide reasonable margins of safety that
325.18 are consistent with more than a summary review of scientific evidence and an emphasis on
325.19 overprotection rather than underprotection when the scientific evidence is ambiguous.

325.20 (h) No unit of local government shall have an ordinance or regulation governing
325.21 regulated lead work standards or methods for lead in paint, dust, drinking water, or soil
325.22 that require a different regulated lead work standard or method than the standards or
325.23 methods established under this section.

325.24 (i) Notwithstanding paragraph (h), the commissioner may approve the use by a unit
325.25 of local government of an innovative lead hazard reduction method which is consistent
325.26 in approach with methods established under this section.

325.27 (j) The commissioner shall adopt rules for issuing lead orders required under section
325.28 144.9504, rules for notification of abatement or interim control activities requirements,
325.29 and other rules necessary to implement sections 144.9501 to 144.9512.

325.30 (k) The commissioner shall adopt rules consistent with section 402(c)(3) of the
325.31 Toxic Substances Control Act to ensure that renovation in a pre-1978 affected property
325.32 where a child or pregnant female resides is conducted in a manner that protects health
325.33 and the environment. Notwithstanding sections 14.125 and 14.128, the authority to adopt
325.34 these rules does not expire.

326.1 (l) The commissioner shall adopt rules consistent with sections 406(a) and 406(b)
326.2 of the Toxic Substances Control Act. Notwithstanding sections 14.125 and 14.128, the
326.3 authority to adopt these rules does not expire.

326.4 Subd. 2a. **Lead standards for exterior surfaces and street dust.** The
326.5 commissioner may, by rule, establish lead standards for exterior horizontal surfaces,
326.6 concrete or other impervious surfaces, and street dust on residential property to protect the
326.7 public health and the environment.

326.8 Subd. 3. **Licensure and certification.** The commissioner shall adopt rules to license
326.9 lead supervisors, lead workers, lead project designers, lead inspectors, lead risk assessors,
326.10 and lead sampling technicians. The commissioner shall also adopt rules requiring
326.11 certification of firms that perform regulated lead work. The commissioner shall require
326.12 periodic renewal of licenses and certificates and shall establish the renewal periods.

326.13 Subd. 4. **Lead training course.** The commissioner shall establish by rule
326.14 requirements for training course providers and the renewal period for each lead-related
326.15 training course required for certification or licensure. The commissioner shall establish
326.16 criteria in rules for the content and presentation of training courses intended to qualify
326.17 trainees for licensure under subdivision 3. The commissioner shall establish criteria in
326.18 rules for the content and presentation of training courses for lead renovation and lead
326.19 sampling technicians. ~~Training course permit fees shall be nonrefundable and must be~~
326.20 ~~submitted with each application in the amount of \$500 for an initial training course, \$250~~
326.21 ~~for renewal of a permit for an initial training course, \$250 for a refresher training course,~~
326.22 ~~and \$125 for renewal of a permit of a refresher training course.~~

326.23 Subd. 5. **Variances.** In adopting the rules required under this section, the
326.24 commissioner shall provide variance procedures for any provision in rules adopted under
326.25 this section, except for the numerical standards for the concentrations of lead in paint,
326.26 dust, bare soil, and drinking water. A variance shall be considered only according to the
326.27 procedures and criteria in Minnesota Rules, parts 4717.7000 to 4717.7050.

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

326.29 Sec. 34. **[144.999] LIFE-SAVING ALLERGY MEDICATION.**

326.30 **Subdivision 1. Definitions.** (a) For purposes of this section, the following terms
326.31 have the meanings given.

326.32 (b) "Administer" means the direct application of an epinephrine auto-injector to
326.33 the body of an individual.

326.34 (c) "Authorized entity" means entities that fall in the categories of recreation camps,
326.35 colleges and universities, preschools and daycares, and any other category of entities or

327.1 organizations that the commissioner authorizes to obtain and administer epinephrine
327.2 auto-injectors without a prescription. This definition does not include a school covered
327.3 under section 121A.2207.

327.4 (d) "Commissioner" means the commissioner of health.

327.5 (e) "Epinephrine auto-injector" means a single-use device used for the automatic
327.6 injection of a premeasured dose of epinephrine into the human body.

327.7 (f) "Provide" means to supply one or more epinephrine auto-injectors to an
327.8 individual or the individual's parent, legal guardian, or caretaker.

327.9 Subd. 2. **Commissioner duties.** The commissioner may identify additional
327.10 categories of entities or organizations to be authorized entities if the commissioner
327.11 determines that individuals may come in contact with allergens capable of causing
327.12 anaphylaxis. Beginning July 1, 2016, the commissioner may annually review the
327.13 categories of authorized entities and may authorize additional categories of authorized
327.14 entities as the commissioner deems appropriate. The commissioner may contract with a
327.15 vendor to perform the review and identification of authorized entities.

327.16 Subd. 3. **Obtaining and storing epinephrine auto-injectors.** (a) Notwithstanding
327.17 section 151.37, an authorized entity may obtain and possess epinephrine auto-injectors
327.18 to be provided or administered to an individual if, in good faith, an owner, manager,
327.19 employee, or agent of an authorized entity believes that the individual is experiencing
327.20 anaphylaxis regardless of whether the individual has a prescription for an epinephrine
327.21 auto-injector. The administration of an epinephrine auto-injector in accordance with
327.22 this section is not the practice of medicine.

327.23 (b) An authorized entity may obtain epinephrine auto-injectors from pharmacies
327.24 licensed as wholesale drug distributors pursuant to section 151.47. Prior to obtaining an
327.25 epinephrine auto-injector, an owner, manager, or authorized agent of the entity must
327.26 present to the pharmacy a valid certificate of training obtained pursuant to subdivision 5.

327.27 (c) An authorized entity shall store epinephrine auto-injectors in a location readily
327.28 accessible in an emergency and in accordance with the epinephrine auto-injector's
327.29 instructions for use and any additional requirements that may be established by the
327.30 commissioner. An authorized entity shall designate employees or agents who have
327.31 completed the training program required under subdivision 5 to be responsible for the
327.32 storage, maintenance, and control of epinephrine auto-injectors obtained and possessed
327.33 by the authorized entity.

327.34 Subd. 4. **Use of epinephrine auto-injectors.** (a) An owner, manager, employee, or
327.35 agent of an authorized entity who has completed the training required under subdivision 5
327.36 may:

328.1 (1) provide an epinephrine auto-injector for immediate administration to an
328.2 individual or the individual's parent, legal guardian, or caregiver if the owner, manager,
328.3 employee, or agent believes, in good faith, the individual is experiencing anaphylaxis,
328.4 regardless of whether the individual has a prescription for an epinephrine auto-injector or
328.5 has previously been diagnosed with an allergy; or

328.6 (2) administer an epinephrine auto-injector to an individual who the owner, manager,
328.7 employee, or agent believes, in good faith, is experiencing anaphylaxis, regardless of
328.8 whether the individual has a prescription for an epinephrine auto-injector or has previously
328.9 been diagnosed with an allergy.

328.10 (b) Nothing in this section shall be construed to require any authorized entity to
328.11 maintain a stock of epinephrine auto-injectors.

328.12 Subd. 5. **Training.** (a) In order to use an epinephrine auto-injector as authorized
328.13 under subdivision 4, an individual must complete, every two years, an anaphylaxis training
328.14 program conducted by a nationally recognized organization experienced in training
328.15 laypersons in emergency health treatment, a statewide organization with experience
328.16 providing training on allergies and anaphylaxis under the supervision of board-certified
328.17 allergy medical advisors, or an entity or individual approved by the commissioner to
328.18 provide an anaphylaxis training program. The commissioner may approve specific entities
328.19 or individuals to conduct the training program or may approve categories of entities or
328.20 individuals to conduct the training program. Training may be conducted online or in
328.21 person and, at a minimum, must cover:

328.22 (1) how to recognize signs and symptoms of severe allergic reactions, including
328.23 anaphylaxis;

328.24 (2) standards and procedures for the storage and administration of an epinephrine
328.25 auto-injector; and

328.26 (3) emergency follow-up procedures.

328.27 (b) The entity or individual conducting the training shall issue a certificate to each
328.28 person who successfully completes the anaphylaxis training program. The commissioner
328.29 may develop, approve, and disseminate a standard certificate of completion. The
328.30 certificate of completion shall be valid for two years from the date issued.

328.31 Subd. 6. **Good samaritan protections.** Any act or omission taken pursuant to
328.32 this section by an authorized entity that possesses and makes available epinephrine
328.33 auto-injectors and its employees or agents, a pharmacy or manufacturer that dispenses
328.34 epinephrine auto-injectors to an authorized entity, or an individual or entity that conducts
328.35 the training described in subdivision 5 is considered "emergency care, advice, or
328.36 assistance" under section 604A.01.

329.1 Sec. 35. Minnesota Statutes 2014, section 144A.70, subdivision 6, is amended to read:

329.2 Subd. 6. **Supplemental nursing services agency.** "Supplemental nursing services
329.3 agency" means a person, firm, corporation, partnership, or association engaged for hire
329.4 in the business of providing or procuring temporary employment in health care facilities
329.5 for nurses, nursing assistants, nurse aides, ~~and orderlies,~~ and other licensed health
329.6 professionals. Supplemental nursing services agency does not include an individual who
329.7 only engages in providing the individual's services on a temporary basis to health care
329.8 facilities. Supplemental nursing services agency does not include a professional home
329.9 care agency licensed as a ~~Class A provider~~ under section ~~144A.46~~ and rules adopted
329.10 thereunder 144A.471 that only provides staff to other home care providers.

329.11 Sec. 36. Minnesota Statutes 2014, section 144A.70, is amended by adding a
329.12 subdivision to read:

329.13 Subd. 7. **Oversight.** The commissioner is responsible for the oversight of
329.14 supplemental nursing services agencies through annual unannounced surveys, complaint
329.15 investigations under sections 144A.51 to 144A.53, and other actions necessary to ensure
329.16 compliance with sections 144A.70 to 144A.74.

329.17 Sec. 37. Minnesota Statutes 2014, section 144A.71, is amended to read:

329.18 **144A.71 SUPPLEMENTAL NURSING SERVICES AGENCY**
329.19 **REGISTRATION.**

329.20 Subdivision 1. **Duty to register.** A person who operates a supplemental nursing
329.21 services agency shall register ~~the agency~~ annually with the commissioner. Each separate
329.22 location of the business of a supplemental nursing services agency shall register the agency
329.23 with the commissioner. Each separate location of the business of a supplemental nursing
329.24 services agency shall have a separate registration. Fees collected under this section shall be
329.25 deposited in the state treasury and credited to the state government special revenue fund.

329.26 Subd. 2. **Application information and fee.** The commissioner shall establish forms
329.27 and procedures for processing each supplemental nursing services agency registration
329.28 application. An application for a supplemental nursing services agency registration must
329.29 include at least the following:

329.30 (1) the names and addresses of the owner or owners of the supplemental nursing
329.31 services agency;

329.32 (2) if the owner is a corporation, copies of its articles of incorporation and current
329.33 bylaws, together with the names and addresses of its officers and directors;

330.1 (3) satisfactory proof of compliance with section 144A.72, subdivision 1, clauses
330.2 (5) to (7);

330.3 (4) any other relevant information that the commissioner determines is necessary
330.4 to properly evaluate an application for registration; **and**

330.5 (5) ~~the annual registration fee for a supplemental nursing services agency, which~~
330.6 ~~is \$891; a policy and procedure that describes how the supplemental nursing services~~
330.7 ~~agency's records will be immediately available at all times to the commissioner; and~~

330.8 (6) a registration fee of \$2,035.

330.9 If a supplemental nursing services agency fails to provide the items in this
330.10 subdivision to the department, the commissioner shall immediately suspend or refuse to
330.11 issue the supplemental nursing services agency registration. The supplemental nursing
330.12 services agency may appeal the commissioner's findings according to section 144A.475,
330.13 subdivisions 3a and 7, except that the hearing must be conducted by an administrative law
330.14 judge within 60 calendar days of the request for hearing assignment.

330.15 **Subd. 3. Registration not transferable.** A registration issued by the commissioner
330.16 according to this section is effective for a period of one year from the date of its issuance
330.17 unless the registration is revoked or suspended under section 144A.72, subdivision 2, or
330.18 unless the supplemental nursing services agency is sold or ownership or management
330.19 is transferred. When a supplemental nursing services agency is sold or ownership or
330.20 management is transferred, the registration of the agency must be voided and the new
330.21 owner or operator may apply for a new registration.

330.22 Sec. 38. Minnesota Statutes 2014, section 144A.72, is amended to read:

330.23 **144A.72 REGISTRATION REQUIREMENTS; PENALTIES.**

330.24 Subdivision 1. **Minimum criteria.** (a) The commissioner shall require that, as a
330.25 condition of registration:

330.26 (1) the supplemental nursing services agency shall document that each temporary
330.27 employee provided to health care facilities currently meets the minimum licensing, training,
330.28 and continuing education standards for the position in which the employee will be working;

330.29 (2) the supplemental nursing services agency shall comply with all pertinent
330.30 requirements relating to the health and other qualifications of personnel employed in
330.31 health care facilities;

330.32 (3) the supplemental nursing services agency must not restrict in any manner the
330.33 employment opportunities of its employees;

330.34 (4) the supplemental nursing services agency shall carry medical malpractice
330.35 insurance to insure against the loss, damage, or expense incident to a claim arising out

331.1 of the death or injury of any person as the result of negligence or malpractice in the
331.2 provision of health care services by the supplemental nursing services agency or by any
331.3 employee of the agency;

331.4 (5) the supplemental nursing services agency shall carry an employee dishonesty
331.5 bond in the amount of \$10,000;

331.6 (6) the supplemental nursing services agency shall maintain insurance coverage
331.7 for workers' compensation for all nurses, nursing assistants, nurse aides, and orderlies
331.8 provided or procured by the agency;

331.9 (7) the supplemental nursing services agency shall file with the commissioner of
331.10 revenue: (i) the name and address of the bank, savings bank, or savings association
331.11 in which the supplemental nursing services agency deposits all employee income tax
331.12 withholdings; and (ii) the name and address of any nurse, nursing assistant, nurse aide, or
331.13 orderly whose income is derived from placement by the agency, if the agency purports
331.14 the income is not subject to withholding;

331.15 (8) the supplemental nursing services agency must not, in any contract with any
331.16 employee or health care facility, require the payment of liquidated damages, employment
331.17 fees, or other compensation should the employee be hired as a permanent employee of a
331.18 health care facility; ~~and~~

331.19 (9) the supplemental nursing services agency shall document that each temporary
331.20 employee provided to health care facilities is an employee of the agency and is not
331.21 an independent contractor; and

331.22 (10) the supplemental nursing services agency shall retain all records for five
331.23 calendar years. All records of the supplemental nursing services agency must be
331.24 immediately available to the department.

331.25 (b) In order to retain registration, the supplemental nursing services agency must
331.26 provide services to a health care facility during the year preceding the supplemental
331.27 nursing services agency's registration renewal date.

331.28 Subd. 2. **Penalties.** ~~A pattern of~~ Failure to comply with this section shall subject
331.29 the supplemental nursing services agency to revocation or nonrenewal of its registration.
331.30 Violations of section 144A.74 are subject to a fine equal to 200 percent of the amount
331.31 billed or received in excess of the maximum permitted under that section.

331.32 Subd. 3. **Revocation.** Notwithstanding subdivision 2, the registration of a
331.33 supplemental nursing services agency that knowingly supplies to a health care facility a
331.34 person with an illegally or fraudulently obtained or issued diploma, registration, license,
331.35 certificate, or background study shall be revoked by the commissioner. The commissioner

332.1 shall notify the supplemental nursing services agency 15 days in advance of the date
332.2 of revocation.

332.3 Subd. 4. **Hearing.** (a) No supplemental nursing services agency's registration
332.4 may be revoked without a hearing held as a contested case in accordance with ~~chapter~~
332.5 ~~14. The hearing must commence within 60 days after the proceedings are initiated~~
332.6 section 144A.475, subdivisions 3a and 7, except the hearing must be conducted by an
332.7 administrative law judge within 60 calendar days of the request for assignment.

332.8 (b) If a controlling person has been notified by the commissioner of health that the
332.9 supplemental nursing services agency will not receive an initial registration or that a
332.10 renewal of the registration has been denied, the controlling person or a legal representative
332.11 on behalf of the supplemental nursing services agency may request and receive a hearing
332.12 on the denial. ~~This~~ The hearing shall be held as a contested case in accordance with
332.13 ~~chapter 14~~ a contested case in accordance with section 144A.475, subdivisions 3a and 7,
332.14 except the hearing must be conducted by an administrative law judge within 60 calendar
332.15 days of the request for assignment.

332.16 Subd. 5. **Period of ineligibility.** (a) The controlling person of a supplemental
332.17 nursing services agency whose registration has not been renewed or has been revoked
332.18 because of noncompliance with the provisions of sections 144A.70 to 144A.74 shall not
332.19 be eligible to apply for nor will be granted a registration for five years following the
332.20 effective date of the nonrenewal or revocation.

332.21 (b) The commissioner shall not issue or renew a registration to a supplemental
332.22 nursing services agency if a controlling person includes any individual or entity who was
332.23 a controlling person of a supplemental nursing services agency whose registration was
332.24 not renewed or was revoked as described in paragraph (a) for five years following the
332.25 effective date of nonrenewal or revocation.

332.26 Sec. 39. Minnesota Statutes 2014, section 144A.73, is amended to read:

332.27 **144A.73 COMPLAINT SYSTEM.**

332.28 The commissioner shall establish a system for reporting complaints against a
332.29 supplemental nursing services agency or its employees. Complaints may be made by
332.30 any member of the public. ~~Written complaints must be forwarded to the employer of~~
332.31 ~~each person against whom a complaint is made. The employer shall promptly report to~~
332.32 ~~the commissioner any corrective action taken~~ Complaints against a supplemental nursing
332.33 services agency shall be investigated by the Office of Health Facility Complaints under
332.34 Minnesota Statutes, sections 144A.51 to 144A.53.

333.1 Sec. 40. Minnesota Statutes 2014, section 144A.75, subdivision 13, is amended to read:

333.2 Subd. 13. **Residential hospice facility.** (a) "Residential hospice facility" means
 333.3 a facility that resembles a single-family home located in a residential area that directly
 333.4 provides 24-hour residential and support services in a home-like setting for hospice patients
 333.5 as an integral part of the continuum of home care provided by a hospice and that houses:

333.6 (1) no more than eight hospice patients; or

333.7 (2) at least nine and no more than 12 hospice patients with the approval of the local
 333.8 governing authority, notwithstanding section 462.357, subdivision 8.

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

333.11 (1) houses no more than 21 hospice patients;

333.12 (2) meets hospice certification regulations adopted pursuant to title XVIII of the
 333.13 federal Social Security Act, United States Code, title 42, section 1395, et seq.; and

333.14 (3) is located on St. Anthony Avenue in St. Paul, Minnesota, and was licensed as a
 333.15 40-bed non-Medicare certified nursing home as of January 1, 2015.

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

333.17 Sec. 41. Minnesota Statutes 2014, section 144D.01, is amended by adding a
 333.18 subdivision to read:

333.19 Subd. 3a. **Direct-care staff.** "Direct-care staff" means staff and employees who
 333.20 provide home care services listed in section 144A.471, subdivisions 6 and 7.

333.21 Sec. 42. **[144D.066] ENFORCEMENT OF DEMENTIA CARE TRAINING**
 333.22 **REQUIREMENTS.**

333.23 Subdivision 1. **Enforcement.** (a) The commissioner shall enforce the dementia care
 333.24 training standards for staff working in housing with services settings and for housing
 333.25 managers according to clauses (1) to (3):

333.26 (1) for dementia care training requirements in section 144D.065, the commissioner
 333.27 shall review training records as part of the home care provider survey process for direct
 333.28 care staff and supervisors of direct care staff, in accordance with section 144A.474. The
 333.29 commissioner may also request and review training records at any time during the year;

333.30 (2) for dementia care training standards in section 144D.065, the commissioner
 333.31 shall review training records for maintenance, housekeeping, and food service staff and
 333.32 other staff not providing direct care working in housing with services settings as part of
 333.33 the housing with services registration application and renewal application process in

334.1 accordance with section 144D.03. The commissioner may also request and review training
334.2 records at any time during the year; and

334.3 (3) for housing managers, the commissioner shall review the statement verifying
334.4 compliance with the required training described in section 144D.10, paragraph (d),
334.5 through the housing with services registration application and renewal application process
334.6 in accordance with section 144D.03. The commissioner may also request and review
334.7 training records at any time during the year.

334.8 (b) The commissioner shall specify the required forms and what constitutes sufficient
334.9 training records for the items listed in paragraph (a), clauses (1) to (3).

334.10 Subd. 2. **Fines for noncompliance.** (a) Beginning January 1, 2017, the
334.11 commissioner may impose a \$200 fine for every staff person required to obtain dementia
334.12 care training who does not have training records to show compliance. For violations of
334.13 subdivision 1, paragraph (a), clause (1), the fine will be imposed upon the home care
334.14 provider, and may be appealed under the contested case procedure in section 144A.475,
334.15 subdivisions 3a, 4, and 7. For violations of subdivision 1, paragraph (a), clauses (2) and
334.16 (3), the fine will be imposed on the housing with services registrant and may be appealed
334.17 under the contested case procedure in section 144A.475, subdivisions 3a, 4, and 7. Prior
334.18 to imposing the fine, the commissioner must allow two weeks for staff to complete the
334.19 required training. Fines collected under this section shall be deposited in the state treasury
334.20 and credited to the state government special revenue fund.

334.21 (b) The housing with services registrant and home care provider must allow
334.22 for the required training as part of employee and staff duties. Imposition of a fine
334.23 by the commissioner does not negate the need for the required training. Continued
334.24 noncompliance with the requirements of sections 144D.065 and 144D.10 may result in
334.25 revocation or nonrenewal of the housing with services registration or home care license.
334.26 The commissioner shall make public the list of all housing with services establishments
334.27 that have complied with the training requirements.

334.28 Subd. 3. **Technical assistance.** From January 1, 2016, to December 31, 2016,
334.29 the commissioner shall provide technical assistance instead of imposing fines for
334.30 noncompliance with the training requirements. During the year of technical assistance,
334.31 the commissioner shall review the training records to determine if the records meet the
334.32 requirements and inform the home care provider. The commissioner shall also provide
334.33 information about available training resources.

334.34 Sec. 43. Minnesota Statutes 2014, section 145.4131, subdivision 1, is amended to read:

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

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

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

335.8 (2) the method used for each abortion;

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

335.10 (i) less than nine weeks;

335.11 (ii) nine to ten weeks;

335.12 (iii) 11 to 12 weeks;

335.13 (iv) 13 to 15 weeks;

335.14 (v) 16 to 20 weeks;

335.15 (vi) 21 to 24 weeks;

335.16 (vii) 25 to 30 weeks;

335.17 (viii) 31 to 36 weeks; or

335.18 (ix) 37 weeks to term;

335.19 (4) the age of the woman at the time the abortion was performed;

335.20 (5) the specific reason for the abortion, including, but not limited to, the following:

335.21 (i) the pregnancy was a result of rape;

335.22 (ii) the pregnancy was a result of incest;

335.23 (iii) economic reasons;

335.24 (iv) the woman does not want children at this time;

335.25 (v) the woman's emotional health is at stake;

335.26 (vi) the woman's physical health is at stake;

335.27 (vii) the woman will suffer substantial and irreversible impairment of a major bodily
335.28 function if the pregnancy continues;

335.29 (viii) the pregnancy resulted in fetal anomalies; or

335.30 (ix) unknown or the woman refused to answer;

335.31 (6) the number of prior induced abortions;

335.32 (7) the number of prior spontaneous abortions;

335.33 (8) whether the abortion was paid for by:

335.34 (i) private coverage;

335.35 (ii) public assistance health coverage; or

335.36 (iii) self-pay;

- 336.1 (9) whether coverage was under:
- 336.2 (i) a fee-for-service plan;
- 336.3 (ii) a capitated private plan; or
- 336.4 (iii) other;
- 336.5 (10) complications, if any, for each abortion and for the aftermath of each abortion.
- 336.6 Space for a description of any complications shall be available on the form; ~~and~~
- 336.7 (11) the medical specialty of the physician performing the abortion;
- 336.8 (12) whether the abortion resulted in a born alive infant, as defined in section
- 336.9 145.423, subdivision 4, and:
- 336.10 (i) any medical actions taken to preserve the life of the born alive infant;
- 336.11 (ii) whether the born alive infant survived; and
- 336.12 (iii) the status of the born alive infant, should the infant survive, if known.

336.13 Sec. 44. Minnesota Statutes 2014, section 145.423, is amended to read:

336.14 **145.423 ABORTION; LIVE BIRTHS.**

336.15 Subdivision 1. **Recognition; medical care.** A ~~live child born~~ born alive infant as a

336.16 result of an abortion shall be fully recognized as a human person, and accorded immediate

336.17 protection under the law. All reasonable measures consistent with good medical practice,

336.18 including the compilation of appropriate medical records, shall be taken by the responsible

336.19 medical personnel to preserve the life and health of the ~~child~~ born alive infant.

336.20 Subd. 2. **Physician required.** When an abortion is performed after the twentieth

336.21 week of pregnancy, a physician, other than the physician performing the abortion, shall

336.22 be immediately accessible to take all reasonable measures consistent with good medical

336.23 practice, including the compilation of appropriate medical records, to preserve the life and

336.24 health of any ~~live birth~~ born alive infant that is the result of the abortion.

336.25 Subd. 3. **Death.** If a ~~child~~ born alive infant described in subdivision 1 dies after

336.26 birth, the body shall be disposed of in accordance with the provisions of section 145.1621.

336.27 Subd. 4. **Definition of born alive infant.** (a) In determining the meaning of

336.28 any Minnesota statute, or of any ruling, regulation, or interpretation of the various

336.29 administrative bureaus and agencies of Minnesota, the words "person," "human being,"

336.30 "child," and "individual" shall include every infant member of the species Homo sapiens

336.31 who is born alive at any stage of development.

336.32 (b) As used in this section, the term "born alive," with respect to a member of the

336.33 species Homo sapiens, means the complete expulsion or extraction from his or her mother

336.34 of that member, at any stage of development, who, after such expulsion or extraction,

336.35 breathes or has a beating heart, pulsation of the umbilical cord, or definite movement of

337.1 voluntary muscles, regardless of whether the umbilical cord has been cut, and regardless
337.2 of whether the expulsion or extraction occurs as a result of a natural or induced labor,
337.3 cesarean section, or induced abortion.

337.4 (c) Nothing in this section shall be construed to affirm, deny, expand, or contract any
337.5 legal status or legal right applicable to any member of the species Homo sapiens at any
337.6 point prior to being born alive, as defined in this section.

337.7 Subd. 5. **Civil and disciplinary actions.** (a) Any person upon whom an abortion
337.8 has been performed, or the parent or guardian of the mother if the mother is a minor,
337.9 and the abortion results in the infant having been born alive, may maintain an action for
337.10 death of or injury to the born alive infant against the person who performed the abortion
337.11 if the death or injury was a result of simple negligence, gross negligence, wantonness,
337.12 willfulness, intentional conduct, or another violation of the legal standard of care.

337.13 (b) Any responsible medical personnel that does not take all reasonable measures
337.14 consistent with good medical practice to preserve the life and health of the born alive
337.15 infant, as required by subdivision 1, may be subject to the suspension or revocation of that
337.16 person's professional license by the professional board with authority over that person.
337.17 Any person who has performed an abortion and against whom judgment has been rendered
337.18 pursuant to paragraph (a) shall be subject to an automatic suspension of the person's
337.19 professional license for at least one year and said license shall be reinstated only after the
337.20 person's professional board requires compliance with this section by all board licensees.

337.21 (c) Nothing in this subdivision shall be construed to hold the mother of the born alive
337.22 infant criminally or civilly liable for the actions of a physician, nurse, or other licensed
337.23 health care provider in violation of this section to which the mother did not give her consent.

337.24 Subd. 6. **Protection of privacy in court proceedings.** In every civil action
337.25 brought under this section, the court shall rule whether the anonymity of any female
337.26 upon whom an abortion has been performed or attempted shall be preserved from public
337.27 disclosure if she does not give her consent to such disclosure. The court, upon motion or
337.28 sua sponte, shall make such a ruling and, upon determining that her anonymity should
337.29 be preserved, shall issue orders to the parties, witnesses, and counsel and shall direct the
337.30 sealing of the record and exclusion of individuals from courtrooms or hearing rooms to
337.31 the extent necessary to safeguard her identity from public disclosure. Each order must be
337.32 accompanied by specific written findings explaining why the anonymity of the female
337.33 should be preserved from public disclosure, why the order is essential to that end, how the
337.34 order is narrowly tailored to serve that interest, and why no reasonable, less restrictive
337.35 alternative exists. This section may not be construed to conceal the identity of the plaintiff
337.36 or of witnesses from the defendant.

338.1 Subd. 7. **Status of born alive infant.** Unless the abortion is performed to save the
338.2 life of the woman or fetus, or, unless one or both of the parents of the born alive infant
338.3 agree within 30 days of the birth to accept the parental rights and responsibilities for the
338.4 child, the child shall be an abandoned ward of the state and the parents shall have no
338.5 parental rights or obligations as if the parental rights had been terminated pursuant to
338.6 section 260C.301. The child shall be provided for pursuant to chapter 256J.

338.7 Subd. 8. **Severability.** If any one or more provision, section, subdivision, sentence,
338.8 clause, phrase, or word of this section or the application of it to any person or circumstance
338.9 is found to be unconstitutional, it is declared to be severable and the balance of this section
338.10 shall remain effective notwithstanding such unconstitutionality. The legislature intends
338.11 that it would have passed this section, and each provision, section, subdivision, sentence,
338.12 clause, phrase, or word, regardless of the fact that any one provision, section, subdivision,
338.13 sentence, clause, phrase, or word is declared unconstitutional.

338.14 Subd. 9. **Short title.** This act may be cited as the "Born Alive Infants Protection Act."

338.15 Sec. 45. Minnesota Statutes 2014, section 145.928, subdivision 13, is amended to read:

338.16 Subd. 13. **Report Reports.** (a) The commissioner shall submit a biennial report
338.17 to the legislature on the local community projects, tribal government, and community
338.18 health board prevention activities funded under this section. These reports must include
338.19 information on grant recipients, activities that were conducted using grant funds,
338.20 evaluation data, and outcome measures, if available. These reports are due by January 15
338.21 of every other year, beginning in the year 2003.

338.22 (b) The commissioner shall submit an annual report to the chairs and ranking
338.23 minority members of the house of representatives and senate committees with jurisdiction
338.24 over public health on grants made under subdivision 7 to decrease racial and ethnic
338.25 disparities in infant mortality rates. The report must provide specific information on the
338.26 amount of each grant awarded to each agency or organization, the population served
338.27 by each agency or organization, outcomes of the programs funded by each grant, and
338.28 the amount of the appropriation retained by the commissioner for administrative and
338.29 associated expenses. The commissioner shall issue a report each January 15 for the
338.30 previous fiscal year beginning January 15, 2016.

338.31 Sec. 46. Minnesota Statutes 2014, section 145.928, is amended by adding a subdivision
338.32 to read:

338.33 Subd. 15. **Promising strategies.** For all grants awarded under this section, the
338.34 commissioner shall consider applicants that present evidence of a promising strategy to

339.1 accomplish the applicant's objective. A promising strategy shall be given the same weight
339.2 as a research or evidence-based strategy based on potential value and measurable outcomes.

339.3 Sec. 47. Minnesota Statutes 2014, section 145.986, subdivision 1a, is amended to read:

339.4 Subd. 1a. **Grants to local communities.** (a) Beginning July 1, 2009, the
339.5 commissioner of health shall award competitive grants to community health boards and
339.6 tribal governments to convene, coordinate, and implement evidence-based strategies
339.7 targeted at reducing the percentage of Minnesotans who are obese or overweight and
339.8 to reduce the use of tobacco. Grants shall be awarded to all community health boards
339.9 and tribal governments whose proposals demonstrate the ability to implement programs
339.10 designed to achieve the purposes in subdivision 1 and other requirements of this section.

339.11 (b) Grantee activities shall:

339.12 (1) be based on scientific evidence;

339.13 (2) be based on community input;

339.14 (3) address behavior change at the individual, community, and systems levels;

339.15 (4) occur in community, school, work site, and health care settings;

339.16 (5) be focused on policy, systems, and environmental changes that support healthy
339.17 behaviors; and

339.18 (6) address the health disparities and inequities that exist in the grantee's community.

339.19 (c) To receive a grant under this section, community health boards and tribal
339.20 governments must submit proposals to the commissioner. A local match of ten percent
339.21 of the total funding allocation is required. This local match may include funds donated
339.22 by community partners.

339.23 (d) In order to receive a grant, community health boards and tribal governments
339.24 must submit a health improvement plan to the commissioner of health for approval. The
339.25 commissioner may require the plan to identify a community leadership team, community
339.26 partners, and a community action plan that includes an assessment of area strengths and
339.27 needs, proposed action strategies, technical assistance needs, and a staffing plan.

339.28 (e) The grant recipient must implement the health improvement plan, evaluate the
339.29 effectiveness of the strategies, and modify or discontinue strategies found to be ineffective.

339.30 (f) Grant recipients shall report their activities and their progress toward the
339.31 outcomes established under subdivision 2 to the commissioner in a format and at a time
339.32 specified by the commissioner.

339.33 (g) All grant recipients shall be held accountable for making progress toward the
339.34 measurable outcomes established in subdivision 2. The commissioner shall require a

340.1 corrective action plan and may reduce the funding level of grant recipients that do not
340.2 make adequate progress toward the measurable outcomes.

340.3 (h) Beginning November 1, 2015, the commissioner shall offer grant recipients the
340.4 option of using a grant awarded under this subdivision to implement health improvement
340.5 strategies that improve the health status, delay the expression of dementia, or slow the
340.6 progression of dementia, for a targeted population at risk for dementia and shall award
340.7 at least two of the grants awarded on November 1, 2015, for these purposes. The grants
340.8 must meet all other requirements of this section. The commissioner shall coordinate grant
340.9 planning activities with the commissioner of human services, the Minnesota Board on
340.10 Aging, and community-based organizations with a focus on dementia. Each grant must
340.11 include selected outcomes and evaluation measures related to the incidence or progression
340.12 of dementia among the targeted population using the procedure described in subdivision 2.

340.13 Sec. 48. Minnesota Statutes 2014, section 145.986, subdivision 2, is amended to read:

340.14 Subd. 2. **Outcomes.** (a) The commissioner shall set measurable outcomes to meet
340.15 the goals specified in subdivision 1, and annually review the progress of grant recipients
340.16 in meeting the outcomes.

340.17 (b) The commissioner shall measure current public health status, using existing
340.18 measures and data collection systems when available, to determine baseline data against
340.19 which progress shall be monitored.

340.20 (c) For grants awarded on or after July 1, 2016, the commissioner, in coordination
340.21 with each grant recipient under section 145.986, must identify:

340.22 (1) each geographic area or population to be targeted;

340.23 (2) the policy, systems, or environmental strategy to be used to address one or more
340.24 of the health indicators listed in section 62U.10, subdivision 6; and

340.25 (3) the selected outcomes and evaluation measures for the grant, related to one or
340.26 more of the health indicators listed in section 62U.10, subdivision 6, within the geographic
340.27 area or among the population targeted.

340.28 Sec. 49. Minnesota Statutes 2014, section 145.986, subdivision 4, is amended to read:

340.29 Subd. 4. **Evaluation.** (a) Using the outcome measures established in subdivision 3,
340.30 the commissioner shall conduct a biennial evaluation of the statewide health improvement
340.31 program funded under this section. Grant recipients shall cooperate with the commissioner
340.32 in the evaluation and provide the commissioner with the information necessary to conduct
340.33 the evaluation, including information on any impact on the health indicators listed in
340.34 section 62U.10, subdivision 6, within the geographic area or among the population targeted.

341.1 (b) Grant recipients will collect, monitor, and submit to the Department of Health
341.2 baseline and annual data and provide information to improve the quality and impact of
341.3 community health improvement strategies.

341.4 (c) For the purposes of carrying out the grant program under this section, including
341.5 for administrative purposes, the commissioner shall award contracts to appropriate entities
341.6 to assist in designing and implementing evaluation systems.

341.7 (d) Contracts awarded under paragraph (c) may be used to:

341.8 (1) develop grantee monitoring and reporting systems to track grantee progress,
341.9 including aggregated and disaggregated data;

341.10 (2) manage, analyze, and report program evaluation data results; and

341.11 (3) utilize innovative support tools to analyze and predict the impact of prevention
341.12 strategies on health outcomes and state health care costs over time.

341.13 Sec. 50. Minnesota Statutes 2014, section 145A.131, subdivision 1, is amended to read:

341.14 Subdivision 1. **Funding formula for community health boards.** (a) Base funding
341.15 for each community health board eligible for a local public health grant under section
341.16 145A.03, subdivision 7, shall be determined by each community health board's fiscal year
341.17 2003 allocations, prior to unallotment, for the following grant programs: community
341.18 health services subsidy; state and federal maternal and child health special projects grants;
341.19 family home visiting grants; TANF MN ENABL grants; TANF youth risk behavior grants;
341.20 and available women, infants, and children grant funds in fiscal year 2003, prior to
341.21 unallotment, distributed based on the proportion of WIC participants served in fiscal year
341.22 2003 within the CHS service area.

341.23 (b) Base funding for a community health board eligible for a local public health
341.24 grant under section 145A.03, subdivision 7, as determined in paragraph (a), shall be
341.25 adjusted by the percentage difference between the base, as calculated in paragraph (a),
341.26 and the funding available for the local public health grant.

341.27 (c) Multicounty or multicity community health boards shall receive a local
341.28 partnership base of up to \$5,000 per year for each county or city in the case of a multicity
341.29 community health board included in the community health board.

341.30 (d) The State Community Health Advisory Committee may recommend a formula
341.31 to the commissioner to use in distributing ~~state and federal~~ funds to community health
341.32 boards ~~organized and operating under sections 145A.03 to 145A.131 to achieve locally~~
341.33 ~~identified priorities under section 145A.04, subdivision 1a, for use in distributing funds to~~
341.34 ~~community health boards beginning January 1, 2006, and thereafter.~~

342.1 (e) Notwithstanding any adjustment in paragraph (b), community health boards, all
342.2 or a portion of which are located outside of the counties of Anoka, Chisago, Carver,
342.3 Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright, are eligible
342.4 to receive an increase equal to ten percent of the grant award to the community health
342.5 board under paragraph (a) starting July 1, 2015. The increase in calendar year 2015 shall
342.6 be prorated for the last six months of the year. For calendar years beginning on or after
342.7 January 1, 2016, the amount distributed under this paragraph shall be adjusted each year
342.8 based on available funding and the number of eligible community health boards.

342.9 Sec. 51. Minnesota Statutes 2014, section 149A.20, subdivision 5, is amended to read:

342.10 Subd. 5. **Examinations.** After having met the educational requirements of
342.11 subdivision 4, a person must attain a passing score on the National Board Examination
342.12 administered by the Conference of Funeral Service Examining Boards of the United
342.13 States, Inc. or any other examination that, in the determination of the commissioner,
342.14 adequately and accurately assesses the knowledge and skills required to practice
342.15 mortuary science. In addition, a person must attain a passing score on the state licensing
342.16 examination administered by or on behalf of the commissioner. The state examination
342.17 shall encompass the laws and rules of Minnesota that pertain to the practice of mortuary
342.18 science. The commissioner shall make available copies of all pertinent laws and rules
342.19 prior to administration of the state licensing examination. If a passing score is not attained
342.20 on the state examination, the individual must wait two weeks before they can retake
342.21 the examination.

342.22 Sec. 52. Minnesota Statutes 2014, section 149A.20, subdivision 6, is amended to read:

342.23 Subd. 6. **Internship.** (a) A person who attains a passing score on both examinations
342.24 in subdivision 5 must complete a registered internship under the direct supervision of an
342.25 individual currently licensed to practice mortuary science in Minnesota. Interns must file
342.26 with the commissioner:

342.27 (1) the appropriate fee; and

342.28 (2) a registration form indicating the name and home address of the intern, the
342.29 date the internship begins, and the name, license number, and business address of the
342.30 supervising mortuary science licensee.

342.31 (b) Any changes in information provided in the registration must be immediately
342.32 reported to the commissioner. The internship shall be a minimum of ~~one calendar year~~
342.33 ~~and a maximum of three calendar years in duration;~~ 2,080 hours to be completed within a
342.34 three-year period, however, the commissioner may waive up to ~~three months~~ 520 hours of

343.1 the internship time requirement upon satisfactory completion of a clinical or practicum
 343.2 in mortuary science administered through the program of mortuary science of the
 343.3 University of Minnesota or a substantially similar program approved by the commissioner.
 343.4 Registrations must be renewed on an annual basis if they exceed one calendar year. During
 343.5 the internship period, the intern must be under the direct supervision of a person holding a
 343.6 current license to practice mortuary science in Minnesota. An intern may be registered
 343.7 under only one licensee at any given time and may be directed and supervised only by
 343.8 the registered licensee. The registered licensee shall have only one intern registered at
 343.9 any given time. The commissioner shall issue to each registered intern a registration
 343.10 permit that must be displayed with the other establishment and practice licenses. While
 343.11 under the direct supervision of the licensee, the intern must ~~actively participate in the~~
 343.12 ~~embalming of at least 25 dead human bodies and in the arrangements for and direction of~~
 343.13 ~~at least 25 funerals~~ complete 25 case reports in each of the following areas: embalming,
 343.14 funeral arrangements, and services. Case reports, on forms provided by the commissioner,
 343.15 shall be completed by the intern, ~~signed by the supervising licensee,~~ and filed with the
 343.16 commissioner ~~for at least 25 embalmings and funerals in which the intern participates~~ prior
 343.17 to the completion of the internship. Information contained in these reports that identifies
 343.18 the subject or the family of the subject embalmed or the subject or the family of the subject
 343.19 of the funeral shall be classified as licensing data under section 13.41, subdivision 2.

343.20 Sec. 53. Minnesota Statutes 2014, section 149A.40, subdivision 11, is amended to read:

343.21 Subd. 11. **Continuing education.** The commissioner ~~may~~ shall require 15
 343.22 continuing education hours for renewal of a license to practice mortuary science. Nine
 343.23 of the hours must be in the following areas: body preparation, care, or handling, 3 CE
 343.24 hours; professional practices, 3 CE hours; regulation and ethics, 3 CE hours. Continuing
 343.25 education hours shall be reported to the commissioner every other year based on the
 343.26 licensee's license number. Licensees whose license ends in an odd number must report CE
 343.27 hours at renewal time every odd year. If a licensee's license ends in an even number, the
 343.28 licensee must report the licensee's CE hours at renewal time every even year.

343.29 Sec. 54. Minnesota Statutes 2014, section 149A.65, is amended to read:

343.30 **149A.65 FEES.**

343.31 Subdivision 1. **Generally.** This section establishes the fees for registrations,
 343.32 examinations, initial and renewal licenses, and late fees authorized under the provisions
 343.33 of this chapter.

343.34 Subd. 2. **Mortuary science fees.** Fees for mortuary science are:

- 344.1 (1) ~~\$50~~ \$75 for the initial and renewal registration of a mortuary science intern;
 344.2 (2) ~~\$100~~ \$125 for the mortuary science examination;
 344.3 (3) ~~\$125~~ \$200 for issuance of initial and renewal mortuary science licenses;
 344.4 (4) ~~\$25~~ \$100 late fee charge for a license renewal; and
 344.5 (5) ~~\$200~~ \$250 for issuing a mortuary science license by endorsement.

344.6 Subd. 3. **Funeral directors.** The license renewal fee for funeral directors is ~~\$125~~
 344.7 \$200. The late fee charge for a license renewal is ~~\$25~~ \$100.

344.8 Subd. 4. **Funeral establishments.** The initial and renewal fee for funeral
 344.9 establishments is ~~\$300~~ \$425. The late fee charge for a license renewal is ~~\$25~~ \$100.

344.10 Subd. 5. **Crematories.** The initial and renewal fee for a crematory is ~~\$300~~ \$425.
 344.11 The late fee charge for a license renewal is ~~\$25~~ \$100.

344.12 Subd. 6. **Alkaline hydrolysis facilities.** The initial and renewal fee for an alkaline
 344.13 hydrolysis facility is ~~\$300~~ \$425. The late fee charge for a license renewal is ~~\$25~~ \$100.

344.14 Subd. 7. **State government special revenue fund.** Fees collected by the
 344.15 commissioner under this section must be deposited in the state treasury and credited to
 344.16 the state government special revenue fund.

344.17 Sec. 55. Minnesota Statutes 2014, section 149A.92, subdivision 1, is amended to read:

344.18 Subdivision 1. **Exemption Establishment update.** ~~All funeral establishments~~
 344.19 ~~having a preparation and embalming room that has not been used for the preparation~~
 344.20 ~~or embalming of a dead human body in the 12 calendar months prior to July 1, 1997,~~
 344.21 ~~are exempt from the minimum requirements in subdivisions 2 to 6, except as provided~~
 344.22 ~~in this section.~~ (a) Notwithstanding subdivision 11, a funeral establishment with other
 344.23 establishment locations that uses one preparation and embalming room for all establishment
 344.24 locations has until July 1, 2017, to bring the other establishment locations that are not used
 344.25 for preparation or embalming into compliance with this section so long as the preparation
 344.26 and embalming room that is used complies with the minimum standards in this section.

344.27 (b) At the time that ownership of a funeral establishment changes, the physical
 344.28 location of the establishment changes, or the building housing the funeral establishment or
 344.29 business space of the establishment is remodeled the existing preparation and embalming
 344.30 room must be brought into compliance with the minimum standards in this section and in
 344.31 accordance with subdivision 11.

344.32 Sec. 56. Minnesota Statutes 2014, section 149A.97, subdivision 7, is amended to read:

344.33 Subd. 7. **Reports to commissioner.** Every funeral provider lawfully doing business
 344.34 in Minnesota that accepts funds under subdivision 2 must make a complete annual report

345.1 to the commissioner. The reports may be on forms provided by the commissioner or
345.2 substantially similar forms containing, at least, identification and the state of each trust
345.3 account, including all transactions involving principal and accrued interest, and must be
345.4 filed by March 31 of the calendar year following the reporting year along with a filing fee
345.5 of \$25 for each report. Fees shall be paid to the commissioner of management and budget,
345.6 state of Minnesota, for deposit in the state government special revenue fund in the state
345.7 treasury. Reports must be signed by an authorized representative of the funeral provider
345.8 and notarized under oath. All reports to the commissioner shall be reviewed for account
345.9 inaccuracies or possible violations of this section. If the commissioner has a reasonable
345.10 belief to suspect that there are account irregularities or possible violations of this section,
345.11 the commissioner shall report that belief, in a timely manner, to the state auditor or other
345.12 state agencies as determined by the commissioner. The commissioner may require a
345.13 funeral provider reporting preneed trust accounts under this section to arrange for and
345.14 pay an independent third-party auditing firm to complete an audit of the preneed trust
345.15 accounts every other year. The funeral provider shall report the findings of the audit to the
345.16 commissioner by March 31 of the calendar year following the reporting year. This report is
345.17 in addition to the annual report. The commissioner shall also file an annual letter with the
345.18 state auditor disclosing whether or not any irregularities or possible violations were detected
345.19 in review of the annual trust fund reports filed by the funeral providers. This letter shall be
345.20 filed with the state auditor by May 31 of the calendar year following the reporting year.

345.21 Sec. 57. Minnesota Statutes 2014, section 157.15, subdivision 8, is amended to read:

345.22 Subd. 8. **Lodging establishment.** "Lodging establishment" means: (1) a building,
345.23 structure, enclosure, or any part thereof used as, maintained as, advertised as, or held out to
345.24 be a place where sleeping accommodations are furnished to the public as regular roomers,
345.25 for periods of one week or more, and having five or more beds to let to the public-; or (2) a
345.26 building, structure, or enclosure or any part thereof located within ten miles distance from
345.27 a hospital or medical center and maintained as, advertised as, or held out to be a place
345.28 where sleeping accommodations are furnished exclusively to patients, their families, and
345.29 caregivers while the patient is receiving or waiting to receive health care treatments or
345.30 procedures for periods of one week or more, and where no supportive services, as defined
345.31 under section 157.17, subdivision 1, paragraph (a), or health supervision services, as
345.32 defined under section 157.17, subdivision 1, paragraph (b), or home care services, as
345.33 defined under section 144A.471, subdivisions 6 and 7, are provided.

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

346.1 Sec. 58. **WORKING GROUP ON VIOLENCE AGAINST ASIAN WOMEN**
346.2 **AND CHILDREN.**

346.3 Subdivision 1. **Establishment.** The commissioner of health, in collaboration with
346.4 the commissioners of human services and public safety, and the Council on Asian-Pacific
346.5 Minnesotans, shall create a multidisciplinary working group to address violence against
346.6 Asian women and children by July 1, 2015.

346.7 Subd. 2. **The working group.** The commissioner of health, in collaboration with
346.8 the commissioners of human services and public safety, and the Council on Asian-Pacific
346.9 Minnesotans, shall appoint 15 members representing the following groups to participate in
346.10 the working group:

- 346.11 (1) advocates;
346.12 (2) survivors;
346.13 (3) service providers;
346.14 (4) community leaders;
346.15 (5) city and county attorneys;
346.16 (6) city officials;
346.17 (7) law enforcement; and
346.18 (8) health professionals.

346.19 At least eight of the members of the working group must be from the Asian-Pacific
346.20 Islander community.

346.21 Subd. 3. **Duties.** (a) The working group must study the nature, scope, and prevalence
346.22 of violence against Asian women and children in Minnesota, including domestic violence,
346.23 trafficking, international abusive marriage, stalking, sexual assault, and other violence.

346.24 (b) The working group may:

- 346.25 (1) evaluate the adequacy and effectiveness of existing support programs;
346.26 (2) conduct a needs assessment of culturally and linguistically appropriate programs
346.27 and interventions;
346.28 (3) identify barriers in delivering services to Asian women and children;
346.29 (4) identify promising prevention and intervention strategies in addressing violence
346.30 against Asian women and children; and
346.31 (5) propose mechanisms to collect and monitor data on violence against Asian
346.32 women and children.

346.33 Subd. 4. **Chair.** The commissioner of health shall designate one member to serve as
346.34 chair of the working group.

346.35 Subd. 5. **First meeting.** The chair shall convene the first meeting by September
346.36 10, 2015.

347.1 Subd. 6. **Compensation; expense reimbursement.** Members of the working group
347.2 shall be compensated and reimbursed for expenses under Minnesota Statutes, section
347.3 15.059, subdivision 3.

347.4 Subd. 7. **Report.** By January 1, 2017, the working group must submit its
347.5 recommendations and any draft legislation necessary to implement those recommendations
347.6 to the commissioners of health, human services, and public safety, and the Council on
347.7 Asian-Pacific Minnesotans. The Council on Asian-Pacific Minnesotans shall submit a
347.8 report of findings and recommendations to the chair and ranking minority members of the
347.9 committees in the house of representatives and senate having jurisdiction over health and
347.10 human services and public safety by February 15, 2017.

347.11 Subd. 8. **Sunset.** The working group on violence against Asian women and children
347.12 sunsetts the day after the Council on Asian-Pacific Minnesotans submits the report under
347.13 subdivision 7.

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

347.15 Sec. 59. **HEALTH EQUITY GRANTS.**

347.16 For the competitive grants awarded under Laws 2014, chapter 312, article 30,
347.17 section 3, subdivision 2, the commissioner of health shall consider applicants who present
347.18 evidence of a promising strategy to accomplish the applicant's objective. A promising
347.19 strategy shall be given the same weight as a research or evidence-based strategy based on
347.20 potential value and measurable outcomes.

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

347.22 **ARTICLE 9**

347.23 **HEALTH CARE DELIVERY**

347.24 Section 1. **[62A.67] SHORT TITLE.**

347.25 Sections 62A.67 to 62A.672 may be cited as the "Minnesota Telemedicine Act."

347.26 **EFFECTIVE DATE.** This section is effective January 1, 2016.

347.27 Sec. 2. **[62A.671] DEFINITIONS.**

347.28 Subdivision 1. **Applicability.** For purposes of sections 62A.67 to 62A.672, the
347.29 terms defined in this section have the meanings given.

348.1 Subd. 2. **Distant site.** "Distant site" means a site at which a licensed health care
348.2 provider is located while providing health care services or consultations by means of
348.3 telemedicine.

348.4 Subd. 3. **Health care provider.** "Health care provider" has the meaning provided
348.5 in section 62A.63, subdivision 2.

348.6 Subd. 4. **Health carrier.** "Health carrier" has the meaning provided in section
348.7 62A.011, subdivision 2.

348.8 Subd. 5. **Health plan.** "Health plan" means a health plan as defined in section
348.9 62A.011, subdivision 3, and includes dental plans as defined in section 62Q.76, subdivision
348.10 3, but does not include dental plans that provide indemnity-based benefits, regardless of
348.11 expenses incurred and are designed to pay benefits directly to the policyholder.

348.12 Subd. 6. **Licensed health care provider.** "Licensed health care provider" means a
348.13 health care provider who is:

348.14 (1) licensed under chapter 147, 147A, 148, 148B, 148E, 148F, 150A, or 153; a
348.15 mental health professional as defined under section 245.462, subdivision 18, or 245.4871,
348.16 subdivision 27; or vendor of medical care defined in section 256B.02, subdivision 7; and

348.17 (2) authorized within their respective scope of practice to provide the particular
348.18 service with no supervision or under general supervision.

348.19 Subd. 7. **Originating site.** "Originating site" means a site including, but not limited
348.20 to, a health care facility at which a patient is located at the time health care services are
348.21 provided to the patient by means of telemedicine.

348.22 Subd. 8. **Store-and-forward technology.** "Store-and-forward technology" means
348.23 the transmission of a patient's medical information from an originating site to a health care
348.24 provider at a distant site without the patient being present, or the delivery of telemedicine
348.25 that does not occur in real time via synchronous transmissions.

348.26 Subd. 9. **Telemedicine.** "Telemedicine" means the delivery of health care services
348.27 or consultations while the patient is at an originating site and the licensed health care
348.28 provider is at a distant site. A communication between licensed health care providers
348.29 that consists solely of a telephone conversation, e-mail, or facsimile transmission does
348.30 not constitute telemedicine consultations or services. A communication between a
348.31 licensed health care provider and a patient that consists solely of an e-mail or facsimile
348.32 transmission does not constitute telemedicine consultations or services. Telemedicine may
348.33 be provided by means of real-time two-way, interactive audio and visual communications,
348.34 including the application of secure video conferencing or store-and-forward technology
348.35 to provide or support health care delivery, which facilitate the assessment, diagnosis,
348.36 consultation, treatment, education, and care management of a patient's health care.

349.1 **EFFECTIVE DATE.** This section is effective January 1, 2016.

349.2 Sec. 3. **[62A.672] COVERAGE OF TELEMEDICINE SERVICES.**

349.3 Subdivision 1. **Coverage of telemedicine.** (a) A health plan sold, issued, or renewed
349.4 by a health carrier for which coverage of benefits begins on or after January 1, 2017, shall
349.5 include coverage for telemedicine benefits in the same manner as any other benefits covered
349.6 under the policy, plan, or contract, and shall comply with the regulations of this section.

349.7 (b) Nothing in this section shall be construed to:

349.8 (1) require a health carrier to provide coverage for services that are not medically
349.9 necessary;

349.10 (2) prohibit a health carrier from establishing criteria that a health care provider
349.11 must meet to demonstrate the safety or efficacy of delivering a particular service via
349.12 telemedicine for which the health carrier does not already reimburse other health
349.13 care providers for delivering via telemedicine, so long as the criteria are not unduly
349.14 burdensome or unreasonable for the particular service; or

349.15 (3) prevent a health carrier from requiring a health care provider to agree to certain
349.16 documentation or billing practices designed to protect the health carrier or patients from
349.17 fraudulent claims so long as the practices are not unduly burdensome or unreasonable
349.18 for the particular service.

349.19 Subd. 2. **Parity between telemedicine and in-person services.** A health carrier
349.20 shall not exclude a service for coverage solely because the service is provided via
349.21 telemedicine and is not provided through in-person consultation or contact between a
349.22 licensed health care provider and a patient.

349.23 Subd. 3. **Reimbursement for telemedicine services.** (a) A health carrier shall
349.24 reimburse the distant site licensed health care provider for covered services delivered via
349.25 telemedicine on the same basis and at the same rate as the health carrier would apply to
349.26 those services if the services had been delivered in person by the distant site licensed
349.27 health care provider.

349.28 (b) It is not a violation of this subdivision for a health carrier to include a
349.29 deductible, co-payment, or coinsurance requirement for a health care service provided via
349.30 telemedicine, provided that the deductible, co-payment, or coinsurance is not in addition
349.31 to, and does not exceed, the deductible, co-payment, or coinsurance applicable if the same
349.32 services were provided through in-person contact.

349.33 **EFFECTIVE DATE.** This section is effective January 1, 2016.

349.34 Sec. 4. Minnesota Statutes 2014, section 62U.02, subdivision 1, is amended to read:

350.1 Subdivision 1. **Development.** (a) The commissioner of health shall develop a
350.2 standardized set of measures by which to assess the quality of health care services offered
350.3 by health care providers, including health care providers certified as health care homes
350.4 under section 256B.0751. Quality measures must be based on medical evidence and be
350.5 developed through a process in which providers participate. The measures shall be used
350.6 for the quality incentive payment system developed in subdivision 2 and must:

350.7 (1) include uniform definitions, measures, and forms for submission of data, to the
350.8 greatest extent possible;

350.9 (2) seek to avoid increasing the administrative burden on health care providers;

350.10 (3) be initially based on existing quality indicators for physician and hospital
350.11 services, which are measured and reported publicly by quality measurement organizations,
350.12 including, but not limited to, Minnesota Community Measurement and specialty societies;

350.13 (4) place a priority on measures of health care outcomes, rather than process
350.14 measures, wherever possible; and

350.15 (5) incorporate measures for primary care, including preventive services, coronary
350.16 artery and heart disease, diabetes, asthma, depression, and other measures as determined
350.17 by the commissioner.

350.18 (b) Effective July 1, 2016, the commissioner shall stratify quality measures by race,
350.19 ethnicity, preferred language, and country of origin beginning with five measures, and
350.20 stratifying additional measures to the extent resources are available. On or after January 1,
350.21 2018, the commissioner may require measures to be stratified by other sociodemographic
350.22 factors that according to reliable data are correlated with health disparities and have an
350.23 impact on performance on quality or cost indicators. New methods of stratifying data
350.24 under this paragraph must be tested and evaluated through pilot projects prior to adding
350.25 them to the statewide system. In determining whether to add additional sociodemographic
350.26 factors and developing the methodology to be used, the commissioner shall consider the
350.27 reporting burden on providers and determine whether there are alternative sources of data
350.28 that could be used. The commissioner shall ensure that categories and data collection
350.29 methods are developed in consultation with those communities impacted by health
350.30 disparities using culturally appropriate community engagement principles and methods.
350.31 The commissioner shall implement this paragraph in coordination with the contracting
350.32 entity retained under section 62U.02, subdivision 4, in order to build upon the data
350.33 stratification methodology that has been developed and tested by the entity. Nothing in
350.34 this paragraph expands or changes the commissioner's authority to collect, analyze, or
350.35 report health care data. Any data collected to implement this paragraph must be data that
350.36 is available or is authorized to be collected under other laws. Nothing in this paragraph

351.1 grants authority to the commissioner to collect or analyze patient-level or patient-specific
351.2 data of the patient characteristics identified under this paragraph.

351.3 ~~(b)~~ (c) The measures shall be reviewed at least annually by the commissioner.

351.4 Sec. 5. Minnesota Statutes 2014, section 62U.02, subdivision 2, is amended to read:

351.5 Subd. 2. **Quality incentive payments.** (a) By July 1, 2009, the commissioner
351.6 shall develop a system of quality incentive payments under which providers are eligible
351.7 for quality-based payments that are in addition to existing payment levels, based upon
351.8 a comparison of provider performance against specified targets, and improvement over
351.9 time. The targets must be based upon and consistent with the quality measures established
351.10 under subdivision 1.

351.11 (b) To the extent possible, the payment system must adjust for variations in patient
351.12 population in order to reduce incentives to health care providers to avoid high-risk patients
351.13 or populations, including those with risk factors related to race, ethnicity, language,
351.14 country of origin, and sociodemographic factors.

351.15 (c) The requirements of section 62Q.101 do not apply under this incentive payment
351.16 system.

351.17 Sec. 6. Minnesota Statutes 2014, section 62U.02, subdivision 3, is amended to read:

351.18 Subd. 3. **Quality transparency.** (a) The commissioner shall establish standards for
351.19 measuring health outcomes, establish a system for risk adjusting quality measures, and
351.20 issue annual public reports on provider quality beginning July 1, 2010.

351.21 (b) Effective July 1, 2017, the risk adjustment system established under this
351.22 subdivision shall adjust for patient characteristics identified under subdivision 1, paragraph
351.23 (b), that are correlated with health disparities and have an impact on performance on cost
351.24 and quality measures. The risk adjustment method may consist of reporting based on an
351.25 actual-to-expected comparison that reflects the characteristics of the patient population
351.26 served by the clinic or hospital. The commissioner shall implement this paragraph in
351.27 coordination with any contracting entity retained under section 62U.02, subdivision 4.

351.28 (c) By January 1, 2010, physician clinics and hospitals shall submit standardized
351.29 electronic information on the outcomes and processes associated with patient care to
351.30 the commissioner or the commissioner's designee. In addition to measures of care
351.31 processes and outcomes, the report may include other measures designated by the
351.32 commissioner, including, but not limited to, care infrastructure and patient satisfaction.
351.33 The commissioner shall ensure that any quality data reporting requirements established
351.34 under this subdivision are not duplicative of publicly reported, communitywide quality

352.1 reporting activities currently under way in Minnesota. Nothing in this subdivision is
352.2 intended to replace or duplicate current privately supported activities related to quality
352.3 measurement and reporting in Minnesota.

352.4 Sec. 7. Minnesota Statutes 2014, section 62U.02, subdivision 4, is amended to read:

352.5 Subd. 4. **Contracting.** The commissioner may contract with a private entity or
352.6 consortium of private entities to complete the tasks in subdivisions 1 to 3. The private
352.7 entity or consortium must be nonprofit and have governance that includes representatives
352.8 from the following stakeholder groups: health care providers, including providers serving
352.9 high concentrations of patients and communities impacted by health disparities; health
352.10 plan companies; consumers, including consumers representing groups who experience
352.11 health disparities; employers or other health care purchasers; and state government. No
352.12 one stakeholder group shall have a majority of the votes on any issue or hold extraordinary
352.13 powers not granted to any other governance stakeholder.

352.14 Sec. 8. Minnesota Statutes 2014, section 144E.001, is amended by adding a subdivision
352.15 to read:

352.16 Subd. 5h. **Community medical response emergency medical technician.**
352.17 "Community medical response emergency medical technician" or "CEMT" means
352.18 a person who is certified as an emergency medical technician, who is a member of a
352.19 registered medical response unit under section 144E.275, and who meets the requirements
352.20 for additional certification as a CEMT as specified in section 144E.275, subdivision 7.

352.21 Sec. 9. Minnesota Statutes 2014, section 144E.275, subdivision 1, is amended to read:

352.22 Subdivision 1. **Definition.** For purposes of this section, the following definitions
352.23 apply:

352.24 (a) "Medical response unit" means an organized service recognized by a local
352.25 political subdivision whose primary responsibility is to respond to medical emergencies to
352.26 provide initial medical care before the arrival of a licensed ambulance service. Medical
352.27 response units may also provide CEMT services as permitted under subdivision 7.

352.28 (b) "Specialized medical response unit" means an organized service recognized by a
352.29 board-approved authority other than a local political subdivision that responds to medical
352.30 emergencies as needed or as required by local procedure or protocol.

352.31 Sec. 10. Minnesota Statutes 2014, section 144E.275, is amended by adding a
352.32 subdivision to read:

353.1 Subd. 7. **Community medical response emergency medical technician.** (a) To be
353.2 eligible for certification by the board as a CEMT, an individual shall:

353.3 (1) be currently certified as an EMT or AEMT;

353.4 (2) have two years of service as an EMT or AEMT;

353.5 (3) be a member of a registered medical response unit as defined under this section;

353.6 (4) successfully complete a CEMT training program from a college or university that

353.7 has been approved by the board or accredited by a board-approved national accrediting

353.8 organization. The training must include clinical experience under the supervision of the

353.9 medical response unit medical director, an advanced practice registered nurse, a physician

353.10 assistant, or a public health nurse operating under the direct authority of a local unit

353.11 of government;

353.12 (5) successfully complete a training program that includes training in providing

353.13 culturally appropriate care; and

353.14 (6) complete a board-approved application form.

353.15 (b) A CEMT must practice in accordance with protocols and supervisory standards

353.16 established by the medical response unit medical director in accordance with section

353.17 144E.265.

353.18 (c) A CEMT may provide services within the CEMT skill set as approved by the

353.19 medical response unit medical director.

353.20 (d) A CEMT may provide episodic individual patient education and prevention

353.21 education but only as directed by a patient care plan developed by the patient's primary

353.22 physician, an advanced practice registered nurse, or a physician assistant, in conjunction

353.23 with the medical response unit medical director and relevant local health care providers.

353.24 The patient care plan must ensure that the services provided by the CEMT are consistent

353.25 with services offered by the patient's health care home, if one exists, that the patient

353.26 receives the necessary services, and that there is no duplication of services to the patient.

353.27 (e) A CEMT is subject to all certification, disciplinary, complaint, and other

353.28 regulatory requirements that apply to EMTs under this chapter.

353.29 (f) A CEMT may not provide services as defined in section 144A.471, subdivisions

353.30 6 and 7, except a CEMT may provide verbal or visual reminders to the patient to:

353.31 (1) take a regularly scheduled medication, but not to provide or bring the patient

353.32 medication; and

353.33 (2) follow regularly scheduled treatment or exercise plans.

353.34 Sec. 11. Minnesota Statutes 2014, section 151.58, subdivision 2, is amended to read:

354.1 Subd. 2. **Definitions.** For purposes of this section only, the terms defined in this
354.2 subdivision have the meanings given.

354.3 (a) "Automated drug distribution system" or "system" means a mechanical system
354.4 approved by the board that performs operations or activities, other than compounding or
354.5 administration, related to the storage, packaging, or dispensing of drugs, and collects,
354.6 controls, and maintains all required transaction information and records.

354.7 (b) "Health care facility" means a nursing home licensed under section 144A.02;
354.8 a housing with services establishment registered under section 144D.01, subdivision 4,
354.9 in which a home provider licensed under chapter 144A is providing centralized storage
354.10 of medications; a boarding care home licensed under sections 144.50 to 144.58 that is
354.11 providing centralized storage of medications; or a Minnesota sex offender program facility
354.12 operated by the Department of Human Services.

354.13 (c) "Managing pharmacy" means a pharmacy licensed by the board that controls and
354.14 is responsible for the operation of an automated drug distribution system.

354.15 Sec. 12. Minnesota Statutes 2014, section 151.58, subdivision 5, is amended to read:

354.16 Subd. 5. **Operation of automated drug distribution systems.** (a) The managing
354.17 pharmacy and the pharmacist in charge are responsible for the operation of an automated
354.18 drug distribution system.

354.19 (b) Access to an automated drug distribution system must be limited to pharmacy
354.20 and nonpharmacy personnel authorized to procure drugs from the system, except that field
354.21 service technicians may access a system located in a health care facility for the purposes of
354.22 servicing and maintaining it while being monitored either by the managing pharmacy, or a
354.23 licensed nurse within the health care facility. In the case of an automated drug distribution
354.24 system that is not physically located within a licensed pharmacy, access for the purpose
354.25 of procuring drugs shall be limited to licensed nurses. Each person authorized to access
354.26 the system must be assigned an individual specific access code. Alternatively, access to
354.27 the system may be controlled through the use of biometric identification procedures. A
354.28 policy specifying time access parameters, including time-outs, logoffs, and lockouts,
354.29 must be in place.

354.30 (c) For the purposes of this section only, the requirements of section 151.215 are met
354.31 if the following clauses are met:

354.32 (1) a pharmacist employed by and working at the managing pharmacy, or at a
354.33 pharmacy that is acting as a central services pharmacy for the managing pharmacy,
354.34 pursuant to Minnesota Rules, part 6800.4075, must review, interpret, and approve all
354.35 prescription drug orders before any drug is distributed from the system to be administered

355.1 to a patient. A pharmacy technician may perform data entry of prescription drug orders
355.2 provided that a pharmacist certifies the accuracy of the data entry before the drug can
355.3 be released from the automated drug distribution system. A pharmacist employed by
355.4 and working at the managing pharmacy must certify the accuracy of the filling of any
355.5 cassettes, canisters, or other containers that contain drugs that will be loaded into the
355.6 automated drug distribution system, unless the filled cassettes, canisters, or containers
355.7 have been provided by a repackager registered with the United States Food and Drug
355.8 Administration and licensed by the board as a manufacturer; and

355.9 (2) when the automated drug dispensing system is located and used within the
355.10 managing pharmacy, a pharmacist must personally supervise and take responsibility for all
355.11 packaging and labeling associated with the use of an automated drug distribution system.

355.12 (d) Access to drugs when a pharmacist has not reviewed and approved the
355.13 prescription drug order is permitted only when a formal and written decision to allow such
355.14 access is issued by the pharmacy and the therapeutics committee or its equivalent. The
355.15 committee must specify the patient care circumstances in which such access is allowed,
355.16 the drugs that can be accessed, and the staff that are allowed to access the drugs.

355.17 (e) In the case of an automated drug distribution system that does not utilize bar
355.18 coding in the loading process, the loading of a system located in a health care facility may
355.19 be performed by a pharmacy technician, so long as the activity is continuously supervised,
355.20 through a two-way audiovisual system by a pharmacist on duty within the managing
355.21 pharmacy. In the case of an automated drug distribution system that utilizes bar coding
355.22 in the loading process, the loading of a system located in a health care facility may be
355.23 performed by a pharmacy technician or a licensed nurse, provided that the managing
355.24 pharmacy retains an electronic record of loading activities.

355.25 (f) The automated drug distribution system must be under the supervision of a
355.26 pharmacist. The pharmacist is not required to be physically present at the site of the
355.27 automated drug distribution system if the system is continuously monitored electronically
355.28 by the managing pharmacy. A pharmacist on duty within a pharmacy licensed by the
355.29 board must be continuously available to address any problems detected by the monitoring
355.30 or to answer questions from the staff of the health care facility. The licensed pharmacy
355.31 may be the managing pharmacy or a pharmacy which is acting as a central services
355.32 pharmacy, pursuant to Minnesota Rules, part 6800.4075, for the managing pharmacy.

355.33 Sec. 13. Minnesota Statutes 2014, section 256B.0625, subdivision 3b, is amended to
355.34 read:

356.1 Subd. 3b. **Telemedicine consultations services.** (a) Medical assistance covers
356.2 medically necessary services and consultations delivered by a licensed health care provider
356.3 via telemedicine consultations. Telemedicine consultations must be made via two-way,
356.4 interactive video or store-and-forward technology. Store-and-forward technology includes
356.5 telemedicine consultations that do not occur in real time via synchronous transmissions,
356.6 and that do not require a face-to-face encounter with the patient for all or any part of any
356.7 such telemedicine consultation. The patient record must include a written opinion from the
356.8 consulting physician providing the telemedicine consultation. A communication between
356.9 two physicians that consists solely of a telephone conversation is not a telemedicine
356.10 consultation in the same manner as if the service or consultation was delivered in person.
356.11 Coverage is limited to three telemedicine consultations services per recipient enrollee per
356.12 calendar week. Telemedicine consultations services shall be paid at the full allowable rate.

356.13 (b) The commissioner shall establish criteria that a health care provider must attest
356.14 to in order to demonstrate the safety or efficacy of delivering a particular service via
356.15 telemedicine. The attestation may include that the health care provider:

356.16 (1) has identified the categories or types of services the health care provider will
356.17 provide via telemedicine;

356.18 (2) has written policies and procedures specific to telemedicine services that are
356.19 regularly reviewed and updated;

356.20 (3) has policies and procedures that adequately address patient safety before, during,
356.21 and after the telemedicine service is rendered;

356.22 (4) has established protocols addressing how and when to discontinue telemedicine
356.23 services; and

356.24 (5) has an established quality assurance process related to telemedicine services.

356.25 (c) As a condition of payment, a licensed health care provider must document
356.26 each occurrence of a health service provided by telemedicine to a medical assistance
356.27 enrollee. Health care service records for services provided by telemedicine must meet
356.28 the requirements set forth in Minnesota Rules, part 9505.2175, subparts 1 and 2, and
356.29 must document:

356.30 (1) the type of service provided by telemedicine;

356.31 (2) the time the service began and the time the service ended, including an a.m. and
356.32 p.m. designation;

356.33 (3) the licensed health care provider's basis for determining that telemedicine is an
356.34 appropriate and effective means for delivering the service to the enrollee;

356.35 (4) the mode of transmission of the telemedicine service and records evidencing that
356.36 a particular mode of transmission was utilized;

357.1 (5) the location of the originating site and the distant site;

357.2 (6) if the claim for payment is based on a physician's telemedicine consultation
357.3 with another physician, the written opinion from the consulting physician providing the
357.4 telemedicine consultation; and

357.5 (7) compliance with the criteria attested to by the health care provider in accordance
357.6 with paragraph (b).

357.7 (d) For purposes of this subdivision, unless otherwise covered under this chapter,
357.8 "telemedicine" is defined as the delivery of health care services or consultations while
357.9 the patient is at an originating site and the licensed health care provider is at a distant
357.10 site. A communication between licensed health care providers, or a licensed health care
357.11 provider and a patient that consists solely of a telephone conversation, e-mail, or facsimile
357.12 transmission does not constitute telemedicine consultations or services. Telemedicine may
357.13 be provided by means of real-time two-way, interactive audio and visual communications,
357.14 including the application of secure video conferencing or store-and-forward technology
357.15 to provide or support health care delivery, which facilitate the assessment, diagnosis,
357.16 consultation, treatment, education, and care management of a patient's health care.

357.17 (e) For purposes of this section, "licensed health care provider" is defined under
357.18 section 62A.671, subdivision 6; "health care provider" is defined under section 62A.671,
357.19 subdivision 3; and "originating site" is defined under section 62A.671, subdivision 7.

357.20 **EFFECTIVE DATE.** This section is effective January 1, 2016.

357.21 Sec. 14. Minnesota Statutes 2014, section 256B.0625, subdivision 13, is amended to
357.22 read:

357.23 Subd. 13. **Drugs.** (a) Medical assistance covers drugs, except for fertility drugs
357.24 when specifically used to enhance fertility, if prescribed by a licensed practitioner and
357.25 dispensed by a licensed pharmacist, by a physician enrolled in the medical assistance
357.26 program as a dispensing physician, or by a physician, physician assistant, or a nurse
357.27 practitioner employed by or under contract with a community health board as defined in
357.28 section 145A.02, subdivision 5, for the purposes of communicable disease control.

357.29 (b) The dispensed quantity of a prescription drug must not exceed a 34-day supply,
357.30 unless authorized by the commissioner.

357.31 (c) For the purpose of this subdivision and subdivision 13d, an "active
357.32 pharmaceutical ingredient" is defined as a substance that is represented for use in a drug
357.33 and when used in the manufacturing, processing, or packaging of a drug becomes an
357.34 active ingredient of the drug product. An "excipient" is defined as an inert substance
357.35 used as a diluent or vehicle for a drug. The commissioner shall establish a list of active

358.1 pharmaceutical ingredients and excipients which are included in the medical assistance
358.2 formulary. Medical assistance covers selected active pharmaceutical ingredients and
358.3 excipients used in compounded prescriptions when the compounded combination is
358.4 specifically approved by the commissioner or when a commercially available product:

358.5 (1) is not a therapeutic option for the patient;

358.6 (2) does not exist in the same combination of active ingredients in the same strengths
358.7 as the compounded prescription; and

358.8 (3) cannot be used in place of the active pharmaceutical ingredient in the
358.9 compounded prescription.

358.10 (d) Medical assistance covers the following over-the-counter drugs when prescribed
358.11 by a licensed practitioner or by a licensed pharmacist who meets standards established by
358.12 the commissioner, in consultation with the board of pharmacy: antacids, acetaminophen,
358.13 family planning products, aspirin, insulin, products for the treatment of lice, vitamins for
358.14 adults with documented vitamin deficiencies, vitamins for children under the age of seven
358.15 and pregnant or nursing women, and any other over-the-counter drug identified by the
358.16 commissioner, in consultation with the formulary committee, as necessary, appropriate,
358.17 and cost-effective for the treatment of certain specified chronic diseases, conditions,
358.18 or disorders, and this determination shall not be subject to the requirements of chapter
358.19 14. A pharmacist may prescribe over-the-counter medications as provided under this
358.20 paragraph for purposes of receiving reimbursement under Medicaid. When prescribing
358.21 over-the-counter drugs under this paragraph, licensed pharmacists must consult with
358.22 the recipient to determine necessity, provide drug counseling, review drug therapy
358.23 for potential adverse interactions, and make referrals as needed to other health care
358.24 professionals. Over-the-counter medications must be dispensed in a quantity that is the
358.25 ~~lower~~ lowest of: (1) the number of dosage units contained in the manufacturer's original
358.26 package; ~~and~~ (2) the number of dosage units required to complete the patient's course of
358.27 therapy; or (3) if applicable, the number of dosage units dispensed from a system using
358.28 retrospective billing, as provided under subdivision 13e, paragraph (b).

358.29 (e) Effective January 1, 2006, medical assistance shall not cover drugs that
358.30 are coverable under Medicare Part D as defined in the Medicare Prescription Drug,
358.31 Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-2(e),
358.32 for individuals eligible for drug coverage as defined in the Medicare Prescription
358.33 Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section
358.34 1860D-1(a)(3)(A). For these individuals, medical assistance may cover drugs from the
358.35 drug classes listed in United States Code, title 42, section 1396r-8(d)(2), subject to this

359.1 subdivision and subdivisions 13a to 13g, except that drugs listed in United States Code,
359.2 title 42, section 1396r-8(d)(2)(E), shall not be covered.

359.3 (f) Medical assistance covers drugs acquired through the federal 340B Drug Pricing
359.4 Program and dispensed by 340B covered entities and ambulatory pharmacies under
359.5 common ownership of the 340B covered entity. Medical assistance does not cover drugs
359.6 acquired through the federal 340B Drug Pricing Program and dispensed by 340B contract
359.7 pharmacies.

359.8 **EFFECTIVE DATE.** This section is effective January 1, 2016, or upon federal
359.9 approval, whichever is later.

359.10 Sec. 15. Minnesota Statutes 2014, section 256B.0625, subdivision 13e, is amended to
359.11 read:

359.12 Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment
359.13 shall be the lower of the actual acquisition costs of the drugs or the maximum allowable
359.14 cost by the commissioner plus the fixed dispensing fee; or the usual and customary price
359.15 charged to the public. The amount of payment basis must be reduced to reflect all discount
359.16 amounts applied to the charge by any provider/insurer agreement or contract for submitted
359.17 charges to medical assistance programs. The net submitted charge may not be greater
359.18 than the patient liability for the service. The pharmacy dispensing fee shall be \$3.65
359.19 for legend prescription drugs, except that the dispensing fee for intravenous solutions
359.20 which must be compounded by the pharmacist shall be \$8 per bag, \$14 per bag for cancer
359.21 chemotherapy products, and \$30 per bag for total parenteral nutritional products dispensed
359.22 in one liter quantities, or \$44 per bag for total parenteral nutritional products dispensed in
359.23 quantities greater than one liter. The pharmacy dispensing fee for over the counter drugs
359.24 shall be \$3.65, except that the fee shall be \$1.31 for retrospectively billing pharmacies
359.25 when billing for quantities less than the number of units contained in the manufacturer's
359.26 original package. Actual acquisition cost includes quantity and other special discounts
359.27 except time and cash discounts. The actual acquisition cost of a drug shall be estimated
359.28 by the commissioner at wholesale acquisition cost plus four percent for independently
359.29 owned pharmacies located in a designated rural area within Minnesota, and at wholesale
359.30 acquisition cost plus two percent for all other pharmacies. A pharmacy is "independently
359.31 owned" if it is one of four or fewer pharmacies under the same ownership nationally. A
359.32 "designated rural area" means an area defined as a small rural area or isolated rural area
359.33 according to the four-category classification of the Rural Urban Commuting Area system
359.34 developed for the United States Health Resources and Services Administration. Effective
359.35 January 1, 2014, the actual acquisition cost of a drug acquired through the federal 340B

360.1 Drug Pricing Program shall be estimated by the commissioner at wholesale acquisition
360.2 cost minus 40 percent. Wholesale acquisition cost is defined as the manufacturer's list
360.3 price for a drug or biological to wholesalers or direct purchasers in the United States, not
360.4 including prompt pay or other discounts, rebates, or reductions in price, for the most
360.5 recent month for which information is available, as reported in wholesale price guides or
360.6 other publications of drug or biological pricing data. The maximum allowable cost of a
360.7 multisource drug may be set by the commissioner and it shall be comparable to, but no
360.8 higher than, the maximum amount paid by other third-party payors in this state who have
360.9 maximum allowable cost programs. Establishment of the amount of payment for drugs
360.10 shall not be subject to the requirements of the Administrative Procedure Act.

360.11 (b) Pharmacies dispensing prescriptions to residents of long-term care facilities
360.12 using an automated drug distribution system meeting the requirements of section 151.58,
360.13 or a packaging system meeting the packaging standards set forth in Minnesota Rules, part
360.14 6800.2700, that govern the return of unused drugs to the pharmacy for reuse, may employ
360.15 retrospective billing for prescription drugs dispensed to long-term care facility residents.
360.16 A retrospectively billing pharmacy must submit a claim only for the quantity of medication
360.17 used by the enrolled recipient during the defined billing period. A retrospectively billing
360.18 pharmacy must use a billing period not less than one calendar month or 30 days.

360.19 (c) An additional dispensing fee of \$.30 may be added to the dispensing fee paid to
360.20 pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities
360.21 when a unit dose blister card system, approved by the department, is used. Under this type
360.22 of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National
360.23 Drug Code (NDC) from the drug container used to fill the blister card must be identified on
360.24 the claim to the department. The unit dose blister card containing the drug must meet the
360.25 packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of
360.26 unused drugs to the pharmacy for reuse. ~~The~~ A pharmacy provider will be using packaging
360.27 that meets the standards set forth in Minnesota Rules, part 6800.2700, is required to credit
360.28 the department for the actual acquisition cost of all unused drugs that are eligible for reuse,
360.29 unless the pharmacy is using retrospective billing. The commissioner may permit the drug
360.30 clozapine to be dispensed in a quantity that is less than a 30-day supply.

360.31 (e) (d) Whenever a maximum allowable cost has been set for a multisource drug,
360.32 payment shall be the lower of the usual and customary price charged to the public or the
360.33 maximum allowable cost established by the commissioner unless prior authorization
360.34 for the brand name product has been granted according to the criteria established by
360.35 the Drug Formulary Committee as required by subdivision 13f, paragraph (a), and the

361.1 prescriber has indicated "dispense as written" on the prescription in a manner consistent
361.2 with section 151.21, subdivision 2.

361.3 ~~(d)~~ (e) The basis for determining the amount of payment for drugs administered in
361.4 an outpatient setting shall be the lower of the usual and customary cost submitted by
361.5 the provider, 106 percent of the average sales price as determined by the United States
361.6 Department of Health and Human Services pursuant to title XVIII, section 1847a of the
361.7 federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost
361.8 set by the commissioner. If average sales price is unavailable, the amount of payment
361.9 must be lower of the usual and customary cost submitted by the provider, the wholesale
361.10 acquisition cost, the specialty pharmacy rate, or the maximum allowable cost set by the
361.11 commissioner. Effective January 1, 2014, the commissioner shall discount the payment
361.12 rate for drugs obtained through the federal 340B Drug Pricing Program by 20 percent. The
361.13 payment for drugs administered in an outpatient setting shall be made to the administering
361.14 facility or practitioner. A retail or specialty pharmacy dispensing a drug for administration
361.15 in an outpatient setting is not eligible for direct reimbursement.

361.16 ~~(e)~~ (f) The commissioner may negotiate lower reimbursement rates for specialty
361.17 pharmacy products than the rates specified in paragraph (a). The commissioner may
361.18 require individuals enrolled in the health care programs administered by the department
361.19 to obtain specialty pharmacy products from providers with whom the commissioner has
361.20 negotiated lower reimbursement rates. Specialty pharmacy products are defined as those
361.21 used by a small number of recipients or recipients with complex and chronic diseases
361.22 that require expensive and challenging drug regimens. Examples of these conditions
361.23 include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis
361.24 C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms
361.25 of cancer. Specialty pharmaceutical products include injectable and infusion therapies,
361.26 biotechnology drugs, antihemophilic factor products, high-cost therapies, and therapies
361.27 that require complex care. The commissioner shall consult with the formulary committee
361.28 to develop a list of specialty pharmacy products subject to this paragraph. In consulting
361.29 with the formulary committee in developing this list, the commissioner shall take into
361.30 consideration the population served by specialty pharmacy products, the current delivery
361.31 system and standard of care in the state, and access to care issues. The commissioner shall
361.32 have the discretion to adjust the reimbursement rate to prevent access to care issues.

361.33 ~~(f)~~ (g) Home infusion therapy services provided by home infusion therapy
361.34 pharmacies must be paid at rates according to subdivision 8d.

361.35 **EFFECTIVE DATE.** This section is effective January 1, 2016, or upon federal
361.36 approval, whichever is later.

362.1 Sec. 16. Minnesota Statutes 2014, section 256B.072, is amended to read:

362.2 **256B.072 PERFORMANCE REPORTING AND QUALITY IMPROVEMENT**
362.3 **SYSTEM.**

362.4 (a) The commissioner of human services shall establish a performance reporting
362.5 system for health care providers who provide health care services to public program
362.6 recipients covered under chapters 256B, 256D, and 256L, reporting separately for
362.7 managed care and fee-for-service recipients.

362.8 (b) The measures used for the performance reporting system for medical groups
362.9 shall include measures of care for asthma, diabetes, hypertension, and coronary artery
362.10 disease and measures of preventive care services. The measures used for the performance
362.11 reporting system for inpatient hospitals shall include measures of care for acute myocardial
362.12 infarction, heart failure, and pneumonia, and measures of care and prevention of surgical
362.13 infections. In the case of a medical group, the measures used shall be consistent with
362.14 measures published by nonprofit Minnesota or national organizations that produce and
362.15 disseminate health care quality measures or evidence-based health care guidelines. In
362.16 the case of inpatient hospital measures, the commissioner shall appoint the Minnesota
362.17 Hospital Association and Stratis Health to advise on the development of the performance
362.18 measures to be used for hospital reporting. To enable a consistent measurement process
362.19 across the community, the commissioner may use measures of care provided for patients in
362.20 addition to those identified in paragraph (a). The commissioner shall ensure collaboration
362.21 with other health care reporting organizations so that the measures described in this
362.22 section are consistent with those reported by those organizations and used by other
362.23 purchasers in Minnesota.

362.24 (c) The commissioner may require providers to submit information in a required
362.25 format to a health care reporting organization or to cooperate with the information collection
362.26 procedures of that organization. The commissioner may collaborate with a reporting
362.27 organization to collect information reported and to prevent duplication of reporting.

362.28 (d) By October 1, 2007, and annually thereafter, the commissioner shall report
362.29 through a public Web site the results by medical groups and hospitals, where possible,
362.30 of the measures under this section, and shall compare the results by medical groups and
362.31 hospitals for patients enrolled in public programs to patients enrolled in private health
362.32 plans. To achieve this reporting, the commissioner may collaborate with a health care
362.33 reporting organization that operates a Web site suitable for this purpose.

362.34 (e) Performance measures must be stratified as provided under section 62U.02,
362.35 subdivision 1, paragraph (b), and risk-adjusted as specified in section 62U.02, subdivision
362.36 3, paragraph (b).

363.1 Sec. 17. **PROPOSAL FOR CHILD PROTECTION FOCUSED "COMMUNITY**
363.2 **MEDICAL RESPONSE EMERGENCY MEDICAL TECHNICIAN" (CEMT)**
363.3 **MODEL.**

363.4 The commissioner shall develop a proposal for a pilot project to create a
363.5 community-based support system that coordinates services between child protection
363.6 services and community emergency medical technicians. This pilot project model shall
363.7 be developed with the input of stakeholders that represent both child protection services
363.8 and community emergency medical technicians. The model must be designed so that the
363.9 collaborative effort results in increased safety for children and increased support for
363.10 families. The pilot project model must be reviewed by the Task Force on the Protection of
363.11 Children, and the commissioner shall make recommendations for the pilot project to the
363.12 members of the legislative committees with primary jurisdiction over CEMT and child
363.13 protection issues no later than January 15, 2016.

363.14 Sec. 18. **COMMUNITY MEDICAL RESPONSE EMERGENCY MEDICAL**
363.15 **TECHNICIAN SERVICES COVERED UNDER THE MEDICAL ASSISTANCE**
363.16 **PROGRAM.**

363.17 (a) The commissioner of human services, in consultation with representatives of
363.18 emergency medical service providers, public health nurses, community health workers,
363.19 the Minnesota State Fire Chiefs Association, the Minnesota Professional Firefighters
363.20 Association, the Minnesota State Firefighters Department Association, Minnesota
363.21 Academy of Family Physicians, Minnesota Licensed Practical Nurses Association,
363.22 Minnesota Nurses Association, and local public health agencies, shall determine specified
363.23 services and payment rates for these services to be performed by community medical
363.24 response emergency medical technicians certified under Minnesota Statutes, section
363.25 144E.275, subdivision 7, and covered by medical assistance under Minnesota Statutes,
363.26 section 256B.0625. Services must be in the CEMT skill set and may include interventions
363.27 intended to prevent avoidable ambulance transportation or hospital emergency department
363.28 use.

363.29 (b) In order to be eligible for payment, services provided by a community medical
363.30 response emergency medical technician must be:

363.31 (1) ordered by a medical response unit medical director;

363.32 (2) part of a patient care plan that has been developed in coordination with the
363.33 patient's primary physician, advanced practice registered nurse, and relevant local health
363.34 care providers; and

364.1 (3) billed by an eligible medical assistance enrolled provider that employs or
 364.2 contracts with the community medical response emergency medical technician.

364.3 In determining the community medical response emergency medical technician services
 364.4 to include under medical assistance coverage, the commissioner of human services shall
 364.5 consider the potential of hospital admittance and emergency room utilization reductions as
 364.6 well as increased access to quality care in rural communities.

364.7 (c) The commissioner of human services shall submit the list of services to be
 364.8 covered by medical assistance to the chairs and ranking minority members of the
 364.9 legislative committees with jurisdiction over health and human services policy and
 364.10 spending by February 15, 2016. These services shall not be covered by medical assistance
 364.11 until legislation providing coverage for the services is enacted in law.

364.12 Sec. 19. **EVALUATION OF COMMUNITY MEDICAL RESPONSE**
 364.13 **EMERGENCY MEDICAL TECHNICIAN SERVICES.**

364.14 If legislation is enacted to cover community medical response emergency medical
 364.15 technician services with medical assistance, the commissioner of human services shall
 364.16 evaluate the effect of medical assistance and MinnesotaCare coverage for those services
 364.17 on the cost and quality of care under those programs and the coordination of those services
 364.18 with the health care home services. The commissioner shall present findings to the chairs
 364.19 and ranking minority members of the legislative committees with jurisdiction over health
 364.20 and human services policy and spending by December 1, 2017. The commissioner shall
 364.21 require medical assistance and MinnesotaCare enrolled providers that employ or contract
 364.22 with community medical response emergency medical technicians to provide to the
 364.23 commissioner, in the form and manner specified by the commissioner, the utilization, cost,
 364.24 and quality data necessary to conduct this evaluation.

364.25 **ARTICLE 10**

364.26 **HEALTH LICENSING BOARDS**

364.27 Section 1. Minnesota Statutes 2014, section 148.52, is amended to read:

364.28 **148.52 BOARD OF OPTOMETRY.**

364.29 The Board of Optometry shall consist of two public members as defined by section
 364.30 214.02 and five ~~qualified~~ Minnesota licensed optometrists appointed by the governor.
 364.31 Membership terms, compensation of members, removal of members, the filling of
 364.32 membership vacancies, and fiscal year and reporting requirements shall be as provided in
 364.33 sections 214.07 to 214.09.

365.1 The provision of staff, administrative services and office space; the review and
365.2 processing of complaints; the setting of board fees; and other provisions relating to board
365.3 operations shall be as provided in chapter 214.

365.4 Sec. 2. Minnesota Statutes 2014, section 148.54, is amended to read:

365.5 **148.54 BOARD; SEAL.**

365.6 The Board of Optometry shall elect from among its members a president, vice
365.7 president, and secretary and may adopt a seal.

365.8 Sec. 3. Minnesota Statutes 2014, section 148.57, subdivision 1, is amended to read:

365.9 Subdivision 1. **Examination.** (a) A person not authorized to practice optometry in
365.10 the state and desiring to do so shall apply to the state Board of Optometry by filling out
365.11 and swearing to an application for a license granted by the board and accompanied by a
365.12 fee ~~in an amount of \$87~~ established by the board, not to exceed the amount specified in
365.13 section 148.59. With the submission of the application form, the candidate shall prove
365.14 that the candidate:

365.15 (1) is of good moral character;

365.16 (2) has obtained a clinical doctorate degree from a board-approved school or college
365.17 of optometry, or is currently enrolled in the final year of study at such an institution; and

365.18 (3) has passed all parts of an examination.

365.19 (b) The examination shall include both a written portion and a clinical practical
365.20 portion and shall thoroughly test the fitness of the candidate to practice in this state. In
365.21 regard to the written and clinical practical examinations, the board may:

365.22 (1) prepare, administer, and grade the examination itself;

365.23 (2) recognize and approve in whole or in part an examination prepared, administered
365.24 and graded by a national board of examiners in optometry; or

365.25 (3) administer a recognized and approved examination prepared and graded by or
365.26 under the direction of a national board of examiners in optometry.

365.27 (c) The board shall issue a license to each applicant who satisfactorily passes the
365.28 examinations and fulfills the other requirements stated in this section ~~and section 148.575~~
365.29 ~~for board certification for the use of legend drugs. Applicants for initial licensure do not~~
365.30 ~~need to apply for or possess a certificate as referred to in sections 148.571 to 148.574. The~~
365.31 ~~fees mentioned in this section are for the use of the board and in no case shall be refunded.~~

365.32 Sec. 4. Minnesota Statutes 2014, section 148.57, subdivision 2, is amended to read:

366.1 Subd. 2. **Endorsement.** (a) An optometrist who holds a current license from
366.2 another state, and who has practiced in that state not less than three years immediately
366.3 preceding application, may apply for licensure in Minnesota by filling out and swearing
366.4 to an application for license by endorsement furnished by the board. The completed
366.5 application with all required documentation shall be filed at the board office along with a
366.6 fee of ~~\$87~~ established by the board, not to exceed the amount specified in section 148.59.
366.7 The application fee shall be for the use of the board and in no case shall be refunded.

366.8 (b) To verify that the applicant possesses the knowledge and ability essential to the
366.9 practice of optometry in this state, the applicant must provide evidence of:

366.10 (1) having obtained a clinical doctorate degree from a board-approved school
366.11 or college of optometry;

366.12 (2) successful completion of both written and practical examinations for licensure in
366.13 the applicant's original state of licensure that thoroughly tested the fitness of the applicant
366.14 to practice;

366.15 (3) successful completion of an examination of Minnesota state optometry laws;

366.16 (4) compliance with the requirements ~~for board certification~~ in section 148.575;

366.17 (5) compliance with all continuing education required for license renewal in every
366.18 state in which the applicant currently holds an active license to practice; and

366.19 (6) being in good standing with every state board from which a license has been
366.20 issued.

366.21 (c) Documentation from a national certification system or program, approved by
366.22 the board, which supports any of the listed requirements, may be used as evidence. The
366.23 applicant may then be issued a license if the requirements for licensure in the other state
366.24 are deemed by the board to be equivalent to those of sections 148.52 to 148.62.

366.25 Sec. 5. Minnesota Statutes 2014, section 148.57, is amended by adding a subdivision
366.26 to read:

366.27 Subd. 5. **Change of address.** A person regulated by the board shall maintain a
366.28 current name and address with the board and shall notify the board in writing within 30
366.29 days of any change in name or address. If a name change only is requested, the regulated
366.30 person must request revised credentials and return the current credentials to the board.
366.31 The board may require the regulated person to substantiate the name change by submitting
366.32 official documentation from a court of law or agency authorized under law to receive and
366.33 officially record a name change. If an address change only is requested, no request for
366.34 revised credentials is required. If the regulated person's current credentials have been lost,
366.35 stolen, or destroyed, the person shall provide a written explanation to the board.

367.1 Sec. 6. Minnesota Statutes 2014, section 148.574, is amended to read:

367.2 **148.574 PROHIBITIONS RELATING TO LEGEND DRUGS;**
367.3 **~~AUTHORIZING SALES BY PHARMACISTS UNDER CERTAIN CONDITIONS.~~**

367.4 ~~An optometrist shall not purchase, possess, administer, prescribe or give any legend~~
367.5 ~~drug as defined in section 151.01 or 152.02 to any person except as is expressly authorized~~
367.6 ~~by sections 148.571 to 148.577. Nothing in chapter 151 shall prevent a pharmacist from~~
367.7 ~~selling topical ocular drugs to an optometrist authorized to use such drugs according to~~
367.8 ~~sections 148.571 to 148.577. Notwithstanding sections 151.37 and 152.12, an optometrist~~
367.9 ~~is prohibited from dispensing legend drugs at retail, unless the legend drug is within the~~
367.10 ~~scope designated in section 148.56, subdivision 1, and is administered to the eye through~~
367.11 ~~an ophthalmic good as defined in section 145.711, subdivision 4.~~

367.12 Sec. 7. Minnesota Statutes 2014, section 148.575, subdivision 2, is amended to read:

367.13 Subd. 2. ~~Board certified~~ **Requirements defined.** "Board certified" means that A
367.14 licensed optometrist has been issued a certificate by the Board of Optometry certifying
367.15 ~~that the optometrist has complied~~ shall comply with the following requirements for the use
367.16 of legend drugs described in section 148.576:

367.17 ~~(1) successful completion of at least 60 hours of study in general and ocular~~
367.18 ~~pharmacology emphasizing drugs used for examination or treatment purposes, their~~
367.19 ~~systemic effects and management or referral of adverse reactions;~~

367.20 ~~(2)~~ (1) successful completion of at least 100 hours of study in the examination,
367.21 diagnosis, and treatment of conditions of the human eye with legend drugs;

367.22 ~~(3)~~ (2) successful completion of two years of supervised clinical experience in
367.23 differential diagnosis of eye disease or disorders as part of optometric training or one year
367.24 of that experience and ten years of actual clinical experience as a licensed optometrist; and

367.25 ~~(4)~~ (3) successful completion of a nationally standardized examination approved or
367.26 administered by the board on the subject of treatment and management of ocular disease.

367.27 Sec. 8. Minnesota Statutes 2014, section 148.577, is amended to read:

367.28 **148.577 STANDARD OF CARE.**

367.29 A licensed optometrist ~~who is board certified under section 148.575~~ is held to the
367.30 same standard of care in the use of those legend drugs as physicians licensed by the state
367.31 of Minnesota.

368.1 Sec. 9. Minnesota Statutes 2014, section 148.59, is amended to read:

368.2 **148.59 LICENSE RENEWAL; FEE LICENSE AND REGISTRATION FEES.**

368.3 A licensed optometrist shall pay to the state Board of Optometry a fee as set by the
368.4 board in order to renew a license as provided by board rule. No fees shall be refunded.
368.5 Fees may not exceed the following amounts but may be adjusted lower by board direction
368.6 and are for the exclusive use of the board:

- 368.7 (1) optometry licensure application, \$160;
368.8 (2) optometry annual licensure renewal, \$135;
368.9 (3) optometry late penalty fee, \$75;
368.10 (4) annual license renewal card, \$10;
368.11 (5) continuing education provider application, \$45;
368.12 (6) emeritus registration, \$10;
368.13 (7) endorsement/reciprocity application, \$160;
368.14 (8) replacement of initial license, \$12; and
368.15 (9) license verification, \$50.

368.16 Sec. 10. Minnesota Statutes 2014, section 148.603, is amended to read:

368.17 **148.603 FORMS OF GROUNDS FOR DISCIPLINARY ACTIONS ACTION.**

368.18 ~~When grounds exist under section 148.57, subdivision 3, or other statute or rule~~
368.19 ~~which the board is authorized to enforce, the board may take one or more of the following~~
368.20 ~~disciplinary actions, provided that disciplinary or corrective action may not be imposed~~
368.21 ~~by the board on any regulated person except after a contested case hearing conducted~~
368.22 ~~pursuant to chapter 14 or by consent of the parties:~~

- 368.23 ~~(1) deny an application for a credential;~~
368.24 ~~(2) revoke the regulated person's credential;~~
368.25 ~~(3) suspend the regulated person's credential;~~
368.26 ~~(4) impose limitations on the regulated person's credential;~~
368.27 ~~(5) impose conditions on the regulated person's credential;~~
368.28 ~~(6) censure or reprimand the regulated person;~~
368.29 ~~(7) impose a civil penalty not exceeding \$10,000 for each separate violation, the~~
368.30 ~~amount of the civil penalty to be fixed so as to deprive the person of any economic~~
368.31 ~~advantage gained by reason of the violation or to discourage similar violations or to~~
368.32 ~~reimburse the board for the cost of the investigation and proceeding. For purposes of~~
368.33 ~~this section, the cost of the investigation and proceeding may include, but is not limited~~
368.34 ~~to, fees paid for services provided by the Office of Administrative Hearings, legal and~~
368.35 ~~investigative services provided by the Office of the Attorney General, court reporters,~~

369.1 witnesses, reproduction of records, board members' per diem compensation, board staff
369.2 time, and travel costs and expenses incurred by board staff and board members; or

369.3 (8) when grounds exist under section 148.57, subdivision 3, or a board rule, enter
369.4 into an agreement with the regulated person for corrective action which may include
369.5 requiring the regulated person:

369.6 (i) to complete an educational course or activity;

369.7 (ii) to submit to the executive director or designated board member a written
369.8 protocol or reports designed to prevent future violations of the same kind;

369.9 (iii) to meet with a board member or board designee to discuss prevention of future
369.10 violations of the same kind; or

369.11 (iv) to perform other action justified by the facts.

369.12 Listing the measures in clause (8) does not preclude the board from including
369.13 them in an order for disciplinary action. The board may refuse to grant a license or
369.14 may impose disciplinary action as described in section 148.607 against any optometrist
369.15 for the following:

369.16 (1) failure to demonstrate the qualifications or satisfy the requirements for a license
369.17 contained in this chapter or in rules of the board. The burden of proof shall be on the
369.18 applicant to demonstrate the qualifications or the satisfaction of the requirements;

369.19 (2) obtaining a license by fraud or cheating, or attempting to subvert the licensing
369.20 examination process. Conduct which subverts or attempts to subvert the licensing
369.21 examination process includes, but is not limited to: (i) conduct which violates the
369.22 security of the examination materials, such as removing examination materials from the
369.23 examination room or having unauthorized possession of any portion of a future, current, or
369.24 previously administered licensing examination; (ii) conduct which violates the standard of
369.25 test administration, such as communicating with another examinee during administration
369.26 of the examination, copying another examinee's answers, permitting another examinee
369.27 to copy one's answers, or possessing unauthorized materials; or (iii) impersonating an
369.28 examinee or permitting an impersonator to take the examination on one's own behalf;

369.29 (3) conviction, during the previous five years, of a felony or gross misdemeanor,
369.30 reasonably related to the practice of optometry. Conviction as used in this section shall
369.31 include a conviction of an offense which if committed in this state would be deemed a
369.32 felony or gross misdemeanor without regard to its designation elsewhere, or a criminal
369.33 proceeding where a finding or verdict of guilt is made or returned but the adjudication of
369.34 guilt is either withheld or not entered thereon;

369.35 (4) revocation, suspension, restriction, limitation, or other disciplinary action against
369.36 the person's optometry license in another state or jurisdiction, failure to report to the

370.1 board that charges regarding the person's license have been brought in another state or
370.2 jurisdiction, or having been refused a license by any other state or jurisdiction;

370.3 (5) advertising which is false or misleading, which violates any rule of the board, or
370.4 which claims without substantiation the positive cure of any disease;

370.5 (6) violating a rule adopted by the board or an order of the board, a state or federal
370.6 law, which relates to the practice of optometry, or a state or federal narcotics or controlled
370.7 substance law;

370.8 (7) engaging in any unethical conduct; conduct likely to deceive, defraud, or harm
370.9 the public, or demonstrating a willful or careless disregard for the health, welfare, or
370.10 safety of a patient; or practice of optometry which is professionally incompetent, in that
370.11 it may create unnecessary danger to any patient's life, health, or safety, which in any of
370.12 the cases, proof of actual injury need not be established;

370.13 (8) failure to supervise an optometrist's assistant or failure to supervise an
370.14 optometrist under any agreement with the board;

370.15 (9) aiding or abetting an unlicensed person in the practice of optometry, except that
370.16 it is not a violation of this section for an optometrist to employ, supervise, or delegate
370.17 functions to a qualified person who may or may not be required to obtain a license or
370.18 registration to provide health services if that person is practicing within the scope of that
370.19 person's license or registration or delegated authority;

370.20 (10) adjudication as mentally incompetent, mentally ill, or developmentally
370.21 disabled, or as a chemically dependent person, a person dangerous to the public, a sexually
370.22 dangerous person, or a person who has a sexual psychopathic personality by a court of
370.23 competent jurisdiction, within or without this state. Such adjudication shall automatically
370.24 suspend a license for the duration of the license unless the board orders otherwise;

370.25 (11) engaging in unprofessional conduct which includes any departure from or the
370.26 failure to conform to the minimal standards of acceptable and prevailing practice in which
370.27 case actual injury to a patient need not be established;

370.28 (12) inability to practice optometry with reasonable skill and safety to patients
370.29 by reason of illness, use of alcohol, drugs, narcotics, chemicals, or any other type of
370.30 material or as a result of any mental or physical condition, including deterioration through
370.31 the aging process or loss of motor skills;

370.32 (13) revealing a privileged communication from or relating to a patient except when
370.33 otherwise required or permitted by law;

370.34 (14) improper management of medical records, including failure to maintain
370.35 adequate medical records, to comply with a patient's request made pursuant to sections
370.36 144.291 to 144.298 or to furnish a medical record or report required by law;

- 371.1 (15) fee splitting, including without limitation:
- 371.2 (i) paying, offering to pay, receiving, or agreeing to receive a commission, rebate, or
- 371.3 remuneration, directly or indirectly, primarily for the referral of patients or the prescription
- 371.4 of drugs or devices; and
- 371.5 (ii) dividing fees with another optometrist, other health care provider, or a
- 371.6 professional corporation, unless the division is in proportion to the services provided
- 371.7 and the responsibility assumed by each professional and the optometrist has disclosed
- 371.8 the terms of the division;
- 371.9 (16) engaging in abusive or fraudulent billing practices, including violations of the
- 371.10 federal Medicare and Medicaid laws or state medical assistance laws;
- 371.11 (17) becoming addicted or habituated to a drug or intoxicant;
- 371.12 (18) prescribing a drug or device for other than accepted therapeutic or experimental
- 371.13 or investigative purposes authorized by the state or a federal agency;
- 371.14 (19) engaging in conduct with a patient which is sexual or may reasonably be
- 371.15 interpreted by the patient as sexual, or in any verbal behavior which is seductive or
- 371.16 sexually demeaning to a patient;
- 371.17 (20) failure to make reports as required by section 148.604 or to cooperate with an
- 371.18 investigation of the board as required by section 148.606;
- 371.19 (21) knowingly providing false or misleading information that is directly related to
- 371.20 the care of a patient; and
- 371.21 (22) practice of a board-regulated profession under lapsed or nonrenewed credentials.

371.22 Sec. 11. **[148.604] REPORTING OBLIGATIONS.**

371.23 Subdivision 1. **Permission to report.** A person who has knowledge of any conduct

371.24 constituting grounds for discipline under sections 148.52 to 148.62 may report the

371.25 violation to the board.

371.26 Subd. 2. **Institutions.** Any hospital, clinic, prepaid medical plan, or other health

371.27 care institution or organization located in this state shall report to the board any action

371.28 taken by the institution or organization or any of its administrators or medical or other

371.29 committees to revoke, suspend, restrict, or condition an optometrist's privilege to practice

371.30 or treat patients in the institution, or as part of the organization, any denial of privileges,

371.31 or any other disciplinary action. The institution or organization shall also report the

371.32 resignation of any optometrist prior to the conclusion of any disciplinary proceeding, or

371.33 prior to the commencement of formal charges but after the optometrist had knowledge

371.34 that formal charges were contemplated or in preparation. Each report made under this

371.35 subdivision must state the nature of the action taken, state in detail the reasons for

372.1 the action, and identify the specific patient medical records upon which the action was
372.2 based. No report shall be required of an optometrist voluntarily limiting the practice of
372.3 the optometrist at a hospital provided that the optometrist notifies all hospitals where the
372.4 optometrist has privileges of the voluntary limitation and the reasons for it.

372.5 Subd. 3. **Licensed professionals.** A licensed optometrist shall report to the board
372.6 personal knowledge of any conduct by any optometrist which the person reasonably
372.7 believes constitutes grounds for disciplinary action under sections 148.52 to 148.62,
372.8 including any conduct indicating that the person may be incompetent, may have engaged
372.9 in unprofessional conduct, or may be physically unable to safely engage in the practice
372.10 of optometry.

372.11 Subd. 4. **Self-reporting.** An optometrist shall report to the board any personal
372.12 action which would require that a report be filed with the board by any person, health care
372.13 facility, business, or organization pursuant to subdivisions 2 and 3.

372.14 Subd. 5. **Deadlines; forms; rulemaking.** Reports required by subdivisions 2 to
372.15 4 must be submitted not later than 30 days after the occurrence of the reportable event
372.16 or transaction. The board may provide forms for the submission of reports required by
372.17 this section, may require that reports be submitted on the forms provided, and may adopt
372.18 rules necessary to ensure prompt and accurate reporting.

372.19 Subd. 6. **Subpoenas.** The board may issue subpoenas for the production of any
372.20 reports required by subdivisions 2 to 4 or any related documents.

372.21 Sec. 12. **[148.605] IMMUNITY.**

372.22 Subdivision 1. **Reporting.** Any person, health care facility, business, or organization
372.23 is immune from civil liability or criminal prosecution for submitting a report to the
372.24 board pursuant to section 148.604 or for otherwise reporting to the board violations or
372.25 alleged violations of section 148.603, if they are acting in good faith and in the exercise
372.26 of reasonable care.

372.27 Subd. 2. **Investigation; indemnification.** (a) Members of the board, persons
372.28 employed by the board, and consultants retained by the board for the purpose of
372.29 investigation of violations, the preparation of charges, and management of board orders on
372.30 behalf of the board are immune from civil liability and criminal prosecution for any actions,
372.31 transactions, or publications in the execution of, or relating to, their duties under sections
372.32 148.52 to 148.62, if they are acting in good faith and in the exercise of reasonable care.

372.33 (b) Members of the board and persons employed by the board or engaged in
372.34 maintaining records and making reports regarding adverse health care events are immune
372.35 from civil liability and criminal prosecution for any actions, transactions, or publications

373.1 in the execution of, or relating to, their duties under sections 148.52 to 148.62, if they are
 373.2 acting in good faith and in the exercise of reasonable care.

373.3 (c) For purposes of this section, a member of the board or a consultant described in
 373.4 paragraph (a) is considered a state employee under section 3.736, subdivision 9.

373.5 **Sec. 13. [148.606] OPTOMETRIST COOPERATION.**

373.6 An optometrist who is the subject of an investigation by or on behalf of the board
 373.7 shall cooperate fully with the investigation. Cooperation includes responding fully and
 373.8 promptly to any question raised by or on behalf of the board relating to the subject of the
 373.9 investigation and providing copies of patient medical records, as reasonably requested
 373.10 by the board, to assist the board in its investigation. If the board does not have written
 373.11 consent from a patient permitting access to the patient's records, the optometrist shall
 373.12 delete any data in the record which identifies the patient before providing it to the board.
 373.13 The board shall maintain any records obtained pursuant to this section as investigative
 373.14 data pursuant to chapter 13.

373.15 **Sec. 14. [148.607] DISCIPLINARY ACTIONS.**

373.16 When the board finds that a licensed optometrist under section 148.57 has violated a
 373.17 provision or provisions of sections 148.52 to 148.62, it may do one or more of the following:

373.18 (1) revoke the license;

373.19 (2) suspend the license;

373.20 (3) impose limitations or conditions on the optometrist's practice of optometry,
 373.21 including the limitation of scope of practice to designated field specialties; the imposition
 373.22 of retraining or rehabilitation requirements; the requirement of practice under supervision;
 373.23 or the conditioning of continued practice on demonstration of knowledge or skills by
 373.24 appropriate examination or other review of skill and competence;

373.25 (4) impose a civil penalty not exceeding \$10,000 for each separate violation, the
 373.26 amount of the civil penalty to be fixed so as to deprive the optometrist of any economic
 373.27 advantage gained by reason of the violation charged or to reimburse the board for the cost
 373.28 of the investigation and proceeding; and

373.29 (5) censure or reprimand the licensed optometrist.

373.30 **Sec. 15. Minnesota Statutes 2014, section 148E.075, is amended to read:**

373.31 **148E.075 INACTIVE LICENSES ALTERNATE LICENSES.**

373.32 **Subdivision 1. ~~Inactive status~~ Temporary leave license.** (a) ~~A licensee qualifies~~
 373.33 ~~for inactive status under either of the circumstances described in paragraph (b) or (c):~~

374.1 ~~(b) A licensee qualifies for inactive status when the licensee is granted temporary~~
374.2 ~~leave from active practice.~~ A licensee qualifies for temporary leave from active practice if
374.3 the licensee demonstrates to the satisfaction of the board that the licensee is not engaged
374.4 in the practice of social work in any setting, including settings in which social workers are
374.5 exempt from licensure according to section 148E.065. A licensee who is granted temporary
374.6 leave from active practice may reactivate the license according to section 148E.080.

374.7 (b) A licensee may maintain a temporary leave license for no more than four
374.8 consecutive years.

374.9 ~~(c) A licensee qualifies for inactive status when a licensee is granted an emeritus~~
374.10 ~~license. A licensee qualifies for an emeritus license if the licensee demonstrates to the~~
374.11 ~~satisfaction of the board that:~~

374.12 ~~(1) the licensee is retired from social work practice; and~~

374.13 ~~(2) the licensee is not engaged in the practice of social work in any setting, including~~
374.14 ~~settings in which social workers are exempt from licensure according to section 148E.065.~~

374.15 ~~A licensee who possesses an emeritus license may reactivate the license according to~~
374.16 ~~section 148E.080.~~

374.17 (c) A licensee who is granted temporary leave from active practice may reactivate
374.18 the license according to section 148E.080. If a licensee does not apply for reactivation
374.19 within 60 days following the end of the consecutive four-year period, the license
374.20 automatically expires. An individual with an expired license may apply for new licensure
374.21 according to section 148E.055.

374.22 (d) Except as provided in paragraph (e), a licensee who holds a temporary leave
374.23 license must not practice, attempt to practice, offer to practice, or advertise or hold out as
374.24 authorized to practice social work.

374.25 (e) The board may grant a variance to the requirements of paragraph (d) if a licensee
374.26 on temporary leave license provides emergency social work services. A variance is
374.27 granted only if the board provides the variance in writing to the licensee. The board may
374.28 impose conditions or restrictions on the variance.

374.29 (f) In making representations of professional status to the public, when holding a
374.30 temporary leave license, a licensee must state that the license is not active and that the
374.31 licensee cannot practice social work.

374.32 Subd. 1a. **Emeritus inactive license.** (a) A licensee qualifies for an emeritus inactive
374.33 license if the licensee demonstrates to the satisfaction of the board that the licensee is:

374.34 (1) retired from social work practice; and

374.35 (2) not engaged in the practice of social work in any setting, including settings in
374.36 which social workers are exempt from licensure according to section 148E.065.

375.1 (b) A licensee with an emeritus inactive license may apply for reactivation according
375.2 to section 148E.080 only during the four years following the granting of the emeritus
375.3 inactive license. However, after four years following the granting of the emeritus inactive
375.4 license, an individual may apply for new licensure according to section 148E.055.

375.5 (c) Except as provided in paragraph (d), a licensee who holds an emeritus inactive
375.6 license must not practice, attempt to practice, offer to practice, or advertise or hold out as
375.7 authorized to practice social work.

375.8 (d) The board may grant a variance to the requirements of paragraph (c) if a licensee
375.9 on emeritus inactive license provides emergency social work services. A variance is
375.10 granted only if the board provides the variance in writing to the licensee. The board may
375.11 impose conditions or restrictions on the variance.

375.12 (e) In making representations of professional status to the public, when holding
375.13 an emeritus inactive license, a licensee must state that the license is not active and that
375.14 the licensee cannot practice social work.

375.15 Subd. 1b. **Emeritus active license.** (a) A licensee qualifies for an emeritus active
375.16 license if the applicant demonstrates to the satisfaction of the board that the licensee is:

375.17 (1) retired from social work practice; and

375.18 (2) in compliance with the supervised practice requirements, as applicable, under
375.19 sections 148E.100 to 148E.125.

375.20 (b) A licensee who is issued an emeritus active license is only authorized to engage in:

375.21 (1) pro bono or unpaid social work practice as specified in section 148E.010,
375.22 subdivisions 6 and 11; or

375.23 (2) paid social work practice not to exceed 240 clock hours per calendar year, for the
375.24 exclusive purpose to provide licensing supervision as specified in sections 148E.100 to
375.25 148E.125; and

375.26 (3) the authorized scope of practice specified in section 148E.050.

375.27 (c) An emeritus active license must be renewed according to the requirements
375.28 specified in section 148E.070, subdivisions 1, 2, 3, 4, and 5.

375.29 (d) At the time of license renewal a licensee must provide evidence satisfactory to the
375.30 board that the licensee has, during the renewal term, completed 20 clock hours of continuing
375.31 education, including at least two clock hours in ethics, as specified in section 148E.130:

375.32 (1) for licensed independent clinical social workers, at least 12 clock hours must be
375.33 in the clinical content areas specified in section 148E.055, subdivision 5; and

375.34 (2) for social workers providing supervision according to sections 148E.100 to
375.35 148E.125, at least three clock hours must be in the practice of supervision.

376.1 (e) Independent study hours must not consist of more than eight clock hours of
376.2 continuing education per renewal term.

376.3 (f) Failure to renew an active emeritus license on the expiration date will result in an
376.4 expired license as specified in section 148E.070, subdivision 5.

376.5 (g) The board may grant a variance to the requirements of paragraph (b) if a licensee
376.6 holding an emeritus active license provides emergency social work services. A variance is
376.7 granted only if the board provides the variance in writing to the licensee. The board may
376.8 impose conditions or restrictions on the variance.

376.9 (h) In making representations of professional status to the public, when holding an
376.10 emeritus active license, a licensee must state that an emeritus active license authorizes only
376.11 pro bono or unpaid social work practice, or paid social work practice not to exceed 240
376.12 clock hours per calendar year, for the exclusive purpose to provide licensing supervision
376.13 as specified in sections 148E.100 to 148E.125.

376.14 (i) Notwithstanding the time limit and emeritus active license renewal requirements
376.15 specified in this section, a licensee who possesses an emeritus active license may
376.16 reactivate the license according to section 148E.080 or apply for new licensure according
376.17 to section 148E.055.

376.18 Subd. 2. **Application.** A licensee may apply for ~~inactive status~~ temporary leave
376.19 license, emeritus inactive license, or emeritus active license:

376.20 (1) at any time when currently licensed under section 148E.055, 148E.0555,
376.21 148E.0556, or 148E.0557, or when licensed as specified in section 148E.075, by
376.22 submitting an application for a temporary leave from active practice or for an emeritus
376.23 license form required by the board; or

376.24 (2) as an alternative to applying for the renewal of a license by so recording on the
376.25 application for license renewal form required by the board and submitting the completed,
376.26 signed application to the board.

376.27 An application that is not completed or signed, or that is not accompanied by the
376.28 correct fee, must be returned to the applicant, along with any fee submitted, and is void.
376.29 For applications submitted electronically, a "signed application" means providing an
376.30 attestation as specified by the board.

376.31 Subd. 3. **Fee.** (a) Regardless of when the application for ~~inactive status~~ temporary
376.32 leave license or emeritus inactive license is submitted, the temporary leave license or
376.33 emeritus inactive license fee specified in section 148E.180, whichever is applicable, must
376.34 accompany the application. A licensee who is approved for ~~inactive status~~ temporary
376.35 leave license or emeritus inactive license before the license expiration date is not entitled
376.36 to receive a refund for any portion of the license or renewal fee.

377.1 (b) If an application for temporary leave or emeritus active license is received after
377.2 the license expiration date, the licensee must pay a renewal late fee as specified in section
377.3 148E.180 in addition to the temporary leave fee.

377.4 (c) Regardless of when the application for emeritus active license is submitted,
377.5 the emeritus active license fee is one-half of the renewal fee for the applicable license
377.6 specified in section 148E.180, subdivision 3, and must accompany the application. A
377.7 licensee who is approved for emeritus active license before the license expiration date is
377.8 not entitled to receive a refund for any portion of the license or renewal fee.

377.9 ~~Subd. 4. **Time limits for temporary leaves.** A licensee may maintain an inactive~~
377.10 ~~license on temporary leave for no more than five consecutive years. If a licensee does~~
377.11 ~~not apply for reactivation within 60 days following the end of the consecutive five-year~~
377.12 ~~period, the license automatically expires.~~

377.13 ~~Subd. 5. **Time limits for emeritus license.** A licensee with an emeritus license may~~
377.14 ~~not apply for reactivation according to section 148E.080 after five years following the~~
377.15 ~~granting of the emeritus license. However, after five years following the granting of the~~
377.16 ~~emeritus license, an individual may apply for new licensure according to section 148E.055.~~

377.17 ~~Subd. 6. **Prohibition on practice.** (a) Except as provided in paragraph (b), a~~
377.18 ~~licensee whose license is inactive must not practice, attempt to practice, offer to practice,~~
377.19 ~~or advertise or hold out as authorized to practice social work.~~

377.20 ~~(b) The board may grant a variance to the requirements of paragraph (a) if a licensee~~
377.21 ~~on inactive status provides emergency social work services. A variance is granted only~~
377.22 ~~if the board provides the variance in writing to the licensee. The board may impose~~
377.23 ~~conditions or restrictions on the variance.~~

377.24 ~~Subd. 7. **Representations of professional status.** In making representations of~~
377.25 ~~professional status to the public, a licensee whose license is inactive must state that the~~
377.26 ~~license is inactive and that the licensee cannot practice social work.~~

377.27 ~~Subd. 8. **Disciplinary or other action.** The board may resolve any pending~~
377.28 ~~complaints against a licensee before approving an application for inactive status an~~
377.29 ~~alternate license specified in this section. The board may take action according to sections~~
377.30 ~~148E.255 to 148E.270 against a licensee whose license is inactive who is issued an~~
377.31 ~~alternate license specified in this section based on conduct occurring before the license is~~
377.32 ~~inactive or conduct occurring while the license is inactive effective.~~

377.33 Sec. 16. Minnesota Statutes 2014, section 148E.080, subdivision 1, is amended to read:

377.34 Subdivision 1. **Mailing notices to licensees on temporary leave.** The board must
377.35 mail a notice for reactivation to a licensee on temporary leave at least 45 days before the

378.1 expiration date of the license according to section 148E.075, subdivision ~~4~~ 1. Mailing
378.2 the notice by United States mail to the licensee's last known mailing address constitutes
378.3 valid mailing. Failure to receive the reactivation notice does not relieve a licensee of the
378.4 obligation to comply with the provisions of this section to reactivate a license.

378.5 Sec. 17. Minnesota Statutes 2014, section 148E.080, subdivision 2, is amended to read:

378.6 Subd. 2. **Reactivation from a temporary leave or emeritus status.** To reactivate a
378.7 license from a temporary leave or emeritus status, a licensee must do the following within
378.8 the time period specified in section 148E.075, subdivisions ~~4 and 5~~ 1, 1a, and 1b:

378.9 (1) complete an application form specified by the board;

378.10 (2) document compliance with the continuing education requirements specified in
378.11 subdivision 4;

378.12 (3) submit a supervision plan, if required;

378.13 (4) pay the reactivation of ~~an inactive licensee~~ a license fee specified in section
378.14 148E.180; and

378.15 (5) pay the wall certificate fee according to section 148E.095, subdivision 1,
378.16 paragraph (b) or (c), if the licensee needs a duplicate license.

378.17 Sec. 18. Minnesota Statutes 2014, section 148E.180, subdivision 2, is amended to read:

378.18 Subd. 2. **License fees.** License fees are as follows:

378.19 (1) for a licensed social worker, \$81;

378.20 (2) for a licensed graduate social worker, \$144;

378.21 (3) for a licensed independent social worker, \$216;

378.22 (4) for a licensed independent clinical social worker, \$238.50;

378.23 (5) for an emeritus inactive license, \$43.20; ~~and~~

378.24 (6) for an emeritus active license, one-half of the renewal fee specified in subdivision
378.25 3; and

378.26 (7) for a temporary leave fee, the same as the renewal fee specified in subdivision 3.

378.27 If the licensee's initial license term is less or more than 24 months, the required
378.28 license fees must be prorated proportionately.

378.29 Sec. 19. Minnesota Statutes 2014, section 148E.180, subdivision 5, is amended to read:

378.30 Subd. 5. **Late fees.** Late fees are as follows:

378.31 (1) renewal late fee, one-fourth of the renewal fee specified in subdivision 3; ~~and~~

378.32 (2) supervision plan late fee, \$40-; and

379.1 (3) license late fee, \$100 plus the prorated share of the license fee specified in
 379.2 subdivision 2 for the number of months during which the individual practiced social
 379.3 work without a license.

379.4 Sec. 20. Minnesota Statutes 2014, section 150A.091, subdivision 4, is amended to read:

379.5 Subd. 4. **Annual license fees.** Each limited faculty or resident dentist shall submit
 379.6 with an annual license renewal application a fee established by the board not to exceed
 379.7 the following amounts:

- 379.8 (1) limited faculty dentist, \$168; and
 379.9 (2) resident dentist or dental provider, ~~\$59~~ \$85.

379.10 Sec. 21. Minnesota Statutes 2014, section 150A.091, subdivision 5, is amended to read:

379.11 Subd. 5. **Biennial license or permit fees.** Each of the following applicants shall
 379.12 submit with a biennial license or permit renewal application a fee as established by the
 379.13 board, not to exceed the following amounts:

- 379.14 (1) dentist or full faculty dentist, ~~\$336~~ \$475;
 379.15 (2) dental therapist, ~~\$180~~ \$300;
 379.16 (3) dental hygienist, ~~\$118~~ \$200;
 379.17 (4) licensed dental assistant, ~~\$80~~ \$150; and
 379.18 (5) dental assistant with a permit as described in Minnesota Rules, part 3100.8500,
 379.19 subpart 3, \$24.

379.20 Sec. 22. Minnesota Statutes 2014, section 150A.091, subdivision 11, is amended to read:

379.21 Subd. 11. **Certificate application fee for anesthesia/sedation.** Each dentist
 379.22 shall submit with a general anesthesia or moderate sedation application ~~or~~ a contracted
 379.23 sedation provider application, or biennial renewal, a fee as established by the board not to
 379.24 exceed the following amounts:

- 379.25 (1) for both a general anesthesia and moderate sedation application, ~~\$250~~ \$400;
 379.26 (2) for a general anesthesia application only, ~~\$250~~ \$400;
 379.27 (3) for a moderate sedation application only, ~~\$250~~ \$400; and
 379.28 (4) for a contracted sedation provider application, ~~\$250~~ \$400.

379.29 Sec. 23. Minnesota Statutes 2014, section 150A.091, is amended by adding a
 379.30 subdivision to read:

380.1 Subd. 17. **Advanced dental therapy examination fee.** Any dental therapist eligible
380.2 to sit for the advanced dental therapy certification examination must submit with the
380.3 application a fee as established by the board, not to exceed \$250.

380.4 Sec. 24. Minnesota Statutes 2014, section 150A.091, is amended by adding a
380.5 subdivision to read:

380.6 Subd. 18. **Corporation or professional firm late fee.** Any corporation or
380.7 professional firm whose annual fee is not postmarked or otherwise received by the board
380.8 by the due date of December 31 shall, in addition to the fee, submit a late fee as established
380.9 by the board, not to exceed \$15.

380.10 Sec. 25. Minnesota Statutes 2014, section 150A.31, is amended to read:

380.11 **150A.31 FEES.**

380.12 (a) The initial biennial registration fee is \$50.

380.13 (b) The biennial renewal registration fee is ~~\$25~~ not to exceed \$80.

380.14 (c) The fees specified in this section are nonrefundable and shall be deposited in
380.15 the state government special revenue fund.

380.16 Sec. 26. Minnesota Statutes 2014, section 151.01, subdivision 15a, is amended to read:

380.17 Subd. 15a. **Pharmacy technician.** "Pharmacy technician" means a person not
380.18 licensed as a pharmacist or registered as a pharmacist intern, who assists the pharmacist
380.19 in the preparation and dispensing of medications by performing computer entry of
380.20 prescription data and other manipulative tasks. A pharmacy technician shall not perform
380.21 tasks specifically reserved to a licensed pharmacist or requiring has been trained in
380.22 pharmacy tasks that do not require the professional judgment of a licensed pharmacist. A
380.23 pharmacy technician may not perform tasks specifically reserved to a licensed pharmacist.

380.24 Sec. 27. Minnesota Statutes 2014, section 151.01, subdivision 27, is amended to read:

380.25 Subd. 27. **Practice of pharmacy.** "Practice of pharmacy" means:

380.26 (1) interpretation and evaluation of prescription drug orders;

380.27 (2) compounding, labeling, and dispensing drugs and devices (except labeling by
380.28 a manufacturer or packager of nonprescription drugs or commercially packaged legend
380.29 drugs and devices);

380.30 (3) participation in clinical interpretations and monitoring of drug therapy for
380.31 assurance of safe and effective use of drugs, including the performance of laboratory tests
380.32 that are waived under the federal Clinical Laboratory Improvement Act of 1988, United

381.1 States Code, title 42, section 263a et seq., provided that a pharmacist may interpret the
381.2 results of laboratory tests but may modify drug therapy only pursuant to a protocol or
381.3 collaborative practice agreement;

381.4 (4) participation in drug and therapeutic device selection; drug administration for first
381.5 dosage and medical emergencies; drug regimen reviews; and drug or drug-related research;

381.6 (5) participation in administration of influenza vaccines to all eligible individuals ~~ten~~
381.7 six years of age and older and all other vaccines to patients ~~18~~ 13 years of age and older
381.8 by written protocol with a physician licensed under chapter 147, a physician assistant
381.9 authorized to prescribe drugs under chapter 147A, or an advanced practice registered
381.10 nurse authorized to prescribe drugs under section 148.235, provided that:

381.11 (i) the protocol includes, at a minimum:

381.12 (A) the name, dose, and route of each vaccine that may be given;

381.13 (B) the patient population for whom the vaccine may be given;

381.14 (C) contraindications and precautions to the vaccine;

381.15 (D) the procedure for handling an adverse reaction;

381.16 (E) the name, signature, and address of the physician, physician assistant, or
381.17 advanced practice registered nurse;

381.18 (F) a telephone number at which the physician, physician assistant, or advanced
381.19 practice registered nurse can be contacted; and

381.20 (G) the date and time period for which the protocol is valid;

381.21 (ii) the pharmacist has successfully completed a program approved by the
381.22 Accreditation Council for Pharmacy Education specifically for the administration of
381.23 immunizations or a program approved by the board;

381.24 (iii) the pharmacist utilizes the Minnesota Immunization Information Connection
381.25 to assess the immunization status of individuals prior to the administration of vaccines,
381.26 except when administering influenza vaccines to individuals age nine and older;

381.27 (iv) the pharmacist reports the administration of the immunization ~~to the patient's~~
381.28 ~~primary physician or clinic~~ or to the Minnesota Immunization Information Connection; and

381.29 ~~(iv)~~ (v) the pharmacist complies with guidelines for vaccines and immunizations
381.30 established by the federal Advisory Committee on Immunization Practices, except that a
381.31 pharmacist does not need to comply with those portions of the guidelines that establish
381.32 immunization schedules when administering a vaccine pursuant to a valid, patient-specific
381.33 order issued by a physician licensed under chapter 147, a physician assistant authorized to
381.34 prescribe drugs under chapter 147A, or an advanced practice nurse authorized to prescribe
381.35 drugs under section 148.235, provided that the order is consistent with the United States
381.36 Food and Drug Administration approved labeling of the vaccine;

- 382.1 (6) participation in the initiation, management, modification, and discontinuation
 382.2 of drug therapy according to a written protocol or collaborative practice agreement
 382.3 between: (i) one or more pharmacists and one or more dentists, optometrists, physicians,
 382.4 podiatrists, or veterinarians; or (ii) one or more pharmacists and one or more physician
 382.5 assistants authorized to prescribe, dispense, and administer under chapter 147A, or
 382.6 advanced practice nurses authorized to prescribe, dispense, and administer under section
 382.7 148.235. Any changes in drug therapy made pursuant to a protocol or collaborative
 382.8 practice agreement must be documented by the pharmacist in the patient's medical record
 382.9 or reported by the pharmacist to a practitioner responsible for the patient's care;
- 382.10 (7) participation in the storage of drugs and the maintenance of records;
- 382.11 (8) patient counseling on therapeutic values, content, hazards, and uses of drugs
 382.12 and devices; and
- 382.13 (9) offering or performing those acts, services, operations, or transactions necessary
 382.14 in the conduct, operation, management, and control of a pharmacy.

382.15 Sec. 28. Minnesota Statutes 2014, section 151.02, is amended to read:

382.16 **151.02 STATE BOARD OF PHARMACY.**

382.17 The Minnesota State Board of Pharmacy shall consist of ~~two~~ three public members
 382.18 as defined by section 214.02 and ~~five~~ six pharmacists actively engaged in the practice of
 382.19 pharmacy in this state. Each of said pharmacists shall have had at least five consecutive
 382.20 years of practical experience as a pharmacist immediately preceding appointment.

382.21 Sec. 29. Minnesota Statutes 2014, section 151.065, subdivision 1, is amended to read:

382.22 Subdivision 1. **Application fees.** Application fees for licensure and registration
 382.23 are as follows:

- 382.24 (1) pharmacist licensed by examination, ~~\$130~~ \$145;
- 382.25 (2) pharmacist licensed by reciprocity, ~~\$225~~ \$240;
- 382.26 (3) pharmacy intern, ~~\$30~~ \$37.50;
- 382.27 (4) pharmacy technician, ~~\$30~~ \$37.50;
- 382.28 (5) pharmacy, ~~\$190~~ \$225;
- 382.29 (6) drug wholesaler, legend drugs only, ~~\$200~~ \$235;
- 382.30 (7) drug wholesaler, legend and nonlegend drugs, ~~\$200~~ \$235;
- 382.31 (8) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, ~~\$175~~ \$210;
- 382.32 (9) drug wholesaler, medical gases, ~~\$150~~ \$175;
- 382.33 (10) drug wholesaler, also licensed as a pharmacy in Minnesota, ~~\$125~~ \$150;
- 382.34 (11) drug manufacturer, legend drugs only, ~~\$200~~ \$235;

- 383.1 (12) drug manufacturer, legend and nonlegend drugs, ~~\$200~~ \$235;
- 383.2 (13) drug manufacturer, nonlegend or veterinary legend drugs, ~~\$175~~ \$210;
- 383.3 (14) drug manufacturer, medical gases, ~~\$150~~ \$185;
- 383.4 (15) drug manufacturer, also licensed as a pharmacy in Minnesota, ~~\$125~~ \$150;
- 383.5 (16) medical gas distributor, ~~\$75~~ \$110;
- 383.6 (17) controlled substance researcher, ~~\$50~~ \$75; and
- 383.7 (18) pharmacy professional corporation, ~~\$100~~ \$125.

383.8 Sec. 30. Minnesota Statutes 2014, section 151.065, subdivision 2, is amended to read:

383.9 Subd. 2. **Original license fee.** The pharmacist original licensure fee, ~~\$130~~ \$145.

383.10 Sec. 31. Minnesota Statutes 2014, section 151.065, subdivision 3, is amended to read:

383.11 Subd. 3. **Annual renewal fees.** Annual licensure and registration renewal fees
383.12 are as follows:

- 383.13 (1) pharmacist, ~~\$130~~ \$145;
- 383.14 (2) pharmacy technician, ~~\$30~~ \$37.50;
- 383.15 (3) pharmacy, ~~\$190~~ \$225;
- 383.16 (4) drug wholesaler, legend drugs only, ~~\$200~~ \$235;
- 383.17 (5) drug wholesaler, legend and nonlegend drugs, ~~\$200~~ \$235;
- 383.18 (6) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, ~~\$175~~ \$210;
- 383.19 (7) drug wholesaler, medical gases, ~~\$150~~ \$185;
- 383.20 (8) drug wholesaler, also licensed as a pharmacy in Minnesota, ~~\$125~~ \$150;
- 383.21 (9) drug manufacturer, legend drugs only, ~~\$200~~ \$235;
- 383.22 (10) drug manufacturer, legend and nonlegend drugs, ~~\$200~~ \$235;
- 383.23 (11) drug manufacturer, nonlegend, veterinary legend drugs, or both, ~~\$175~~ \$210;
- 383.24 (12) drug manufacturer, medical gases, ~~\$150~~ \$185;
- 383.25 (13) drug manufacturer, also licensed as a pharmacy in Minnesota, ~~\$125~~ \$150;
- 383.26 (14) medical gas distributor, ~~\$75~~ \$110;
- 383.27 (15) controlled substance researcher, ~~\$50~~ \$75; and
- 383.28 (16) pharmacy professional corporation, ~~\$45~~ \$75.

383.29 Sec. 32. Minnesota Statutes 2014, section 151.065, subdivision 4, is amended to read:

383.30 Subd. 4. **Miscellaneous fees.** Fees for issuance of affidavits and duplicate licenses
383.31 and certificates are as follows:

- 383.32 (1) intern affidavit, ~~\$15~~ \$20;
- 383.33 (2) duplicate small license, ~~\$15~~ \$20; and

384.1 (3) duplicate large certificate, ~~\$25~~ \$30.

384.2 Sec. 33. Minnesota Statutes 2014, section 151.102, is amended to read:

384.3 **151.102 PHARMACY TECHNICIAN.**

384.4 Subdivision 1. **General.** A pharmacy technician may assist a pharmacist in the
 384.5 practice of pharmacy by performing ~~nonjudgmental~~ tasks and that are not reserved to, and
 384.6 do not require the professional judgment of, a licensed pharmacist. A pharmacy technician
 384.7 works under the personal and direct supervision of the pharmacist. A pharmacist may
 384.8 supervise ~~two~~ up to three technicians, ~~as long as the~~. A pharmacist assumes responsibility
 384.9 is responsible for all the functions work performed by the technicians who are under the
 384.10 supervision of the pharmacist. A pharmacy may exceed the ratio of pharmacy technicians
 384.11 to pharmacists permitted in this subdivision or in rule by a total of one technician at
 384.12 any given time in the pharmacy, provided at least one technician in the pharmacy
 384.13 holds a valid certification from the Pharmacy Technician Certification Board or from
 384.14 another national certification body for pharmacy technicians that requires passage of a
 384.15 nationally recognized, psychometrically valid certification examination for certification as
 384.16 determined by the Board of Pharmacy. The Board of Pharmacy may, by rule, set ratios of
 384.17 technicians to pharmacists greater than ~~two~~ three to one for the functions specified in rule.
 384.18 ~~The delegation of any duties, tasks, or functions by a pharmacist to a pharmacy technician~~
 384.19 ~~is subject to continuing review and becomes the professional and personal responsibility of~~
 384.20 ~~the pharmacist who directed the pharmacy technician to perform the duty, task, or function.~~

384.21 Subd. 2. **Waivers by board permitted.** A pharmacist in charge in a pharmacy may
 384.22 petition the board for authorization to allow a pharmacist to supervise more than ~~two~~ three
 384.23 pharmacy technicians. The pharmacist's petition must include provisions addressing ~~the~~
 384.24 ~~maintenance of~~ how patient care and safety will be maintained. A petition filed with the
 384.25 board under this subdivision shall be deemed approved 90 days after the board receives
 384.26 the petition, unless the board denies the petition within 90 days of receipt and notifies the
 384.27 petitioning pharmacist of the petition's denial and the board's reasons for denial.

384.28 Subd. 3. **Registration fee.** The board shall not register an individual as a pharmacy
 384.29 technician unless all applicable fees specified in section 151.065 have been paid.

384.30 Sec. 34. **REPEALER.**

384.31 Minnesota Statutes 2014, sections 148.57, subdivisions 3 and 4; 148.571; 148.572;
 384.32 148.573, subdivision 1; 148.575, subdivisions 1, 3, 5, and 6; 148.576; 148E.060,
 384.33 subdivision 12; and 148E.075, subdivisions 4, 5, 6, and 7, are repealed.

385.1 **ARTICLE 11**

385.2 **HEALTH CARE**

385.3 Section 1. Minnesota Statutes 2014, section 62A.045, is amended to read:

385.4 **62A.045 PAYMENTS ON BEHALF OF ENROLLEES IN GOVERNMENT**
385.5 **HEALTH PROGRAMS.**

385.6 (a) As a condition of doing business in Minnesota or providing coverage to
385.7 residents of Minnesota covered by this section, each health insurer shall comply with the
385.8 requirements of the federal Deficit Reduction Act of 2005, Public Law 109-171, including
385.9 any federal regulations adopted under that act, to the extent that it imposes a requirement
385.10 that applies in this state and that is not also required by the laws of this state. This section
385.11 does not require compliance with any provision of the federal act prior to the effective date
385.12 provided for that provision in the federal act. The commissioner shall enforce this section.

385.13 For the purpose of this section, "health insurer" includes self-insured plans, group
385.14 health plans (as defined in section 607(1) of the Employee Retirement Income Security
385.15 Act of 1974), service benefit plans, managed care organizations, pharmacy benefit
385.16 managers, or other parties that are by contract legally responsible to pay a claim for a
385.17 health-care item or service for an individual receiving benefits under paragraph (b).

385.18 (b) No plan offered by a health insurer issued or renewed to provide coverage to
385.19 a Minnesota resident shall contain any provision denying or reducing benefits because
385.20 services are rendered to a person who is eligible for or receiving medical benefits pursuant
385.21 to title XIX of the Social Security Act (Medicaid) in this or any other state; chapter 256;
385.22 256B; or 256D or services pursuant to section 252.27; 256L.01 to 256L.10; 260B.331,
385.23 subdivision 2; 260C.331, subdivision 2; or 393.07, subdivision 1 or 2. No health insurer
385.24 providing benefits under plans covered by this section shall use eligibility for medical
385.25 programs named in this section as an underwriting guideline or reason for nonacceptance
385.26 of the risk.

385.27 (c) If payment for covered expenses has been made under state medical programs for
385.28 health care items or services provided to an individual, and a third party has a legal liability
385.29 to make payments, the rights of payment and appeal of an adverse coverage decision for the
385.30 individual, or in the case of a child their responsible relative or caretaker, will be subrogated
385.31 to the state agency. The state agency may assert its rights under this section within three
385.32 years of the date the service was rendered. For purposes of this section, "state agency"
385.33 includes prepaid health plans under contract with the commissioner according to sections
385.34 256B.69, 256D.03, subdivision 4, paragraph (c), and 256L.12; children's mental health
385.35 collaboratives under section 245.493; demonstration projects for persons with disabilities

386.1 under section 256B.77; nursing homes under the alternative payment demonstration project
386.2 under section 256B.434; and county-based purchasing entities under section 256B.692.

386.3 (d) Notwithstanding any law to the contrary, when a person covered by a plan
386.4 offered by a health insurer receives medical benefits according to any statute listed in this
386.5 section, payment for covered services or notice of denial for services billed by the provider
386.6 must be issued directly to the provider. If a person was receiving medical benefits through
386.7 the Department of Human Services at the time a service was provided, the provider must
386.8 indicate this benefit coverage on any claim forms submitted by the provider to the health
386.9 insurer for those services. If the commissioner of human services notifies the health
386.10 insurer that the commissioner has made payments to the provider, payment for benefits or
386.11 notices of denials issued by the health insurer must be issued directly to the commissioner.
386.12 Submission by the department to the health insurer of the claim on a Department of
386.13 Human Services claim form is proper notice and shall be considered proof of payment of
386.14 the claim to the provider and supersedes any contract requirements of the health insurer
386.15 relating to the form of submission. Liability to the insured for coverage is satisfied to the
386.16 extent that payments for those benefits are made by the health insurer to the provider or
386.17 the commissioner as required by this section.

386.18 (e) When a state agency has acquired the rights of an individual eligible for medical
386.19 programs named in this section and has health benefits coverage through a health insurer,
386.20 the health insurer shall not impose requirements that are different from requirements
386.21 applicable to an agent or assignee of any other individual covered.

386.22 (f) A health insurer must process a clean claim made by a state agency for covered
386.23 expenses paid under state medical programs within 90 business days of the claim's
386.24 submission. A health insurer must process all other claims made by a state agency for
386.25 covered expenses paid under a state medical program within the timeline set forth in Code
386.26 of Federal Regulations, title 42, section 447.45(d)(4).

386.27 (g) A health insurer may request a refund of a claim paid in error to the Department
386.28 of Human Services within two years of the date the payment was made to the department.
386.29 A request for a refund shall not be honored by the department if the health insurer makes
386.30 the request after the time period has lapsed.

386.31 Sec. 2. Minnesota Statutes 2014, section 150A.06, subdivision 1b, is amended to read:

386.32 Subd. 1b. **Resident dentists.** A person who is a graduate of a dental school and
386.33 is an enrolled graduate student or student of an accredited advanced dental education
386.34 program and who is not licensed to practice dentistry in the state shall obtain from the
386.35 board a license to practice dentistry as a resident dentist. The license must be designated

387.1 "resident dentist license" and authorizes the licensee to practice dentistry only under the
387.2 supervision of a licensed dentist. A University of Minnesota School of Dentistry dental
387.3 resident holding a resident dentist license is eligible for enrollment in medical assistance,
387.4 as provided under section 256B.0625, subdivision 9b. A resident dentist license must be
387.5 renewed annually pursuant to the board's rules. An applicant for a resident dentist license
387.6 shall pay a nonrefundable fee set by the board for issuing and renewing the license. The
387.7 requirements of sections 150A.01 to 150A.21 apply to resident dentists except as specified
387.8 in rules adopted by the board. A resident dentist license does not qualify a person for
387.9 licensure under subdivision 1.

387.10 Sec. 3. Minnesota Statutes 2014, section 174.29, subdivision 1, is amended to read:

387.11 Subdivision 1. **Definition.** For the purpose of sections 174.29 and 174.30 "special
387.12 transportation service" means motor vehicle transportation provided on a regular basis
387.13 by a public or private entity or person that is designed exclusively or primarily to serve
387.14 individuals who are elderly or disabled and who are unable to use regular means of
387.15 transportation but do not require ambulance service, as defined in section 144E.001,
387.16 subdivision 3. Special transportation service includes but is not limited to service provided
387.17 by specially equipped buses, vans, taxis, and volunteers driving private automobiles.
387.18 Special transportation service also means those nonemergency medical transportation
387.19 services under section 256B.0625, subdivision 17, that are subject to the operating
387.20 standards for special transportation service under sections 174.29 to 174.30 and Minnesota
387.21 Rules, chapter 8840.

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

387.23 Sec. 4. Minnesota Statutes 2014, section 174.30, subdivision 3, is amended to read:

387.24 Subd. 3. **Other standards; wheelchair securement; protected transport.** (a) A
387.25 special transportation service that transports individuals occupying wheelchairs is subject
387.26 to the provisions of sections 299A.11 to 299A.18 concerning wheelchair securement
387.27 devices. The commissioners of transportation and public safety shall cooperate in the
387.28 enforcement of this section and sections 299A.11 to 299A.18 so that a single inspection
387.29 is sufficient to ascertain compliance with sections 299A.11 to 299A.18 and with the
387.30 standards adopted under this section. Representatives of the Department of Transportation
387.31 may inspect wheelchair securement devices in vehicles operated by special transportation
387.32 service providers to determine compliance with sections 299A.11 to 299A.18 and to issue
387.33 certificates under section 299A.14, subdivision 4.

388.1 (b) In place of a certificate issued under section 299A.14, the commissioner may
388.2 issue a decal under subdivision 4 for a vehicle equipped with a wheelchair securement
388.3 device if the device complies with sections 299A.11 to 299A.18 and the decal displays the
388.4 information in section 299A.14, subdivision 4.

388.5 (c) For vehicles designated as protected transport under section 256B.0625,
388.6 subdivision 17, paragraph (h), the commissioner of transportation, during the
388.7 commissioner's inspection, shall check to ensure the safety provisions contained in that
388.8 paragraph are in working order.

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

388.10 Sec. 5. Minnesota Statutes 2014, section 174.30, subdivision 4, is amended to read:

388.11 Subd. 4. **Vehicle and equipment inspection; rules; decal; complaint contact**
388.12 **information; restrictions on name of service.** (a) The commissioner shall inspect or
388.13 provide for the inspection of vehicles at least annually. In addition to scheduled annual
388.14 inspections and reinspections scheduled for the purpose of verifying that deficiencies have
388.15 been corrected, unannounced inspections of any vehicle may be conducted.

388.16 (b) On determining that a vehicle or vehicle equipment is in a condition that is likely
388.17 to cause an accident or breakdown, the commissioner shall require the vehicle to be taken
388.18 out of service immediately. The commissioner shall require that vehicles and equipment
388.19 not meeting standards be repaired and brought into conformance with the standards
388.20 and shall require written evidence of compliance from the operator before allowing the
388.21 operator to return the vehicle to service.

388.22 (c) The commissioner shall provide in the rules procedures for inspecting vehicles,
388.23 removing unsafe vehicles from service, determining and requiring compliance, and
388.24 reviewing driver qualifications.

388.25 (d) The commissioner shall design a distinctive decal to be issued to special
388.26 transportation service providers with a current certificate of compliance under this section.
388.27 A decal is valid for one year from the last day of the month in which it is issued. A person
388.28 who is subject to the operating standards adopted under this section may not provide
388.29 special transportation service in a vehicle that does not conspicuously display a decal
388.30 issued by the commissioner.

388.31 (e) All special transportation service providers shall pay an annual fee of \$45
388.32 to obtain a decal. Providers of ambulance service, as defined in section 144E.001,
388.33 subdivision 3, are exempt from the annual fee. Fees collected under this paragraph must
388.34 be deposited in the trunk highway fund, and are appropriated to the commissioner to pay
388.35 for costs related to administering the special transportation service program.

389.1 (f) Special transportation service providers shall prominently display in each vehicle
389.2 all contact information for the submission of complaints regarding the transportation
389.3 services provided to that individual. All vehicles providing service under section
389.4 473.386 shall display contact information for the Metropolitan Council. All other special
389.5 transportation service vehicles shall display contact information for the commissioner of
389.6 transportation.

389.7 (g) Nonemergency medical transportation providers must comply with Minnesota
389.8 Rules, part 8840.5450, except that a provider may use the phrase "nonemergency medical
389.9 transportation" in its name or in advertisements or information describing the service.

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

389.11 Sec. 6. Minnesota Statutes 2014, section 174.30, is amended by adding a subdivision
389.12 to read:

389.13 Subd. 4b. **Variance from the standards.** A nonemergency medical transportation
389.14 provider who was not subject to the standards in this section prior to July 1, 2014, must
389.15 apply for a variance from the commissioner if the provider cannot meet the standards
389.16 by January 1, 2017. The commissioner may grant or deny the variance application.
389.17 Variances, if granted, shall not exceed 60 days unless extended by the commissioner.

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

389.19 Sec. 7. Minnesota Statutes 2014, section 174.30, is amended by adding a subdivision
389.20 to read:

389.21 Subd. 10. **Background studies.** (a) Providers of special transportation service
389.22 regulated under this section must initiate background studies in accordance with chapter
389.23 245C on the following individuals:

389.24 (1) each person with a direct or indirect ownership interest of five percent or higher
389.25 in the transportation service provider;

389.26 (2) each controlling individual as defined under section 245A.02;

389.27 (3) managerial officials as defined in section 245A.02;

389.28 (4) each driver employed by the transportation service provider;

389.29 (5) each individual employed by the transportation service provider to assist a
389.30 passenger during transport; and

389.31 (6) all employees of the transportation service agency who provide administrative
389.32 support, including those who:

390.1 (i) may have face-to-face contact with or access to passengers, their personal
390.2 property, or their private data;

390.3 (ii) perform any scheduling or dispatching tasks; or

390.4 (iii) perform any billing activities.

390.5 (b) The transportation service provider must initiate the background studies required
390.6 under paragraph (a) using the online NETStudy system operated by the commissioner
390.7 of human services.

390.8 (c) The transportation service provider shall not permit any individual to provide
390.9 any service listed in paragraph (a) until the transportation service provider has received
390.10 notification from the commissioner of human services indicating that the individual:

390.11 (1) is not disqualified under chapter 245C; or

390.12 (2) is disqualified, but has received a set-aside of that disqualification according to
390.13 section 245C.23 related to that transportation service provider.

390.14 (d) When a local or contracted agency is authorizing a ride under section 256B.0625,
390.15 subdivision 17, by a volunteer driver, and the agency authorizing the ride has reason
390.16 to believe the volunteer driver has a history that would disqualify the individual or
390.17 that may pose a risk to the health or safety of passengers, the agency may initiate a
390.18 background study to be completed according to chapter 245C using the commissioner
390.19 of human services' online NETStudy system, or through contacting the Department of
390.20 Human Services background study division for assistance. The agency that initiates the
390.21 background study under this paragraph shall be responsible for providing the volunteer
390.22 driver with the privacy notice required under section 245C.05, subdivision 2c, and
390.23 payment for the background study required under section 245C.10, subdivision 11, before
390.24 the background study is completed.

390.25 **EFFECTIVE DATE.** This section is effective January 1, 2016.

390.26 Sec. 8. Minnesota Statutes 2014, section 245C.03, is amended by adding a subdivision
390.27 to read:

390.28 Subd. 11. **Providers of special transportation service.** The commissioner shall
390.29 conduct background studies on any individual required under section 174.30 to have a
390.30 background study completed under this chapter.

390.31 **EFFECTIVE DATE.** This section is effective January 1, 2016.

390.32 Sec. 9. Minnesota Statutes 2014, section 245C.10, is amended by adding a subdivision
390.33 to read:

391.1 Subd. 12. Providers of special transportation service. The commissioner shall
391.2 recover the cost of background studies initiated by providers of special transportation
391.3 service under section 174.30 through a fee of no more than \$20 per study. The fees
391.4 collected under this subdivision are appropriated to the commissioner for the purpose of
391.5 conducting background studies.

391.6 **EFFECTIVE DATE.** This section is effective January 1, 2016.

391.7 Sec. 10. Minnesota Statutes 2014, section 256.015, subdivision 7, is amended to read:

391.8 Subd. 7. **Cooperation with information requests required.** (a) Upon the request
391.9 of the commissioner of human services:

391.10 (1) any state agency or third-party payer shall cooperate by furnishing information to
391.11 help establish a third-party liability, as required by the federal Deficit Reduction Act of
391.12 2005, Public Law 109-171;

391.13 (2) any employer or third-party payer shall cooperate by furnishing a data file
391.14 containing information about group health insurance plan or medical benefit plan coverage
391.15 of its employees or insureds within 60 days of the request. The information in the data file
391.16 must include at least the following: full name, date of birth, Social Security number if
391.17 collected and stored in a system routinely used for producing data files by the employer
391.18 or third-party payer, employer name, policy identification number, group identification
391.19 number, and plan or coverage type.

391.20 (b) For purposes of section 176.191, subdivision 4, the commissioner of labor and
391.21 industry may allow the commissioner of human services and county agencies direct access
391.22 and data matching on information relating to workers' compensation claims in order to
391.23 determine whether the claimant has reported the fact of a pending claim and the amount
391.24 paid to or on behalf of the claimant to the commissioner of human services.

391.25 (c) For the purpose of compliance with section 169.09, subdivision 13, and
391.26 federal requirements under Code of Federal Regulations, title 42, section 433.138

391.27 (d)(4), the commissioner of public safety shall provide accident data as requested by
391.28 the commissioner of human services. The disclosure shall not violate section 169.09,
391.29 subdivision 13, paragraph (d).

391.30 (d) The commissioner of human services and county agencies shall limit its use of
391.31 information gained from agencies, third-party payers, and employers to purposes directly
391.32 connected with the administration of its public assistance and child support programs. The
391.33 provision of information by agencies, third-party payers, and employers to the department
391.34 under this subdivision is not a violation of any right of confidentiality or data privacy.

392.1 Sec. 11. Minnesota Statutes 2014, section 256.969, subdivision 1, is amended to read:

392.2 Subdivision 1. **Hospital cost index.** (a) The hospital cost index shall be the change
392.3 in the ~~Consumer Price Index-All Items (United States city average) (CPI-U) forecasted~~
392.4 ~~by Data Resources, Inc.~~ Centers for Medicare and Medicaid Services Inpatient Hospital
392.5 Market Basket. The commissioner shall use the indices as forecasted ~~in the third quarter~~
392.6 ~~of the calendar year prior to the rate year.~~ The hospital cost index may be used to adjust
392.7 the base year operating payment rate through the rate year on an annually compounded
392.8 basis for the midpoint of the prior rate year to the midpoint of the current rate year.

392.9 (b) For fiscal years beginning on or after July 1, 1993, the commissioner of human
392.10 services shall not provide automatic annual inflation adjustments for hospital payment
392.11 rates under medical assistance. ~~The commissioner of management and budget shall~~
392.12 ~~include as a budget change request in each biennial detailed expenditure budget submitted~~
392.13 ~~to the legislature under section 16A.11 annual adjustments in hospital payment rates under~~
392.14 ~~medical assistance based upon the hospital cost index.~~

392.15 Sec. 12. Minnesota Statutes 2014, section 256.969, subdivision 2b, is amended to read:

392.16 Subd. 2b. **Hospital payment rates.** (a) For discharges occurring on or after
392.17 November 1, 2014, hospital inpatient services for hospitals located in Minnesota shall be
392.18 paid according to the following:

392.19 (1) critical access hospitals as defined by Medicare shall be paid using a cost-based
392.20 methodology;

392.21 (2) long-term hospitals as defined by Medicare shall be paid on a per diem
392.22 methodology under subdivision 25;

392.23 (3) rehabilitation hospitals or units of hospitals that are recognized as rehabilitation
392.24 distinct parts as defined by Medicare shall be paid according to the methodology under
392.25 subdivision 12; and

392.26 (4) all other hospitals shall be paid on a diagnosis-related group (DRG) methodology.

392.27 (b) For the period beginning January 1, 2011, through October 31, 2014, rates shall
392.28 not be rebased, except that a Minnesota long-term hospital shall be rebased effective
392.29 January 1, 2011, based on its most recent Medicare cost report ending on or before
392.30 September 1, 2008, with the provisions under subdivisions 9 and 23, based on the rates
392.31 in effect on December 31, 2010. For rate setting periods after November 1, 2014, in
392.32 which the base years are updated, a Minnesota long-term hospital's base year shall remain
392.33 within the same period as other hospitals.

392.34 (c) Effective for discharges occurring on and after November 1, 2014, payment rates
392.35 for hospital inpatient services provided by hospitals located in Minnesota or the local trade

393.1 area, except for the hospitals paid under the methodologies described in paragraph (a),
393.2 clauses (2) and (3), shall be rebased, incorporating cost and payment methodologies in a
393.3 manner similar to Medicare. The base year for the rates effective November 1, 2014, shall
393.4 be calendar year 2012. The rebasing under this paragraph shall be budget neutral, ensuring
393.5 that the total aggregate payments under the rebased system are equal to the total aggregate
393.6 payments that were made for the same number and types of services in the base year.
393.7 Separate budget neutrality calculations shall be determined for payments made to critical
393.8 access hospitals and payments made to hospitals paid under the DRG system. Only the rate
393.9 increases or decreases under subdivision 3a or 3c that applied to the hospitals being rebased
393.10 during the entire base period shall be incorporated into the budget neutrality calculation.

393.11 (d) For discharges occurring on or after November 1, 2014, through ~~June 30, 2016~~
393.12 the next rebasing that occurs, the rebased rates under paragraph (c) that apply to hospitals
393.13 under paragraph (a), clause (4), shall include adjustments to the projected rates that result
393.14 in no greater than a five percent increase or decrease from the base year payments for any
393.15 hospital. Any adjustments to the rates made by the commissioner under this paragraph and
393.16 paragraph (e) shall maintain budget neutrality as described in paragraph (c).

393.17 (e) For discharges occurring on or after November 1, 2014, through ~~June 30, 2016~~,
393.18 the next rebasing that occurs the commissioner may make additional adjustments to the
393.19 rebased rates, and when evaluating whether additional adjustments should be made, the
393.20 commissioner shall consider the impact of the rates on the following:

- 393.21 (1) pediatric services;
- 393.22 (2) behavioral health services;
- 393.23 (3) trauma services as defined by the National Uniform Billing Committee;
- 393.24 (4) transplant services;
- 393.25 (5) obstetric services, newborn services, and behavioral health services provided
393.26 by hospitals outside the seven-county metropolitan area;
- 393.27 (6) outlier admissions;
- 393.28 (7) low-volume providers; and
- 393.29 (8) services provided by small rural hospitals that are not critical access hospitals.

393.30 (f) Hospital payment rates established under paragraph (c) must incorporate the
393.31 following:

393.32 (1) for hospitals paid under the DRG methodology, the base year payment rate per
393.33 admission is standardized by the applicable Medicare wage index and adjusted by the
393.34 hospital's disproportionate population adjustment;

393.35 (2) for critical access hospitals, ~~interim per diem~~ payment rates for discharges
393.36 between November 1, 2014, and June 30, 2015, shall be ~~based on the ratio of cost~~

394.1 ~~and charges reported on the base year Medicare cost report or reports and applied to~~
394.2 ~~medical assistance utilization data. Final settlement payments for a state fiscal year must~~
394.3 ~~be determined based on a review of the medical assistance cost report required under~~
394.4 ~~subdivision 4b for the applicable state fiscal year~~ set to the same rate of payment that
394.5 applied for discharges on October 31, 2014;

394.6 (3) the cost and charge data used to establish hospital payment rates must only
394.7 reflect inpatient services covered by medical assistance; and

394.8 (4) in determining hospital payment rates for discharges occurring on or after the
394.9 rate year beginning January 1, 2011, through December 31, 2012, the hospital payment
394.10 rate per discharge shall be based on the cost-finding methods and allowable costs of the
394.11 Medicare program in effect during the base year or years.

394.12 (g) The commissioner shall validate the rates effective November 1, 2014, by
394.13 applying the rates established under paragraph (c), and any adjustments made to the rates
394.14 under paragraph (d) or (e), to hospital claims paid in calendar year 2013 to determine
394.15 whether the total aggregate payments for the same number and types of services under the
394.16 rebased rates are equal to the total aggregate payments made during calendar year 2013.

394.17 (h) Effective for discharges occurring on or after July 1, 2017, and every two
394.18 years thereafter, payment rates under this section shall be rebased to reflect only those
394.19 changes in hospital costs between the existing base year and the next base year. The
394.20 commissioner shall establish the base year for each rebasing period considering the most
394.21 recent year for which filed Medicare cost reports are available. The estimated change in
394.22 the average payment per hospital discharge resulting from a scheduled rebasing must be
394.23 calculated and made available to the legislature by January 15 of each year in which
394.24 rebasing is scheduled to occur, and must include by hospital the differential in payment
394.25 rates compared to the individual hospital's costs.

394.26 (i) Effective for discharges occurring on or after July 1, 2015, payment rates for
394.27 critical access hospitals located in Minnesota or the local trade area shall be determined
394.28 using a new cost-based methodology. The commissioner shall establish within the
394.29 methodology tiers of payment designed to promote efficiency and cost-effectiveness.
394.30 Payment rates for hospitals under this paragraph shall be set at a level that does not exceed
394.31 the total cost for critical access hospitals as reflected in base year cost reports. Until the
394.32 next rebasing that occurs, the new methodology shall result in no greater than a five
394.33 percent decrease from the base year payments for any hospital, except a hospital that
394.34 had payments that were greater than 100 percent of the hospital's costs in the base year
394.35 shall have their rate set equal to 100 percent of costs in the base year. The rates paid for
394.36 discharges on and after July 1, 2016, covered under this paragraph shall be increased by

395.1 the inflation factor in subdivision 1, paragraph (a). The new cost-based rate shall be the
 395.2 final rate and shall not be settled to actual incurred costs. Hospitals shall be assigned a
 395.3 payment tier based on the following criteria:

395.4 (1) hospitals that had payments at or below 80 percent of their costs in the base year
 395.5 shall have a rate set that equals 85 percent of their base year costs;

395.6 (2) hospitals that had payments that were above 80 percent, up to and including
 395.7 90 percent of their costs in the base year shall have a rate set that equals 95 percent of
 395.8 their base year costs; and

395.9 (3) hospitals that had payments that were above 90 percent of their costs in the base
 395.10 year shall have a rate set that equals 100 percent of their base year costs.

395.11 (j) The commissioner may refine the payment tiers and criteria for critical access
 395.12 hospitals to coincide with the next rebasing under paragraph (h). The factors used to
 395.13 develop the new methodology may include, but are not limited to:

395.14 (1) the ratio between the hospital's costs for treating medical assistance patients and
 395.15 the hospital's charges to the medical assistance program;

395.16 (2) the ratio between the hospital's costs for treating medical assistance patients and
 395.17 the hospital's payments received from the medical assistance program for the care of
 395.18 medical assistance patients;

395.19 (3) the ratio between the hospital's charges to the medical assistance program and
 395.20 the hospital's payments received from the medical assistance program for the care of
 395.21 medical assistance patients;

395.22 (4) the statewide average increases in the ratios identified in clauses (1), (2), and (3);

395.23 (5) the proportion of that hospital's costs that are administrative and trends in
 395.24 administrative costs; and

395.25 (6) geographic location.

395.26 Sec. 13. Minnesota Statutes 2014, section 256.969, subdivision 2d, is amended to read:

395.27 Subd. 2d. **Interim payments.** Notwithstanding subdivision 2b, paragraph (c), for
 395.28 discharges occurring on or after November 1, 2014, through ~~June 30, 2015~~ March 1, 2016,
 395.29 the commissioner may implement an interim payment process to pay hospitals, including
 395.30 payments based on each hospital's average payments per claim for state fiscal years 2011
 395.31 and 2012. These interim payments may be used to pay hospitals if the rebasing under
 395.32 subdivision 2b, paragraph (c), is not implemented by November 1, 2014, or if electronic
 395.33 systems changes necessary to support the conversion to the International Classification of
 395.34 Diseases, 10th revision (ICD-10) coding system are not completed. Claims paid at interim

396.1 payment rates shall be reprocessed and paid at the rates established under subdivision 2b,
396.2 paragraphs (c) and (d), upon implementation of the rebased rates.

396.3 Sec. 14. Minnesota Statutes 2014, section 256.969, subdivision 3a, is amended to read:

396.4 Subd. 3a. **Payments.** (a) Acute care hospital billings under the medical assistance
396.5 program must not be submitted until the recipient is discharged. However, the
396.6 commissioner shall establish monthly interim payments for inpatient hospitals that have
396.7 individual patient lengths of stay over 30 days regardless of diagnostic category. Except
396.8 as provided in section 256.9693, medical assistance reimbursement for treatment of
396.9 mental illness shall be reimbursed based on diagnostic classifications. Individual hospital
396.10 payments established under this section and sections 256.9685, 256.9686, and 256.9695, in
396.11 addition to third-party and recipient liability, for discharges occurring during the rate year
396.12 shall not exceed, in aggregate, the charges for the medical assistance covered inpatient
396.13 services paid for the same period of time to the hospital. Services that have rates established
396.14 under subdivision 11 or 12, must be limited separately from other services. After
396.15 consulting with the affected hospitals, the commissioner may consider related hospitals
396.16 one entity and may merge the payment rates while maintaining separate provider numbers.
396.17 The operating and property base rates per admission or per day shall be derived from the
396.18 best Medicare and claims data available when rates are established. The commissioner
396.19 shall determine the best Medicare and claims data, taking into consideration variables of
396.20 recency of the data, audit disposition, settlement status, and the ability to set rates in a
396.21 timely manner. The commissioner shall notify hospitals of payment rates 30 days prior to
396.22 implementation. The rate setting data must reflect the admissions data used to establish
396.23 relative values. The commissioner may adjust base year cost, relative value, and case mix
396.24 index data to exclude the costs of services that have been discontinued by the October
396.25 1 of the year preceding the rate year or that are paid separately from inpatient services.
396.26 Inpatient stays that encompass portions of two or more rate years shall have payments
396.27 established based on payment rates in effect at the time of admission unless the date of
396.28 admission preceded the rate year in effect by six months or more. In this case, operating
396.29 payment rates for services rendered during the rate year in effect and established based on
396.30 the date of admission shall be adjusted to the rate year in effect by the hospital cost index.

396.31 (b) For fee-for-service admissions occurring on or after July 1, 2002, the total
396.32 payment, before third-party liability and spenddown, made to hospitals for inpatient
396.33 services is reduced by .5 percent from the current statutory rates.

396.34 (c) In addition to the reduction in paragraph (b), the total payment for fee-for-service
396.35 admissions occurring on or after July 1, 2003, made to hospitals for inpatient services before

397.1 third-party liability and spenddown, is reduced five percent from the current statutory
397.2 rates. Mental health services within diagnosis related groups 424 to 432 or corresponding
397.3 APR-DRGs, and facilities defined under subdivision 16 are excluded from this paragraph.

397.4 (d) In addition to the reduction in paragraphs (b) and (c), the total payment for
397.5 fee-for-service admissions occurring on or after August 1, 2005, made to hospitals for
397.6 inpatient services before third-party liability and spenddown, is reduced 6.0 percent from
397.7 the current statutory rates. Mental health services within diagnosis related groups 424
397.8 to 432 or corresponding APR-DRGs, and facilities defined under subdivision 16 are
397.9 excluded from this paragraph. Payments made to managed care plans shall be reduced for
397.10 services provided on or after January 1, 2006, to reflect this reduction.

397.11 (e) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for
397.12 fee-for-service admissions occurring on or after July 1, 2008, through June 30, 2009, made
397.13 to hospitals for inpatient services before third-party liability and spenddown, is reduced
397.14 3.46 percent from the current statutory rates. Mental health services with diagnosis
397.15 related groups 424 to 432 or corresponding APR-DRGs, and facilities defined under
397.16 subdivision 16 are excluded from this paragraph. Payments made to managed care plans
397.17 shall be reduced for services provided on or after January 1, 2009, through June 30, 2009,
397.18 to reflect this reduction.

397.19 (f) In addition to the reductions in paragraphs (b), (c), and (d), the total payment
397.20 for fee-for-service admissions occurring on or after July 1, 2009, through June 30, 2011,
397.21 made to hospitals for inpatient services before third-party liability and spenddown, is
397.22 reduced 1.9 percent from the current statutory rates. Mental health services with diagnosis
397.23 related groups 424 to 432 or corresponding APR-DRGs, and facilities defined under
397.24 subdivision 16 are excluded from this paragraph. Payments made to managed care plans
397.25 shall be reduced for services provided on or after July 1, 2009, through June 30, 2011,
397.26 to reflect this reduction.

397.27 (g) In addition to the reductions in paragraphs (b), (c), and (d), the total payment
397.28 for fee-for-service admissions occurring on or after July 1, 2011, made to hospitals for
397.29 inpatient services before third-party liability and spenddown, is reduced 1.79 percent from
397.30 the current statutory rates. Mental health services with diagnosis related groups 424 to 432
397.31 or corresponding APR-DRGs, and facilities defined under subdivision 16 are excluded
397.32 from this paragraph. Payments made to managed care plans shall be reduced for services
397.33 provided on or after July 1, 2011, to reflect this reduction.

397.34 (h) In addition to the reductions in paragraphs (b), (c), (d), (f), and (g), the total
397.35 payment for fee-for-service admissions occurring on or after July 1, 2009, made to
397.36 hospitals for inpatient services before third-party liability and spenddown, is reduced

398.1 one percent from the current statutory rates. Facilities defined under subdivision 16 are
398.2 excluded from this paragraph. Payments made to managed care plans shall be reduced for
398.3 services provided on or after October 1, 2009, to reflect this reduction.

398.4 (i) In addition to the reductions in paragraphs (b), (c), (d), (g), and (h), the total
398.5 payment for fee-for-service admissions occurring on or after July 1, 2011, made to
398.6 hospitals for inpatient services before third-party liability and spenddown, is reduced
398.7 1.96 percent from the current statutory rates. Facilities defined under subdivision 16 are
398.8 excluded from this paragraph. Payments made to managed care plans shall be reduced for
398.9 services provided on or after January 1, 2011, to reflect this reduction.

398.10 (j) Effective for discharges on and after November 1, 2014, from hospitals paid
398.11 under subdivision 2b, paragraph (a), clauses (1) and (4), the rate adjustments in this
398.12 subdivision must be incorporated into the rebased rates established under subdivision 2b,
398.13 paragraph (c), and must not be applied to each claim.

398.14 (k) Effective for discharges on and after July 1, 2015, from hospitals paid under
398.15 subdivision 2b, paragraph (a), clauses (2) and (3), the rate adjustments in this subdivision
398.16 must be incorporated into the rates and must not be applied to each claim.

398.17 Sec. 15. Minnesota Statutes 2014, section 256.969, subdivision 3c, is amended to read:

398.18 Subd. 3c. **Rateable reduction and readmissions reduction.** (a) The total payment
398.19 for fee for service admissions occurring on or after September 1, 2011, to October 31,
398.20 2014, made to hospitals for inpatient services before third-party liability and spenddown,
398.21 is reduced ten percent from the current statutory rates. Facilities defined under subdivision
398.22 16, long-term hospitals as determined under the Medicare program, children's hospitals
398.23 whose inpatients are predominantly under 18 years of age, and payments under managed
398.24 care are excluded from this paragraph.

398.25 (b) Effective for admissions occurring during calendar year 2010 and each year
398.26 after, the commissioner shall calculate a readmission rate for admissions to all hospitals
398.27 occurring within 30 days of a previous discharge using data from the Reducing Avoidable
398.28 Readmissions Effectively (RARE) campaign. The commissioner may adjust the
398.29 readmission rate taking into account factors such as the medical relationship, complicating
398.30 conditions, and sequencing of treatment between the initial admission and subsequent
398.31 readmissions.

398.32 (c) Effective for payments to all hospitals on or after July 1, 2013, through October
398.33 31, 2014, the reduction in paragraph (a) is reduced one percentage point for every
398.34 percentage point reduction in the overall readmissions rate between the two previous
398.35 calendar years to a maximum of five percent.

399.1 (d) The exclusion from the rate reduction in paragraph (a) shall apply to a hospital
399.2 located in Hennepin County with a licensed capacity of 1,700 beds as of September 1,
399.3 2011, for admissions of children under 18 years of age occurring on or after September 1,
399.4 2011, through August 31, 2013, but shall not apply to payments for admissions occurring
399.5 on or after September 1, 2013, through October 31, 2014.

399.6 (e) Effective for discharges on or after November 1, 2014, from hospitals paid under
399.7 subdivision 2b, paragraph (a), clauses (1) and (4), the rate adjustments in this subdivision
399.8 must be incorporated into the rebased rates established under subdivision 2b, paragraph
399.9 (c), and must not be applied to each claim.

399.10 (f) Effective for discharges on and after July 1, 2015, from hospitals paid under
399.11 subdivision 2b, paragraph (a), clauses (2) and (3), the rate adjustments in this subdivision
399.12 must be incorporated into the rates and must not be applied to each claim.

399.13 Sec. 16. Minnesota Statutes 2014, section 256.969, subdivision 9, is amended to read:

399.14 Subd. 9. **Disproportionate numbers of low-income patients served.** (a) For
399.15 admissions occurring on or after July 1, 1993, the medical assistance disproportionate
399.16 population adjustment shall comply with federal law and shall be paid to a hospital,
399.17 excluding regional treatment centers and facilities of the federal Indian Health Service,
399.18 with a medical assistance inpatient utilization rate in excess of the arithmetic mean. The
399.19 adjustment must be determined as follows:

399.20 (1) for a hospital with a medical assistance inpatient utilization rate above the
399.21 arithmetic mean for all hospitals excluding regional treatment centers and facilities of the
399.22 federal Indian Health Service but less than or equal to one standard deviation above the
399.23 mean, the adjustment must be determined by multiplying the total of the operating and
399.24 property payment rates by the difference between the hospital's actual medical assistance
399.25 inpatient utilization rate and the arithmetic mean for all hospitals excluding regional
399.26 treatment centers and facilities of the federal Indian Health Service; and

399.27 (2) for a hospital with a medical assistance inpatient utilization rate above one
399.28 standard deviation above the mean, the adjustment must be determined by multiplying
399.29 the adjustment that would be determined under clause (1) for that hospital by 1.1.
399.30 ~~The commissioner may establish a separate disproportionate population payment rate~~
399.31 ~~adjustment for critical access hospitals.~~ The commissioner shall report annually on the
399.32 number of hospitals likely to receive the adjustment authorized by this paragraph. The
399.33 commissioner shall specifically report on the adjustments received by public hospitals and
399.34 public hospital corporations located in cities of the first class.

400.1 (b) Certified public expenditures made by Hennepin County Medical Center shall
400.2 be considered Medicaid disproportionate share hospital payments. Hennepin County
400.3 and Hennepin County Medical Center shall report by June 15, 2007, on payments made
400.4 beginning July 1, 2005, or another date specified by the commissioner, that may qualify
400.5 for reimbursement under federal law. Based on these reports, the commissioner shall
400.6 apply for federal matching funds.

400.7 (c) Upon federal approval of the related state plan amendment, paragraph (b) is
400.8 effective retroactively from July 1, 2005, or the earliest effective date approved by the
400.9 Centers for Medicare and Medicaid Services.

400.10 (d) Effective July 1, 2015, disproportionate share hospital (DSH) payments shall
400.11 be paid in accordance with a new methodology using 2012 as the base year. Annual
400.12 payments made under this paragraph shall equal the total amount of payments made for
400.13 2012. A licensed children's hospital shall receive only a single DSH factor for children's
400.14 hospitals. Other DSH factors may be combined to arrive at a single factor for each hospital
400.15 that is eligible for DSH payments. The new methodology shall make payments only to
400.16 hospitals located in Minnesota and include the following factors:

400.17 (1) a licensed children's hospital with at least 1,000 fee-for-service discharges in
400.18 the base year shall receive a factor of 0.868. A licensed children's hospital with less than
400.19 1,000 fee-for-service discharges in the base year shall receive a factor of 0.7880;

400.20 (2) a hospital that has in effect for the initial rate year a contract with the
400.21 commissioner to provide extended psychiatric inpatient services under section 256.9693
400.22 shall receive a factor of 0.0160;

400.23 (3) a hospital that has received payment from the fee-for-service program for at least
400.24 20 transplant services in the base year shall receive a factor of 0.0435;

400.25 (4) a hospital that has a medical assistance utilization rate in the base year between
400.26 20 percent up to one standard deviation above the statewide mean utilization rate shall
400.27 receive a factor of 0.0468;

400.28 (5) a hospital that has a medical assistance utilization rate in the base year that is at
400.29 least one standard deviation above the statewide mean utilization rate but is less than three
400.30 standard deviations above the mean shall receive a factor of 0.2300; and

400.31 (6) a hospital that has a medical assistance utilization rate in the base year that is
400.32 at least three standard deviations above the statewide mean utilization rate shall receive
400.33 a factor of 0.3711.

400.34 (e) Any payments or portion of payments made to a hospital under this subdivision
400.35 that are subsequently returned to the commissioner because the payments are found to
400.36 exceed the hospital-specific DSH limit for that hospital shall be redistributed, proportionate

401.1 to the number of fee-for-service discharges, to other DSH-eligible nonchildren's hospitals
401.2 that have a medical assistance utilization rate that is at least one standard deviation above
401.3 the mean.

401.4 Sec. 17. **[256B.0561] PERIODIC DATA MATCHING TO EVALUATE**
401.5 **CONTINUED ELIGIBILITY.**

401.6 Subdivision 1. **Definition.** For the purposes of this section, "periodic data
401.7 matching" means obtaining updated electronic information about medical assistance and
401.8 MinnesotaCare recipients on the MNsure information system from federal and state data
401.9 sources accessible to the MNsure information system and using that data to evaluate
401.10 continued eligibility between regularly scheduled renewals.

401.11 Subd. 2. **Periodic data matching.** (a) Beginning March 1, 2016, the commissioner
401.12 shall conduct periodic data matching to identify recipients who, based on available
401.13 electronic data, may not meet eligibility criteria for the public health care program in
401.14 which the recipient is enrolled. The commissioner shall conduct data matching for
401.15 medical assistance or MinnesotaCare recipients at least once during a recipient's 12-month
401.16 period of eligibility.

401.17 (b) If data matching indicates a recipient may no longer qualify for medical
401.18 assistance or MinnesotaCare, the commissioner must notify the recipient and allow the
401.19 recipient no more than 30 days to confirm the information obtained through the periodic
401.20 data matching or provide a reasonable explanation for the discrepancy to the state or
401.21 county agency directly responsible for the recipient's case. If a recipient does not respond
401.22 within the advance notice period or does not respond with information that demonstrates
401.23 eligibility or provides a reasonable explanation for the discrepancy within the 30-day time
401.24 period, the commissioner shall terminate the recipient's eligibility in the manner provided
401.25 for by the laws and regulations governing the health care program for which the recipient
401.26 has been identified as being ineligible.

401.27 (c) The commissioner shall not terminate eligibility for a recipient who is
401.28 cooperating with the requirements of paragraph (b) and needs additional time to provide
401.29 information in response to the notification.

401.30 (d) Any termination of eligibility for benefits under this section may be appealed
401.31 as provided for in sections 256.045 to 256.0451, and the laws governing the health care
401.32 programs for which eligibility is terminated.

401.33 Subd. 3. **Recipient communication requirements.** The commissioner shall
401.34 include in all communications with recipients affected by the periodic data matching the
401.35 following contact information for: (1) the state or county agency directly responsible for

402.1 the recipient's case; and (2) consumer assistance partners who may be able to assist the
402.2 recipient in the periodic data matching process.

402.3 Subd. 4. **Report.** By September 1, 2017, and each September 1 thereafter, the
402.4 commissioner shall submit a report to the chairs and ranking minority members of the
402.5 house and senate committees with jurisdiction over human services finance that includes
402.6 the number of cases affected by periodic data matching under this section, the number
402.7 of recipients identified as possibly ineligible as a result of a periodic data match, and the
402.8 number of recipients whose eligibility was terminated as a result of a periodic data match.
402.9 The report must also specify, for recipients whose eligibility was terminated, how many
402.10 cases were closed due to failure to cooperate.

402.11 Subd. 5. **Federal compliance.** The commissioner shall ensure that the
402.12 implementation of this section complies with the Affordable Care Act, including the state's
402.13 maintenance of effort requirements. The commissioner shall not terminate eligibility
402.14 under this section if eligibility terminations would not conform with federal requirements,
402.15 including requirements not yet codified in Minnesota Statutes.

402.16 Sec. 18. Minnesota Statutes 2014, section 256B.06, is amended by adding a
402.17 subdivision to read:

402.18 Subd. 6. **Legal referral and assistance grants.** (a) The commissioner shall award
402.19 grants to one or more nonprofit programs that provide legal services based on indigency to
402.20 provide legal services to individuals with emergency medical conditions or chronic health
402.21 conditions who are not currently eligible for medical assistance or other public health
402.22 care programs based on their legal status, but who may meet eligibility requirements
402.23 with legal assistance.

402.24 (b) The grantees, in collaboration with hospitals and safety net providers, shall
402.25 provide referral assistance to connect individuals identified in paragraph (a) with
402.26 alternative resources and services to assist in meeting their health care needs.

402.27 Sec. 19. Minnesota Statutes 2014, section 256B.0625, is amended by adding a
402.28 subdivision to read:

402.29 Subd. 9b. **Dental services provided by faculty members and resident dentists**
402.30 at a dental school. (a) A dentist who is not enrolled as a medical assistance provider,
402.31 is a faculty or adjunct member at the University of Minnesota or a resident dentist
402.32 licensed under section 150A.06, subdivision 1b, and is providing dental services at a
402.33 dental clinic owned or operated by the University of Minnesota, may be enrolled as a
402.34 medical assistance provider if the provider completes and submits to the commissioner an

403.1 agreement form developed by the commissioner. The agreement must specify that the
 403.2 faculty or adjunct member or resident dentist:

403.3 (1) will not receive payment for the services provided to medical assistance or
 403.4 MinnesotaCare enrollees performed at the dental clinics owned or operated by the
 403.5 University of Minnesota;

403.6 (2) will not be listed in the medical assistance or MinnesotaCare provider directory;
 403.7 and

403.8 (3) is not required to serve medical assistance and MinnesotaCare enrollees when
 403.9 providing nonvolunteer services in a private practice.

403.10 (b) A dentist or resident dentist enrolled under this subdivision as a fee-for-service
 403.11 provider shall not otherwise be enrolled in or receive payments from medical assistance or
 403.12 MinnesotaCare as a fee-for-service provider.

403.13 Sec. 20. Minnesota Statutes 2014, section 256B.0625, subdivision 13h, is amended to
 403.14 read:

403.15 Subd. 13h. **Medication therapy management services.** (a) Medical assistance ~~and~~
 403.16 ~~general assistance medical care cover~~ covers medication therapy management services
 403.17 for a recipient taking ~~three or more~~ prescriptions to treat or prevent one or more chronic
 403.18 medical conditions; ~~a recipient with a drug therapy problem that is identified by the~~
 403.19 ~~commissioner or identified by a pharmacist and approved by the commissioner; or prior~~
 403.20 ~~authorized by the commissioner that has resulted or is likely to result in significant~~
 403.21 ~~nondrug program costs. The commissioner may cover medical therapy management~~
 403.22 ~~services under MinnesotaCare if the commissioner determines this is cost-effective. For~~
 403.23 purposes of this subdivision, "medication therapy management" means the provision
 403.24 of the following pharmaceutical care services by a licensed pharmacist to optimize the
 403.25 therapeutic outcomes of the patient's medications:

403.26 (1) performing or obtaining necessary assessments of the patient's health status;

403.27 (2) formulating a medication treatment plan;

403.28 (3) monitoring and evaluating the patient's response to therapy, including safety
 403.29 and effectiveness;

403.30 (4) performing a comprehensive medication review to identify, resolve, and prevent
 403.31 medication-related problems, including adverse drug events;

403.32 (5) documenting the care delivered and communicating essential information to
 403.33 the patient's other primary care providers;

403.34 (6) providing verbal education and training designed to enhance patient
 403.35 understanding and appropriate use of the patient's medications;

404.1 (7) providing information, support services, and resources designed to enhance
404.2 patient adherence with the patient's therapeutic regimens; and

404.3 (8) coordinating and integrating medication therapy management services within the
404.4 broader health care management services being provided to the patient.

404.5 Nothing in this subdivision shall be construed to expand or modify the scope of practice of
404.6 the pharmacist as defined in section 151.01, subdivision 27.

404.7 (b) To be eligible for reimbursement for services under this subdivision, a pharmacist
404.8 must meet the following requirements:

404.9 (1) have a valid license issued by the Board of Pharmacy of the state in which the
404.10 medication therapy management service is being performed;

404.11 (2) have graduated from an accredited college of pharmacy on or after May 1996, or
404.12 completed a structured and comprehensive education program approved by the Board of
404.13 Pharmacy and the American Council of Pharmaceutical Education for the provision and
404.14 documentation of pharmaceutical care management services that has both clinical and
404.15 didactic elements;

404.16 (3) be practicing in an ambulatory care setting as part of a multidisciplinary team or
404.17 have developed a structured patient care process that is offered in a private or semiprivate
404.18 patient care area that is separate from the commercial business that also occurs in the
404.19 setting, or in home settings, including long-term care settings, group homes, and facilities
404.20 providing assisted living services, but excluding skilled nursing facilities; and

404.21 (4) make use of an electronic patient record system that meets state standards.

404.22 (c) For purposes of reimbursement for medication therapy management services,
404.23 the commissioner may enroll individual pharmacists as medical assistance ~~and general~~
404.24 ~~assistance medical care~~ providers. The commissioner may also establish contact
404.25 requirements between the pharmacist and recipient, including limiting the number of
404.26 reimbursable consultations per recipient.

404.27 (d) If there are no pharmacists who meet the requirements of paragraph (b) practicing
404.28 within a reasonable geographic distance of the patient, a pharmacist who meets the
404.29 requirements may provide the services via two-way interactive video. Reimbursement
404.30 shall be at the same rates and under the same conditions that would otherwise apply to
404.31 the services provided. To qualify for reimbursement under this paragraph, the pharmacist
404.32 providing the services must meet the requirements of paragraph (b), and must be
404.33 located within an ambulatory care setting ~~approved by the commissioner~~ that meets the
404.34 requirements of paragraph (b), clause (3). The patient must also be located within an
404.35 ambulatory care setting ~~approved by the commissioner~~ that meets the requirements of

405.1 paragraph (b), clause (3). Services provided under this paragraph may not be transmitted
405.2 into the patient's residence.

405.3 ~~(e) The commissioner shall establish a pilot project for an intensive medication~~
405.4 ~~therapy management program for patients identified by the commissioner with multiple~~
405.5 ~~chronic conditions and a high number of medications who are at high risk of preventable~~
405.6 ~~hospitalizations, emergency room use, medication complications, and suboptimal~~
405.7 ~~treatment outcomes due to medication-related problems. For purposes of the pilot~~
405.8 ~~project, medication therapy management services may be provided in a patient's home~~
405.9 ~~or community setting, in addition to other authorized settings. The commissioner may~~
405.10 ~~waive existing payment policies and establish special payment rates for the pilot project.~~
405.11 ~~The pilot project must be designed to produce a net savings to the state compared to the~~
405.12 ~~estimated costs that would otherwise be incurred for similar patients without the program.~~
405.13 ~~The pilot project must begin by January 1, 2010, and end June 30, 2012.~~

405.14 (e) Medication therapy management services may be delivered into a patient's
405.15 residence via secure interactive video if the medication therapy management services
405.16 are performed electronically during a covered home care visit by an enrolled provider.
405.17 Reimbursement shall be at the same rates and under the same conditions that would
405.18 otherwise apply to the services provided. To qualify for reimbursement under this
405.19 paragraph, the pharmacist providing the services must meet the requirements of paragraph
405.20 (b) and must be located within an ambulatory care setting that meets the requirements of
405.21 paragraph (b), clause (3).

405.22 Sec. 21. Minnesota Statutes 2014, section 256B.0625, subdivision 17, is amended to
405.23 read:

405.24 Subd. 17. **Transportation costs.** (a) "Nonemergency medical transportation
405.25 service" means motor vehicle transportation provided by a public or private person
405.26 that serves Minnesota health care program beneficiaries who do not require emergency
405.27 ambulance service, as defined in section 144E.001, subdivision 3, to obtain covered
405.28 medical services. ~~Nonemergency medical transportation service includes, but is not~~
405.29 ~~limited to, special transportation service, defined in section 174.29, subdivision 1.~~

405.30 (b) Medical assistance covers medical transportation costs incurred solely for
405.31 obtaining emergency medical care or transportation costs incurred by eligible persons in
405.32 obtaining emergency or nonemergency medical care when paid directly to an ambulance
405.33 company, common carrier, or other recognized providers of transportation services.

405.34 Medical transportation must be provided by:

406.1 (1) nonemergency medical transportation providers who meet the requirements
406.2 of this subdivision;

406.3 (2) ambulances, as defined in section 144E.001, subdivision 2;

406.4 (3) taxicabs ~~and~~;

406.5 (4) public transit, as defined in section 174.22, subdivision 7; or

406.6 ~~(4)~~ (5) not-for-hire vehicles, including volunteer drivers.

406.7 (c) Medical assistance covers nonemergency medical transportation provided by
406.8 nonemergency medical transportation providers enrolled in the Minnesota health care
406.9 programs. All nonemergency medical transportation providers must comply with the
406.10 operating standards for special transportation service as defined in sections 174.29 to
406.11 174.30 and Minnesota Rules, chapter 8840, and in consultation with the Minnesota
406.12 Department of Transportation. All nonemergency medical transportation providers shall
406.13 bill for nonemergency medical transportation services in accordance with Minnesota
406.14 health care programs criteria. Publicly operated transit systems, volunteers, and
406.15 not-for-hire vehicles are exempt from the requirements outlined in this paragraph.

406.16 (d) The administrative agency of nonemergency medical transportation must:

406.17 (1) adhere to the policies defined by the commissioner in consultation with the
406.18 Nonemergency Medical Transportation Advisory Committee;

406.19 (2) pay nonemergency medical transportation providers for services provided to
406.20 Minnesota health care programs beneficiaries to obtain covered medical services;

406.21 (3) provide data monthly to the commissioner on appeals, complaints, no-shows,
406.22 canceled trips, and number of trips by mode; and

406.23 (4) by July 1, 2016, in accordance with subdivision 18e, utilize a Web-based single
406.24 administrative structure assessment tool that meets the technical requirements established
406.25 by the commissioner, reconciles trip information with claims being submitted by
406.26 providers, and ensures prompt payment for nonemergency medical transportation services.

406.27 (e) Until the commissioner implements the single administrative structure and
406.28 delivery system under subdivision 18e, clients shall obtain their level-of-service certificate
406.29 from the commissioner or an entity approved by the commissioner that does not dispatch
406.30 rides for clients using modes of transportation under paragraph (h), clauses (4), (5), (6),
406.31 and (7).

406.32 (f) The commissioner may use an order by the recipient's attending physician or a
406.33 medical or mental health professional to certify that the recipient requires nonemergency
406.34 medical transportation services. Nonemergency medical transportation providers shall
406.35 perform driver-assisted services for eligible individuals, when appropriate. Driver-assisted
406.36 service includes passenger pickup at and return to the individual's residence or place of

407.1 business, assistance with admittance of the individual to the medical facility, and assistance
407.2 in passenger securement or in securing of wheelchairs or stretchers in the vehicle.

407.3 ~~Nonemergency medical transportation providers must have trip logs, which include pickup
407.4 and drop-off times, signed by the medical provider or client attesting mileage traveled to
407.5 obtain covered medical services, whichever is deemed most appropriate. Nonemergency
407.6 medical transportation providers may not bill for separate base rates for the continuation
407.7 of a trip beyond the original destination. Nonemergency medical transportation providers
407.8 must take clients to the health care provider, using the most direct route, and must not
407.9 exceed 30 miles for a trip to a primary care provider or 60 miles for a trip to a specialty
407.10 care provider, unless the client receives authorization from the local agency. The minimum
407.11 medical assistance reimbursement rates for special transportation services are:~~

407.12 ~~(1)(i) \$17 for the base rate and \$1.35 per mile for special transportation services to
407.13 eligible persons who need a wheelchair-accessible van;~~

407.14 ~~(ii) \$11.50 for the base rate and \$1.30 per mile for special transportation services to
407.15 eligible persons who do not need a wheelchair-accessible van; and~~

407.16 ~~(iii) \$60 for the base rate and \$2.40 per mile, and an attendant rate of \$9 per trip,
407.17 for special transportation services to eligible persons who need a stretcher-accessible
407.18 vehicle; and~~

407.19 ~~(2) Nonemergency medical transportation providers must take clients to the health
407.20 care provider using the most direct route, and must not exceed 30 miles for a trip to a
407.21 primary care provider or 60 miles for a trip to a specialty care provider, unless the client
407.22 receives authorization from the local agency.~~

407.23 ~~Nonemergency medical transportation providers may not bill for separate base rates
407.24 for the continuation of a trip beyond the original destination. Nonemergency medical
407.25 transportation providers must maintain trip logs, which include pickup and drop-off times,
407.26 signed by the medical provider or client, whichever is deemed most appropriate, attesting
407.27 to mileage traveled to obtain covered medical services. Clients requesting client mileage
407.28 reimbursement must sign the trip log attesting mileage traveled to obtain covered medical
407.29 services.~~

407.30 ~~(g) The covered modes of nonemergency medical transportation include
407.31 transportation provided directly by clients or family members of clients with their own
407.32 transportation, volunteers using their own vehicles, taxicabs, and public transit, or
407.33 provided to a client who needs a stretcher-accessible vehicle, a lift/ramp equipped vehicle,
407.34 or a vehicle that is not stretcher-accessible or lift/ramp equipped designed to transport ten
407.35 or fewer persons. Upon implementation of a new rate structure, a new covered mode of
407.36 nonemergency medical transportation shall include transportation provided to a client who~~

408.1 ~~needs a protected vehicle that is not an ambulance or police car and has safety locks, a~~
 408.2 ~~video recorder, and a transparent thermoplastic partition between the passenger and the~~
 408.3 ~~vehicle driver.~~

408.4 ~~(h)~~ (g) The administrative agency shall use the level of service process established
 408.5 by the commissioner in consultation with the Nonemergency Medical Transportation
 408.6 Advisory Committee to determine the client's most appropriate mode of transportation.
 408.7 If public transit or a certified transportation provider is not available to provide the
 408.8 appropriate service mode for the client, the client may receive a onetime service upgrade.

408.9 ~~(h)~~ The new covered modes of transportation, which may not be implemented
 408.10 without a new rate structure, are:

408.11 (1) client reimbursement, which includes client mileage reimbursement provided to
 408.12 clients who have their own transportation, or to family or an acquaintance who provides
 408.13 transportation to the client;

408.14 (2) volunteer transport, which includes transportation by volunteers using their
 408.15 own vehicle;

408.16 (3) unassisted transport, which includes transportation provided to a client by a
 408.17 taxicab or public transit. If a taxicab or ~~publicly operated~~ public transit system is not
 408.18 available, the client can receive transportation from another nonemergency medical
 408.19 transportation provider;

408.20 (4) assisted transport, which includes transport provided to clients who require
 408.21 assistance by a nonemergency medical transportation provider;

408.22 (5) lift-equipped/ramp transport, which includes transport provided to a client who
 408.23 is dependent on a device and requires a nonemergency medical transportation provider
 408.24 with a vehicle containing a lift or ramp;

408.25 (6) protected transport, which includes transport provided to a client who has
 408.26 received a prescreening that has deemed other forms of transportation inappropriate and
 408.27 who requires a provider: (i) with a protected vehicle that is not an ambulance or police car
 408.28 and has safety locks, a video recorder, and a transparent thermoplastic partition between
 408.29 the passenger and the vehicle driver; and (ii) who is certified as a protected transport
 408.30 provider; and

408.31 (7) stretcher transport, which includes transport for a client in a prone or supine
 408.32 position and requires a nonemergency medical transportation provider with a vehicle that
 408.33 can transport a client in a prone or supine position.

408.34 (i) ~~In accordance with subdivision 18c, by July 1, 2016,~~ The local agency shall be
 408.35 the single administrative agency and shall administer and reimburse for modes defined in
 408.36 paragraph (h) according to ~~a new rate structure, once this is adopted~~ paragraphs (l) and

409.1 (m) when the commissioner has developed, made available, and funded the Web-based
409.2 single administrative structure, assessment tool, and level of need assessment under
409.3 subdivision 18e. The local agency's financial obligation is limited to funds provided by
409.4 the state or federal government.

409.5 (j) The commissioner shall:

409.6 (1) in consultation with the Nonemergency Medical Transportation Advisory
409.7 Committee, verify that the mode and use of nonemergency medical transportation is
409.8 appropriate;

409.9 (2) verify that the client is going to an approved medical appointment; and

409.10 (3) investigate all complaints and appeals.

409.11 (k) The administrative agency shall pay for the services provided in this subdivision
409.12 and seek reimbursement from the commissioner, if appropriate. As vendors of medical
409.13 care, local agencies are subject to the provisions in section 256B.041, the sanctions and
409.14 monetary recovery actions in section 256B.064, and Minnesota Rules, parts 9505.2160
409.15 to 9505.2245.

409.16 (l) Payments for nonemergency medical transportation must be paid based on
409.17 the client's assessed mode under paragraph (g), not the type of vehicle used to provide
409.18 the service. The medical assistance reimbursement rates for nonemergency medical
409.19 transportation services that are payable by or on behalf of the commissioner for
409.20 nonemergency medical transportation services are:

409.21 (1) \$0.22 per mile for client reimbursement;

409.22 (2) up to 100 percent of the Internal Revenue Service business deduction rate for
409.23 volunteer transport;

409.24 (3) equivalent to the standard fare for unassisted transport when provided by public
409.25 transit, and \$11 for the base rate and \$1.30 per mile when provided by a nonemergency
409.26 medical transportation provider;

409.27 (4) \$13 for the base rate and \$1.30 per mile for assisted transport;

409.28 (5) \$18 for the base rate and \$1.55 per mile for lift-equipped/ramp transport;

409.29 (6) \$75 for the base rate and \$2.40 per mile for protected transport; and

409.30 (7) \$60 for the base rate and \$2.40 per mile for stretcher transport, and \$9 per trip
409.31 for an additional attendant if deemed medically necessary.

409.32 ~~The base rates for special transportation services in areas defined under RUCA to be~~
409.33 ~~super rural shall be equal to the reimbursement rate established in paragraph (f), clause~~
409.34 ~~(1), plus 11.3 percent, and for special~~

409.35 (m) The base rate for nonemergency medical transportation services in areas
409.36 defined under RUCA to be super rural is equal to 111.3 percent of the respective base

410.1 rate in paragraph (l), clauses (1) to (7). The mileage rate for nonemergency medical
 410.2 transportation services in areas defined under RUCA to be rural or super rural areas is:

410.3 (1) for a trip equal to 17 miles or less, ~~mileage reimbursement shall be equal to 125~~
 410.4 ~~percent of the respective mileage rate in paragraph (f) (l), clause clauses (1) to (7); and~~

410.5 (2) for a trip between 18 and 50 miles, ~~mileage reimbursement shall be equal to~~
 410.6 ~~112.5 percent of the respective mileage rate in paragraph (f) (l), clause clauses (1) to (7).~~

410.7 ~~(m) (n)~~ For purposes of reimbursement rates for special nonemergency medical
 410.8 transportation services under paragraph (e) paragraphs (l) and (m), the zip code of the
 410.9 recipient's place of residence shall determine whether the urban, rural, or super rural
 410.10 reimbursement rate applies.

410.11 ~~(n) (o)~~ For purposes of this subdivision, "rural urban commuting area" or "RUCA"
 410.12 means a census-tract based classification system under which a geographical area is
 410.13 determined to be urban, rural, or super rural.

410.14 ~~(o) Effective for services provided on or after September 1, 2011, nonemergency~~
 410.15 ~~transportation rates, including special transportation, taxi, and other commercial carriers,~~
 410.16 ~~are reduced 4.5 percent. Payments made to managed care plans and county-based~~
 410.17 ~~purchasing plans must be reduced for services provided on or after January 1, 2012,~~
 410.18 ~~to reflect this reduction.~~

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

410.20 Sec. 22. Minnesota Statutes 2014, section 256B.0625, subdivision 17a, is amended to
 410.21 read:

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

410.28 ~~(b) Effective for services provided on or after September 1, 2011, ambulance~~
 410.29 ~~services payment rates are reduced 4.5 percent. Payments made to managed care plans~~
 410.30 ~~and county-based purchasing plans must be reduced for services provided on or after~~
 410.31 ~~January 1, 2012, to reflect this reduction.~~

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

411.1 Sec. 23. Minnesota Statutes 2014, section 256B.0625, subdivision 18a, is amended to
411.2 read:

411.3 Subd. 18a. **Access to medical services.** (a) Medical assistance reimbursement for
411.4 meals for persons traveling to receive medical care may not exceed \$5.50 for breakfast,
411.5 \$6.50 for lunch, or \$8 for dinner.

411.6 (b) Medical assistance reimbursement for lodging for persons traveling to receive
411.7 medical care may not exceed \$50 per day unless prior authorized by the local agency.

411.8 ~~(c) Medical assistance direct mileage reimbursement to the eligible person or the
411.9 eligible person's driver may not exceed 20 cents per mile.~~

411.10 (d) Regardless of the number of employees that an enrolled health care provider
411.11 may have, medical assistance covers sign and oral language interpreter services when
411.12 provided by an enrolled health care provider during the course of providing a direct,
411.13 person-to-person covered health care service to an enrolled recipient with limited English
411.14 proficiency or who has a hearing loss and uses interpreting services. Coverage for
411.15 face-to-face oral language interpreter services shall be provided only if the oral language
411.16 interpreter used by the enrolled health care provider is listed in the registry or roster
411.17 established under section 144.058.

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

411.19 Sec. 24. Minnesota Statutes 2014, section 256B.0625, subdivision 18e, is amended to
411.20 read:

411.21 Subd. 18e. **Single administrative structure and delivery system.** The
411.22 commissioner, in coordination with the commissioner of transportation, shall implement
411.23 a single administrative structure and delivery system for nonemergency medical
411.24 transportation, beginning the latter of the date the single administrative assessment tool
411.25 required in this subdivision is available for use, as determined by the commissioner or by
411.26 July 1, 2016.

411.27 In coordination with the Department of Transportation, the commissioner shall
411.28 develop and authorize a Web-based single administrative structure and assessment
411.29 tool, which must operate 24 hours a day, seven days a week, to facilitate the enrollee
411.30 assessment process for nonemergency medical transportation services. The Web-based
411.31 tool shall facilitate the transportation eligibility determination process initiated by clients
411.32 and client advocates; shall include an accessible automated intake and assessment
411.33 process and real-time identification of level of service eligibility; and shall authorize an
411.34 appropriate and auditable mode of transportation authorization. The tool shall provide a
411.35 single framework for reconciling trip information with claiming and collecting complaints

412.1 regarding inappropriate level of need determinations, inappropriate transportation modes
412.2 utilized, and interference with accessing nonemergency medical transportation. The
412.3 Web-based single administrative structure shall operate on a trial basis for one year from
412.4 implementation and, if approved by the commissioner, shall be permanent thereafter.
412.5 The commissioner shall seek input from the Nonemergency Medical Transportation
412.6 Advisory Committee to ensure the software is effective and user-friendly and make
412.7 recommendations regarding funding of the single administrative system.

412.8 **EFFECTIVE DATE.** This section is effective July 1, 2015.

412.9 Sec. 25. Minnesota Statutes 2014, section 256B.0625, subdivision 28a, is amended to
412.10 read:

412.11 Subd. 28a. **Licensed physician assistant services.** (a) Medical assistance covers
412.12 services performed by a licensed physician assistant if the service is otherwise covered
412.13 under this chapter as a physician service and if the service is within the scope of practice
412.14 of a licensed physician assistant as defined in section 147A.09.

412.15 (b) Licensed physician assistants, who are supervised by a physician certified by
412.16 the American Board of Psychiatry and Neurology or eligible for board certification in
412.17 psychiatry, may bill for medication management and evaluation and management services
412.18 provided to medical assistance enrollees in inpatient hospital settings, and in outpatient
412.19 settings after the licensed physician assistant completes 2,000 hours of clinical experience
412.20 in the evaluation and treatment of mental health, consistent with their authorized scope of
412.21 practice, as defined in section 147A.09, with the exception of performing psychotherapy
412.22 or diagnostic assessments or providing clinical supervision.

412.23 Sec. 26. Minnesota Statutes 2014, section 256B.0625, subdivision 31, is amended to
412.24 read:

412.25 Subd. 31. **Medical supplies and equipment.** (a) Medical assistance covers medical
412.26 supplies and equipment. Separate payment outside of the facility's payment rate shall
412.27 be made for wheelchairs and wheelchair accessories for recipients who are residents
412.28 of intermediate care facilities for the developmentally disabled. Reimbursement for
412.29 wheelchairs and wheelchair accessories for ICF/DD recipients shall be subject to the same
412.30 conditions and limitations as coverage for recipients who do not reside in institutions. A
412.31 wheelchair purchased outside of the facility's payment rate is the property of the recipient.
412.32 ~~The commissioner may set reimbursement rates for specified categories of medical~~
412.33 ~~supplies at levels below the Medicare payment rate.~~

413.1 (b) Vendors of durable medical equipment, prosthetics, orthotics, or medical supplies
413.2 must enroll as a Medicare provider.

413.3 (c) When necessary to ensure access to durable medical equipment, prosthetics,
413.4 orthotics, or medical supplies, the commissioner may exempt a vendor from the Medicare
413.5 enrollment requirement if:

413.6 (1) the vendor supplies only one type of durable medical equipment, prosthetic,
413.7 orthotic, or medical supply;

413.8 (2) the vendor serves ten or fewer medical assistance recipients per year;

413.9 (3) the commissioner finds that other vendors are not available to provide same or
413.10 similar durable medical equipment, prosthetics, orthotics, or medical supplies; and

413.11 (4) the vendor complies with all screening requirements in this chapter and Code of
413.12 Federal Regulations, title 42, part 455. The commissioner may also exempt a vendor from
413.13 the Medicare enrollment requirement if the vendor is accredited by a Centers for Medicare
413.14 and Medicaid Services approved national accreditation organization as complying with
413.15 the Medicare program's supplier and quality standards and the vendor serves primarily
413.16 pediatric patients.

413.17 (d) Durable medical equipment means a device or equipment that:

413.18 (1) can withstand repeated use;

413.19 (2) is generally not useful in the absence of an illness, injury, or disability; and

413.20 (3) is provided to correct or accommodate a physiological disorder or physical
413.21 condition or is generally used primarily for a medical purpose.

413.22 (e) Electronic tablets may be considered durable medical equipment if the electronic
413.23 tablet will be used as an augmentative and alternative communication system as defined
413.24 under subdivision 31a, paragraph (a). To be covered by medical assistance, the device
413.25 must be locked in order to prevent use not related to communication.

413.26 Sec. 27. Minnesota Statutes 2014, section 256B.0625, subdivision 57, is amended to
413.27 read:

413.28 Subd. 57. **Payment for Part B Medicare crossover claims.** (a) Effective for
413.29 services provided on or after January 1, 2012, medical assistance payment for an enrollee's
413.30 cost-sharing associated with Medicare Part B is limited to an amount up to the medical
413.31 assistance total allowed, when the medical assistance rate exceeds the amount paid by
413.32 Medicare.

413.33 (b) Excluded from this limitation are payments for mental health services and
413.34 payments for dialysis services provided to end-stage renal disease patients. The exclusion

414.1 for mental health services does not apply to payments for physician services provided by
 414.2 psychiatrists and advanced practice nurses with a specialty in mental health.

414.3 (c) Excluded from this limitation are payments to federally qualified health centers
 414.4 and rural health clinics.

414.5 **EFFECTIVE DATE.** This section is effective January 1, 2016.

414.6 Sec. 28. Minnesota Statutes 2014, section 256B.0625, subdivision 58, is amended to
 414.7 read:

414.8 Subd. 58. **Early and periodic screening, diagnosis, and treatment services.**

414.9 Medical assistance covers early and periodic screening, diagnosis, and treatment services
 414.10 (EPSDT). The payment amount for a complete EPSDT screening shall not include charges
 414.11 for ~~vaccines~~ health care services and products that are available at no cost to the provider
 414.12 and shall not exceed the rate established per Minnesota Rules, part 9505.0445, item M,
 414.13 effective October 1, 2010.

414.14 Sec. 29. Minnesota Statutes 2014, section 256B.0631, is amended to read:

414.15 **256B.0631 MEDICAL ASSISTANCE CO-PAYMENTS.**

414.16 Subdivision 1. **Cost-sharing.** (a) Except as provided in subdivision 2, the medical
 414.17 assistance benefit plan shall include the following cost-sharing for all recipients, effective
 414.18 for services provided on or after September 1, 2011:

414.19 (1) \$3 per nonpreventive visit, except as provided in paragraph (b). For purposes
 414.20 of this subdivision, a visit means an episode of service which is required because of
 414.21 a recipient's symptoms, diagnosis, or established illness, and which is delivered in an
 414.22 ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse
 414.23 midwife, advanced practice nurse, audiologist, optician, or optometrist;

414.24 (2) \$3.50 for nonemergency visits to a hospital-based emergency room, except that
 414.25 this co-payment shall be increased to \$20 upon federal approval;

414.26 (3) \$3 per brand-name drug prescription and \$1 per generic drug prescription,
 414.27 subject to a \$12 per month maximum for prescription drug co-payments. No co-payments
 414.28 shall apply to antipsychotic drugs when used for the treatment of mental illness;

414.29 (4) ~~effective January 1, 2012,~~ a family deductible equal to the ~~maximum amount~~
 414.30 ~~allowed under Code of Federal Regulations, title 42, part 447.54~~ \$2.75 per month per
 414.31 family and adjusted annually by the percentage increase in the medical care component
 414.32 of the CPI-U for the period of September to September of the preceding calendar year,
 414.33 rounded to the next higher five-cent increment; and

415.1 (5) ~~for individuals identified by the commissioner with income at or below 100~~
415.2 ~~percent of the federal poverty guidelines~~, total monthly cost-sharing must not exceed five
415.3 percent of family income. For purposes of this paragraph, family income is the total
415.4 earned and unearned income of the individual and the individual's spouse, if the spouse is
415.5 enrolled in medical assistance and also subject to the five percent limit on cost-sharing.
415.6 This paragraph does not apply to premiums charged to individuals described under section
415.7 256B.057, subdivision 9.

415.8 (b) Recipients of medical assistance are responsible for all co-payments and
415.9 deductibles in this subdivision.

415.10 (c) Notwithstanding paragraph (b), the commissioner, through the contracting
415.11 process under sections 256B.69 and 256B.692, may allow managed care plans and
415.12 county-based purchasing plans to waive the family deductible under paragraph (a),
415.13 clause (4). The value of the family deductible shall not be included in the capitation
415.14 payment to managed care plans and county-based purchasing plans. Managed care plans
415.15 and county-based purchasing plans shall certify annually to the commissioner the dollar
415.16 value of the family deductible.

415.17 (d) Notwithstanding paragraph (b), the commissioner may waive the collection of
415.18 the family deductible described under paragraph (a), clause (4), from individuals and
415.19 allow long-term care and waived service providers to assume responsibility for payment.

415.20 (e) Notwithstanding paragraph (b), the commissioner, through the contracting
415.21 process under section 256B.0756 shall allow the pilot program in Hennepin County to
415.22 waive co-payments. The value of the co-payments shall not be included in the capitation
415.23 payment amount to the integrated health care delivery networks under the pilot program.

415.24 Subd. 2. **Exceptions.** Co-payments and deductibles shall be subject to the following
415.25 exceptions:

415.26 (1) children under the age of 21;

415.27 (2) pregnant women for services that relate to the pregnancy or any other medical
415.28 condition that may complicate the pregnancy;

415.29 (3) recipients expected to reside for at least 30 days in a hospital, nursing home, or
415.30 intermediate care facility for the developmentally disabled;

415.31 (4) recipients receiving hospice care;

415.32 (5) 100 percent federally funded services provided by an Indian health service;

415.33 (6) emergency services;

415.34 (7) family planning services;

415.35 (8) services that are paid by Medicare, resulting in the medical assistance program
415.36 paying for the coinsurance and deductible;

416.1 (9) co-payments that exceed one per day per provider for nonpreventive visits,
 416.2 eyeglasses, and nonemergency visits to a hospital-based emergency room; and

416.3 (10) services, fee-for-service payments subject to volume purchase through
 416.4 competitive bidding;

416.5 (11) American Indians who meet the requirements in Code of Federal Regulations,
 416.6 title 42, sections 447.51 and 447.56;

416.7 (12) persons needing treatment for breast or cervical cancer as described under
 416.8 section 256B.057, subdivision 10; and

416.9 (13) services that currently have a rating of A or B from the United States Preventive
 416.10 Services Task Force (USPSTF), immunizations recommended by the Advisory Committee
 416.11 on Immunization Practices of the Centers for Disease Control and Prevention, and
 416.12 preventive services and screenings provided to women as described in Code of Federal
 416.13 Regulations, title 45, section 147.130.

416.14 Subd. 3. **Collection.** (a) The medical assistance reimbursement to the provider shall
 416.15 be reduced by the amount of the co-payment or deductible, except that reimbursements
 416.16 shall not be reduced:

416.17 (1) once a recipient has reached the \$12 per month maximum for prescription drug
 416.18 co-payments; or

416.19 (2) for a recipient ~~identified by the commissioner under 100 percent of the federal~~
 416.20 ~~poverty guidelines~~ who has met their monthly five percent cost-sharing limit.

416.21 (b) The provider collects the co-payment or deductible from the recipient. Providers
 416.22 may not deny services to recipients who are unable to pay the co-payment or deductible.

416.23 (c) Medical assistance reimbursement to fee-for-service providers and payments to
 416.24 managed care plans shall not be increased as a result of the removal of co-payments or
 416.25 deductibles effective on or after January 1, 2009.

416.26 **EFFECTIVE DATE.** The amendment to subdivision 1, paragraph (a), clause (4), is
 416.27 effective retroactively from January 1, 2014.

416.28 Sec. 30. **[256B.0638] OPIOID PRESCRIBING IMPROVEMENT PROGRAM.**

416.29 **Subdivision 1. Program established.** The commissioner of human services, in
 416.30 conjunction with the commissioner of health, shall coordinate and implement an opioid
 416.31 prescribing improvement program to reduce opioid dependency and substance use by
 416.32 Minnesotans due to the prescribing of opioid analgesics by health care providers.

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

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

417.1 (c) "Commissioners" means the commissioner of human services and the
417.2 commissioner of health.

417.3 (d) "DEA" means the United States Drug Enforcement Administration.

417.4 (e) "Minnesota health care program" means a public health care program
417.5 administered by the commissioner of human services under chapters 256B and 256L, and
417.6 the Minnesota restricted recipient program.

417.7 (f) "Opioid disenrollment standards" means parameters of opioid prescribing
417.8 practices that fall outside community standard thresholds for prescribing to such a degree
417.9 that a provider must be disenrolled as a medical assistance provider.

417.10 (g) "Opioid prescriber" means a licensed health care provider who prescribes opioids
417.11 to medical assistance and MinnesotaCare enrollees under the fee-for-service system or
417.12 under a managed care or county-based purchasing plan.

417.13 (h) "Opioid quality improvement standard thresholds" means parameters of opioid
417.14 prescribing practices that fall outside community standards for prescribing to such a
417.15 degree that quality improvement is required.

417.16 (i) "Program" means the statewide opioid prescribing improvement program
417.17 established under this section.

417.18 (j) "Provider group" means a clinic, hospital, or primary or specialty practice group
417.19 that employs, contracts with, or is affiliated with an opioid prescriber. Provider group does
417.20 not include a professional association supported by dues-paying members.

417.21 (k) "Sentinel measures" means measures of opioid use that identify variations in
417.22 prescribing practices during the prescribing intervals.

417.23 Subd. 3. **Opioid prescribing work group.** (a) The commissioner of human
417.24 services, in consultation with the commissioner of health, shall appoint the following
417.25 voting members to an opioid prescribing work group:

417.26 (1) two consumer members who have been impacted by an opioid abuse disorder or
417.27 opioid dependence disorder, either personally or with family members;

417.28 (2) one member who is a licensed physician actively practicing in Minnesota and
417.29 registered as a practitioner with the DEA;

417.30 (3) one member who is a licensed pharmacist actively practicing in Minnesota and
417.31 registered as a practitioner with the DEA;

417.32 (4) one member who is a licensed nurse practitioner actively practicing in Minnesota
417.33 and registered as a practitioner with the DEA;

417.34 (5) one member who is a licensed dentist actively practicing in Minnesota and
417.35 registered as a practitioner with the DEA;

418.1 (6) two members who are nonphysician licensed health care professionals actively
418.2 engaged in the practice of their profession in Minnesota, and their practice includes
418.3 treating pain;

418.4 (7) one member who is a mental health professional who is licensed or registered
418.5 in a mental health profession, who is actively engaged in the practice of that profession
418.6 in Minnesota, and whose practice includes treating patients with chemical dependency
418.7 or substance abuse;

418.8 (8) one member who is a medical examiner for a Minnesota county;

418.9 (9) one member of the Health Services Policy Committee established under section
418.10 256B.0625, subdivisions 3c to 3e;

418.11 (10) one member who is a medical director of a health plan company doing business
418.12 in Minnesota;

418.13 (11) one member who is a pharmacy director of a health plan company doing
418.14 business in Minnesota; and

418.15 (12) one member representing Minnesota law enforcement.

418.16 (b) In addition, the work group shall include the following nonvoting members:

418.17 (1) the medical director for the medical assistance program;

418.18 (2) a member representing the Department of Human Services pharmacy unit; and

418.19 (3) the medical director for the Department of Labor and Industry.

418.20 (c) An honorarium of \$200 per meeting and reimbursement for mileage and parking
418.21 shall be paid to each voting member in attendance.

418.22 Subd. 4. **Program components.** (a) The working group shall recommend to the
418.23 commissioners the components of the statewide opioid prescribing improvement program,
418.24 including, but not limited to, the following:

418.25 (1) developing criteria for opioid prescribing protocols, including:

418.26 (i) prescribing for the interval of up to four days immediately after an acute painful
418.27 event;

418.28 (ii) prescribing for the interval of up to 45 days after an acute painful event; and

418.29 (iii) prescribing for chronic pain, which for purposes of this program means pain
418.30 lasting longer than 45 days after an acute painful event;

418.31 (2) developing sentinel measures;

418.32 (3) developing educational resources for opioid prescribers about communicating
418.33 with patients about pain management and the use of opioids to treat pain;

418.34 (4) developing opioid quality improvement standard thresholds and opioid
418.35 disenrollment standards for opioid prescribers and provider groups. In developing opioid
418.36 disenrollment standards, the standards may be described in terms of the length of time in

419.1 which prescribing practices fall outside community standards and the nature and amount
419.2 of opioid prescribing that fall outside community standards; and

419.3 (5) addressing other program issues as determined by the commissioners.

419.4 (b) The opioid prescribing protocols shall not apply to opioids prescribed for patients
419.5 who are experiencing pain caused by a malignant condition or who are receiving hospice
419.6 care, or to opioids prescribed as medication-assisted therapy to treat opioid dependency.

419.7 (c) All opioid prescribers who prescribe opioids to Minnesota health care program
419.8 enrollees must participate in the program in accordance with subdivision 5. Any other
419.9 prescriber who prescribes opioids may comply with the components of this program
419.10 described in paragraph (a) on a voluntary basis.

419.11 Subd. 5. **Program implementation.** (a) The commissioner shall implement the
419.12 programs within the Minnesota health care program to improve the health of and quality
419.13 of care provided to Minnesota health care program enrollees. The commissioner shall
419.14 annually collect and report to opioid prescribers data showing the sentinel measures of
419.15 their opioid prescribing patterns compared to their anonymized peers.

419.16 (b) The commissioner shall notify an opioid prescriber and all provider groups
419.17 with which the opioid prescriber is employed or affiliated when the opioid prescriber's
419.18 prescribing pattern exceeds the opioid quality improvement standard thresholds. An
419.19 opioid prescriber and any provider group that receives a notice under this paragraph shall
419.20 submit to the commissioner a quality improvement plan for review and approval by the
419.21 commissioner with the goal of bringing the opioid prescriber's prescribing practices into
419.22 alignment with community standards. A quality improvement plan must include:

419.23 (1) components of the program described in subdivision 4, paragraph (a);

419.24 (2) internal practice-based measures to review the prescribing practice of the
419.25 opioid prescriber and, where appropriate, any other opioid prescribers employed by or
419.26 affiliated with any of the provider groups with which the opioid prescriber is employed or
419.27 affiliated; and

419.28 (3) appropriate use of the prescription monitoring program under section 152.126.

419.29 (c) If, after a year from the commissioner's notice under paragraph (b), the opioid
419.30 prescriber's prescribing practices do not improve so that they are consistent with
419.31 community standards, the commissioner shall take one or more of the following steps:

419.32 (1) monitor prescribing practices more frequently than annually;

419.33 (2) monitor more aspects of the opioid prescriber's prescribing practices than the
419.34 sentinel measures; or

420.1 (3) require the opioid prescriber to participate in additional quality improvement
 420.2 efforts, including but not limited to mandatory use of the prescription monitoring program
 420.3 established under section 152.126.

420.4 (d) The commissioner shall terminate from Minnesota health care programs all
 420.5 opioid prescribers and provider groups whose prescribing practices fall within the
 420.6 applicable opioid disenrollment standards.

420.7 Subd. 6. **Data practices.** (a) Reports and data identifying an opioid prescriber
 420.8 are private data on individuals as defined under section 13.02, subdivision 12, until an
 420.9 opioid prescriber is subject to termination as a medical assistance provider under this
 420.10 section. Notwithstanding this data classification, the commissioner shall share with all of
 420.11 the provider groups with which an opioid prescriber is employed or affiliated, a report
 420.12 identifying an opioid prescriber who is subject to quality improvement activities under
 420.13 subdivision 5, paragraph (b) or (c).

420.14 (b) Reports and data identifying a provider group are nonpublic data as defined
 420.15 under section 13.02, subdivision 9, until the provider group is subject to termination as a
 420.16 medical assistance provider under this section.

420.17 (c) Upon termination under this section, reports and data identifying an opioid
 420.18 prescriber or provider group are public, except that any identifying information of
 420.19 Minnesota health care program enrollees must be redacted by the commissioner.

420.20 Subd. 7. **Annual report to legislature.** By September 15, 2016, and annually
 420.21 thereafter, the commissioner of human services shall report to the legislature on the
 420.22 implementation of the opioid prescribing improvement program in the Minnesota health
 420.23 care programs. The report must include data on the utilization of opioids within the
 420.24 Minnesota health care programs.

420.25 Sec. 31. Minnesota Statutes 2014, section 256B.0757, is amended to read:

420.26 **256B.0757 COORDINATED CARE THROUGH A HEALTH HOME.**

420.27 Subdivision 1. **Provision of coverage.** (a) The commissioner shall provide
 420.28 medical assistance coverage of health home services for eligible individuals with chronic
 420.29 conditions who select a designated provider, ~~a team of health care professionals, or a~~
 420.30 ~~health team~~ as the individual's health home.

420.31 (b) The commissioner shall implement this section in compliance with the
 420.32 requirements of the state option to provide health homes for enrollees with chronic
 420.33 conditions, as provided under the Patient Protection and Affordable Care Act, Public
 420.34 Law 111-148, sections 2703 and 3502. Terms used in this section have the meaning
 420.35 provided in that act.

421.1 (c) The commissioner shall establish health homes to serve populations with serious
 421.2 mental illness who meet the eligibility requirements described under subdivision 2, clause
 421.3 (4). The health home services provided by health homes shall focus on both the behavioral
 421.4 and the physical health of these populations.

421.5 Subd. 2. **Eligible individual.** An individual is eligible for health home services
 421.6 under this section if the individual is eligible for medical assistance under this chapter
 421.7 and has at least:

421.8 (1) two chronic conditions;

421.9 (2) one chronic condition and is at risk of having a second chronic condition; ~~or~~

421.10 (3) one serious and persistent mental health condition; or

421.11 (4) a condition that meets the definition in section 245.462, subdivision 20,

421.12 paragraph (a), or 245.4871, subdivision 15, clause (2); and has a current diagnostic

421.13 assessment as defined in Minnesota Rules, part 9505.0372, subpart 1, item B or C, as

421.14 performed or reviewed by a mental health professional employed by or under contract

421.15 with the behavioral health home. The commissioner shall establish criteria for determining

421.16 continued eligibility.

421.17 Subd. 3. **Health home services.** (a) Health home services means comprehensive and
 421.18 timely high-quality services that are provided by a health home. These services include:

421.19 (1) comprehensive care management;

421.20 (2) care coordination and health promotion;

421.21 (3) comprehensive transitional care, including appropriate follow-up, from inpatient
 421.22 to other settings;

421.23 (4) patient and family support, including authorized representatives;

421.24 (5) referral to community and social support services, if relevant; and

421.25 (6) use of health information technology to link services, as feasible and appropriate.

421.26 (b) The commissioner shall maximize the number and type of services included

421.27 in this subdivision to the extent permissible under federal law, including physician,

421.28 outpatient, mental health treatment, and rehabilitation services necessary for

421.29 comprehensive transitional care following hospitalization.

421.30 Subd. 4. ~~Health teams~~ **Designated provider.** (a) Health home services

421.31 are voluntary and an eligible individual may choose any designated provider. The

421.32 commissioner shall establish health teams to support the patient-centered designated

421.33 providers to serve as health home homes and provide the services described in subdivision

421.34 3 to individuals eligible under subdivision 2. The commissioner shall apply for grants ~~or~~

421.35 ~~contracts~~ as provided under section 3502 of the Patient Protection and Affordable Care Act

421.36 to establish health teams homes and provide capitated payments to primary care designated

422.1 providers. For purposes of this section, "~~health teams~~" "designated provider" means
422.2 ~~community-based, interdisciplinary, interprofessional teams of health care providers that~~
422.3 ~~support primary care practices. These providers may include medical specialists, nurses,~~
422.4 ~~advanced practice registered nurses, pharmacists, nutritionists, social workers, behavioral~~
422.5 ~~and mental health providers, doctors of chiropractic, licensed complementary and~~
422.6 ~~alternative medicine practitioners, and physician assistants.~~ a provider, clinical practice or
422.7 clinical group practice, rural clinic, community health center, community mental health
422.8 center, or any other entity that is determined by the commissioner to be qualified to be a
422.9 health home for eligible individuals. This determination must be based on documentation
422.10 evidencing that the designated provider has the systems and infrastructure in place to
422.11 provide health home services and satisfies the qualification standards established by the
422.12 commissioner in consultation with stakeholders and approved by the Centers for Medicare
422.13 and Medicaid Services.

422.14 (b) The commissioner shall develop and implement certification standards for
422.15 designated providers under this subdivision.

422.16 Subd. 5. **Payments.** The commissioner shall make payments to each ~~health home~~
422.17 ~~and each health team~~ designated provider for the provision of health home services
422.18 described in subdivision 3 to each eligible individual with chronic conditions under
422.19 subdivision 2 that selects the health home as a provider.

422.20 Subd. 6. **Coordination.** The commissioner, to the extent feasible, shall ensure that
422.21 the requirements and payment methods for ~~health homes and health teams~~ designated
422.22 providers developed under this section are consistent with the requirements and payment
422.23 methods for health care homes established under sections 256B.0751 and 256B.0753. The
422.24 commissioner may modify requirements and payment methods under sections 256B.0751
422.25 and 256B.0753 in order to be consistent with federal health home requirements and
422.26 payment methods.

422.27 Subd. 8. **Evaluation and continued development.** (a) For continued certification
422.28 under this section, health homes must meet process, outcome, and quality standards
422.29 developed and specified by the commissioner. The commissioner shall collect data from
422.30 health homes as necessary to monitor compliance with certification standards.

422.31 (b) The commissioner may contract with a private entity to evaluate patient and
422.32 family experiences, health care utilization, and costs.

422.33 (c) The commissioner shall utilize findings from the implementation of behavioral
422.34 health homes to determine populations to serve under subsequent health home models
422.35 for individuals with chronic conditions.

423.1 **EFFECTIVE DATE.** This section is effective July 1, 2016, or upon federal
423.2 approval, whichever is later. The commissioner of human services shall notify the revisor
423.3 of statutes when federal approval is obtained.

423.4 Sec. 32. **[256B.0758] HEALTH CARE DELIVERY PILOT PROGRAM.**

423.5 (a) The commissioner may establish a health care delivery pilot program to test
423.6 alternative and innovative integrated health care delivery networks, including accountable
423.7 care organizations or a community-based collaborative care network created by or
423.8 including North Memorial Health Care. If required, the commissioner shall seek federal
423.9 approval of a new waiver request or amend an existing demonstration pilot project waiver.

423.10 (b) Individuals eligible for the pilot program shall be individuals who are eligible for
423.11 medical assistance under section 256B.055. The commissioner may identify individuals
423.12 to be enrolled in the pilot program based on zip code or whether the individuals would
423.13 benefit from an integrated health care delivery network.

423.14 (c) In developing a payment system for the pilot programs, the commissioner shall
423.15 establish a total cost of care for the individuals enrolled in the pilot program that equals
423.16 the cost of care that would otherwise be spent for these enrollees in the prepaid medical
423.17 assistance program.

423.18 Sec. 33. Minnesota Statutes 2014, section 256B.69, subdivision 5a, is amended to read:

423.19 Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section
423.20 and section 256L.12 shall be entered into or renewed on a calendar year basis. The
423.21 commissioner may issue separate contracts with requirements specific to services to
423.22 medical assistance recipients age 65 and older.

423.23 (b) A prepaid health plan providing covered health services for eligible persons
423.24 pursuant to chapters 256B and 256L is responsible for complying with the terms of its
423.25 contract with the commissioner. Requirements applicable to managed care programs
423.26 under chapters 256B and 256L established after the effective date of a contract with the
423.27 commissioner take effect when the contract is next issued or renewed.

423.28 (c) The commissioner shall withhold five percent of managed care plan payments
423.29 under this section and county-based purchasing plan payments under section 256B.692
423.30 for the prepaid medical assistance program pending completion of performance targets.
423.31 Each performance target must be quantifiable, objective, measurable, and reasonably
423.32 attainable, except in the case of a performance target based on a federal or state law
423.33 or rule. Criteria for assessment of each performance target must be outlined in writing
423.34 prior to the contract effective date. Clinical or utilization performance targets and their

424.1 related criteria must consider evidence-based research and reasonable interventions when
424.2 available or applicable to the populations served, and must be developed with input from
424.3 external clinical experts and stakeholders, including managed care plans, county-based
424.4 purchasing plans, and providers. The managed care or county-based purchasing plan
424.5 must demonstrate, to the commissioner's satisfaction, that the data submitted regarding
424.6 attainment of the performance target is accurate. The commissioner shall periodically
424.7 change the administrative measures used as performance targets in order to improve plan
424.8 performance across a broader range of administrative services. The performance targets
424.9 must include measurement of plan efforts to contain spending on health care services and
424.10 administrative activities. The commissioner may adopt plan-specific performance targets
424.11 that take into account factors affecting only one plan, including characteristics of the
424.12 plan's enrollee population. The withheld funds must be returned no sooner than July of the
424.13 following year if performance targets in the contract are achieved. The commissioner may
424.14 exclude special demonstration projects under subdivision 23.

424.15 (d) The commissioner shall require that managed care plans use the assessment and
424.16 authorization processes, forms, timelines, standards, documentation, and data reporting
424.17 requirements, protocols, billing processes, and policies consistent with medical assistance
424.18 fee-for-service or the Department of Human Services contract requirements consistent
424.19 with medical assistance fee-for-service or the Department of Human Services contract
424.20 requirements for all personal care assistance services under section 256B.0659.

424.21 (e) Effective for services rendered on or after January 1, 2012, the commissioner
424.22 shall include as part of the performance targets described in paragraph (c) a reduction
424.23 in the health plan's emergency department utilization rate for medical assistance and
424.24 MinnesotaCare enrollees, as determined by the commissioner. For 2012, the reduction
424.25 shall be based on the health plan's utilization in 2009. To earn the return of the withhold
424.26 each subsequent year, the managed care plan or county-based purchasing plan must
424.27 achieve a qualifying reduction of no less than ten percent of the plan's emergency
424.28 department utilization rate for medical assistance and MinnesotaCare enrollees, excluding
424.29 enrollees in programs described in subdivisions 23 and 28, compared to the previous
424.30 measurement year until the final performance target is reached. When measuring
424.31 performance, the commissioner must consider the difference in health risk in a managed
424.32 care or county-based purchasing plan's membership in the baseline year compared to the
424.33 measurement year, and work with the managed care or county-based purchasing plan to
424.34 account for differences that they agree are significant.

424.35 The withheld funds must be returned no sooner than July 1 and no later than July 31
424.36 of the following calendar year if the managed care plan or county-based purchasing plan

425.1 demonstrates to the satisfaction of the commissioner that a reduction in the utilization rate
425.2 was achieved. The commissioner shall structure the withhold so that the commissioner
425.3 returns a portion of the withheld funds in amounts commensurate with achieved reductions
425.4 in utilization less than the targeted amount.

425.5 The withhold described in this paragraph shall continue for each consecutive contract
425.6 period until the plan's emergency room utilization rate for state health care program
425.7 enrollees is reduced by 25 percent of the plan's emergency room utilization rate for medical
425.8 assistance and MinnesotaCare enrollees for calendar year 2009. Hospitals shall cooperate
425.9 with the health plans in meeting this performance target and shall accept payment
425.10 withholds that may be returned to the hospitals if the performance target is achieved.

425.11 (f) Effective for services rendered on or after January 1, 2012, the commissioner
425.12 shall include as part of the performance targets described in paragraph (c) a reduction
425.13 in the plan's hospitalization admission rate for medical assistance and MinnesotaCare
425.14 enrollees, as determined by the commissioner. To earn the return of the withhold each
425.15 year, the managed care plan or county-based purchasing plan must achieve a qualifying
425.16 reduction of no less than five percent of the plan's hospital admission rate for medical
425.17 assistance and MinnesotaCare enrollees, excluding enrollees in programs described in
425.18 subdivisions 23 and 28, compared to the previous calendar year until the final performance
425.19 target is reached. When measuring performance, the commissioner must consider the
425.20 difference in health risk in a managed care or county-based purchasing plan's membership
425.21 in the baseline year compared to the measurement year, and work with the managed care
425.22 or county-based purchasing plan to account for differences that they agree are significant.

425.23 The withheld funds must be returned no sooner than July 1 and no later than July
425.24 31 of the following calendar year if the managed care plan or county-based purchasing
425.25 plan demonstrates to the satisfaction of the commissioner that this reduction in the
425.26 hospitalization rate was achieved. The commissioner shall structure the withhold so that
425.27 the commissioner returns a portion of the withheld funds in amounts commensurate with
425.28 achieved reductions in utilization less than the targeted amount.

425.29 The withhold described in this paragraph shall continue until there is a 25 percent
425.30 reduction in the hospital admission rate compared to the hospital admission rates in
425.31 calendar year 2011, as determined by the commissioner. The hospital admissions in this
425.32 performance target do not include the admissions applicable to the subsequent hospital
425.33 admission performance target under paragraph (g). Hospitals shall cooperate with the
425.34 plans in meeting this performance target and shall accept payment withholds that may be
425.35 returned to the hospitals if the performance target is achieved.

426.1 (g) Effective for services rendered on or after January 1, 2012, the commissioner
426.2 shall include as part of the performance targets described in paragraph (c) a reduction in
426.3 the plan's hospitalization admission rates for subsequent hospitalizations within 30 days of
426.4 a previous hospitalization of a patient regardless of the reason, for medical assistance and
426.5 MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the
426.6 withhold each year, the managed care plan or county-based purchasing plan must achieve
426.7 a qualifying reduction of the subsequent hospitalization rate for medical assistance and
426.8 MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23
426.9 and 28, of no less than five percent compared to the previous calendar year until the
426.10 final performance target is reached.

426.11 The withheld funds must be returned no sooner than July 1 and no later than July
426.12 31 of the following calendar year if the managed care plan or county-based purchasing
426.13 plan demonstrates to the satisfaction of the commissioner that a qualifying reduction in
426.14 the subsequent hospitalization rate was achieved. The commissioner shall structure the
426.15 withhold so that the commissioner returns a portion of the withheld funds in amounts
426.16 commensurate with achieved reductions in utilization less than the targeted amount.

426.17 The withhold described in this paragraph must continue for each consecutive
426.18 contract period until the plan's subsequent hospitalization rate for medical assistance and
426.19 MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23
426.20 and 28, is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar
426.21 year 2011. Hospitals shall cooperate with the plans in meeting this performance target and
426.22 shall accept payment withholds that must be returned to the hospitals if the performance
426.23 target is achieved.

426.24 (h) Effective for services rendered on or after January 1, 2013, through December
426.25 31, 2013, the commissioner shall withhold 4.5 percent of managed care plan payments
426.26 under this section and county-based purchasing plan payments under section 256B.692
426.27 for the prepaid medical assistance program. The withheld funds must be returned no
426.28 sooner than July 1 and no later than July 31 of the following year. The commissioner may
426.29 exclude special demonstration projects under subdivision 23.

426.30 (i) Effective for services rendered on or after January 1, 2014, the commissioner
426.31 shall withhold three percent of managed care plan payments under this section and
426.32 county-based purchasing plan payments under section 256B.692 for the prepaid medical
426.33 assistance program. The withheld funds must be returned no sooner than July 1 and
426.34 no later than July 31 of the following year. The commissioner may exclude special
426.35 demonstration projects under subdivision 23.

427.1 (j) A managed care plan or a county-based purchasing plan under section 256B.692
 427.2 may include as admitted assets under section 62D.044 any amount withheld under this
 427.3 section that is reasonably expected to be returned.

427.4 (k) Contracts between the commissioner and a prepaid health plan are exempt from
 427.5 the set-aside and preference provisions of section 16C.16, subdivisions 6, paragraph
 427.6 (a), and 7.

427.7 (l) The return of the withhold under paragraphs (h) and (i) is not subject to the
 427.8 requirements of paragraph (c).

427.9 (m) Managed care plans and county-based purchasing plans shall maintain current
 427.10 and fully executed agreements for all subcontractors, including bargaining groups, for
 427.11 administrative services that are expensed to the state's public health care programs.
 427.12 Subcontractor agreements determined to be material, as defined by the commissioner after
 427.13 taking into account state contracting and relevant statutory requirements, must be in the
 427.14 form of a written instrument or electronic document containing the elements of offer,
 427.15 acceptance, consideration, payment terms, scope, duration of the contract, and how the
 427.16 subcontractor services relate to state public health care programs. Upon request, the
 427.17 commissioner shall have access to all subcontractor documentation under this paragraph.
 427.18 Nothing in this paragraph shall allow release of information that is nonpublic data
 427.19 pursuant to section 13.02.

427.20 Sec. 34. Minnesota Statutes 2014, section 256B.69, subdivision 5i, is amended to read:

427.21 Subd. 5i. **Administrative expenses.** ~~(a) Managed care plan and county-based~~
 427.22 ~~purchasing plan~~ Administrative costs for a prepaid health plan provided paid to managed
 427.23 care plans and county-based purchasing plans under this section or, section 256B.692,
 427.24 and section 256L.12 must not exceed by more than five 6.6 percent that prepaid health
 427.25 plan's or county-based purchasing plan's actual calculated administrative spending for the
 427.26 previous calendar year as a percentage of total revenue of total payments made to all
 427.27 managed care plans and county-based purchasing plans in aggregate across all state public
 427.28 health care programs, based on payments expected to be made at the beginning of each
 427.29 calendar year. The penalty for exceeding this limit must be the amount of administrative
 427.30 spending in excess of 105 percent of the actual calculated amount. The commissioner may
 427.31 waive this penalty if the excess administrative spending is the result of unexpected shifts
 427.32 in enrollment or member needs or new program requirements. The commissioner may
 427.33 reduce or eliminate administrative requirements to meet the administrative cost limit.
 427.34 For purposes of this paragraph, administrative costs do not include premium taxes paid

428.1 under section 297I.05, subdivision 5, provider surcharges paid under section 256.9657,
428.2 subdivision 3, and health insurance fees under section 9010 of the Affordable Care Act.

428.3 (b) The following expenses are not allowable administrative expenses for rate-setting
428.4 purposes under this section:

428.5 (1) charitable contributions made by the managed care plan or the county-based
428.6 purchasing plan;

428.7 (2) ~~any portion of an individual's compensation in excess of \$200,000 paid by the~~
428.8 ~~managed care plan or county-based purchasing plan~~ compensation of individuals within
428.9 the organization in excess of \$200,000 such that the allocation of compensation for an
428.10 individual across all state public health care programs in total cannot exceed \$200,000;

428.11 (3) any penalties or fines assessed against the managed care plan or county-based
428.12 purchasing plan; ~~and~~

428.13 (4) any indirect marketing or advertising expenses of the managed care plan or
428.14 county-based purchasing plan, including but not limited to costs to promote the managed
428.15 care or county-based purchasing plan, costs of facilities used for special events, and costs
428.16 of displays, demonstrations, donations, and promotional items such as memorabilia,
428.17 models, gifts, and souvenirs. The commissioner may classify an item listed in this clause
428.18 as an allowable administrative expense for rate-setting purposes, if the commissioner
428.19 determines that the expense is incidental to an activity related to state public health care
428.20 programs that is an allowable cost for purposes of rate setting;

428.21 (5) any lobbying and political activities, events, or contributions;

428.22 (6) administrative expenses related to the provision of services not covered under
428.23 the state plan or waiver;

428.24 (7) alcoholic beverages and related costs;

428.25 (8) membership in any social, dining, or country club or organization; and

428.26 (9) entertainment, including amusement, diversion, and social activities, and any
428.27 costs directly associated with these costs, including but not limited to tickets to shows or
428.28 sporting events, meals, lodging, rentals, transportation, and gratuities.

428.29 For the purposes of this subdivision, compensation includes salaries, bonuses and
428.30 incentives, other reportable compensation on an IRS 990 form, retirement and other
428.31 deferred compensation, and nontaxable benefits. Charitable contributions under clause
428.32 (1) include payments for or to any organization or entity selected by the managed care
428.33 plan or county-based purchasing plan that is operated for charitable, educational, political,
428.34 religious, or scientific purposes, that are not related to medical and administrative services
428.35 covered under state public health care programs.

429.1 (c) Payments to a quality improvement organization are an allowable administrative
429.2 expense for rate-setting purposes under this section, to the extent they are allocated to a
429.3 state public health care program and approved by the commissioner.

429.4 (d) Where reasonably possible, expenses for an administrative item shall be directly
429.5 allocated so as to assign costs for an item to an individual state public health care program
429.6 when the cost can be specifically identified with and benefits the individual state public
429.7 health care program. For administrative services expensed to the state's public health care
429.8 programs, managed care plans and county-based purchasing plans must clearly identify
429.9 and separately record expense items listed under paragraph (b) in their accounting systems
429.10 in a manner that allows for independent verification of unallowable expenses for purposes
429.11 of determining payment rates for state public health care programs.

429.12 (e) Notwithstanding paragraph (a), the commissioner shall reduce administrative
429.13 expenses paid to managed care plans and county-based purchasing plans by .50 of a
429.14 percentage point for contracts beginning January 1, 2016, and ending December 31,
429.15 2017. To meet the administrative reductions under this paragraph, the commissioner
429.16 may reduce or eliminate administrative requirements, exclude additional unallowable
429.17 administrative expenses identified under this section and resulting from the financial
429.18 audits conducted under subdivision 9d, and utilize competitive bidding to gain efficiencies
429.19 through economies of scale from increased enrollment. If the total reduction cannot be
429.20 achieved through administrative reduction, the commissioner may limit total rate increases
429.21 on payments to managed care plans and county-based purchasing plans.

429.22 Sec. 35. Minnesota Statutes 2014, section 256B.69, subdivision 9c, is amended to read:

429.23 Subd. 9c. **Managed care financial reporting.** (a) The commissioner shall collect
429.24 detailed data regarding financials, provider payments, provider rate methodologies, and
429.25 other data as determined by the commissioner. The commissioner, in consultation with the
429.26 commissioners of health and commerce, and in consultation with managed care plans and
429.27 county-based purchasing plans, shall set uniform criteria, definitions, and standards for the
429.28 data to be submitted, and shall require managed care and county-based purchasing plans
429.29 to comply with these criteria, definitions, and standards when submitting data under this
429.30 section. In carrying out the responsibilities of this subdivision, the commissioner shall
429.31 ensure that the data collection is implemented in an integrated and coordinated manner
429.32 that avoids unnecessary duplication of effort. To the extent possible, the commissioner
429.33 shall use existing data sources and streamline data collection in order to reduce public
429.34 and private sector administrative costs. Nothing in this subdivision shall allow release of
429.35 information that is nonpublic data pursuant to section 13.02.

430.1 (b) Effective January 1, 2014, each managed care and county-based purchasing plan
430.2 must quarterly provide to the commissioner the following information on state public
430.3 programs, in the form and manner specified by the commissioner, according to guidelines
430.4 developed by the commissioner in consultation with managed care plans and county-based
430.5 purchasing plans under contract:

430.6 (1) an income statement by program;

430.7 (2) financial statement footnotes;

430.8 (3) quarterly profitability by program and population group;

430.9 (4) a medical liability summary by program and population group;

430.10 (5) received but unpaid claims report by program;

430.11 (6) services versus payment lags by program for hospital services, outpatient
430.12 services, physician services, other medical services, and pharmaceutical benefits;

430.13 (7) utilization reports that summarize utilization and unit cost information by
430.14 program for hospitalization services, outpatient services, physician services, and other
430.15 medical services;

430.16 (8) pharmaceutical statistics by program and population group for measures of price
430.17 and utilization of pharmaceutical services;

430.18 (9) subcapitation expenses by population group;

430.19 (10) third-party payments by program;

430.20 (11) all new, active, and closed subrogation cases by program;

430.21 (12) all new, active, and closed fraud and abuse cases by program;

430.22 (13) medical loss ratios by program;

430.23 (14) administrative expenses by category and subcategory by program that reconcile
430.24 to other state and federal regulatory agencies, including Minnesota Supplement Report
430.25 #1A;

430.26 (15) revenues by program, including investment income;

430.27 (16) nonadministrative service payments, provider payments, and reimbursement
430.28 rates by provider type or service category, by program, paid by the managed care plan
430.29 under this section or the county-based purchasing plan under section 256B.692 to
430.30 providers and vendors for administrative services under contract with the plan, including
430.31 but not limited to:

430.32 (i) individual-level provider payment and reimbursement rate data;

430.33 (ii) provider reimbursement rate methodologies by provider type, by program,
430.34 including a description of alternative payment arrangements and payments outside the
430.35 claims process;

430.36 (iii) data on implementation of legislatively mandated provider rate changes; and

431.1 (iv) individual-level provider payment and reimbursement rate data and plan-specific
 431.2 provider reimbursement rate methodologies by provider type, by program, including
 431.3 alternative payment arrangements and payments outside the claims process, provided to
 431.4 the commissioner under this subdivision are nonpublic data as defined in section 13.02;

431.5 (17) data on the amount of reinsurance or transfer of risk by program; and

431.6 (18) contribution to reserve, by program.

431.7 (c) In the event a report is published or released based on data provided under
 431.8 this subdivision, the commissioner shall provide the report to managed care plans and
 431.9 county-based purchasing plans 15 days prior to the publication or release of the report.
 431.10 Managed care plans and county-based purchasing plans shall have 15 days to review the
 431.11 report and provide comment to the commissioner.

431.12 The quarterly reports shall be submitted to the commissioner no later than 60 days after the
 431.13 end of the previous quarter, except the fourth-quarter report, which shall be submitted by
 431.14 April 1 of each year. The fourth-quarter report shall include audited financial statements,
 431.15 parent company audited financial statements, an income statement reconciliation report,
 431.16 and any other documentation necessary to reconcile the detailed reports to the audited
 431.17 financial statements.

431.18 (d) Managed care plans and county-based purchasing plans shall certify to the
 431.19 commissioner for the purpose of financial reporting for state public health care programs
 431.20 under this subdivision that costs reported for state public health care programs include:

431.21 (1) only services covered under the state plan and waivers, and related allowable
 431.22 administrative expenses; and

431.23 (2) the dollar value of unallowable and nonstate plan services, including both
 431.24 medical and administrative expenditures, that have been excluded.

431.25 Sec. 36. Minnesota Statutes 2014, section 256B.69, subdivision 9d, is amended to read:

431.26 Subd. 9d. **Financial audit and quality assurance audits.** (a) The legislative
 431.27 ~~auditor shall contract with an audit firm to conduct a biennial independent third-party~~
 431.28 ~~financial audit of the information required to be provided by managed care plans and~~
 431.29 ~~county-based purchasing plans under subdivision 9c, paragraph (b). The audit shall be~~
 431.30 ~~conducted in accordance with generally accepted government auditing standards issued~~
 431.31 ~~by the United States Government Accountability Office. The contract with the audit~~
 431.32 ~~firm shall be designed and administered so as to render the independent third-party audit~~
 431.33 ~~eligible for a federal subsidy, if available. The contract shall require the audit to include~~
 431.34 ~~a determination of compliance with the federal Medicaid rate certification process. The~~
 431.35 ~~contract shall require the audit to determine if the administrative expenses and investment~~

432.1 ~~income reported by the managed care plans and county-based purchasing plans are~~
 432.2 ~~compliant with state and federal law.~~

432.3 ~~(b) For purposes of this subdivision, "independent third party" means an audit firm~~
 432.4 ~~that is independent in accordance with government auditing standards issued by the United~~
 432.5 ~~States Government Accountability Office and licensed in accordance with chapter 326A.~~
 432.6 ~~An audit firm under contract to provide services in accordance with this subdivision must~~
 432.7 ~~not have provided services to a managed care plan or county-based purchasing plan during~~
 432.8 ~~the period for which the audit is being conducted.~~

432.9 ~~(e) (a)~~ The commissioner shall require, in the request for bids and resulting contracts
 432.10 with managed care plans and county-based purchasing plans under this section and section
 432.11 256B.692, that each managed care plan and county-based purchasing plan submit to and
 432.12 fully cooperate with the independent third-party financial ~~audit~~ audits by the legislative
 432.13 auditor under subdivision 9e of the information required under subdivision 9c, paragraph
 432.14 (b). Each contract with a managed care plan or county-based purchasing plan under this
 432.15 section or section 256B.692 must provide the commissioner ~~and, the audit firm~~ legislative
 432.16 auditor, and vendors contracting with the legislative auditor, access to all data required to
 432.17 complete the audit. ~~For purposes of this subdivision, the contracting audit firm shall have~~
 432.18 ~~the same investigative power as the legislative auditor under section 3.978, subdivision 2~~
 432.19 audits under subdivision 9e.

432.20 ~~(d) (b)~~ Each managed care plan and county-based purchasing plan providing services
 432.21 under this section shall provide to the commissioner biweekly encounter data and claims
 432.22 data for state public health care programs and shall participate in a quality assurance
 432.23 program that verifies the timeliness, completeness, accuracy, and consistency of the data
 432.24 provided. The commissioner shall develop written protocols for the quality assurance
 432.25 program and shall make the protocols publicly available. The commissioner shall contract
 432.26 for an independent third-party audit to evaluate the quality assurance protocols as to
 432.27 the capacity of the protocols to ensure complete and accurate data and to evaluate the
 432.28 commissioner's implementation of the protocols. ~~The audit firm under contract to provide~~
 432.29 ~~this evaluation must meet the requirements in paragraph (b).~~

432.30 ~~(e) Upon completion of the audit under paragraph (a) and receipt by the legislative~~
 432.31 ~~auditor, the legislative auditor shall provide copies of the audit report to the commissioner,~~
 432.32 ~~the state auditor, the attorney general, and the chairs and ranking minority members of the~~
 432.33 ~~health and human services finance committees of the legislature.~~ (c) Upon completion
 432.34 of the evaluation under paragraph ~~(d) (b)~~, the commissioner shall provide copies of the
 432.35 report to the legislative auditor and the chairs and ranking minority members of the health

433.1 ~~finance committees of the legislature~~ legislative committees with jurisdiction over health
 433.2 care policy and financing.

433.3 ~~(f)~~ (d) Any actuary under contract with the commissioner to provide actuarial
 433.4 services must meet the independence requirements under the professional code for fellows
 433.5 in the Society of Actuaries and must not have provided actuarial services to a managed
 433.6 care plan or county-based purchasing plan that is under contract with the commissioner
 433.7 pursuant to this section and section 256B.692 during the period in which the actuarial
 433.8 services are being provided. An actuary or actuarial firm meeting the requirements
 433.9 of this paragraph must certify and attest to the rates paid to the managed care plans
 433.10 and county-based purchasing plans under this section and section 256B.692, and the
 433.11 certification and attestation must be auditable.

433.12 (e) The commissioner, to the extent of available funding, shall conduct ad hoc audits
 433.13 of state public health care program administrative and medical expenses reported by
 433.14 managed care plans and county-based purchasing plans. This includes: financial and
 433.15 encounter data reported to the commissioner under subdivision 9c, including payments to
 433.16 providers and subcontractors; supporting documentation for expenditures; categorization
 433.17 of administrative and medical expenses; and allocation methods used to attribute
 433.18 administrative expenses to state public health care programs. These audits also must
 433.19 monitor compliance with data and financial report certification requirements established
 433.20 by the commissioner for the purposes of managed care capitation payment rate-setting.
 433.21 The managed care plans and county-based purchasing plans shall fully cooperate with
 433.22 the audits in this subdivision. The commissioner shall report to the chairs and ranking
 433.23 minority members of the legislative committees with jurisdiction over health and human
 433.24 services policy and finance by February 1, 2016, and each February 1 thereafter, the
 433.25 number of ad hoc audits conducted in the past calendar year and the results of these audits.

433.26 ~~(g)~~ (f) Nothing in this subdivision shall allow the release of information that is
 433.27 nonpublic data pursuant to section 13.02.

433.28 Sec. 37. Minnesota Statutes 2014, section 256B.69, is amended by adding a
 433.29 subdivision to read:

433.30 Subd. 9e. **Financial audits.** (a) The legislative auditor shall conduct or contract with
 433.31 vendors to conduct independent third-party financial audits of the information required to
 433.32 be provided by managed care plans and county-based purchasing plans under subdivision
 433.33 9c, paragraph (b). The audits by the vendors shall be conducted as vendor resources
 433.34 permit and in accordance with generally accepted government auditing standards issued
 433.35 by the United States Government Accountability Office. The contract with the vendors

434.1 shall be designed and administered so as to render the independent third-party audits
434.2 eligible for a federal subsidy, if available. The contract shall require the audits to include a
434.3 determination of compliance with the federal Medicaid rate certification process.

434.4 (b) For purposes of this subdivision, "independent third-party" means a vendor that
434.5 is independent in accordance with government auditing standards issued by the United
434.6 States Government Accountability Office.

434.7 Sec. 38. Minnesota Statutes 2014, section 256B.75, is amended to read:

434.8 **256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.**

434.9 (a) For outpatient hospital facility fee payments for services rendered on or after
434.10 October 1, 1992, the commissioner of human services shall pay the lower of (1) submitted
434.11 charge, or (2) 32 percent above the rate in effect on June 30, 1992, except for those
434.12 services for which there is a federal maximum allowable payment. Effective for services
434.13 rendered on or after January 1, 2000, payment rates for nonsurgical outpatient hospital
434.14 facility fees and emergency room facility fees shall be increased by eight percent over the
434.15 rates in effect on December 31, 1999, except for those services for which there is a federal
434.16 maximum allowable payment. Services for which there is a federal maximum allowable
434.17 payment shall be paid at the lower of (1) submitted charge, or (2) the federal maximum
434.18 allowable payment. Total aggregate payment for outpatient hospital facility fee services
434.19 shall not exceed the Medicare upper limit. If it is determined that a provision of this
434.20 section conflicts with existing or future requirements of the United States government with
434.21 respect to federal financial participation in medical assistance, the federal requirements
434.22 prevail. The commissioner may, in the aggregate, prospectively reduce payment rates to
434.23 avoid reduced federal financial participation resulting from rates that are in excess of
434.24 the Medicare upper limitations.

434.25 (b) Notwithstanding paragraph (a), payment for outpatient, emergency, and
434.26 ambulatory surgery hospital facility fee services for critical access hospitals designated
434.27 under section 144.1483, clause (9), shall be paid on a cost-based payment system that is
434.28 based on the cost-finding methods and allowable costs of the Medicare program. Effective
434.29 for services provided on or after July 1, 2015, rates established for critical access hospitals
434.30 under this paragraph for the applicable payment year shall be the final payment and shall
434.31 not be settled to actual costs.

434.32 (c) Effective for services provided on or after July 1, 2003, rates that are based
434.33 on the Medicare outpatient prospective payment system shall be replaced by a budget
434.34 neutral prospective payment system that is derived using medical assistance data. The

435.1 commissioner shall provide a proposal to the 2003 legislature to define and implement
435.2 this provision.

435.3 (d) For fee-for-service services provided on or after July 1, 2002, the total payment,
435.4 before third-party liability and spenddown, made to hospitals for outpatient hospital
435.5 facility services is reduced by .5 percent from the current statutory rate.

435.6 (e) In addition to the reduction in paragraph (d), the total payment for fee-for-service
435.7 services provided on or after July 1, 2003, made to hospitals for outpatient hospital
435.8 facility services before third-party liability and spenddown, is reduced five percent from
435.9 the current statutory rates. Facilities defined under section 256.969, subdivision 16, are
435.10 excluded from this paragraph.

435.11 (f) In addition to the reductions in paragraphs (d) and (e), the total payment for
435.12 fee-for-service services provided on or after July 1, 2008, made to hospitals for outpatient
435.13 hospital facility services before third-party liability and spenddown, is reduced three
435.14 percent from the current statutory rates. Mental health services and facilities defined under
435.15 section 256.969, subdivision 16, are excluded from this paragraph.

435.16 Sec. 39. Minnesota Statutes 2014, section 256B.76, subdivision 1, is amended to read:

435.17 Subdivision 1. **Physician reimbursement.** (a) Effective for services rendered on
435.18 or after October 1, 1992, the commissioner shall make payments for physician services
435.19 as follows:

435.20 (1) payment for level one Centers for Medicare and Medicaid Services' common
435.21 procedural coding system codes titled "office and other outpatient services," "preventive
435.22 medicine new and established patient," "delivery, antepartum, and postpartum care,"
435.23 "critical care," cesarean delivery and pharmacologic management provided to psychiatric
435.24 patients, and level three codes for enhanced services for prenatal high risk, shall be paid
435.25 at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June
435.26 30, 1992. If the rate on any procedure code within these categories is different than the
435.27 rate that would have been paid under the methodology in section 256B.74, subdivision 2,
435.28 then the larger rate shall be paid;

435.29 (2) payments for all other services shall be paid at the lower of (i) submitted charges,
435.30 or (ii) 15.4 percent above the rate in effect on June 30, 1992; and

435.31 (3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th
435.32 percentile of 1989, less the percent in aggregate necessary to equal the above increases
435.33 except that payment rates for home health agency services shall be the rates in effect
435.34 on September 30, 1992.

436.1 (b) Effective for services rendered on or after January 1, 2000, payment rates for
436.2 physician and professional services shall be increased by three percent over the rates
436.3 in effect on December 31, 1999, except for home health agency and family planning
436.4 agency services. The increases in this paragraph shall be implemented January 1, 2000,
436.5 for managed care.

436.6 (c) Effective for services rendered on or after July 1, 2009, payment rates for
436.7 physician and professional services shall be reduced by five percent, except that for the
436.8 period July 1, 2009, through June 30, 2010, payment rates shall be reduced by 6.5 percent
436.9 for the medical assistance and general assistance medical care programs, over the rates in
436.10 effect on June 30, 2009. This reduction and the reductions in paragraph (d) do not apply
436.11 to office or other outpatient visits, preventive medicine visits and family planning visits
436.12 billed by physicians, advanced practice nurses, or physician assistants in a family planning
436.13 agency or in one of the following primary care practices: general practice, general internal
436.14 medicine, general pediatrics, general geriatrics, and family medicine. This reduction
436.15 and the reductions in paragraph (d) do not apply to federally qualified health centers,
436.16 rural health centers, and Indian health services. Effective October 1, 2009, payments
436.17 made to managed care plans and county-based purchasing plans under sections 256B.69,
436.18 256B.692, and 256L.12 shall reflect the payment reduction described in this paragraph.

436.19 (d) Effective for services rendered on or after July 1, 2010, payment rates for
436.20 physician and professional services shall be reduced an additional seven percent over
436.21 the five percent reduction in rates described in paragraph (c). This additional reduction
436.22 does not apply to physical therapy services, occupational therapy services, and speech
436.23 pathology and related services provided on or after July 1, 2010. This additional reduction
436.24 does not apply to physician services billed by a psychiatrist or an advanced practice nurse
436.25 with a specialty in mental health. Effective October 1, 2010, payments made to managed
436.26 care plans and county-based purchasing plans under sections 256B.69, 256B.692, and
436.27 256L.12 shall reflect the payment reduction described in this paragraph.

436.28 (e) Effective for services rendered on or after September 1, 2011, through June 30,
436.29 2013, payment rates for physician and professional services shall be reduced three percent
436.30 from the rates in effect on August 31, 2011. This reduction does not apply to physical
436.31 therapy services, occupational therapy services, and speech pathology and related services.

436.32 (f) Effective for services rendered on or after September 1, 2014, payment rates for
436.33 physician and professional services, including physical therapy, occupational therapy,
436.34 speech pathology, and mental health services shall be increased by five percent from the
436.35 rates in effect on August 31, 2014. In calculating this rate increase, the commissioner
436.36 shall not include in the base rate for August 31, 2014, the rate increase provided under

437.1 section 256B.76, subdivision 7. This increase does not apply to federally qualified health
437.2 centers, rural health centers, and Indian health services. Payments made to managed
437.3 care plans and county-based purchasing plans shall not be adjusted to reflect payments
437.4 under this paragraph.

437.5 (g) Effective for services rendered on or after July 1, 2015, payment rates for
437.6 physical therapy, occupational therapy, and speech pathology and related services provided
437.7 by a hospital meeting the criteria specified in section 62Q.19, subdivision 1, paragraph
437.8 (a), clause (4), shall be increased by 90 percent from the rates in effect on June 30, 2015.
437.9 Payments made to managed care plans and county-based purchasing plans shall not be
437.10 adjusted to reflect payments under this paragraph.

437.11 Sec. 40. Minnesota Statutes 2014, section 256B.76, subdivision 2, is amended to read:

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

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

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

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

437.20 (c) Effective for services rendered on or after January 1, 2000, payment rates for
437.21 dental services shall be increased by three percent over the rates in effect on December
437.22 31, 1999.

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

437.26 (e) The increases listed in paragraphs (b) and (c) shall be implemented January 1,
437.27 2000, for managed care.

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

437.33 (g) Beginning in fiscal year 2011, if the payments to state-operated dental clinics
437.34 in paragraph (f), including state and federal shares, are less than \$1,850,000 per fiscal
437.35 year, a supplemental state payment equal to the difference between the total payments

438.1 in paragraph (f) and \$1,850,000 shall be paid from the general fund to state-operated
438.2 services for the operation of the dental clinics.

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

438.8 (i) Effective for services rendered on or after September 1, 2011, through June 30,
438.9 2013, payment rates for dental services shall be reduced by three percent. This reduction
438.10 does not apply to state-operated dental clinics in paragraph (f).

438.11 (j) Effective for services rendered on or after January 1, 2014, payment rates for
438.12 dental services shall be increased by five percent from the rates in effect on December
438.13 31, 2013. This increase does not apply to state-operated dental clinics in paragraph (f),
438.14 federally qualified health centers, rural health centers, and Indian health services. Effective
438.15 January 1, 2014, payments made to managed care plans and county-based purchasing
438.16 plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment increase
438.17 described in this paragraph.

438.18 (k) Effective for services rendered on or after July 1, 2015, the commissioner shall
438.19 increase payment rates for services furnished by dental providers located outside of the
438.20 seven-county metropolitan area by the maximum percentage possible above the rates in
438.21 effect on June 30, 2015, while remaining within the limits of funding appropriated for this
438.22 purpose. This increase does not apply to state-operated dental clinics in paragraph (f),
438.23 federally qualified health centers, rural health centers, and Indian health services. Effective
438.24 January 1, 2016, payments to managed care plans and county-based purchasing plans
438.25 under sections 256B.69 and 256B.692 shall reflect the payment increase described in this
438.26 paragraph. The commissioner shall require managed care and county-based purchasing
438.27 plans to pass on the full amount of the increase, in the form of higher payment rates to
438.28 dental providers located outside of the seven-county metropolitan area.

438.29 Sec. 41. Minnesota Statutes 2014, section 256B.76, subdivision 4, as amended by
438.30 Laws 2015, chapter 21, article 1, section 58, is amended to read:

438.31 Subd. 4. **Critical access dental providers.** (a) Effective for dental services
438.32 rendered on or after January 1, 2002, the commissioner shall increase reimbursements
438.33 to dentists and dental clinics deemed by the commissioner to be critical access dental
438.34 providers. For dental services rendered on or after July 1, 2007, the commissioner shall
438.35 increase reimbursement by 35 percent above the reimbursement rate that would otherwise

439.1 be paid to the critical access dental provider. The commissioner shall pay the managed
439.2 care plans and county-based purchasing plans in amounts sufficient to reflect increased
439.3 reimbursements to critical access dental providers as approved by the commissioner.

439.4 (b) The commissioner shall designate the following dentists and dental clinics as
439.5 critical access dental providers:

439.6 (1) nonprofit community clinics that:

439.7 (i) have nonprofit status in accordance with chapter 317A;

439.8 (ii) have tax exempt status in accordance with the Internal Revenue Code, section
439.9 501(c)(3);

439.10 (iii) are established to provide oral health services to patients who are low income,
439.11 uninsured, have special needs, and are underserved;

439.12 (iv) have professional staff familiar with the cultural background of the clinic's
439.13 patients;

439.14 (v) charge for services on a sliding fee scale designed to provide assistance to
439.15 low-income patients based on current poverty income guidelines and family size;

439.16 (vi) do not restrict access or services because of a patient's financial limitations
439.17 or public assistance status; and

439.18 (vii) have free care available as needed;

439.19 (2) federally qualified health centers, rural health clinics, and public health clinics;

439.20 (3) city or county owned and operated hospital-based dental clinics;

439.21 (4) a dental clinic or dental group owned and operated by a nonprofit corporation in
439.22 accordance with chapter 317A with more than 10,000 patient encounters per year with
439.23 patients who are uninsured or covered by medical assistance or MinnesotaCare;

439.24 (5) a dental clinic owned and operated by the University of Minnesota or the
439.25 Minnesota State Colleges and Universities system; and

439.26 (6) private practicing dentists if:

439.27 (i) the dentist's office is located within a health professional shortage area as defined
439.28 under Code of Federal Regulations, title 42, part 5, and United States Code, title 42,
439.29 section 254E;

439.30 (ii) more than 50 percent of the dentist's patient encounters per year are with patients
439.31 who are uninsured or covered by medical assistance or MinnesotaCare; and

439.32 ~~(iii) the dentist does not restrict access or services because of a patient's financial
439.33 limitations or public assistance status; and~~

439.34 ~~(iv)~~ (iii) the level of service provided by the dentist is critical to maintaining
439.35 adequate levels of patient access within the service area in which the dentist operates.

440.1 Sec. 42. Minnesota Statutes 2014, section 256B.762, is amended to read:

440.2 **256B.762 REIMBURSEMENT FOR HEALTH CARE SERVICES.**

440.3 (a) Effective for services provided on or after October 1, 2005, payment rates
440.4 for the following services shall be increased by five percent over the rates in effect on
440.5 September 30, 2005, when these services are provided as home health services under
440.6 section 256B.0625, subdivision 6a:

- 440.7 (1) skilled nursing visit;
440.8 (2) physical therapy visit;
440.9 (3) occupational therapy visit;
440.10 (4) speech therapy visit; and
440.11 (5) home health aide visit.

440.12 (b) Effective for services provided on or after July 1, 2015, payment rates for
440.13 managed care and fee-for-service visits for the following services shall be increased by
440.14 ten percent over the rates in effect on June 30, 2015, when these services are provided as
440.15 home health services under section 256B.0625, subdivision 6a:

- 440.16 (1) physical therapy;
440.17 (2) occupational therapy; and
440.18 (3) speech therapy.

440.19 The commissioner shall adjust managed care and county-based purchasing plan capitation
440.20 rates to reflect the payment rates under this paragraph.

440.21 Sec. 43. Minnesota Statutes 2014, section 256B.766, is amended to read:

440.22 **256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.**

440.23 (a) Effective for services provided on or after July 1, 2009, total payments for basic
440.24 care services, shall be reduced by three percent, except that for the period July 1, 2009,
440.25 through June 30, 2011, total payments shall be reduced by 4.5 percent for the medical
440.26 assistance and general assistance medical care programs, prior to third-party liability and
440.27 spenddown calculation. Effective July 1, 2010, the commissioner shall classify physical
440.28 therapy services, occupational therapy services, and speech-language pathology and
440.29 related services as basic care services. The reduction in this paragraph shall apply to
440.30 physical therapy services, occupational therapy services, and speech-language pathology
440.31 and related services provided on or after July 1, 2010.

440.32 (b) Payments made to managed care plans and county-based purchasing plans shall
440.33 be reduced for services provided on or after October 1, 2009, to reflect the reduction

441.1 effective July 1, 2009, and payments made to the plans shall be reduced effective October
441.2 1, 2010, to reflect the reduction effective July 1, 2010.

441.3 (c) Effective for services provided on or after September 1, 2011, through June 30,
441.4 2013, total payments for outpatient hospital facility fees shall be reduced by five percent
441.5 from the rates in effect on August 31, 2011.

441.6 (d) Effective for services provided on or after September 1, 2011, through June
441.7 30, 2013, total payments for ambulatory surgery centers facility fees, medical supplies
441.8 and durable medical equipment not subject to a volume purchase contract, prosthetics
441.9 and orthotics, renal dialysis services, laboratory services, public health nursing services,
441.10 physical therapy services, occupational therapy services, speech therapy services,
441.11 eyeglasses not subject to a volume purchase contract, hearing aids not subject to a volume
441.12 purchase contract, and anesthesia services shall be reduced by three percent from the
441.13 rates in effect on August 31, 2011.

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

441.21 (f) Payments for medical supplies and durable medical equipment not subject to a
441.22 volume purchase contract, and prosthetics and orthotics, provided on or after July 1, 2014,
441.23 through June 30, 2015, shall be decreased by .33 percent. Payments for medical supplies
441.24 and durable medical equipment not subject to a volume purchase contract, and prosthetics
441.25 and orthotics, provided on or after July 1, 2015, shall be increased by three percent from
441.26 the rates ~~in effect on June 30, 2014~~ as determined under paragraph (i).

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

441.34 (h) This section does not apply to physician and professional services, inpatient
441.35 hospital services, family planning services, mental health services, dental services,

442.1 prescription drugs, medical transportation, federally qualified health centers, rural health
442.2 centers, Indian health services, and Medicare cost-sharing.

442.3 (i) Effective July 1, 2015, the medical assistance payment rate for durable medical
442.4 equipment, prosthetics, orthotics, or supplies shall be restored to the January 1, 2008,
442.5 medical assistance fee schedule, updated to include subsequent rate increases in the
442.6 Medicare and medical assistance fee schedules, and including individually priced
442.7 items for the following categories: enteral nutrition and supplies, customized and other
442.8 specialized tracheostomy tubes and supplies, electric patient lifts, and durable medical
442.9 equipment repair and service. This paragraph does not apply to medical supplies and
442.10 durable medical equipment subject to a volume purchase contract, products subject to the
442.11 preferred diabetic testing supply program, and items provided to dually eligible recipients
442.12 when Medicare is the primary payer for the item.

442.13 Sec. 44. Minnesota Statutes 2014, section 256B.767, is amended to read:

442.14 **256B.767 MEDICARE PAYMENT LIMIT.**

442.15 (a) Effective for services rendered on or after July 1, 2010, fee-for-service payment
442.16 rates for physician and professional services under section 256B.76, subdivision 1, and
442.17 basic care services subject to the rate reduction specified in section 256B.766, shall not
442.18 exceed the Medicare payment rate for the applicable service, as adjusted for any changes
442.19 in Medicare payment rates after July 1, 2010. The commissioner shall implement this
442.20 section after any other rate adjustment that is effective July 1, 2010, and shall reduce rates
442.21 under this section by first reducing or eliminating provider rate add-ons.

442.22 (b) This section does not apply to services provided by advanced practice certified
442.23 nurse midwives licensed under chapter 148 or traditional midwives licensed under chapter
442.24 147D. Notwithstanding this exemption, medical assistance fee-for-service payment rates
442.25 for advanced practice certified nurse midwives and licensed traditional midwives shall
442.26 equal and shall not exceed the medical assistance payment rate to physicians for the
442.27 applicable service.

442.28 (c) This section does not apply to mental health services or physician services billed
442.29 by a psychiatrist or an advanced practice registered nurse with a specialty in mental health.

442.30 ~~(d) Effective for durable medical equipment, prosthetics, orthotics, or supplies~~
442.31 ~~provided on or after July 1, 2013, through June 30, 2015, the payment rate for items~~
442.32 ~~that are subject to the rates established under Medicare's National Competitive Bidding~~
442.33 ~~Program shall be equal to the rate that applies to the same item when not subject to the~~
442.34 ~~rate established under Medicare's National Competitive Bidding Program. This paragraph~~

443.1 ~~does not apply to mail-order diabetic supplies and does not apply to items provided to~~
 443.2 ~~dually eligible recipients when Medicare is the primary payer of the item.~~

443.3 (d) Effective July 1, 2015, this section shall not apply to durable medical equipment,
 443.4 prosthetics, orthotics, or supplies.

443.5 (e) This section does not apply to physical therapy, occupational therapy, speech
 443.6 pathology and related services, and basic care services provided by a hospital meeting the
 443.7 criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause (4).

443.8 **Sec. 45. [256B.79] INTEGRATED CARE FOR HIGH-RISK PREGNANT**
 443.9 **WOMEN.**

443.10 Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms
 443.11 have the meanings given them.

443.12 (b) "Adverse outcomes" means maternal opiate addiction, other reportable prenatal
 443.13 substance abuse, low birth weight, or preterm birth.

443.14 (c) "Qualified integrated perinatal care collaborative" or "collaborative" means
 443.15 a combination of (1) members of community-based organizations that represent
 443.16 communities within the identified targeted populations, and (2) local or tribally based
 443.17 service entities, including health care, public health, social services, mental health,
 443.18 chemical dependency treatment, and community-based providers, determined by the
 443.19 commissioner to meet the criteria for the provision of integrated care and enhanced
 443.20 services for enrollees within targeted populations.

443.21 (d) "Targeted populations" means pregnant medical assistance enrollees residing
 443.22 in geographic areas identified by the commissioner as being at above-average risk for
 443.23 adverse outcomes.

443.24 Subd. 2. **Pilot program established.** The commissioner shall implement a pilot
 443.25 program to improve birth outcomes and strengthen early parental resilience for pregnant
 443.26 women who are medical assistance enrollees, are at significantly elevated risk for adverse
 443.27 outcomes of pregnancy, and are in targeted populations. The program must promote the
 443.28 provision of integrated care and enhanced services to these pregnant women, including
 443.29 postpartum coordination to ensure ongoing continuity of care, by qualified integrated
 443.30 perinatal care collaboratives.

443.31 Subd. 3. **Grant awards.** The commissioner shall award grants to qualifying
 443.32 applicants to support interdisciplinary, integrated perinatal care. Grants must be awarded
 443.33 beginning July 1, 2016. Grant funds must be distributed through a request for proposals
 443.34 process to a designated lead agency within an entity that has been determined to be a
 443.35 qualified integrated perinatal care collaborative or within an entity in the process of

444.1 meeting the qualifications to become a qualified integrated perinatal care collaborative.
444.2 Grant awards must be used to support interdisciplinary, team-based needs assessments,
444.3 planning, and implementation of integrated care and enhanced services for targeted
444.4 populations. In determining grant award amounts, the commissioner shall consider the
444.5 identified health and social risks linked to adverse outcomes and attributed to enrollees
444.6 within the identified targeted population.

444.7 Subd. 4. **Eligibility for grants.** To be eligible for a grant under this section, an
444.8 entity must show that the entity meets or is in the process of meeting qualifications
444.9 established by the commissioner to be a qualified integrated perinatal care collaborative.
444.10 These qualifications must include evidence that the entity has or is in the process of
444.11 developing policies, services, and partnerships to support interdisciplinary, integrated care.
444.12 The policies, services, and partnerships must meet specific criteria and be approved by the
444.13 commissioner. The commissioner shall establish a process to review the collaborative's
444.14 capacity for interdisciplinary, integrated care, to be reviewed at the commissioner's
444.15 discretion. In determining whether the entity meets the qualifications for a qualified
444.16 integrated perinatal care collaborative, the commissioner shall verify and review whether
444.17 the entity's policies, services, and partnerships:

444.18 (1) optimize early identification of drug and alcohol dependency and abuse during
444.19 pregnancy, effectively coordinate referrals and follow-up of identified patients to
444.20 evidence-based or evidence-informed treatment, and integrate perinatal care services with
444.21 behavioral health and substance abuse services;

444.22 (2) enhance access to, and effective use of, needed health care or tribal health care
444.23 services, public health or tribal public health services, social services, mental health
444.24 services, chemical dependency services, or services provided by community-based
444.25 providers by bridging cultural gaps within systems of care and by integrating
444.26 community-based paraprofessionals such as doulas and community health workers as
444.27 routinely available service components;

444.28 (3) encourage patient education about prenatal care, birthing, and postpartum
444.29 care, and document how patient education is provided. Patient education may include
444.30 information on nutrition, reproductive life planning, breastfeeding, and parenting;

444.31 (4) integrate child welfare case planning with substance abuse treatment planning
444.32 and monitoring, as appropriate;

444.33 (5) effectively systematize screening, collaborative care planning, referrals, and
444.34 follow up for behavioral and social risks known to be associated with adverse outcomes
444.35 and known to be prevalent within the targeted populations;

445.1 (6) facilitate ongoing continuity of care to include postpartum coordination and
445.2 referrals for interconception care, continued treatment for substance abuse, identification
445.3 and referrals for maternal depression and other chronic mental health conditions,
445.4 continued medication management for chronic diseases, and appropriate referrals to tribal
445.5 or county-based social services agencies and tribal or county-based public health nursing
445.6 services; and

445.7 (7) implement ongoing quality improvement activities as determined by the
445.8 commissioner, including collection and use of data from qualified providers on metrics
445.9 of quality such as health outcomes and processes of care, and the use of other data that
445.10 has been collected by the commissioner.

445.11 Subd. 5. **Gaps in communication, support, and care.** A collaborative receiving
445.12 a grant under this section must develop means of identifying and reporting gaps in the
445.13 collaborative's communication, administrative support, and direct care that must be
445.14 remedied for the collaborative to effectively provide integrated care and enhanced services
445.15 to targeted populations.

445.16 Subd. 6. **Report.** By January 31, 2019, the commissioner shall report to the chairs
445.17 and ranking minority members of the legislative committees with jurisdiction over health
445.18 and human services policy and finance on the status and progress of the pilot program.

445.19 The report must:

445.20 (1) describe the capacity of collaboratives receiving grants under this section;

445.21 (2) contain aggregate information about enrollees served within targeted populations;

445.22 (3) describe the utilization of enhanced prenatal services;

445.23 (4) for enrollees identified with maternal substance use disorders, describe the
445.24 utilization of substance use treatment and dispositions of any child protection cases;

445.25 (5) contain data on outcomes within targeted populations and compare these
445.26 outcomes to outcomes statewide, using standard categories of race and ethnicity; and

445.27 (6) include recommendations for continuing the program or sustaining improvements
445.28 through other means beyond June 30, 2019.

445.29 Subd. 7. **Expiration.** This section expires June 30, 2019.

445.30 Sec. 46. Minnesota Statutes 2014, section 256L.01, subdivision 3a, is amended to read:

445.31 Subd. 3a. **Family.** (a) Except as provided in paragraphs (c) and (d), "family" has
445.32 the meaning given for family and family size as defined in Code of Federal Regulations,
445.33 title 26, section 1.36B-1.

445.34 (b) The term includes children who are temporarily absent from the household in
445.35 settings such as schools, camps, or parenting time with noncustodial parents.

446.1 (c) For an individual who does not expect to file a federal tax return and does not
446.2 expect to be claimed as a dependent for the applicable tax year, "family" has the meaning
446.3 given in Code of Federal Regulations, title 42, section 435.603(f)(3).

446.4 (d) For a married couple, "family" has the meaning given in Code of Federal
446.5 Regulations, title 42, section 435.603(f)(4).

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

446.7 Sec. 47. Minnesota Statutes 2014, section 256L.01, subdivision 5, is amended to read:

446.8 Subd. 5. **Income.** "Income" has the meaning given for modified adjusted gross
446.9 income, as defined in Code of Federal Regulations, title 26, section 1.36B-1, and means a
446.10 household's projected annual income for the applicable tax year

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

446.12 Sec. 48. Minnesota Statutes 2014, section 256L.03, subdivision 5, is amended to read:

446.13 Subd. 5. **Cost-sharing.** (a) Except as otherwise provided in this subdivision, the
446.14 MinnesotaCare benefit plan shall include the following cost-sharing requirements for all
446.15 enrollees:

446.16 (1) \$3 per prescription for adult enrollees;

446.17 (2) \$25 for eyeglasses for adult enrollees;

446.18 (3) \$3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an
446.19 episode of service which is required because of a recipient's symptoms, diagnosis, or
446.20 established illness, and which is delivered in an ambulatory setting by a physician or
446.21 physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse,
446.22 audiologist, optician, or optometrist;

446.23 (4) \$6 for nonemergency visits to a hospital-based emergency room for services
446.24 provided through December 31, 2010, and \$3.50 effective January 1, 2011; and

446.25 (5) a family deductible equal to ~~the maximum amount allowed under Code of~~
446.26 ~~Federal Regulations, title 42, part 447.54.~~ \$2.75 per month per family and adjusted
446.27 annually by the percentage increase in the medical care component of the CPI-U for
446.28 the period of September to September of the preceding calendar year, rounded to the
446.29 next-higher five cent increment.

446.30 (b) Paragraph (a) does not apply to children under the age of 21 and to American
446.31 Indians as defined in Code of Federal Regulations, title 42, section 447.51.

446.32 (c) Paragraph (a), clause (3), does not apply to mental health services.

447.1 (d) MinnesotaCare reimbursements to fee-for-service providers and payments to
 447.2 managed care plans or county-based purchasing plans shall not be increased as a result of
 447.3 the reduction of the co-payments in paragraph (a), clause (4), effective January 1, 2011.

447.4 (e) The commissioner, through the contracting process under section 256L.12,
 447.5 may allow managed care plans and county-based purchasing plans to waive the family
 447.6 deductible under paragraph (a), clause (5). The value of the family deductible shall not be
 447.7 included in the capitation payment to managed care plans and county-based purchasing
 447.8 plans. Managed care plans and county-based purchasing plans shall certify annually to the
 447.9 commissioner the dollar value of the family deductible.

447.10 (f) The commissioner shall increase co-payments for covered services in a manner
 447.11 sufficient to reduce the actuarial value of the benefit to 94 percent. The cost-sharing
 447.12 changes described in this paragraph do not apply to eligible recipients or services exempt
 447.13 from cost-sharing under state law. The cost-sharing changes described in this paragraph
 447.14 shall not be implemented prior to January 1, 2016.

447.15 (g) The cost-sharing changes authorized under paragraph (f) must satisfy the
 447.16 requirements for cost-sharing under the Basic Health Program as set forth in Code of
 447.17 Federal Regulations, title 42, sections 600.510 and 600.520.

447.18 **EFFECTIVE DATE.** The amendment to paragraph (a), clause (5), is effective
 447.19 retroactively from January 1, 2014. The amendment to paragraph (b) is effective the
 447.20 day following final enactment.

447.21 Sec. 49. Minnesota Statutes 2014, section 256L.04, subdivision 1c, is amended to read:

447.22 Subd. 1c. **General requirements.** To be eligible for ~~coverage under~~ MinnesotaCare,
 447.23 a person must meet the eligibility requirements of this section. A person eligible for
 447.24 MinnesotaCare shall not be considered a qualified individual under section 1312 of the
 447.25 Affordable Care Act, and is not eligible for enrollment in a qualified health plan offered
 447.26 through MNsure under chapter 62V.

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

447.28 Sec. 50. Minnesota Statutes 2014, section 256L.04, subdivision 7b, is amended to read:

447.29 Subd. 7b. **Annual income limits adjustment.** The commissioner shall adjust the
 447.30 income limits under this section ~~each July 1 by the annual update of the federal poverty~~
 447.31 ~~guidelines following publication by the United States Department of Health and Human~~
 447.32 ~~Services except that the income standards shall not go below those in effect on July 1,~~

448.1 ~~2009~~ annually on January 1 as provided in Code of Federal Regulations, title 26, section
448.2 1.36B-1(h).

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

448.4 Sec. 51. Minnesota Statutes 2014, section 256L.05, is amended by adding a subdivision
448.5 to read:

448.6 Subd. 2a. **Eligibility and coverage.** For purposes of this chapter, an individual
448.7 is eligible for MinnesotaCare following a determination by the commissioner that the
448.8 individual meets the eligibility criteria for the applicable period of eligibility. For an
448.9 individual required to pay a premium, coverage is only available in each month of the
448.10 applicable period of eligibility for which a premium is paid.

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

448.12 Sec. 52. Minnesota Statutes 2014, section 256L.05, subdivision 3, is amended to read:

448.13 Subd. 3. **Effective date of coverage.** (a) The effective date of coverage is the first
448.14 day of the month following the month in which eligibility is approved and the first premium
448.15 payment has been received. The effective date of coverage for new members added to the
448.16 family is the first day of the month following the month in which the change is reported. All
448.17 eligibility criteria must be met by the family at the time the new family member is added.
448.18 The income of the new family member is included with the family's modified adjusted gross
448.19 income and the adjusted premium begins in the month the new family member is added.

448.20 (b) The initial premium must be received by the last working day of the month for
448.21 coverage to begin the first day of the following month.

448.22 (c) Notwithstanding any other law to the contrary, benefits under sections 256L.01 to
448.23 256L.18 are secondary to a plan of insurance or benefit program under which an eligible
448.24 person may have coverage and the commissioner shall use cost avoidance techniques to
448.25 ensure coordination of any other health coverage for eligible persons. The commissioner
448.26 shall identify eligible persons who may have coverage or benefits under other plans of
448.27 insurance or who become eligible for medical assistance.

448.28 (d) The effective date of coverage for individuals or families who are exempt from
448.29 paying premiums under section 256L.15, subdivision 1, paragraph (c), is the first day of
448.30 the month following the month in which ~~verification of American Indian status is received~~
448.31 or eligibility is approved, ~~whichever is later.~~

448.32 Sec. 53. Minnesota Statutes 2014, section 256L.05, subdivision 3a, is amended to read:

449.1 Subd. 3a. **Renewal Redetermination of eligibility.** ~~(a) Beginning July 1, 2007,~~ An
 449.2 enrollee's eligibility must be renewed every 12 months redetermined on an annual basis.
 449.3 ~~The 12-month period begins in the month after the month the application is approved. The~~
 449.4 period of eligibility is the entire calendar year following the year in which eligibility is
 449.5 redetermined. Beginning in calendar year 2015, eligibility redeterminations shall occur
 449.6 during the open enrollment period for qualified health plans as specified in Code of
 449.7 Federal Regulations, title 45, section 155.410.

449.8 (b) Each new period of eligibility must take into account any changes in
 449.9 circumstances that impact eligibility and premium amount. ~~An enrollee must provide all~~
 449.10 ~~the information needed to redetermine eligibility by the first day of the month that ends~~
 449.11 ~~the eligibility period. The premium for the new period of eligibility must be received~~
 449.12 Coverage begins as provided in section 256L.06 in order for eligibility to continue.

449.13 ~~(c) For children enrolled in MinnesotaCare, the first period of renewal begins the~~
 449.14 ~~month the enrollee turns 21 years of age.~~

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

449.16 Sec. 54. Minnesota Statutes 2014, section 256L.05, subdivision 4, is amended to read:

449.17 Subd. 4. **Application processing.** The commissioner of human services shall
 449.18 determine an applicant's eligibility for MinnesotaCare no more than ~~30~~45 days from the
 449.19 date that the application is received by the Department of Human Services as set forth in
 449.20 Code of Federal Regulations, title 42, section 435.912. ~~Beginning January 1, 2000, this~~
 449.21 ~~requirement also applies to local county human services agencies that determine eligibility~~
 449.22 ~~for MinnesotaCare.~~

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

449.24 Sec. 55. Minnesota Statutes 2014, section 256L.06, subdivision 3, is amended to read:

449.25 Subd. 3. **Commissioner's duties and payment.** (a) Premiums are dedicated to the
 449.26 commissioner for MinnesotaCare.

449.27 (b) The commissioner shall develop and implement procedures to: (1) require
 449.28 enrollees to report changes in income; (2) adjust sliding scale premium payments, based
 449.29 upon both increases and decreases in enrollee income, at the time the change in income
 449.30 is reported; and (3) disenroll enrollees from MinnesotaCare for failure to pay required
 449.31 premiums. Failure to pay includes payment with a dishonored check, a returned automatic
 449.32 bank withdrawal, or a refused credit card or debit card payment. The commissioner may

450.1 demand a guaranteed form of payment, including a cashier's check or a money order, as
450.2 the only means to replace a dishonored, returned, or refused payment.

450.3 (c) Premiums are calculated on a calendar month basis and may be paid on a
450.4 monthly, quarterly, or semiannual basis, with the first payment due upon notice from the
450.5 commissioner of the premium amount required. The commissioner shall inform applicants
450.6 and enrollees of these premium payment options. Premium payment is required before
450.7 enrollment is complete and to maintain eligibility in MinnesotaCare. Premium payments
450.8 received before noon are credited the same day. Premium payments received after noon
450.9 are credited on the next working day.

450.10 (d) Nonpayment of the premium will result in disenrollment from the plan
450.11 effective for the calendar month following the month for which the premium was due.
450.12 ~~Persons disenrolled for nonpayment who pay all past due premiums as well as current~~
450.13 ~~premiums due, including premiums due for the period of disenrollment, within 20 days of~~
450.14 ~~disenrollment, shall be reenrolled retroactively to the first day of disenrollment~~ may not
450.15 reenroll prior to the first day of the month following the payment of an amount equal to
450.16 two months' premiums.

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

450.18 Sec. 56. Minnesota Statutes 2014, section 256L.121, subdivision 1, is amended to read:

450.19 Subdivision 1. **Competitive process.** The commissioner of human services shall
450.20 establish a competitive process for entering into contracts with participating entities for
450.21 the offering of standard health plans through MinnesotaCare. Coverage through standard
450.22 health plans must be available to enrollees beginning January 1, 2015. Each standard
450.23 health plan must cover the health services listed in and meet the requirements of section
450.24 256L.03. The competitive process must meet the requirements of section 1331 of the
450.25 Affordable Care Act and be designed to ensure enrollee access to high-quality health care
450.26 coverage options. The commissioner, to the extent feasible, shall seek to ensure that
450.27 enrollees have a choice of coverage from more than one participating entity within a
450.28 geographic area. In counties that were part of a county-based purchasing plan on January
450.29 1, 2013, the commissioner shall use the medical assistance competitive procurement
450.30 process under section 256B.69, ~~subdivisions 1 to 32~~, under which selection of entities is
450.31 based on criteria related to provider network access, coordination of health care with other
450.32 local services, alignment with local public health goals, and other factors.

450.33 Sec. 57. Minnesota Statutes 2014, section 256L.15, subdivision 1, is amended to read:

451.1 Subdivision 1. **Premium determination for MinnesotaCare.** (a) Families with
451.2 children and individuals shall pay a premium determined according to subdivision 2.

451.3 (b) Members of the military and their families who meet the eligibility criteria
451.4 for MinnesotaCare upon eligibility approval made within 24 months following the end
451.5 of the member's tour of active duty shall have their premiums paid by the commissioner.
451.6 The effective date of coverage for an individual or family who meets the criteria of this
451.7 paragraph shall be the first day of the month following the month in which eligibility is
451.8 approved. This exemption applies for 12 months.

451.9 (c) Beginning July 1, 2009, American Indians enrolled in MinnesotaCare and their
451.10 families shall have their premiums waived by the commissioner in accordance with
451.11 section 5006 of the American Recovery and Reinvestment Act of 2009, Public Law 111-5.
451.12 An individual must document status as an American Indian, as defined under Code of
451.13 Federal Regulations, title 42, section 447.50, to qualify for the waiver of premiums.

451.14 (d) For premiums effective August 1, 2015, and after, the commissioner, after
451.15 consulting with the chairs and ranking minority members of the legislative committees
451.16 with jurisdiction over human services, shall increase premiums under subdivision 2
451.17 for recipients based on June 2015 program enrollment. Premium increases shall be
451.18 sufficient to increase projected revenue to the fund described in section 16A.724 by at
451.19 least \$27,800,000 for the biennium ending June 30, 2017. The commissioner shall publish
451.20 the revised premium scale on the Department of Human Services Web site and in the State
451.21 Register no later than June 15, 2015. The revised premium scale applies to all premiums
451.22 on or after August 1, 2015, in place of the scale under subdivision 2.

451.23 (e) By July 1, 2015, the commissioner shall provide the chairs and ranking minority
451.24 members of the legislative committees with jurisdiction over human services the revised
451.25 premium scale effective August 1, 2015, and statutory language to codify the revised
451.26 premium schedule.

451.27 (f) Premium changes authorized under paragraph (d) must only apply to enrollees not
451.28 otherwise excluded from paying premiums under state or federal law. Premium changes
451.29 authorized under paragraph (d) must satisfy the requirements for premiums for the Basic
451.30 Health Program under title 42 of the Code of Federal Regulations, section 600.505.

451.31 Sec. 58. Minnesota Statutes 2014, section 256L.15, subdivision 2, is amended to read:

451.32 Subd. 2. **Sliding fee scale; monthly individual or family income.** (a) The
451.33 commissioner shall establish a sliding fee scale to determine the percentage of monthly
451.34 individual or family income that households at different income levels must pay to obtain

452.1 coverage through the MinnesotaCare program. The sliding fee scale must be based on the
452.2 enrollee's monthly individual or family income.

452.3 (b) Beginning January 1, 2014, MinnesotaCare enrollees shall pay premiums
452.4 according to the premium scale specified in paragraph (e) ~~with the exception that children~~
452.5 ~~20 years of age and younger in families with income at or below 200 percent of the federal~~
452.6 ~~poverty guidelines shall pay no premiums~~ (d).

452.7 (c) Paragraph (b) does not apply to:

452.8 (1) children 20 years of age or younger; and

452.9 (2) individuals with household incomes below 35 percent of the federal poverty
452.10 guidelines.

452.11 (e) (d) The following premium scale is established for each individual in the
452.12 household who is 21 years of age or older and enrolled in MinnesotaCare:

Federal Poverty Guideline		Individual Premium
Greater than or Equal to	Less than	Amount
0% 35%	55%	\$4
55%	80%	\$6
80%	90%	\$8
90%	100%	\$10
100%	110%	\$12
110%	120%	\$15 <u>\$14</u>
120%	130%	\$18 <u>\$15</u>
130%	140%	\$21 <u>\$16</u>
140%	150%	\$25
150%	160%	\$29
160%	170%	\$33
170%	180%	\$38
180%	190%	\$43
190%		\$50

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

452.30 Sec. 59. Laws 2008, chapter 363, article 18, section 3, subdivision 5, is amended to read:

452.31 Subd. 5. **Basic Health Care Grants**

452.32 (a) **MinnesotaCare Grants**

452.33 **Health Care Access** -0- (770,000)

452.34 **Incentive Program and Outreach Grants.**

452.35 Of the appropriation for the Minnesota health
452.36 care outreach program in Laws 2007, chapter

453.1 147, article 19, section 3, subdivision 7,
453.2 paragraph (b):

453.3 (1) \$400,000 in fiscal year 2009 from the
453.4 general fund and \$200,000 in fiscal year 2009
453.5 from the health care access fund are for the
453.6 incentive program under Minnesota Statutes,
453.7 section 256.962, subdivision 5. For the
453.8 biennium beginning July 1, 2009, base level
453.9 funding for this activity shall be \$360,000
453.10 from the general fund and \$160,000 from the
453.11 health care access fund; and

453.12 (2) \$100,000 in fiscal year 2009 from the
453.13 general fund and \$50,000 in fiscal year 2009
453.14 from the health care access fund are for the
453.15 outreach grants under Minnesota Statutes,
453.16 section 256.962, subdivision 2. For the
453.17 biennium beginning July 1, 2009, base level
453.18 funding for this activity shall be \$90,000
453.19 from the general fund and \$40,000 from the
453.20 health care access fund.

453.21 **(b) MA Basic Health Care Grants - Families**
453.22 **and Children**

-0- (17,280,000)

453.23 **Third-Party Liability.** (a) During
453.24 fiscal year 2009, the commissioner shall
453.25 employ a contractor paid on a percentage
453.26 basis to improve third-party collections.
453.27 Improvement initiatives may include, but not
453.28 be limited to, efforts to improve postpayment
453.29 collection from nonresponsive claims and
453.30 efforts to uncover third-party payers the
453.31 commissioner has been unable to identify.

453.32 (b) In fiscal year 2009, the first \$1,098,000
453.33 of recoveries, after contract payments and
453.34 federal repayments, is appropriated to

454.1 the commissioner for technology-related
454.2 expenses.

454.3 ~~**Administrative Costs.** (a) For contracts~~
454.4 ~~effective on or after January 1, 2009,~~
454.5 ~~the commissioner shall limit aggregate~~
454.6 ~~administrative costs paid to managed care~~
454.7 ~~plans under Minnesota Statutes, section~~
454.8 ~~256B.69, and to county-based purchasing~~
454.9 ~~plans under Minnesota Statutes, section~~
454.10 ~~256B.692, to an overall average of 6.6 percent~~
454.11 ~~of total contract payments under Minnesota~~
454.12 ~~Statutes, sections 256B.69 and 256B.692,~~
454.13 ~~for each calendar year. For purposes of~~
454.14 ~~this paragraph, administrative costs do not~~
454.15 ~~include premium taxes paid under Minnesota~~
454.16 ~~Statutes, section 297I.05, subdivision 5, and~~
454.17 ~~provider surcharges paid under Minnesota~~
454.18 ~~Statutes, section 256.9657, subdivision 3.~~

454.19 ~~(b) Notwithstanding any law to the contrary,~~
454.20 ~~the commissioner may reduce or eliminate~~
454.21 ~~administrative requirements to meet the~~
454.22 ~~administrative target under paragraph (a).~~

454.23 ~~(c) Notwithstanding any contrary provision~~
454.24 ~~of this article, this rider shall not expire.~~

454.25 **Hospital Payment Delay.** Notwithstanding
454.26 Laws 2005, First Special Session chapter 4,
454.27 article 9, section 2, subdivision 6, payments
454.28 from the Medicaid Management Information
454.29 System that would otherwise have been made
454.30 for inpatient hospital services for medical
454.31 assistance enrollees are delayed as follows:
454.32 (1) for fiscal year 2008, June payments must
454.33 be included in the first payments in fiscal
454.34 year 2009; and (2) for fiscal year 2009,
454.35 June payments must be included in the first

455.1 payment of fiscal year 2010. The provisions
 455.2 of Minnesota Statutes, section 16A.124,
 455.3 do not apply to these delayed payments.
 455.4 Notwithstanding any contrary provision in
 455.5 this article, this paragraph expires on June
 455.6 30, 2010.

455.7 **(c) MA Basic Health Care Grants - Elderly and**
 455.8 **Disabled**

(14,028,000)

(9,368,000)

455.9 **Minnesota Disability Health Options Rate**

455.10 **Setting Methodology.** The commissioner
 455.11 shall develop and implement a methodology
 455.12 for risk adjusting payments for community
 455.13 alternatives for disabled individuals (CADI)
 455.14 and traumatic brain injury (TBI) home
 455.15 and community-based waiver services
 455.16 delivered under the Minnesota disability
 455.17 health options program (MnDHO) effective
 455.18 January 1, 2009. The commissioner shall
 455.19 take into account the weighting system used
 455.20 to determine county waiver allocations in
 455.21 developing the new payment methodology.
 455.22 Growth in the number of enrollees receiving
 455.23 CADI or TBI waiver payments through
 455.24 MnDHO is limited to an increase of 200
 455.25 enrollees in each calendar year from January
 455.26 2009 through December 2011. If those limits
 455.27 are reached, additional members may be
 455.28 enrolled in MnDHO for basic care services
 455.29 only as defined under Minnesota Statutes,
 455.30 section 256B.69, subdivision 28, and the
 455.31 commissioner may establish a waiting list for
 455.32 future access of MnDHO members to those
 455.33 waiver services.

455.34 **MA Basic Elderly and Disabled**

455.35 **Adjustments.** For the fiscal year ending June
 455.36 30, 2009, the commissioner may adjust the

456.1 rates for each service affected by rate changes
 456.2 under this section in such a manner across
 456.3 the fiscal year to achieve the necessary cost
 456.4 savings and minimize disruption to service
 456.5 providers, notwithstanding the requirements
 456.6 of Laws 2007, chapter 147, article 7, section
 456.7 71.

456.8 **(d) General Assistance Medical Care Grants** -0- (6,971,000)

456.9 **(e) Other Health Care Grants** -0- (17,000)

456.10 **MinnesotaCare Outreach Grants Special**

456.11 **Revenue Account.** The balance in the
 456.12 MinnesotaCare outreach grants special
 456.13 revenue account on July 1, 2009, estimated
 456.14 to be \$900,000, must be transferred to the
 456.15 general fund.

456.16 **Grants Reduction.** Effective July 1, 2008,
 456.17 base level funding for nonforecast, general
 456.18 fund health care grants issued under this
 456.19 paragraph shall be reduced by 1.8 percent at
 456.20 the allotment level.

456.21 Sec. 60. Laws 2014, chapter 312, article 24, section 45, subdivision 2, is amended to
 456.22 read:

456.23 Subd. 2. **Application for and terms of variance.** A new provider may apply to the
 456.24 commissioner, on a form supplied by the commissioner for this purpose, for a variance
 456.25 from special transportation service operating standards. The commissioner may grant or
 456.26 deny the variance application. Variances expire on the earlier of February 1, ~~2016~~ 2017, or
 456.27 ~~the date that the commissioner of transportation begins certifying new providers under the~~
 456.28 ~~terms of this act and successor legislation~~ one year after the date the variance was issued.
 456.29 The commissioner must not grant variances under this subdivision after June 30, 2016.

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

456.31 Sec. 61. **STATEWIDE OPIOID PRESCRIBING IMPROVEMENT PROGRAM.**

456.32 The commissioner of human services, in collaboration with the commissioner of
 456.33 health, shall report to the legislature by December 1, 2015, on recommendations made

457.1 by the opioid prescribing work group under Minnesota Statutes, section 256B.0638,
457.2 subdivision 4, and steps taken by the commissioner of human services to implement the
457.3 opioid prescribing improvement program under Minnesota Statutes, section 256B.0638,
457.4 subdivision 5.

457.5 **Sec. 62. TASK FORCE ON HEALTH CARE FINANCING.**

457.6 Subdivision 1. **Task force.** (a) The governor shall convene a task force on health
457.7 care financing to advise the governor and legislature on strategies that will increase access
457.8 to and improve the quality of health care for Minnesotans. These strategies shall include
457.9 options for sustainable health care financing, coverage, purchasing, and delivery for all
457.10 insurance affordability programs, including MNsure, medical assistance, MinnesotaCare,
457.11 and individuals eligible to purchase coverage with federal advanced premium tax credits
457.12 and cost-sharing subsidies.

457.13 (b) The task force shall consist of:

457.14 (1) seven members appointed by the senate, four members appointed by the majority
457.15 leader of the senate, one of whom must be a legislator; and three members appointed by
457.16 the minority leader of the senate, one of whom must be a legislator;

457.17 (2) seven members of the house of representatives, four members appointed by the
457.18 speaker of the house, one of whom must be a legislator; and three members appointed by
457.19 the minority leader of the house of representatives, one of whom must be a legislator;

457.20 (3) 11 members appointed by the governor, including public and private health care
457.21 experts and consumer representatives. The consumer representatives must include one
457.22 member from a nonprofit organization with legal expertise representing low-income
457.23 consumers, at least one member from a broad-based nonprofit consumer advocacy
457.24 organization, and at least one member from an organization representing consumers of
457.25 color; and

457.26 (4) the commissioners of human services, commerce, and health, and the executive
457.27 director of MNsure, or their designees.

457.28 (c) The commissioner of human services and a member of the task force voted
457.29 by the task force shall serve as cochairs of the task force. The commissioner of human
457.30 services shall convene the first meeting and the members shall vote on the cochair position
457.31 at the first meeting.

457.32 Subd. 2. **Duties.** (a) The task force shall consider opportunities, including
457.33 alternatives to MNsure, options under section 1332 of the Patient Protection and Affordable
457.34 Care Act, and options under a section 1115 waiver of the Social Security Act, including:

458.1 (1) options for providing and financing seamless coverage for persons
458.2 otherwise eligible for insurance affordability programs, including medical assistance,
458.3 MinnesotaCare, and advanced premium tax credits used to purchase commercial
458.4 insurance. This includes, but is not limited to: alignment of eligibility and enrollment
458.5 requirements; smoothing consumer cost-sharing across programs; alignment and
458.6 alternatives to benefit sets; alternatives to the individual mandate; the employer mandate
458.7 and penalties; advanced premium tax credits; and qualified health plans;

458.8 (2) options for transforming health care purchasing and delivery, including, but not
458.9 limited to: expansion of value-based direct contracting with providers and other entities
458.10 to reward improved health outcomes and reduced costs, including selective contracting;
458.11 contracting to provide services to public programs and commercial products; and payment
458.12 models that support and reward coordination of care across the continuum of services
458.13 and programs;

458.14 (3) options for alignment, consolidation, and governance of certain operational
458.15 components, including, but not limited to: MNsure; program eligibility, enrollment, call
458.16 centers, and contracting; and the shared eligibility IT platform; and

458.17 (4) examining the impact of options on the health care workforce and delivery
458.18 system, including, but not limited to, rural and safety net providers, clinics, and hospitals.

458.19 (b) In development of the options in paragraph (a), the task force options and
458.20 recommendations shall include the following goals:

458.21 (1) seamless consumer experience across all programs;

458.22 (2) reducing barriers to accessibility and affordability of coverage;

458.23 (3) improving sustainable financing of health programs, including impact on the
458.24 state budget;

458.25 (4) assessing the impact of options for innovation on their potential to reduce
458.26 health disparities;

458.27 (5) expanding innovative health care purchasing and delivery systems strategies that
458.28 reduce cost and improve health;

458.29 (6) promoting effectively and efficiently aligning program resources and operations;

458.30 and

458.31 (7) increasing transparency and accountability of program operations.

458.32 Subd. 3. **Staff.** (a) The commissioner of human services shall provide staff and
458.33 administrative services for the task force. The commissioner may accept outside resources
458.34 to help support its efforts and shall leverage its existing vendor contracts to provide
458.35 technical expertise to develop options under subdivision 2. The commissioner of human

459.1 services shall receive expedited review and publication of competitive procurements for
459.2 additional vendor support needed to support the task force.

459.3 (b) Technical assistance shall be provided by the Departments of Health, Commerce,
459.4 Human Services, and Management and Budget.

459.5 Subd. 4. **Report.** The commissioner of human services shall submit
459.6 recommendations by January 15, 2016, to the governor and the chairs and ranking
459.7 minority members of the legislative committees with jurisdiction over health, human
459.8 services, and commerce policy and finance.

459.9 Subd. 5. **Expiration.** The task force expires the day after submitting the report
459.10 required under subdivision 4.

459.11 Sec. 63. **HEALTH DISPARITIES PAYMENT ENHANCEMENT.**

459.12 (a) The commissioner of human services shall develop a methodology to pay a
459.13 higher payment rate for health care providers and services that takes into consideration
459.14 the higher cost, complexity, and resources needed to serve patients and populations
459.15 who experience the greatest health disparities in order to achieve the same health and
459.16 quality outcomes that are achieved for other patients and populations. In developing
459.17 the methodology, the commissioner shall take into consideration all existing payment
459.18 methods and rates, including add-on or enhanced rates paid to providers serving high
459.19 concentrations of low-income patients or populations or providing access in underserved
459.20 regions or populations. The new methodology must not result in a net decrease in total
459.21 payment from all sources for those providers who qualify for additional add-on payments
459.22 or enhanced payments, including, but not limited to, critical access dental, community
459.23 clinic add-ons, federally qualified health centers payment rates, and disproportionate share
459.24 payments. The commissioner shall develop the methodology in consultation with affected
459.25 stakeholders, including communities impacted by health disparities, using culturally
459.26 appropriate methods of community engagement. The proposed methodology must include
459.27 recommendations for how the methodology could be incorporated into payment methods
459.28 used in both fee-for-service and managed care plans.

459.29 (b) The commissioner shall submit a report on the analysis and provide options
459.30 for new payment methodologies that incorporate health disparities to the chairs and
459.31 ranking minority members of the legislative committees with jurisdiction over health care
459.32 policy and finance by February 1, 2016. The scope of the report and the development
459.33 work described in paragraph (a) is limited to data currently available to the Department
459.34 of Human Services; analyses of the data for reliability and completeness; analyses of

460.1 how these data relate to health disparities, outcomes, and expenditures; and options for
 460.2 incorporating these data or measures into a payment methodology.

460.3 Sec. 64. **CAPITATION PAYMENT DELAY.**

460.4 The commissioner of human services shall delay \$135,000,000 of the medical
 460.5 assistance capitation payment to managed care plans and county-based purchasing plans
 460.6 due in May 2017 and the payment due in April 2017 for special needs basic care until
 460.7 July 1, 2017. The payment shall be made no earlier than July 1, 2017, and no later than
 460.8 July 31, 2017.

460.9 Sec. 65. **REPEALER.**

460.10 (a) Minnesota Statutes 2014, sections 256.01, subdivision 35; 256.969, subdivisions
 460.11 23 and 30; and 256B.69, subdivision 32, are repealed effective July 1, 2015.

460.12 (b) Minnesota Statutes 2014, sections 256L.02, subdivision 3; and 256L.05,
 460.13 subdivisions 1b, 1c, 3c, and 5, are repealed effective the day following final enactment.

460.14 (c) Minnesota Rules, part 8840.5900, subparts 12 and 14, are repealed effective
 460.15 January 1, 2016.

460.16 **ARTICLE 12**
 460.17 **MNSURE**

460.18 Section 1. Minnesota Statutes 2014, section 62A.02, subdivision 2, is amended to read:

460.19 Subd. 2. **Approval.** (a) The health plan form shall not be issued, nor shall any
 460.20 application, rider, endorsement, or rate be used in connection with it, until the expiration
 460.21 of 60 days after it has been filed unless the commissioner approves it before that time.

460.22 (b) Notwithstanding paragraph (a), a rate filed with respect to a policy of accident and
 460.23 sickness insurance as defined in section 62A.01 by an insurer licensed under chapter 60A,
 460.24 may be used on or after the date of filing with the commissioner. Rates that are not approved
 460.25 or disapproved within the 60-day time period are deemed approved. This paragraph does
 460.26 not apply to Medicare-related coverage as defined in section 62A.3099, subdivision 17.

460.27 (c) For coverage to begin on or after January 1, 2016, and each January 1 thereafter,
 460.28 health plans in the individual and small group markets that are not grandfathered plans to
 460.29 be offered outside MNSure and qualified health plans to be offered inside MNSure must
 460.30 receive rate approval from the commissioner no later than 30 days prior to the beginning
 460.31 of the annual open enrollment period for MNSure. Premium rates for all carriers in the
 460.32 applicable market for the next calendar year must be made available to the public by the
 460.33 commissioner only after all rates for the applicable market are final and approved. Final

461.1 and approved rates must be publicly released at a uniform time for all individual and small
 461.2 group health plans that are not grandfathered plans to be offered outside MNsure and
 461.3 qualified health plans to be offered inside MNsure, and no later than 30 days prior to the
 461.4 beginning of the annual open enrollment period for MNsure.

461.5 Sec. 2. Minnesota Statutes 2014, section 62V.03, subdivision 2, is amended to read:

461.6 Subd. 2. **Application of other law.** (a) MNsure must be reviewed by the legislative
 461.7 auditor under section 3.971. The legislative auditor shall audit the books, accounts, and
 461.8 affairs of MNsure once each year or less frequently as the legislative auditor's funds and
 461.9 personnel permit. Upon the audit of the financial accounts and affairs of MNsure, MNsure
 461.10 is liable to the state for the total cost and expenses of the audit, including the salaries paid
 461.11 to the examiners while actually engaged in making the examination. The legislative
 461.12 auditor may bill MNsure either monthly or at the completion of the audit. All collections
 461.13 received for the audits must be deposited in the general fund and are appropriated to
 461.14 the legislative auditor. Pursuant to section 3.97, subdivision 3a, the Legislative Audit
 461.15 Commission is requested to direct the legislative auditor to report by March 1, 2014, to
 461.16 the legislature on any duplication of services that occurs within state government as a
 461.17 result of the creation of MNsure. The legislative auditor may make recommendations on
 461.18 consolidating or eliminating any services deemed duplicative. The board shall reimburse
 461.19 the legislative auditor for any costs incurred in the creation of this report.

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

461.22 (c) All meetings of the board shall comply with the open meeting law in chapter
 461.23 13D, ~~except that:~~

461.24 ~~(1) meetings, or portions of meetings, regarding compensation negotiations with the~~
 461.25 ~~director or managerial staff may be closed in the same manner and according to the same~~
 461.26 ~~procedures identified in section 13D.03;~~

461.27 ~~(2) meetings regarding contract negotiation strategy may be closed in the same~~
 461.28 ~~manner and according to the same procedures identified in section 13D.05, subdivision 3,~~
 461.29 ~~paragraph (c); and~~

461.30 ~~(3) meetings, or portions of meetings, regarding not public data described in section~~
 461.31 ~~62V.06, subdivision 3, and regarding trade secret information as defined in section 13.37,~~
 461.32 ~~subdivision 1, paragraph (b), are closed to the public, but must otherwise comply with~~
 461.33 ~~the procedures identified in chapter 13D.~~

461.34 (d) MNsure and provisions specified under this chapter are exempt from:

461.35 (1) chapter 14, including section 14.386, except as specified in section 62V.05; and

462.1 ~~(2) chapters 16B and 16C, with the exception of sections 16C.08, subdivision 2,~~
 462.2 ~~paragraph (b), clauses (1) to (8); 16C.086; 16C.09, paragraph (a), clauses (1) and (3),~~
 462.3 ~~paragraph (b), and paragraph (c); and section 16C.16. However, MNsure, in consultation~~
 462.4 ~~with the commissioner of administration, shall implement policies and procedures to~~
 462.5 ~~establish an open and competitive procurement process for MNsure that, to the extent~~
 462.6 ~~practicable, conforms to the principles and procedures contained in chapters 16B and 16C.~~
 462.7 ~~In addition, MNsure may enter into an agreement with the commissioner of administration~~
 462.8 ~~for other services.~~

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

462.12 ~~(f)~~ (e) Section 3.3005 applies to any federal funds received by MNsure.

462.13 ~~(g) MNsure is exempt from the following sections in chapter 16E: 16E.01,~~
 462.14 ~~subdivision 3, paragraph (b); 16E.03, subdivisions 3 and 4; 16E.04, subdivision 1,~~
 462.15 ~~subdivision 2, paragraph (c), and subdivision 3, paragraph (b); 16E.0465; 16E.055;~~
 462.16 ~~16E.145; 16E.15; 16E.16; 16E.17; 16E.18; and 16E.22.~~

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

462.20 Sec. 3. Minnesota Statutes 2014, section 62V.05, subdivision 6, is amended to read:

462.21 Subd. 6. **Appeals.** (a) The board may conduct hearings, appoint hearing officers,
 462.22 and recommend final orders related to appeals of any MNsure determinations, except for
 462.23 those determinations identified in paragraph (d). An appeal by a health carrier regarding
 462.24 a specific certification or selection determination made by MNsure under subdivision 5
 462.25 must be conducted as a contested case proceeding under chapter 14, with the report or
 462.26 order of the administrative law judge constituting the final decision in the case, subject to
 462.27 judicial review under sections 14.63 to 14.69. For other appeals, the board shall establish
 462.28 hearing processes which provide for a reasonable opportunity to be heard and timely
 462.29 resolution of the appeal and which are consistent with the requirements of federal law and
 462.30 guidance. An appealing party may be represented by legal counsel at these hearings, but
 462.31 this is not a requirement.

462.32 (b) MNsure may establish service-level agreements with state agencies to conduct
 462.33 hearings for appeals. Notwithstanding section 471.59, subdivision 1, a state agency is
 462.34 authorized to enter into service-level agreements for this purpose with MNsure.

463.1 (c) For proceedings under this subdivision, MNsure may be represented by an
463.2 attorney who is an employee of MNsure.

463.3 (d) This subdivision does not apply to appeals of determinations where a state
463.4 agency hearing is available under section 256.045.

463.5 (e) An appellant aggrieved by an order of MNsure issued in an eligibility appeal, as
463.6 defined in Minnesota Rules, part 7700.0101, may appeal the order to the district court of
463.7 the appellant's county of residence by serving a written copy of a notice of appeal upon
463.8 MNsure and any other adverse party of record within 30 days after the date MNsure
463.9 issued the order, the amended order, or order affirming the original order, and by filing
463.10 the original notice and proof of service with the court administrator of the district court.
463.11 Service may be made personally or by mail; service by mail is complete upon mailing;
463.12 no filing fee shall be required by the court administrator in appeals taken pursuant to this
463.13 subdivision. MNsure shall furnish all parties to the proceedings with a copy of the decision
463.14 and a transcript of any testimony, evidence, or other supporting papers from the hearing
463.15 held before the appeals examiner within 45 days after service of the notice of appeal.

463.16 (f) Any party aggrieved by the failure of an adverse party to obey an order issued
463.17 by MNsure may compel performance according to the order in the manner prescribed in
463.18 sections 586.01 to 586.12.

463.19 (g) Any party may obtain a hearing at a special term of the district court by serving a
463.20 written notice of the time and place of the hearing at least ten days prior to the date of
463.21 the hearing. The court may consider the matter in or out of chambers, and shall take no
463.22 new or additional evidence unless it determines that such evidence is necessary for a
463.23 more equitable disposition of the appeal.

463.24 (h) Any party aggrieved by the order of the district court may appeal the order as in
463.25 other civil cases. No costs or disbursements shall be taxed against any party nor shall any
463.26 filing fee or bond be required of any party.

463.27 (i) If MNsure or district court orders eligibility for qualified health plan coverage
463.28 through MNsure, or eligibility for federal advance payment of premium tax credits
463.29 or cost-sharing reductions contingent upon full payment of respective premiums, the
463.30 premiums must be paid or provided pending appeal to the district court, Court of Appeals,
463.31 or Supreme Court. Provision of eligibility by MNsure pending appeal does not render
463.32 moot MNsure's position in a court of law.

463.33 Sec. 4. Minnesota Statutes 2014, section 62V.05, subdivision 7, is amended to read:

463.34 Subd. 7. **Agreements; consultation.** (a) The board shall:

464.1 ~~(1) establish and maintain an agreement with the chief information officer of the~~
464.2 ~~Office of MN.IT Services for information technology services that ensures coordination~~
464.3 ~~with public health care programs. The board may establish and maintain agreements~~
464.4 ~~with the chief information officer of the Office of MN.IT Services for other information~~
464.5 ~~technology services, including an agreement that would permit MNsure to administer~~
464.6 ~~eligibility for additional health care and public assistance programs under the authority~~
464.7 ~~of the commissioner of human services;~~

464.8 (2) (1) establish and maintain an agreement with the commissioner of human
464.9 services for cost allocation and services regarding eligibility determinations and
464.10 enrollment for public health care programs that use a modified adjusted gross income
464.11 standard to determine program eligibility. The board may establish and maintain an
464.12 agreement with the commissioner of human services for other services;

464.13 ~~(3)~~ (2) establish and maintain an agreement with the commissioners of commerce and
464.14 health for services regarding enforcement of MNsure certification requirements for health
464.15 plans and dental plans offered through MNsure. The board may establish and maintain
464.16 agreements with the commissioners of commerce and health for other services; and

464.17 ~~(4)~~ (3) establish interagency agreements to transfer funds to other state agencies for
464.18 their costs related to implementing and operating MNsure, excluding medical assistance
464.19 allocatable costs.

464.20 (b) The board shall consult with the commissioners of commerce and health
464.21 regarding the operations of MNsure.

464.22 (c) The board shall consult with Indian tribes and organizations regarding the
464.23 operation of MNsure.

464.24 (d) Beginning March 15, ~~2014~~ 2016, and each March 15 thereafter, the board shall
464.25 submit a report to the chairs and ranking minority members of the committees in the
464.26 senate and house of representatives with primary jurisdiction over commerce, health, and
464.27 human services on all the agreements entered into with the chief information officer of the
464.28 Office of MN.IT Services, or the commissioners of human services, health, or commerce
464.29 in accordance with this subdivision. The report shall include the agency in which the
464.30 agreement is with; the time period of the agreement; the purpose of the agreement; and
464.31 a summary of the terms of the agreement. A copy of the agreement must be submitted
464.32 to the extent practicable.

464.33 Sec. 5. Minnesota Statutes 2014, section 62V.05, subdivision 8, is amended to read:

465.1 Subd. 8. **Rulemaking.** ~~(a) If the board's policies, procedures, or other statements are~~
 465.2 ~~rules, as defined in section 14.02, subdivision 4, the requirements in either paragraph (b)~~
 465.3 ~~or (c) apply, as applicable.~~

465.4 ~~(b) Effective upon enactment until January 1, 2015:~~

465.5 ~~(1) the board shall publish notice of proposed rules in the State Register after~~
 465.6 ~~complying with section 14.07, subdivision 2;~~

465.7 ~~(2) interested parties have 21 days to comment on the proposed rules. The board~~
 465.8 ~~must consider comments it receives. After the board has considered all comments and~~
 465.9 ~~has complied with section 14.07, subdivision 2, the board shall publish notice of the~~
 465.10 ~~final rule in the State Register;~~

465.11 ~~(3) if the adopted rules are the same as the proposed rules, the notice shall state that~~
 465.12 ~~the rules have been adopted as proposed and shall cite the prior publication. If the adopted~~
 465.13 ~~rules differ from the proposed rules, the portions of the adopted rules that differ from the~~
 465.14 ~~proposed rules shall be included in the notice of adoption, together with a citation to the~~
 465.15 ~~prior State Register that contained the notice of the proposed rules; and~~

465.16 ~~(4) rules published in the State Register before January 1, 2014, take effect upon~~
 465.17 ~~publication of the notice. Rules published in the State Register on and after January 1,~~
 465.18 ~~2014, take effect 30 days after publication of the notice.~~

465.19 ~~(e) Beginning January 1, 2015, The board may adopt rules to implement any~~
 465.20 ~~provisions in this chapter using the expedited rulemaking process in section 14.389.~~

465.21 ~~(d) The notice of proposed rules required in paragraph (b) must provide information~~
 465.22 ~~as to where the public may obtain a copy of the rules. The board shall post the proposed~~
 465.23 ~~rules on the MNsure Web site at the same time the notice is published in the State Register.~~

465.24 Sec. 6. Minnesota Statutes 2014, section 62V.05, is amended by adding a subdivision
 465.25 to read:

465.26 Subd. 12. **Prohibition on other product lines.** MNsure is prohibited from
 465.27 certifying, selecting, or offering products and policies of coverage that do not meet the
 465.28 definition of health plan or dental plan as provided in section 62V.02.

465.29 Sec. 7. **EXPANDED ACCESS TO THE SMALL BUSINESS HEALTH CARE**
 465.30 **TAX CREDIT.**

465.31 (a) The commissioner of human services, in consultation with the Board of Directors
 465.32 of MNsure and the MNsure Legislative Oversight Committee, shall develop a proposal
 465.33 to allow small employers the ability to receive the small business health care tax credit
 465.34 when the small employer pays the premiums on behalf of employees enrolled in either a

466.1 qualified health plan offered through a small business health options program (SHOP)
 466.2 marketplace or a small group health plan offered outside of the SHOP marketplace within
 466.3 MNsure. To be eligible for the tax credit, the small employer must meet the requirements
 466.4 under the Affordable Care Act, except that employees may be enrolled in a small group
 466.5 health plan product offered outside of MNsure.

466.6 (b) The commissioner shall seek all federal waivers and approvals necessary to
 466.7 implement the proposal in paragraph (a). The commissioner shall submit a draft proposal
 466.8 to the MNsure board and the MNsure Legislative Oversight Committee at least 30 days
 466.9 before submitting a final proposal to the federal government, and shall notify the board
 466.10 and Legislative Oversight Committee of any federal decision or action received regarding
 466.11 the proposal and submitted waiver.

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

466.13 Sec. 8. **EXPANDED ACCESS TO QUALIFIED HEALTH PLANS AND**
 466.14 **SUBSIDIES.**

466.15 The commissioner of commerce, in consultation with the Board of Directors of
 466.16 MNsure and the MNsure Legislative Oversight Committee, shall develop a proposal to
 466.17 allow individuals to purchase qualified health plans outside of MNsure directly from
 466.18 health plan companies and to allow eligible individuals to receive advanced premium tax
 466.19 credits and cost-sharing reductions when purchasing these health plans. The commissioner
 466.20 shall seek all federal waivers and approvals necessary to implement this proposal.
 466.21 The commissioner shall submit a draft proposal to the MNsure board and the MNsure
 466.22 Legislative Oversight Committee at least 30 days before submitting a final proposal to the
 466.23 federal government and shall notify the board and legislative oversight committee of any
 466.24 federal decision or action related to the proposal.

466.25 Sec. 9. **REPEALER.**

466.26 Minnesota Statutes 2014, section 62V.11, subdivision 3, is repealed.

466.27 **ARTICLE 13**

466.28 **HUMAN SERVICES FORECAST ADJUSTMENTS**

466.29 Section 1. **DEPARTMENT OF HUMAN SERVICES FORECAST ADJUSTMENT.**

466.30 The dollar amounts shown are added to or, if shown in parentheses, are subtracted
 466.31 from the appropriations in Laws 2013, chapter 108, article 14, as amended by Laws 2014,
 466.32 chapter 312, article 30, from the general fund, or any other fund named, to the Department

468.1 Subd. 3. Technical Activities 998,000

468.2 This appropriation is from the TANF fund.

468.3 **Sec. 3. EFFECTIVE DATE.**

468.4 Sections 1 and 2 are effective the day following final enactment.

468.5 **ARTICLE 14**

468.6 **HEALTH AND HUMAN SERVICES APPROPRIATIONS**

468.7 Section 1. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

468.8 The sums shown in the columns marked "Appropriations" are appropriated to the
 468.9 agencies and for the purposes specified in this article. The appropriations are from the
 468.10 general fund, or another named fund, and are available for the fiscal years indicated
 468.11 for each purpose. The figures "2016" and "2017" used in this article mean that the
 468.12 appropriations listed under them are available for the fiscal year ending June 30, 2016, or
 468.13 June 30, 2017, respectively. "The first year" is fiscal year 2016. "The second year" is fiscal
 468.14 year 2017. "The biennium" is fiscal years 2016 and 2017.

	<u>APPROPRIATIONS</u>	
	<u>Available for the Year</u>	
	<u>Ending June 30</u>	
	<u>2016</u>	<u>2017</u>

468.19 **Sec. 2. COMMISSIONER OF HUMAN**
 468.20 **SERVICES**

468.21 Subdivision 1. Total Appropriation **\$ 7,236,563,000 \$ 7,443,496,000**

468.22 Appropriations by Fund

	<u>2016</u>	<u>2017</u>
468.23 <u>General</u>	<u>5,903,939,000</u>	<u>6,448,469,000</u>
468.24 <u>State Government</u>		
468.25 <u>Special Revenue</u>	<u>4,514,000</u>	<u>4,274,000</u>
468.26 <u>Health Care Access</u>	<u>1,059,147,000</u>	<u>725,326,000</u>
468.27 <u>Federal TANF</u>	<u>267,070,000</u>	<u>263,531,000</u>
468.28 <u>Lottery Prize</u>	<u>1,893,000</u>	<u>1,896,000</u>

468.29 **Receipts for Systems Projects.**

468.30 Appropriations and federal receipts for
 468.31 information systems projects for MAXIS,
 468.32 PRISM, MMIS, ISDS, and SSIS must
 468.33 be deposited in the state systems account

469.1 authorized in Minnesota Statutes, section
469.2 256.014. Money appropriated for computer
469.3 projects approved by the commissioner
469.4 of the Office of MN.IT Services, funded
469.5 by the legislature, and approved by the
469.6 commissioner of management and budget
469.7 may be transferred from one project to
469.8 another and from development to operations
469.9 as the commissioner of human services
469.10 considers necessary. Any unexpended
469.11 balance in the appropriation for these
469.12 projects does not cancel but is available for
469.13 ongoing development and operations.

469.14 **TANF Maintenance of Effort.** (a) In order
469.15 to meet the basic maintenance of effort
469.16 (MOE) requirements of the TANF block grant
469.17 specified under Code of Federal Regulations,
469.18 title 45, section 263.1, the commissioner may
469.19 only report nonfederal money expended for
469.20 allowable activities listed in the following
469.21 clauses as TANF/MOE expenditures:

469.22 (1) MFIP cash, diversionary work program,
469.23 and food assistance benefits under Minnesota
469.24 Statutes, chapter 256J;

469.25 (2) the child care assistance programs
469.26 under Minnesota Statutes, sections 119B.03
469.27 and 119B.05, and county child care
469.28 administrative costs under Minnesota
469.29 Statutes, section 119B.15;

469.30 (3) state and county MFIP administrative
469.31 costs under Minnesota Statutes, chapters
469.32 256J and 256K;

469.33 (4) state, county, and tribal MFIP
469.34 employment services under Minnesota
469.35 Statutes, chapters 256J and 256K;

470.1 (5) expenditures made on behalf of legal
470.2 noncitizen MFIP recipients who qualify for
470.3 the MinnesotaCare program under Minnesota
470.4 Statutes, chapter 256L;

470.5 (6) qualifying working family credit
470.6 expenditures under Minnesota Statutes,
470.7 section 290.0671; and

470.8 (7) qualifying Minnesota education credit
470.9 expenditures under Minnesota Statutes,
470.10 section 290.0674.

470.11 (b) The commissioner shall ensure that
470.12 sufficient qualified nonfederal expenditures
470.13 are made each year to meet the state's
470.14 TANF/MOE requirements. For the activities
470.15 listed in paragraph (a), clauses (2) to
470.16 (7), the commissioner may only report
470.17 expenditures that are excluded from the
470.18 definition of assistance under Code of
470.19 Federal Regulations, title 45, section 260.31.

470.20 (c) For fiscal years beginning with state fiscal
470.21 year 2003, the commissioner shall ensure
470.22 that the maintenance of effort used by the
470.23 commissioner of management and budget
470.24 for the February and November forecasts
470.25 required under Minnesota Statutes, section
470.26 16A.103, contains expenditures under
470.27 paragraph (a), clause (1), equal to at least 16
470.28 percent of the total required under Code of
470.29 Federal Regulations, title 45, section 263.1.

470.30 (d) The requirement in Minnesota Statutes,
470.31 section 256.011, subdivision 3, that federal
470.32 grants or aids secured or obtained under that
470.33 subdivision be used to reduce any direct
470.34 appropriations provided by law, does not

471.1 apply if the grants or aids are federal TANF
471.2 funds.

471.3 (e) For the federal fiscal years beginning on
471.4 or after October 1, 2007, the commissioner
471.5 may not claim an amount of TANF/MOE in
471.6 excess of the 75 percent standard in Code
471.7 of Federal Regulations, title 45, section
471.8 263.1(a)(2), except:

471.9 (1) to the extent necessary to meet the 80
471.10 percent standard under Code of Federal
471.11 Regulations, title 45, section 263.1(a)(1),
471.12 if it is determined by the commissioner
471.13 that the state will not meet the TANF work
471.14 participation target rate for the current year;

471.15 (2) to provide any additional amounts
471.16 under Code of Federal Regulations, title 45,
471.17 section 264.5, that relate to replacement of
471.18 TANF funds due to the operation of TANF
471.19 penalties; and

471.20 (3) to provide any additional amounts that
471.21 may contribute to avoiding or reducing
471.22 TANF work participation penalties through
471.23 the operation of the excess MOE provisions
471.24 of Code of Federal Regulations, title 45,
471.25 section 261.43(a)(2).

471.26 (f) For the purposes of paragraph (e), clauses
471.27 (1) to (3), the commissioner may supplement
471.28 the MOE claim with working family credit
471.29 expenditures or other qualified expenditures
471.30 to the extent such expenditures are otherwise
471.31 available after considering the expenditures
471.32 allowed in this subdivision and subdivision 2.

471.33 (g) Notwithstanding any contrary provision
471.34 in this article, paragraphs (a) to (f) expire
471.35 June 30, 2019.

472.1 **Working Family Credit Expenditure**
 472.2 **as TANF/MOE.** The commissioner may
 472.3 claim as TANF maintenance of effort up to
 472.4 \$6,707,000 per year of working family credit
 472.5 expenditures in each fiscal year.

472.6 **Subd. 2. Working Family Credit to be Claimed**
 472.7 **for TANF/MOE**

472.8 The commissioner may count the following
 472.9 additional amounts of working family credit
 472.10 expenditures as TANF maintenance of effort:

472.11 (1) fiscal year 2016, \$0;

472.12 (2) fiscal year 2017, \$1,283,000;

472.13 (3) fiscal year 2018, \$0; and

472.14 (4) fiscal year 2019, \$0.

472.15 Notwithstanding any contrary provision in
 472.16 this article, this subdivision expires June 30,
 472.17 2019.

472.18 **Subd. 3. Central Office**

472.19 The amounts that may be spent from this
 472.20 appropriation for each purpose are as follows:

472.21 **(a) Operations**

	<u>Appropriations by Fund</u>	
472.22		
472.23	<u>General</u>	<u>115,577,000</u> <u>113,733,000</u>
472.24	<u>State Government</u>	
472.25	<u>Special Revenue</u>	<u>4,389,000</u> <u>4,149,000</u>
472.26	<u>Health Care Access</u>	<u>9,793,000</u> <u>10,076,000</u>
472.27	<u>Federal TANF</u>	<u>100,000</u> <u>100,000</u>

472.28 **Administrative Recovery; Set-Aside.** The
 472.29 commissioner may invoice local entities
 472.30 through the SWIFT accounting system as an
 472.31 alternative means to recover the actual cost
 472.32 of administering the following provisions:

472.33 (1) Minnesota Statutes, section 125A.744,
 472.34 subdivision 3;

- 473.1 (2) Minnesota Statutes, section 245.495,
473.2 paragraph (b);
- 473.3 (3) Minnesota Statutes, section 256B.0625,
473.4 subdivision 20, paragraph (k);
- 473.5 (4) Minnesota Statutes, section 256B.0924,
473.6 subdivision 6, paragraph (g);
- 473.7 (5) Minnesota Statutes, section 256B.0945,
473.8 subdivision 4, paragraph (d); and
- 473.9 (6) Minnesota Statutes, section 256F.10,
473.10 subdivision 6, paragraph (b).
- 473.11 **IT Appropriations Generally.** This
473.12 appropriation includes funds for information
473.13 technology projects, services, and support.
- 473.14 Notwithstanding Minnesota Statutes,
473.15 section 16E.0466, funding for information
473.16 technology project costs shall be incorporated
473.17 into the service level agreement and paid
473.18 to the Office of MN.IT Services by the
473.19 Department of Human Services under
473.20 the rates and mechanism specified in that
473.21 agreement.
- 473.22 **Periodic Data Matching for Medical**
473.23 **Assistance and MinnesotaCare.** \$1,598,000
473.24 in fiscal year 2016 and \$2,017,000 in fiscal
473.25 year 2017 from the general fund are for
473.26 periodic data matching for medical assistance
473.27 and MinnesotaCare recipients under
473.28 Minnesota Statutes, section 256B.0561, and
473.29 related administrative services.
- 473.30 **Base Level Adjustment.** The general fund
473.31 base is increased by \$1,240,000 in fiscal
473.32 year 2018 and by \$1,291,000 in fiscal year
473.33 2019. The health care access fund base is

474.1 decreased by \$455,000 in fiscal year 2018

474.2 and by \$455,000 in fiscal year 2019.

474.3 **(b) Children and Families**

474.4 Appropriations by Fund

474.5 General 9,974,000 9,829,000

474.6 Federal TANF 2,582,000 2,582,000

474.7 **Financial Institution Data Match and**

474.8 **Payment of Fees.** The commissioner is

474.9 authorized to allocate up to \$310,000 each

474.10 year in fiscal year 2016 and fiscal year

474.11 2017 from the PRISM special revenue

474.12 account to make payments to financial

474.13 institutions in exchange for performing

474.14 data matches between account information

474.15 held by financial institutions and the public

474.16 authority's database of child support obligors

474.17 as authorized by Minnesota Statutes, section

474.18 13B.06, subdivision 7.

474.19 **Child Support Work Group.** \$12,000 in

474.20 fiscal year 2016 is from the general fund for

474.21 facilitation of the duties of the child support

474.22 work group.

474.23 **Base Level Adjustment.** The general fund

474.24 base is increased by \$31,000 in fiscal year

474.25 2018 and by \$31,000 in fiscal year 2019.

474.26 **(c) Health Care**

474.27 Appropriations by Fund

474.28 General 16,667,000 16,309,000

474.29 Health Care Access 33,185,000 34,007,000

474.30 **Periodic Data Matching for Medical**

474.31 **Assistance and MinnesotaCare.** \$116,000

474.32 in fiscal year 2017 from the health care

474.33 access fund is for periodic data matching

474.34 for medical assistance and MinnesotaCare

474.35 recipients under Minnesota Statutes, section

475.1 256B.0561, and related administrative
475.2 services.

475.3 **Task Force.** Of the general fund
475.4 appropriation, \$770,000 in fiscal year 2016 is
475.5 for administrative services and support to the
475.6 Task Force on Health Care Financing. This
475.7 is a onetime appropriation.

475.8 **Base Level Adjustment.** The general fund
475.9 base is decreased by \$98,000 in fiscal year
475.10 2019. The health care access fund base is
475.11 increased by \$43,000 in fiscal year 2018 and
475.12 by \$150,000 in fiscal year 2019.

475.13 **(d) Continuing Care**

	<u>Appropriations by Fund</u>	
475.14		
475.15	<u>General</u>	<u>32,950,000</u> <u>29,924,000</u>
475.16	<u>State Government</u>	
475.17	<u>Special Revenue</u>	<u>125,000</u> <u>125,000</u>

475.18 **Training of Direct Support Services**

475.19 **Providers.** \$250,000 in fiscal year 2017 is
475.20 for training of individual providers of direct
475.21 support services as defined in Minnesota
475.22 Statutes, section 256B.0711, subdivision
475.23 1. This appropriation is only available
475.24 if the labor agreement between the state
475.25 of Minnesota and the Service Employees
475.26 International Union Healthcare Minnesota
475.27 under Minnesota Statutes, section 179A.54,
475.28 is approved under Minnesota Statutes,
475.29 sections 3.855 and 179A.22.

475.30 **Deaf and Hard-of-Hearing Services**

475.31 **Division.** \$650,000 in fiscal year 2016
475.32 and \$500,000 in fiscal year 2017 are
475.33 from the general fund for the Deaf and
475.34 Hard-of-Hearing Services Division under
475.35 Minnesota Statutes, section 256C.233. This

476.1 is a onetime appropriation. The funds must
 476.2 be used:
 476.3 (1) to provide linguistically and culturally
 476.4 appropriate mental health services;
 476.5 (2) to ensure that each regional advisory
 476.6 committee meets at least quarterly;
 476.7 (3) to increase the number of deafblind
 476.8 Minnesotans receiving services;
 476.9 (4) to conduct an analysis of how the regional
 476.10 offices and staff are operated, in consultation
 476.11 with the Commission of Deaf, DeafBlind,
 476.12 and Hard of Hearing Minnesotans;
 476.13 (5) during fiscal year 2016, to provide direct
 476.14 services to clients and purchase additional
 476.15 technology for the technology labs; and
 476.16 (6) to conduct an analysis of whether
 476.17 deafblind services are being provided in the
 476.18 best and most efficient way possible, with
 476.19 input from deafblind Minnesotans receiving
 476.20 services.

476.21 **Nursing Facilities.** \$890,000 in fiscal year
 476.22 2016 is from the general fund for the nursing
 476.23 facility property rate setting appraisals and
 476.24 study. This is a onetime appropriation.

476.25 **Base Level Adjustment.** The general fund
 476.26 base is decreased by \$174,000 in fiscal year
 476.27 2018 and by \$234,000 in fiscal year 2019.

476.28 **(e) Chemical and Mental Health**

	<u>Appropriations by Fund</u>	
476.29		
476.30	<u>General</u>	<u>7,058,000</u> <u>7,240,000</u>
476.31	<u>Lottery Prize</u>	<u>160,000</u> <u>163,000</u>

476.32 **Base Level Adjustment.** The general fund
 476.33 base is decreased by \$301,000 in fiscal year

477.1 2018 and is decreased by \$354,000 in fiscal
 477.2 year 2019.

477.3 Subd. 4. **Forecasted Programs**

477.4 The amounts that may be spent from this
 477.5 appropriation for each purpose are as follows:

477.6 (a) **MFIP/DWP**

	<u>Appropriations by Fund</u>	
477.7		
477.8	<u>General</u>	<u>93,620,000</u> <u>98,452,000</u>
477.9	<u>Federal TANF</u>	<u>85,266,000</u> <u>80,971,000</u>

477.10	<u>(b) MFIP Child Care Assistance</u>	<u>101,315,000</u>	<u>108,521,000</u>
--------	--	--------------------	--------------------

477.11	<u>(c) General Assistance</u>	<u>55,117,000</u>	<u>57,847,000</u>
--------	--------------------------------------	-------------------	-------------------

477.12 **General Assistance Standard.** The
 477.13 commissioner shall set the monthly standard
 477.14 of assistance for general assistance units
 477.15 consisting of an adult recipient who is
 477.16 childless and unmarried or living apart
 477.17 from parents or a legal guardian at \$203.
 477.18 The commissioner may reduce this amount
 477.19 according to Laws 1997, chapter 85, article
 477.20 3, section 54.

477.21 **Emergency General Assistance.** The
 477.22 amount appropriated for emergency
 477.23 general assistance is limited to no more
 477.24 than \$6,729,812 in fiscal year 2016 and
 477.25 \$6,729,812 in fiscal year 2017. Funds
 477.26 to counties shall be allocated by the
 477.27 commissioner using the allocation method
 477.28 under Minnesota Statutes, section 256D.06.

477.29	<u>(d) Minnesota Supplemental Aid</u>	<u>39,668,000</u>	<u>41,169,000</u>
--------	--	-------------------	-------------------

477.30	<u>(e) Group Residential Housing</u>	<u>155,753,000</u>	<u>167,194,000</u>
--------	---	--------------------	--------------------

477.31	<u>(f) Northstar Care for Children</u>	<u>41,096,000</u>	<u>46,337,000</u>
--------	---	-------------------	-------------------

477.32	<u>(g) MinnesotaCare</u>	<u>361,114,000</u>	<u>387,081,000</u>
--------	---------------------------------	--------------------	--------------------

478.1 This appropriation is from the health care
 478.2 access fund.

478.3 **(h) Medical Assistance**

478.4 Appropriations by Fund

478.5	<u>General</u>	<u>4,468,089,000</u>	<u>4,977,237,000</u>
478.6	<u>Health Care Access</u>	<u>650,139,000</u>	<u>288,224,000</u>

478.7 **Behavioral Health Services. \$1,000,000**

478.8 each fiscal year is for behavioral health
 478.9 services provided by hospitals identified
 478.10 under Minnesota Statutes, section 256.969,
 478.11 subdivision 2b, paragraph (a), clause (4).
 478.12 The increase in payments shall be made by
 478.13 increasing the adjustment under Minnesota
 478.14 Statutes, section 256.969, subdivision 2b,
 478.15 paragraph (e), clause (2).

478.16 **Base Adjustment.** The health care access
 478.17 fund base for medical assistance is decreased
 478.18 by \$30,917,000 in fiscal year 2018 and by
 478.19 \$16,108,000 in fiscal year 2019.

478.20	<u>(i) Alternative Care</u>	<u>43,997,000</u>	<u>43,590,000</u>
--------	------------------------------------	-------------------	-------------------

478.21 **Alternative Care Transfer.** Any money
 478.22 allocated to the alternative care program that
 478.23 is not spent for the purposes indicated does
 478.24 not cancel but must be transferred to the
 478.25 medical assistance account.

478.26	<u>(j) Chemical Dependency Treatment Fund</u>	<u>83,868,000</u>	<u>86,962,000</u>
--------	--	-------------------	-------------------

478.27 **Subd. 5. Grant Programs**

478.28 The amounts that may be spent from this
 478.29 appropriation for each purpose are as follows:

478.30 **(a) Support Services Grants**

478.31 Appropriations by Fund

478.32	<u>General</u>	<u>13,133,000</u>	<u>8,715,000</u>
478.33	<u>Federal TANF</u>	<u>96,311,000</u>	<u>96,311,000</u>

479.1 **(b) Basic Sliding Fee Child Care Assistance**
 479.2 **Grants**

48,439,000

51,559,000

479.3 **Basic Sliding Fee Waiting List Allocation.**

479.4 Notwithstanding Minnesota Statutes, section
 479.5 119B.03, \$5,413,000 in fiscal year 2016 is to
 479.6 reduce the basic sliding fee program waiting
 479.7 list as follows:

479.8 (1) The calendar year 2016 allocation shall
 479.9 be increased to serve families on the waiting
 479.10 list. To receive funds appropriated for this
 479.11 purpose, a county must have:

479.12 (i) a waiting list in the most recent published
 479.13 waiting list month;

479.14 (ii) an average of at least ten families on the
 479.15 most recent six months of published waiting
 479.16 list; and

479.17 (iii) total expenditures in calendar year
 479.18 2014 that met or exceeded 80 percent of the
 479.19 county's available final allocation.

479.20 (2) Funds shall be distributed proportionately
 479.21 based on the average of the most recent six
 479.22 months of published waiting lists to counties
 479.23 that meet the criteria in clause (1).

479.24 (3) Allocations in calendar years 2017
 479.25 and beyond shall be calculated using the
 479.26 allocation formula in Minnesota Statutes,
 479.27 section 119B.03.

479.28 (4) The guaranteed floor for calendar year
 479.29 2017 shall be based on the revised calendar
 479.30 year 2016 allocation.

479.31 **Base Level Adjustment.** The general fund
 479.32 base is increased by \$810,000 in fiscal year
 479.33 2018 and increased by \$821,000 in fiscal
 479.34 year 2019.

480.1	<u>(c) Child Care Development Grants</u>	<u>1,737,000</u>	<u>1,737,000</u>
480.2	<u>(d) Child Support Enforcement Grants</u>	<u>50,000</u>	<u>50,000</u>
480.3	<u>(e) Children's Services Grants</u>		
480.4	<u>Appropriations by Fund</u>		
480.5	<u>General</u>	<u>39,015,000</u>	<u>38,665,000</u>
480.6	<u>Federal TANF</u>	<u>140,000</u>	<u>140,000</u>
480.7	<u>Safe Place for Newborns.</u> \$350,000 from		
480.8	<u>the general fund in fiscal year 2016 is to</u>		
480.9	<u>distribute information on the Safe Place</u>		
480.10	<u>for Newborns law in Minnesota to increase</u>		
480.11	<u>public awareness of the law. This is a</u>		
480.12	<u>onetime appropriation.</u>		
480.13	<u>Child Protection.</u> \$23,350,000 in fiscal year		
480.14	<u>2016 and \$23,350,000 in fiscal year 2017</u>		
480.15	<u>are to address child protection staffing and</u>		
480.16	<u>services under Minnesota Statutes, section</u>		
480.17	<u>256M.41. \$1,650,000 in fiscal year 2016 and</u>		
480.18	<u>\$1,650,000 in fiscal year 2017 are for child</u>		
480.19	<u>protection grants to address child welfare</u>		
480.20	<u>disparities under Minnesota Statutes, section</u>		
480.21	<u>256E.28.</u>		
480.22	<u>Title IV-E Adoption Assistance.</u> Additional		
480.23	<u>federal reimbursement to the state as a result</u>		
480.24	<u>of the Fostering Connections to Success</u>		
480.25	<u>and Increasing Adoptions Act's expanded</u>		
480.26	<u>eligibility for title IV-E adoption assistance</u>		
480.27	<u>is appropriated to the commissioner</u>		
480.28	<u>for postadoption services, including a</u>		
480.29	<u>parent-to-parent support network.</u>		
480.30	<u>Adoption Assistance Incentive Grants.</u>		
480.31	<u>Federal funds available during fiscal years</u>		
480.32	<u>2016 and 2017 for adoption incentive</u>		
480.33	<u>grants are appropriated to the commissioner</u>		

481.1 for postadoption services, including a
 481.2 parent-to-parent support network.

481.3 **(f) Children and Community Service Grants** 56,301,000 56,301,000

481.4 **(g) Children and Economic Support Grants** 26,778,000 26,966,000

481.5 **Mobile Food Shelf Grants.** (a) \$1,000,000

481.6 in fiscal year 2016 and \$1,000,000 in

481.7 fiscal year 2017 are for a grant to Hunger

481.8 Solutions. This is a onetime appropriation

481.9 and is available until June 30, 2017.

481.10 (b) Hunger Solutions shall award grants of

481.11 up to \$75,000 on a competitive basis. Grant

481.12 applications must include:

481.13 (1) the location of the project;

481.14 (2) a description of the mobile program,

481.15 including size and scope;

481.16 (3) evidence regarding the unserved or

481.17 underserved nature of the community in

481.18 which the project is to be located;

481.19 (4) evidence of community support for the

481.20 project;

481.21 (5) the total cost of the project;

481.22 (6) the amount of the grant request and how

481.23 funds will be used;

481.24 (7) sources of funding or in-kind

481.25 contributions for the project that will

481.26 supplement any grant award;

481.27 (8) a commitment to mobile programs by the

481.28 applicant and an ongoing commitment to

481.29 maintain the mobile program; and

481.30 (9) any additional information requested by

481.31 Hunger Solutions.

481.32 (c) Priority may be given to applicants who:

- 482.1 (1) serve underserved areas;
- 482.2 (2) create a new or expand an existing mobile
- 482.3 program;
- 482.4 (3) serve areas where a high amount of need
- 482.5 is identified;
- 482.6 (4) provide evidence of strong support for the
- 482.7 project from citizens and other institutions in
- 482.8 the community;
- 482.9 (5) leverage funding for the project from
- 482.10 other private and public sources; and
- 482.11 (6) commit to maintaining the program on a
- 482.12 multilayer basis.
- 482.13 **Homeless Youth Act.** Of this appropriation,
- 482.14 at least \$500,000 must be awarded to
- 482.15 providers in greater Minnesota, with at least
- 482.16 25 percent of this amount for new applicant
- 482.17 providers. The commissioner shall provide
- 482.18 outreach and technical assistance to greater
- 482.19 Minnesota providers and new providers to
- 482.20 encourage responding to the request for
- 482.21 proposals.
- 482.22 **Stearns County Veterans Housing.**
- 482.23 \$85,000 in fiscal year 2016 and \$85,000
- 482.24 in fiscal year 2017 are for a grant to
- 482.25 Stearns County to provide administrative
- 482.26 funding in support of a service provider
- 482.27 serving veterans in Stearns County. The
- 482.28 administrative funding grant may be used to
- 482.29 support group residential housing services,
- 482.30 corrections-related services, veteran services,
- 482.31 and other social services related to the service
- 482.32 provider serving veterans in Stearns County.
- 482.33 **Safe Harbor.** \$800,000 in fiscal year 2016
- 482.34 and \$800,000 in fiscal year 2017 are from

483.1 the general fund for emergency shelter and
 483.2 transitional and long-term housing beds for
 483.3 sexually exploited youth and youth at risk of
 483.4 sexual exploitation. Of this appropriation,
 483.5 \$150,000 in fiscal year 2016 and \$150,000 in
 483.6 fiscal year 2017 are from the general fund for
 483.7 statewide youth outreach workers connecting
 483.8 sexually exploited youth and youth at risk of
 483.9 sexual exploitation with shelter and services.

483.10 **Minnesota Food Assistance Program.**

483.11 Unexpended funds for the Minnesota food
 483.12 assistance program for fiscal year 2016 do
 483.13 not cancel but are available for this purpose
 483.14 in fiscal year 2017.

483.15 **Base Level Adjustment.** The general fund
 483.16 base is decreased by \$816,000 in fiscal year
 483.17 2018 and is decreased by \$606,000 in fiscal
 483.18 year 2019.

483.19 **(h) Health Care Grants**

	<u>Appropriations by Fund</u>	
483.20		
483.21	<u>General</u>	<u>536,000</u> <u>2,482,000</u>
483.22	<u>Health Care Access</u>	<u>3,341,000</u> <u>3,465,000</u>

483.23 **Grants for Periodic Data Matching for**

483.24 **Medical Assistance and MinnesotaCare.**

483.25 Of the general fund appropriation, \$26,000
 483.26 in fiscal year 2016 and \$1,276,000 in fiscal
 483.27 year 2017 are for grants to counties for
 483.28 costs related to periodic data matching
 483.29 for medical assistance and MinnesotaCare
 483.30 recipients under Minnesota Statutes,
 483.31 section 256B.0561. The commissioner
 483.32 must distribute these grants to counties in
 483.33 proportion to each county's number of cases
 483.34 in the prior year in the affected programs.

484.1 **Base Level Adjustment.** The general fund
 484.2 base is increased by \$1,637,000 in fiscal year
 484.3 2018 and increased by \$1,229,000 in fiscal
 484.4 year 2019.

484.5 **(i) Other Long-Term Care Grants** 1,551,000 3,069,000

484.6 **Transition Populations.** \$1,551,000 in fiscal
 484.7 year 2016 and \$1,725,000 in fiscal year 2017
 484.8 are for home and community-based services
 484.9 transition grants to assist in providing home
 484.10 and community-based services and treatment
 484.11 for transition populations under Minnesota
 484.12 Statutes, section 256.478.

484.13 **Base Level Adjustment.** The general fund
 484.14 base is increased by \$156,000 in fiscal year
 484.15 2018 and by \$581,000 in fiscal year 2019.

484.16 **(j) Aging and Adult Services Grants** 28,463,000 28,162,000

484.17 **Dementia Grants.** \$750,000 in fiscal year
 484.18 2016 and \$750,000 in fiscal year 2017
 484.19 are for the Minnesota Board on Aging for
 484.20 regional and local dementia grants authorized
 484.21 in Minnesota Statutes, section 256.975,
 484.22 subdivision 11.

484.23 **(k) Deaf and Hard-of-Hearing Grants** 2,225,000 2,375,000

484.24 **Deaf, Deafblind, and Hard-of-Hearing**
 484.25 **Grants.** \$350,000 in fiscal year 2016 and
 484.26 \$500,000 in fiscal year 2017 are for deaf
 484.27 and hard-of-hearing grants. The funds
 484.28 must be used to increase the number of
 484.29 deafblind Minnesotans receiving services
 484.30 under Minnesota Statutes, section 256C.261,
 484.31 and to provide linguistically and culturally
 484.32 appropriate mental health services to children
 484.33 who are deaf, deafblind, and hard-of-hearing.
 484.34 This is a onetime appropriation.

485.1 **Base Level Adjustment.** The general fund
 485.2 base is decreased by \$500,000 in fiscal year
 485.3 2018 and by \$500,000 in fiscal year 2019.

485.4 **(l) Disabilities Grants** 20,820,000 20,858,000

485.5 **State Quality Council.** \$573,000 in fiscal
 485.6 year 2016 and \$600,000 in fiscal year
 485.7 2017 are for the State Quality Council to
 485.8 provide technical assistance and monitoring
 485.9 of person-centered outcomes related to
 485.10 inclusive community living and employment.
 485.11 The funding must be used by the State
 485.12 Quality Council to assure a statewide plan
 485.13 for systems change in person-centered
 485.14 planning that will achieve desired outcomes
 485.15 including increased integrated employment
 485.16 and community living.

485.17 **(m) Adult Mental Health Grants**

	<u>Appropriations by Fund</u>		
485.18			
485.19	<u>General</u>	<u>69,992,000</u>	<u>71,244,000</u>
485.20	<u>Health Care Access</u>	<u>1,575,000</u>	<u>2,473,000</u>
485.21	<u>Lottery Prize</u>	<u>1,733,000</u>	<u>1,733,000</u>

485.22 **Funding Usage.** Up to 75 percent of a fiscal
 485.23 year's appropriation for adult mental health
 485.24 grants may be used to fund allocations in that
 485.25 portion of the fiscal year ending December
 485.26 31.

485.27 **Culturally Specific Mental Health**
 485.28 **Services.** \$100,000 in fiscal year 2016 is for
 485.29 grants to nonprofit organizations to provide
 485.30 resources and referrals for culturally specific
 485.31 mental health services to Southeast Asian
 485.32 veterans born before 1965 who do not qualify
 485.33 for services available to veterans formally
 485.34 discharged from the United States armed
 485.35 forces.

486.1 **Problem Gambling.** \$225,000 in fiscal year
 486.2 2016 and \$225,000 in fiscal year 2017 are
 486.3 from the lottery prize fund for a grant to the
 486.4 state affiliate recognized by the National
 486.5 Council on Problem Gambling. The affiliate
 486.6 must provide services to increase public
 486.7 awareness of problem gambling, education,
 486.8 and training for individuals and organizations
 486.9 providing effective treatment services to
 486.10 problem gamblers and their families, and
 486.11 research related to problem gambling.

486.12 **Sustainability Grants.** \$2,125,000 in fiscal
 486.13 year 2016 and \$2,125,000 in fiscal year 2017
 486.14 are for sustainability grants under Minnesota
 486.15 Statutes, section 256B.0622, subdivision 11.

486.16 **Beltrami County Mental Health Services**
 486.17 **Grant.** \$1,000,000 in fiscal year 2016 and
 486.18 \$1,000,000 in fiscal year 2017 are from the
 486.19 general fund for a grant to Beltrami County
 486.20 to fund the planning and development of
 486.21 a comprehensive mental health services
 486.22 program under article 2, section 41,
 486.23 Comprehensive Mental Health Program
 486.24 in Beltrami County. This is a onetime
 486.25 appropriation.

486.26 **Base Level Adjustment.** The general fund
 486.27 base is increased by \$723,000 in fiscal year
 486.28 2018 and by \$723,000 in fiscal year 2019.
 486.29 The health care access fund base is decreased
 486.30 by \$1,723,000 in fiscal year 2018 and by
 486.31 \$1,723,000 in fiscal year 2019.

486.32 **(n) Child Mental Health Grants** 23,386,000 24,313,000

486.33 **Services and Supports for First Episode**
 486.34 **Psychosis.** \$177,000 in fiscal year 2017 is
 486.35 for grants under Minnesota Statutes, section

487.1 245.4889, to mental health providers to pilot
 487.2 evidence-based interventions for youth at risk
 487.3 of developing or experiencing a first episode
 487.4 of psychosis and for a public awareness
 487.5 campaign on the signs and symptoms of
 487.6 psychosis. The base for these grants is
 487.7 \$236,000 in fiscal year 2018 and \$301,000 in
 487.8 fiscal year 2019.

487.9 **Adverse Childhood Experiences.** The base
 487.10 for grants under Minnesota Statutes, section
 487.11 245.4889, to children's mental health and
 487.12 family services collaboratives for adverse
 487.13 childhood experiences (ACEs) training
 487.14 grants and for an interactive Web site
 487.15 connection to support ACEs in Minnesota is
 487.16 \$363,000 in fiscal year 2018 and \$363,000 in
 487.17 fiscal year 2019.

487.18 **Funding Usage.** Up to 75 percent of a fiscal
 487.19 year's appropriation for child mental health
 487.20 grants may be used to fund allocations in that
 487.21 portion of the fiscal year ending December
 487.22 31.

487.23 **Base Level Adjustment.** The general fund
 487.24 base is increased by \$422,000 in fiscal year
 487.25 2018 and is increased by \$487,000 in fiscal
 487.26 year 2019.

487.27 **(o) Chemical Dependency Treatment Support**
 487.28 **Grants**

1,561,000

1,561,000

487.29 **Chemical Dependency Prevention.**
 487.30 \$150,000 in fiscal year 2016 and \$150,000
 487.31 in fiscal year 2017 are for grants to
 487.32 nonprofit organizations to provide chemical
 487.33 dependency prevention programs in
 487.34 secondary schools. When making grants, the
 487.35 commissioner must consider the expertise,

488.1 prior experience, and outcomes achieved
488.2 by applicants that have provided prevention
488.3 programming in secondary education
488.4 environments. An applicant for the grant
488.5 funds must provide verification to the
488.6 commissioner that the applicant has available
488.7 and will contribute sufficient funds to match
488.8 the grant given by the commissioner. This is
488.9 a onetime appropriation.

488.10 **Fetal Alcohol Syndrome Grants. \$250,000**
488.11 in fiscal year 2016 and \$250,000 in fiscal year
488.12 2017 are for grants to be administered by the
488.13 Minnesota Organization on Fetal Alcohol
488.14 Syndrome to provide comprehensive,
488.15 gender-specific services to pregnant and
488.16 parenting women suspected of or known
488.17 to use or abuse alcohol or other drugs.
488.18 This appropriation is for grants to no fewer
488.19 than three eligible recipients. Minnesota
488.20 Organization on Fetal Alcohol Syndrome
488.21 must report to the commissioner of human
488.22 services annually by January 15 on the
488.23 grants funded by this appropriation. The
488.24 report must include measurable outcomes for
488.25 the previous year, including the number of
488.26 pregnant women served and the number of
488.27 toxic-free babies born.

488.28 **Base Level Adjustment.** The general fund
488.29 base is decreased by \$150,000 in fiscal year
488.30 2018 and by \$150,000 in fiscal year 2019.

488.31 **Subd. 6. DCT State-Operated Services**
488.32 **Transfer Authority for State-Operated**
488.33 **Services.** Money appropriated for
488.34 state-operated services may be transferred
488.35 between fiscal years of the biennium

489.1 with the approval of the commissioner of
 489.2 management and budget.

489.3 The amounts that may be spent from the
 489.4 appropriation for each purpose are as follows:

489.5 **(a) DCT State-Operated Services Mental**
 489.6 **Health**

130,070,000

131,795,000

489.7 **Increased Capacity at AMRTC. \$4,108,000**
 489.8 in fiscal year 2016 and \$4,108,000 in fiscal
 489.9 year 2017 are to increase the number
 489.10 of staffed beds at the Anoka Regional
 489.11 Treatment Center so that 15 additional beds
 489.12 are available for patients above the number
 489.13 of beds that are available on June 30, 2015.

489.14 **Transfer.** Notwithstanding Minnesota
 489.15 Statutes, section 246.18, subdivision 8,
 489.16 the commissioner of human services shall
 489.17 transfer \$2,000,000 in fiscal year 2017 from
 489.18 the account under Minnesota Statutes, section
 489.19 246.18, subdivision 8, in the special revenue
 489.20 fund to the general fund. This is a onetime
 489.21 transfer for repeal of never implemented
 489.22 grants for mental health specialty treatment
 489.23 services.

489.24 **Dedicated Receipts Available.** Of the
 489.25 revenue received under Minnesota Statutes,
 489.26 section 246.18, subdivision 8, paragraph
 489.27 (a), up to \$1,000,000 each year is available
 489.28 for the purposes of Minnesota Statutes,
 489.29 section 246.18, subdivision 8, paragraph (b),
 489.30 clause (1); and up to \$2,713,000 each year
 489.31 is available for the purposes of Minnesota
 489.32 Statutes, section 246.18, subdivision 8,
 489.33 paragraph (b), clause (3).

489.34 **Transfers from State-Operated Services**
 489.35 **Account.** (a) If the commissioner of

490.1 human services notifies the commissioner
490.2 of management and budget by July 31,
490.3 2015, that the fiscal year 2015 general
490.4 fund expenditures exceed the general fund
490.5 appropriation for state-operated services
490.6 mental health to the Department of Human
490.7 Services, notwithstanding Minnesota
490.8 Statutes, section 246.18, subdivision 8,
490.9 the commissioner of human services,
490.10 with the approval of the commissioner of
490.11 management and budget, shall transfer up
490.12 to \$1,000,000 in fiscal year 2015 from the
490.13 account under Minnesota Statutes, section
490.14 246.18, subdivision 8, in the special revenue
490.15 fund to the general fund. The amount
490.16 transferred under this paragraph must
490.17 not exceed the amount of the fiscal year
490.18 2015 negative balance in the general fund
490.19 appropriation for state-operated services
490.20 mental health to the Department of Human
490.21 Services. The amount transferred under
490.22 this paragraph, up to \$1,000,000 in fiscal
490.23 year 2015, is appropriated from the general
490.24 fund to the commissioner of human services
490.25 for state-operated services mental health
490.26 expenditures. This paragraph is effective the
490.27 day following final enactment and expires
490.28 on October 1, 2015. Any amount transferred
490.29 under this paragraph that is not expended
490.30 by September 30, 2015, shall cancel to
490.31 the account from which the amount was
490.32 transferred.

490.33 (b) If the commissioner of human services
490.34 notifies the commissioner of management
490.35 and budget by July 31, 2015, that the
490.36 balance in fiscal year 2015 in the Minnesota

491.1 state-operated community services fund is a
491.2 negative amount, notwithstanding Minnesota
491.3 Statutes, section 246.18, subdivision 8, the
491.4 commissioner of human services, with the
491.5 approval of the commissioner of management
491.6 and budget, shall transfer up to \$3,200,000
491.7 in fiscal year 2015 from the account
491.8 under Minnesota Statutes, section 246.18,
491.9 subdivision 8, in the special revenue fund
491.10 to the Minnesota state-operated community
491.11 services fund. The amount transferred under
491.12 this paragraph must not exceed the amount
491.13 of the fiscal year 2015 negative balance in
491.14 the Minnesota state-operated community
491.15 services fund. This paragraph is effective the
491.16 day following final enactment and expires
491.17 on October 1, 2015. Any amount transferred
491.18 under this paragraph that is not expended
491.19 by September 30, 2015, shall cancel to
491.20 the account from which the amount was
491.21 transferred.

491.22 **Appropriations Retroactive to Fiscal Year**
491.23 **2015.** If the commissioner of human services
491.24 notifies the commissioner of management and
491.25 budget by July 31, 2015, that the fiscal year
491.26 2015 general fund expenditures exceed the
491.27 general fund appropriation for state-operated
491.28 services mental health to the Department of
491.29 Human Services, up to \$5,000,000 of this
491.30 appropriation in fiscal year 2016 may be
491.31 used in fiscal year 2015 for state-operated
491.32 services mental health expenditures. The
491.33 commissioner of human services must
491.34 report to the commissioner of management
491.35 and budget the purpose and amount of any
491.36 expenditures under this paragraph, and the

492.1 commissioner of management and budget
 492.2 must approve the total amount attributable to
 492.3 this paragraph. This paragraph is effective
 492.4 the day following final enactment and expires
 492.5 on October 1, 2015.

492.6 **(b) DCT State-Operated Services Enterprise**
 492.7 **Services**

9,626,000

6,113,000

492.8 **Community Addiction Recovery**
 492.9 **Enterprise.** \$9,626,000 in fiscal year 2016
 492.10 and \$6,113,000 in fiscal year 2017 are for
 492.11 the C.A.R.E. program. The commissioner
 492.12 must transfer these amounts to the enterprise
 492.13 fund for the Community Addiction Recovery
 492.14 Enterprise. The base for this purpose
 492.15 is \$5,991,000 in fiscal year 2018 and
 492.16 \$5,991,000 in fiscal year 2019.

492.17 **Transfers from Consolidated Chemical**
 492.18 **Dependency Treatment Fund.** (a) If the
 492.19 commissioner of human services notifies the
 492.20 commissioner of management and budget by
 492.21 July 31, 2015, that the balance in fiscal year
 492.22 2015 in the community addiction recovery
 492.23 enterprise fund is a negative amount,
 492.24 notwithstanding Minnesota Statutes, section
 492.25 254B.06, subdivision 1, the commissioner
 492.26 of human services, with the approval of the
 492.27 commissioner of management and budget,
 492.28 shall transfer \$2,000,000 in fiscal year 2015
 492.29 from the consolidated chemical dependency
 492.30 treatment fund account in the special revenue
 492.31 fund to the community addiction recovery
 492.32 enterprise fund. The amount transferred
 492.33 under this paragraph must not exceed the
 492.34 amount of the fiscal year 2015 negative
 492.35 balance in the community addiction recovery
 492.36 enterprise fund. This paragraph is effective

493.1 the day following final enactment and expires
493.2 on October 1, 2015. Any amount transferred
493.3 under this paragraph that is not expended
493.4 by September 30, 2015, shall cancel to
493.5 the account from which the amount was
493.6 transferred.

493.7 (b) If the commissioner of human services
493.8 notifies the commissioner of management
493.9 and budget by July 31, 2015, that the
493.10 fiscal year 2015 general fund expenditures
493.11 exceed the general fund appropriation
493.12 for state-operated services mental health
493.13 to the Department of Human Services,
493.14 notwithstanding Minnesota Statutes, section
493.15 254B.06, subdivision 1, the commissioner
493.16 of human services, with the approval of the
493.17 commissioner of management and budget,
493.18 shall transfer \$1,500,000 in fiscal year 2015
493.19 from the consolidated chemical dependency
493.20 treatment fund account in the special revenue
493.21 fund to the general fund. \$1,500,000 in
493.22 fiscal year 2015 is appropriated from the
493.23 general fund to the commissioner of human
493.24 services for state-operated services mental
493.25 health expenditures. The amount transferred
493.26 under this paragraph must not exceed the
493.27 amount of the fiscal year 2015 negative
493.28 balance in the general fund appropriation
493.29 for state-operated services mental health to
493.30 the Department of Human Services. This
493.31 paragraph is effective the day following final
493.32 enactment and expires on October 1, 2015.
493.33 Any amount transferred under this paragraph
493.34 that is not expended by September 30, 2015,
493.35 shall cancel to the account from which the
493.36 amount was transferred.

- 494.1 **Base Level Adjustment.** The general fund
 494.2 base is decreased by \$122,000 in fiscal year
 494.3 2018 and by \$122,000 in fiscal year 2019.
- 494.4 **(c) DCT State-Operated Services Minnesota**
 494.5 **Security Hospital** 81,821,000 83,233,000
- 494.6 **Base Level Adjustment.** The general fund
 494.7 base is increased by \$17,000 in fiscal year
 494.8 2018 and by \$34,000 in fiscal year 2019.
- 494.9 **Subd. 7. DCT Minnesota Sex Offender**
 494.10 **Program** 83,686,000 84,927,000
- 494.11 **Transfer Authority for Minnesota Sex**
 494.12 **Offender Program.** Money appropriated
 494.13 for the Minnesota sex offender program
 494.14 may be transferred between fiscal years
 494.15 of the biennium with the approval of the
 494.16 commissioner of management and budget.
- 494.17 **Limited Carryforward Allowed.**
 494.18 Notwithstanding any contrary provision
 494.19 in this article, of this appropriation, up to
 494.20 \$875,000 in fiscal year 2016 and \$2,625,000
 494.21 in fiscal year 2017 are available until June
 494.22 30, 2019.
- 494.23 **Minnesota Sex Offender Program.** Any
 494.24 funds from the appropriation made by Laws
 494.25 2014, chapter 312, article 30, section 2,
 494.26 subdivision 6, that are not used for payment
 494.27 of court-ordered costs in compliance with
 494.28 the United States District Court order of
 494.29 February 20, 2014, in the matter of Karsjens
 494.30 et al. v. Jesson et al., including any funds
 494.31 returned by the court that had been deposited
 494.32 with the court but not spent, may be used by
 494.33 the commissioner of human services to offset
 494.34 past and future litigation expenses in the

495.1 same matter and to comply with any future
 495.2 orders of the United States District Court.

495.3 **Subd. 8. Technical Activities** 82,671,000 83,427,000

495.4 This appropriation is from the federal TANF
 495.5 fund.

495.6 **Base Level Adjustment.** The TANF fund
 495.7 appropriation is increased by \$392,000 in
 495.8 fiscal year 2018 and by \$80,000 in fiscal year
 495.9 2019.

495.10 **Sec. 3. COMMISSIONER OF HEALTH**

495.11 **Subdivision 1. Total Appropriation** **\$ 188,912,000** **\$ 188,939,000**

495.12 Appropriations by Fund

	<u>2016</u>	<u>2017</u>
495.13		
495.14 <u>General</u>	<u>89,369,000</u>	<u>91,357,000</u>
495.15 <u>State Government</u>		
495.16 <u>Special Revenue</u>	<u>53,843,000</u>	<u>52,448,000</u>
495.17 <u>Health Care Access</u>	<u>33,987,000</u>	<u>33,421,000</u>
495.18 <u>Federal TANF</u>	<u>11,713,000</u>	<u>11,713,000</u>

495.19 The amounts that may be spent for each
 495.20 purpose are specified in the following
 495.21 subdivisions.

495.22 **Subd. 2. Health Improvement**

495.23 Appropriations by Fund

495.24 <u>General</u>	<u>68,653,000</u>	<u>68,984,000</u>
495.25 <u>State Government</u>		
495.26 <u>Special Revenue</u>	<u>6,264,000</u>	<u>6,182,000</u>
495.27 <u>Health Care Access</u>	<u>33,987,000</u>	<u>33,421,000</u>
495.28 <u>Federal TANF</u>	<u>11,713,000</u>	<u>11,713,000</u>

495.29 **Violence Against Asian Women Working**

495.30 **Group.** \$200,000 in fiscal year 2016 from
 495.31 the general fund is for the working group on
 495.32 violence against Asian women and children.

495.33 **MERC Program.** \$1,000,000 in fiscal year
 495.34 2016 and \$1,000,000 in fiscal year 2017 are
 495.35 from the general fund for the MERC program

496.1 under Minnesota Statutes, section 62J.692,
496.2 subdivision 4.

496.3 **Poison Information Center Grants.**

496.4 \$750,000 in fiscal year 2016 and \$750,000 in
496.5 fiscal year 2017 are from the general fund
496.6 for regional poison information center grants
496.7 under Minnesota Statutes, section 145.93.

496.8 **Advanced Care Planning.** \$250,000 in
496.9 fiscal year 2016 is from the general fund
496.10 to award a grant to a statewide advance
496.11 care planning resource organization that has
496.12 expertise in convening and coordinating
496.13 community-based strategies to encourage
496.14 individuals, families, caregivers, and health
496.15 care providers to begin conversations
496.16 regarding end-of-life care choices that
496.17 express an individual's health care values
496.18 and preferences and are based on informed
496.19 health care decisions. This is a onetime
496.20 appropriation.

496.21 **Early Dental Prevention Initiatives.**

496.22 \$172,000 in fiscal year 2016 and \$140,000 in
496.23 fiscal year 2017 are for the development and
496.24 distribution of the early dental prevention
496.25 initiative under Minnesota Statutes, section
496.26 144.3875.

496.27 **International Medical Graduate**

496.28 **Assistance Program.** (a) \$500,000 in fiscal
496.29 year 2016 and \$500,000 in fiscal year 2017
496.30 are from the health care access fund for
496.31 the grant programs and necessary contracts
496.32 under Minnesota Statutes, section 144.1911,
496.33 subdivisions 3, paragraph (a), clause (4), and
496.34 4 and 5. The commissioner may use up to
496.35 \$133,000 per year of the appropriation for

497.1 international medical graduate assistance
497.2 program administration duties in Minnesota
497.3 Statutes, section 144.1911, subdivisions
497.4 3, 9, and 10, and for administering the
497.5 grant programs under Minnesota Statutes,
497.6 section 144.1911, subdivisions 4, 5,
497.7 and 6. The commissioner shall develop
497.8 recommendations for any additional funding
497.9 required for initiatives needed to achieve the
497.10 objectives of Minnesota Statutes, section
497.11 144.1911. The commissioner shall report the
497.12 funding recommendations to the legislature
497.13 by January 15, 2016, in the report required
497.14 under Minnesota Statutes, section 144.1911,
497.15 subdivision 10. The base for this purpose is
497.16 \$1,000,000 in fiscal years 2018 and 2019.
497.17 (b) \$500,000 in fiscal year 2016 and
497.18 \$500,000 in fiscal year 2017 are from the
497.19 health care access fund for transfer to the
497.20 revolving international medical graduate
497.21 residency account established in Minnesota
497.22 Statutes, section 144.1911, subdivision 6.
497.23 This is a onetime appropriation.
497.24 **Federally Qualified Health Centers.**
497.25 \$1,000,000 in fiscal year 2016 and
497.26 \$1,000,000 in fiscal year 2017 are from the
497.27 general fund to provide subsidies to federally
497.28 qualified health centers under Minnesota
497.29 Statutes, section 145.9269. This is a onetime
497.30 appropriation.
497.31 **Organ Donation.** \$200,000 in fiscal year
497.32 2016 is from the general fund to establish
497.33 a grant program to develop and create
497.34 culturally appropriate outreach programs that
497.35 provide education about the importance of

498.1 organ donation. Grants shall be awarded to
498.2 a federally designated organ procurement
498.3 organization and hospital system that
498.4 performs transplants. This is a onetime
498.5 appropriation.

498.6 **Primary Care Residency.** \$1,500,000 in
498.7 fiscal year 2016 and \$1,500,000 in fiscal
498.8 year 2017 are from the general fund for
498.9 the purposes of the primary care residency
498.10 expansion grant program under Minnesota
498.11 Statutes, section 144.1506.

498.12 **Somali Women's Health Pilot Program.**

498.13 (a) The commissioner of health shall
498.14 establish a pilot program between one or
498.15 more federally qualified health centers, as
498.16 defined under Minnesota Statutes, section
498.17 145.9269, a nonprofit organization that
498.18 helps Somali women, and the Minnesota
498.19 Evaluation Studies Institute, to develop
498.20 a promising strategy to address the
498.21 preventative and primary health care needs
498.22 of, and address health inequities experienced
498.23 by, first generation Somali women. The
498.24 pilot program must collaboratively develop
498.25 a patient flow process for first generation
498.26 Somali women by:

498.27 (1) addressing and identifying clinical and
498.28 cultural barriers to Somali women accessing
498.29 preventative and primary care, including,
498.30 but not limited to, cervical and breast cancer
498.31 screenings;

498.32 (2) developing a culturally appropriate health
498.33 curriculum for Somali women based on
498.34 the outcomes from the community-based
498.35 participatory research report "Cultural

499.1 Traditions and the Reproductive Health
499.2 of Somali Refugees and Immigrants" to
499.3 increase the health literacy of Somali women
499.4 and develop culturally specific health care
499.5 information; and
499.6 (3) training the federally qualified health
499.7 center's providers and staff to enhance
499.8 provider and staff cultural competence
499.9 regarding the cultural barriers, including
499.10 female genital cutting.

499.11 (b) The pilot program must develop a process
499.12 that results in increased screening rates
499.13 for cervical and breast cancer and can be
499.14 replicated by other providers serving ethnic
499.15 minorities. The pilot program must conduct
499.16 an evaluation of the new patient flow process
499.17 used by Somali women to access federally
499.18 qualified health centers services.

499.19 (c) The pilot program must report the
499.20 outcomes to the commissioner by June 30,
499.21 2017.

499.22 (d) \$110,000 in fiscal year 2016 is for the
499.23 Somali women's health pilot program. Of
499.24 this appropriation, the commissioner may
499.25 use up to \$10,000 to administer the program.
499.26 This appropriation is available until June 30,
499.27 2017. This is a onetime appropriation.

499.28 **Menthol Cigarette Usage in**
499.29 **African-American Community**
499.30 **Intervention Grants.** Of the health care
499.31 access fund appropriation for the statewide
499.32 health improvement program, \$200,000 in
499.33 fiscal year 2016 is for at least one grant that
499.34 must be awarded by the commissioner to
499.35 implement strategies and interventions to

500.1 reduce the disproportionately high usage of
500.2 cigarettes by African-Americans, especially
500.3 the use of menthol-flavored cigarettes, as
500.4 well as the disproportionate harm tobacco
500.5 causes in that community. The grantee shall
500.6 engage members of the African-American
500.7 community and community-based
500.8 organizations. This grant shall be awarded
500.9 as part of the statewide health improvement
500.10 program grants awarded on November 1,
500.11 2015, and must meet the requirements of
500.12 Minnesota Statutes, section 145.986.

500.13 **Targeted Home Visiting System. (a)**
500.14 \$75,000 in fiscal year 2016 is for the
500.15 commissioner of health, in consultation
500.16 with the commissioners of human services
500.17 and education, community health boards,
500.18 tribal nations, and other home visiting
500.19 stakeholders, to design baseline training
500.20 for new home visitors to ensure statewide
500.21 coordination across home visiting programs.

500.22 (b) \$575,000 in fiscal year 2016 and
500.23 \$2,000,000 fiscal year 2017 are to provide
500.24 grants to community health boards and
500.25 tribal nations for start-up grants for new
500.26 nurse-family partnership programs and
500.27 for grants to expand existing programs
500.28 to serve first-time mothers, prenatally by
500.29 28 weeks gestation until the child is two
500.30 years of age, who are eligible for medical
500.31 assistance under Minnesota Statutes, chapter
500.32 256B, or the federal Special Supplemental
500.33 Nutrition Program for Women, Infants, and
500.34 Children. The commissioner shall award
500.35 grants to community health boards or tribal
500.36 nations in metropolitan and rural areas of

501.1 the state. Priority for all grants shall be
501.2 given to nurse-family partnership programs
501.3 that provide services through a Minnesota
501.4 health care program-enrolled provider that
501.5 accepts medical assistance. Additionally,
501.6 priority for grants to rural areas shall be
501.7 given to community health boards and tribal
501.8 nations that expand services within regional
501.9 partnerships that provide the nurse-family
501.10 partnership program. Funding available
501.11 under this paragraph may only be used to
501.12 supplement, not to replace, funds being used
501.13 for nurse-family partnership home visiting
501.14 services as of June 30, 2015.

501.15 **Opiate Antagonists.** \$270,000 in fiscal
501.16 year 2016 and \$20,000 in fiscal year 2017
501.17 are from the general fund for grants to the
501.18 eight regional emergency medical services
501.19 programs to purchase opiate antagonists
501.20 and educate and train emergency medical
501.21 services persons, as defined in Minnesota
501.22 Statutes, section 144.7401, subdivision
501.23 4, clauses (1) and (2), in the use of these
501.24 antagonists in the event of an opioid or
501.25 heroin overdose. For the purposes of
501.26 this paragraph, "opiate antagonist" means
501.27 naloxone hydrochloride or any similarly
501.28 acting drug approved by the federal Food
501.29 and Drug Administration for the treatment of
501.30 drug overdose. Grants under this paragraph
501.31 must be distributed to all eight regional
501.32 emergency medical services programs. This
501.33 is a onetime appropriation and is available
501.34 until June 30, 2017. The commissioner may
501.35 use up to \$20,000 of the amount for opiate
501.36 antagonists for administration.

- 502.1 **Local and Tribal Public Health Grants. (a)**
- 502.2 \$894,000 in fiscal year 2016 and \$894,000 in
- 502.3 fiscal year 2017 are for an increase in local
- 502.4 public health grants for community health
- 502.5 boards under Minnesota Statutes, section
- 502.6 145A.131, subdivision 1, paragraph (e).
- 502.7 **(b) \$106,000 in fiscal year 2016 and \$106,000**
- 502.8 in fiscal year 2017 are for an increase in
- 502.9 special grants to tribal governments under
- 502.10 Minnesota Statutes, section 145A.14,
- 502.11 subdivision 2a.
- 502.12 **HCBS Employee Scholarships. \$1,000,000**
- 502.13 in fiscal year 2016 and \$1,000,000 in fiscal
- 502.14 year 2017 are from the general fund for
- 502.15 the home and community-based services
- 502.16 employee scholarship program under
- 502.17 Minnesota Statutes, section 144.1503. The
- 502.18 commissioner may use up to \$50,000 of the
- 502.19 amount for the HCBS employee scholarships
- 502.20 for administration.
- 502.21 **Family Planning Special Projects.**
- 502.22 \$1,000,000 in fiscal year 2016 and
- 502.23 \$1,000,000 in fiscal year 2017 are from the
- 502.24 general fund for family planning special
- 502.25 project grants under Minnesota Statutes,
- 502.26 section 145.925.
- 502.27 **Positive Alternatives. \$1,000,000 in fiscal**
- 502.28 year 2016 and \$1,000,000 in fiscal year
- 502.29 2017 are from the general fund for positive
- 502.30 abortion alternatives under Minnesota
- 502.31 Statutes, section 145.4235.
- 502.32 **Safe Harbor for Sexually Exploited Youth.**
- 502.33 \$700,000 in fiscal year 2016 and \$700,000 in
- 502.34 fiscal year 2017 are from the general fund
- 502.35 for the safe harbor program under Minnesota

- 503.1 Statutes, sections 145.4716 to 145.4718.
- 503.2 Funds shall be used for grants to increase
- 503.3 the number of regional navigators; training
- 503.4 for professionals who engage with exploited
- 503.5 or at-risk youth; implementing statewide
- 503.6 protocols and best practices for effectively
- 503.7 identifying, interacting with, and referring
- 503.8 sexually exploited youth to appropriate
- 503.9 resources; and program operating costs.
- 503.10 **Health Care Grants for Uninsured**
- 503.11 **Individuals.** (a) \$125,000 in fiscal year 2016
- 503.12 and \$125,000 in fiscal year 2017 are from
- 503.13 the general fund for dental provider grants
- 503.14 in Minnesota Statutes, section 145.929,
- 503.15 subdivision 1.
- 503.16 (b) \$437,500 in fiscal year 2016 and \$437,500
- 503.17 in fiscal year 2017 are from the general fund
- 503.18 for community mental health program grants
- 503.19 in Minnesota Statutes, section 145.929,
- 503.20 subdivision 2.
- 503.21 (c) \$1,500,000 in fiscal year 2016 and
- 503.22 \$1,500,000 in fiscal year 2017 are from the
- 503.23 general fund for the emergency medical
- 503.24 assistance outlier grant program in Minnesota
- 503.25 Statutes, section 145.929, subdivision 3.
- 503.26 (d) \$437,500 of the general fund
- 503.27 appropriation in fiscal years 2016 and 2017
- 503.28 is for community health center grants under
- 503.29 Minnesota Statutes, section 145.9269. A
- 503.30 community health center that receives a grant
- 503.31 from this appropriation is not eligible for a
- 503.32 grant under paragraph (b).
- 503.33 (e) The commissioner may use up to \$25,000
- 503.34 of the appropriations for health care grants

504.1 for uninsured individuals in fiscal years 2016
504.2 and 2017 for grant administration.

504.3 **TANF Appropriations.** (a) \$1,156,000 of
504.4 the TANF funds is appropriated each year of
504.5 the biennium to the commissioner for family
504.6 planning grants under Minnesota Statutes,
504.7 section 145.925.

504.8 (b) \$3,579,000 of the TANF funds is
504.9 appropriated each year of the biennium to
504.10 the commissioner for home visiting and
504.11 nutritional services listed under Minnesota
504.12 Statutes, section 145.882, subdivision 7,
504.13 clauses (6) and (7). Funds must be distributed
504.14 to community health boards according to
504.15 Minnesota Statutes, section 145A.131,
504.16 subdivision 1.

504.17 (c) \$2,000,000 of the TANF funds is
504.18 appropriated each year of the biennium to
504.19 the commissioner for decreasing racial and
504.20 ethnic disparities in infant mortality rates
504.21 under Minnesota Statutes, section 145.928,
504.22 subdivision 7.

504.23 (d) \$4,978,000 of the TANF funds is
504.24 appropriated each year of the biennium to the
504.25 commissioner for the family home visiting
504.26 grant program according to Minnesota
504.27 Statutes, section 145A.17. \$4,000,000 of the
504.28 funding must be distributed to community
504.29 health boards according to Minnesota
504.30 Statutes, section 145A.131, subdivision 1.
504.31 \$978,000 of the funding must be distributed to
504.32 tribal governments as provided in Minnesota
504.33 Statutes, section 145A.14, subdivision 2a.

504.34 (e) The commissioner may use up to 6.23
504.35 percent of the funds appropriated each fiscal

505.1 year to conduct the ongoing evaluations
505.2 required under Minnesota Statutes, section
505.3 145A.17, subdivision 7, and training and
505.4 technical assistance as required under
505.5 Minnesota Statutes, section 145A.17,
505.6 subdivisions 4 and 5.

505.7 **TANF Carryforward.** Any unexpended
505.8 balance of the TANF appropriation in the
505.9 first year of the biennium does not cancel but
505.10 is available for the second year.

505.11 **Health Professional Loan Forgiveness.**
505.12 \$2,631,000 in fiscal year 2016 and \$2,631,000
505.13 in fiscal year 2017 are from the general
505.14 fund for the purposes of Minnesota Statutes,
505.15 section 144.1501. Of this appropriation, the
505.16 commissioner may use up to \$131,000 each
505.17 year to administer the program.

505.18 **Minnesota Stroke System.** \$350,000 in
505.19 fiscal year 2016 and \$350,000 in fiscal
505.20 year 2017 are from the general fund for the
505.21 Minnesota stroke system.

505.22 **Prevention of Violence in Health Care.**
505.23 \$50,000 in fiscal year 2016 is to continue the
505.24 prevention of violence in health care program
505.25 and creating violence prevention resources
505.26 for hospitals and other health care providers
505.27 to use in training their staff on violence
505.28 prevention. This is a onetime appropriation
505.29 and is available until June 30, 2017.

505.30 **Health Care Savings Determinations. (a)**
505.31 The health care access fund base for the state
505.32 health improvement program is decreased by
505.33 \$261,000 in fiscal year 2016 and decreased
505.34 by \$110,000 in fiscal year 2017.

506.1 (b) \$261,000 in fiscal year 2016 and \$110,000
 506.2 in fiscal year 2017 are from the health care
 506.3 access fund for the forecasting, cost reporting,
 506.4 and analysis required by Minnesota Statutes,
 506.5 section 62U.10, subdivisions 6 and 7.

506.6 **Base Level Adjustments.** The general fund
 506.7 base is decreased by \$1,070,000 in fiscal
 506.8 year 2018 and by \$1,020,000 in fiscal year
 506.9 2019. The state government special revenue
 506.10 fund base is increased by \$33,000 in fiscal
 506.11 year 2018. The health care access fund base
 506.12 is increased by \$610,000 in fiscal year 2018
 506.13 and by \$23,000 in fiscal year 2019.

506.14 **Subd. 3. Health Protection**

506.15	<u>Appropriations by Fund</u>		
506.16	<u>General</u>	<u>12,506,000</u>	<u>14,149,000</u>
506.17	<u>State Government</u>		
506.18	<u>Special Revenue</u>	<u>47,579,000</u>	<u>46,266,000</u>

506.19 **Base Level Adjustments.** The state
 506.20 government special revenue fund base is
 506.21 increased by \$322,000 in fiscal year 2018
 506.22 and by \$300,000 in fiscal year 2019.

506.23 **Subd. 4. Administrative Support Services** 8,210,000 8,224,000

506.24 **Sec. 4. HEALTH-RELATED BOARDS**

506.25 **Subdivision 1. Total Appropriation** \$ 19,707,000 \$ 19,597,000

506.26 This appropriation is from the state
 506.27 government special revenue fund. The
 506.28 amounts that may be spent for each purpose
 506.29 are specified in the following subdivisions.

506.30 **Subd. 2. Board of Chiropractic Examiners** 507,000 513,000

506.31 **Subd. 3. Board of Dentistry** 2,192,000 2,206,000

507.1 This appropriation includes \$864,000 in fiscal
 507.2 year 2016 and \$878,000 in fiscal year 2017
 507.3 for the health professional services program.

507.4 Subd. 4. **Board of Dietetics and Nutrition**
 507.5 **Practice**

113,000

115,000

507.6 Subd. 5. **Board of Marriage and Family**
 507.7 **Therapy**

234,000

237,000

507.8 Subd. 6. **Board of Medical Practice**

3,933,000

3,962,000

507.9 Subd. 7. **Board of Nursing**

4,189,000

4,243,000

507.10 Subd. 8. **Board of Nursing Home**
 507.11 **Administrators**

2,365,000

2,062,000

507.12 **Administrative Services Unit - Operating**

507.13 **Costs.** Of this appropriation, \$1,482,000

507.14 in fiscal year 2016 and \$1,497,000 in

507.15 fiscal year 2017 are for operating costs

507.16 of the administrative services unit. The

507.17 administrative services unit may receive

507.18 and expend reimbursements for services

507.19 performed by other agencies.

507.20 **Administrative Services Unit - Volunteer**

507.21 **Health Care Provider Program.** Of this

507.22 appropriation, \$150,000 in fiscal year 2016

507.23 and \$150,000 in fiscal year 2017 are to pay

507.24 for medical professional liability coverage

507.25 required under Minnesota Statutes, section

507.26 214.40.

507.27 **Administrative Services Unit - Retirement**

507.28 **Costs.** Of this appropriation, \$320,000 in

507.29 fiscal year 2016 is a onetime appropriation

507.30 to the administrative services unit to pay for

507.31 the retirement costs of health-related board

507.32 employees. This funding may be transferred

507.33 to the health board incurring the retirement

507.34 costs. These funds are available either year

507.35 of the biennium.

508.1 **Administrative Services Unit - Contested**
 508.2 **Cases and Other Legal Proceedings.** Of
 508.3 this appropriation, \$200,000 in fiscal year
 508.4 2016 and \$200,000 in fiscal year 2017 are
 508.5 for costs of contested case hearings and other
 508.6 unanticipated costs of legal proceedings
 508.7 involving health-related boards funded
 508.8 under this section. Upon certification by a
 508.9 health-related board to the administrative
 508.10 services unit that the costs will be incurred
 508.11 and that there is insufficient money available
 508.12 to pay for the costs out of money currently
 508.13 available to that board, the administrative
 508.14 services unit is authorized to transfer money
 508.15 from this appropriation to the board for
 508.16 payment of those costs with the approval
 508.17 of the commissioner of management and
 508.18 budget. The commissioner of management
 508.19 and budget must require any board that
 508.20 has an unexpended balance for an amount
 508.21 transferred under this paragraph to transfer
 508.22 the unexpended amount to the administrative
 508.23 services unit to be deposited in the state
 508.24 government special revenue fund.

508.25	<u>Subd. 9. Board of Optometry</u>	<u>138,000</u>	<u>143,000</u>
508.26	<u>Subd. 10. Board of Pharmacy</u>	<u>2,847,000</u>	<u>2,888,000</u>
508.27	<u>Subd. 11. Board of Physical Therapy</u>	<u>354,000</u>	<u>359,000</u>
508.28	<u>Subd. 12. Board of Podiatry</u>	<u>78,000</u>	<u>79,000</u>
508.29	<u>Subd. 13. Board of Psychology</u>	<u>874,000</u>	<u>884,000</u>
508.30	<u>Subd. 14. Board of Social Work</u>	<u>1,141,000</u>	<u>1,155,000</u>
508.31	<u>Subd. 15. Board of Veterinary Medicine</u>	<u>262,000</u>	<u>265,000</u>
508.32	<u>Subd. 16. Board of Behavioral Health and</u>		
508.33	<u>Therapy</u>	<u>480,000</u>	<u>486,000</u>

509.1	Sec. 5. <u>EMERGENCY MEDICAL SERVICES</u>			
509.2	<u>REGULATORY BOARD</u>	\$	<u>2,904,000</u>	\$ <u>3,037,000</u>
509.3	<u>Cooper/Sams Volunteer Ambulance</u>			
509.4	<u>Program.</u> \$700,000 in fiscal year 2016 and			
509.5	<u>\$700,000 in fiscal year 2017 are for the</u>			
509.6	<u>Cooper/Sams volunteer ambulance program</u>			
509.7	<u>under Minnesota Statutes, section 144E.40.</u>			
509.8	<u>(a) Of this amount, \$611,000 in fiscal year</u>			
509.9	<u>2016 and \$611,000 in fiscal year 2017</u>			
509.10	<u>are for the ambulance service personnel</u>			
509.11	<u>longevity award and incentive program under</u>			
509.12	<u>Minnesota Statutes, section 144E.40.</u>			
509.13	<u>(b) Of this amount, \$89,000 in fiscal year</u>			
509.14	<u>2016 and \$89,000 in fiscal year 2017 are</u>			
509.15	<u>for the operations of the ambulance service</u>			
509.16	<u>personnel longevity award and incentive</u>			
509.17	<u>program under Minnesota Statutes, section</u>			
509.18	<u>144E.40.</u>			
509.19	<u>Ambulance Training Grant.</u> \$361,000 in			
509.20	<u>fiscal year 2016 and \$361,000 in fiscal year</u>			
509.21	<u>2017 are for training grants.</u>			
509.22	<u>EMSRB Board Operations.</u> \$1,226,000 in			
509.23	<u>fiscal year 2016 and \$1,360,000 in fiscal year</u>			
509.24	<u>2017 are for board operations.</u>			
509.25	<u>Regional Grants.</u> \$585,000 in fiscal year			
509.26	<u>2016 and \$585,000 in fiscal year 2017 are</u>			
509.27	<u>for regional emergency medical services</u>			
509.28	<u>programs, to be distributed equally to the</u>			
509.29	<u>eight emergency medical service regions.</u>			
509.30	Sec. 6. <u>COUNCIL ON DISABILITY</u>	\$	<u>622,000</u>	\$ <u>629,000</u>
509.31	Sec. 7. <u>OMBUDSMAN FOR MENTAL</u>			
509.32	<u>HEALTH AND DEVELOPMENTAL</u>			
509.33	<u>DISABILITIES</u>	\$	<u>1,917,000</u>	\$ <u>2,032,000</u>

510.1 Sec. 8. **OMBUDSPERSONS FOR FAMILIES** \$ 392,000 \$ 453,000

510.2 Sec. 9. **COMMISSIONER OF COMMERCE** \$ 210,000 \$ 213,000

510.3 The commissioner of commerce shall
 510.4 develop a proposal to allow individuals
 510.5 to purchase qualified health plans outside
 510.6 of MNsure directly from health plan
 510.7 companies and to allow eligible individuals
 510.8 to receive advanced premium tax credits and
 510.9 cost-sharing reductions when purchasing
 510.10 qualified health plans outside of MNsure.

510.11 Sec. 10. **APPROPRIATION.**

510.12 \$455,000,000 is appropriated in fiscal year 2015 from the general fund to the
 510.13 commissioner of human services. The commissioner of human services must transfer
 510.14 \$455,000,000 from the general fund to the health care access fund by June 30, 2015.

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

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

510.18 Subd. 40. **Nonfederal share transfers.** The nonfederal share of activities for
 510.19 which federal administrative reimbursement is appropriated to the commissioner may
 510.20 be transferred to the special revenue fund.

510.21 Sec. 12. **TRANSFERS.**

510.22 Subdivision 1. **Grants.** The commissioner of human services, with the approval of
 510.23 the commissioner of management and budget, may transfer unencumbered appropriation
 510.24 balances for the biennium ending June 30, 2017, within fiscal years among the MFIP,
 510.25 general assistance, general assistance medical care under Minnesota Statutes 2009
 510.26 Supplement, section 256D.03, subdivision 3, medical assistance, MinnesotaCare, MFIP
 510.27 child care assistance under Minnesota Statutes, section 119B.05, Minnesota supplemental
 510.28 aid, and group residential housing programs, the entitlement portion of Northstar Care
 510.29 for Children under Minnesota Statutes, chapter 256N, and the entitlement portion of
 510.30 the chemical dependency consolidated treatment fund, and between fiscal years of the
 510.31 biennium. The commissioner shall inform the chairs and ranking minority members of

511.1 the senate Health and Human Services Finance Division and the house of representatives
511.2 Health and Human Services Finance Committee quarterly about transfers made under
511.3 this subdivision.

511.4 Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative
511.5 money may be transferred within the Departments of Health and Human Services as the
511.6 commissioners consider necessary, with the advance approval of the commissioner of
511.7 management and budget. The commissioner shall inform the chairs and ranking minority
511.8 members of the senate Health and Human Services Finance Division and the house of
511.9 representatives Health and Human Services Finance Committee quarterly about transfers
511.10 made under this subdivision.

511.11 Sec. 13. **INDIRECT COSTS NOT TO FUND PROGRAMS.**

511.12 The commissioners of health and human services shall not use indirect cost
511.13 allocations to pay for the operational costs of any program for which they are responsible.

511.14 Sec. 14. **EXPIRATION OF UNCODIFIED LANGUAGE.**

511.15 All uncodified language contained in this article expires on June 30, 2017, unless a
511.16 different expiration date is explicit.

511.17 Sec. 15. **EFFECTIVE DATE.**

511.18 This article is effective July 1, 2015, unless a different effective date is specified.

APPENDIX
Article locations in S1458-3

ARTICLE 1	CHILDREN AND FAMILY SERVICES	Page.Ln 3.12
ARTICLE 2	CHEMICAL AND MENTAL HEALTH SERVICES	Page.Ln 111.15
ARTICLE 3	WITHDRAWAL MANAGEMENT PROGRAMS	Page.Ln 147.11
ARTICLE 4	DIRECT CARE AND TREATMENT	Page.Ln 172.1
ARTICLE 5	SIMPLIFICATION OF PUBLIC ASSISTANCE PROGRAMS	Page.Ln 173.27
	NURSING FACILITY PAYMENT REFORM AND WORKFORCE	
ARTICLE 6	DEVELOPMENT	Page.Ln 193.2
ARTICLE 7	CONTINUING CARE	Page.Ln 233.16
ARTICLE 8	HEALTH DEPARTMENT AND PUBLIC HEALTH	Page.Ln 282.28
ARTICLE 9	HEALTH CARE DELIVERY	Page.Ln 347.22
ARTICLE 10	HEALTH LICENSING BOARDS	Page.Ln 364.25
ARTICLE 11	HEALTH CARE	Page.Ln 385.1
ARTICLE 12	MNSURE	Page.Ln 460.16
ARTICLE 13	HUMAN SERVICES FORECAST ADJUSTMENTS	Page.Ln 466.27
ARTICLE 14	HEALTH AND HUMAN SERVICES APPROPRIATIONS	Page.Ln 468.5

62V.11 LEGISLATIVE OVERSIGHT COMMITTEE.

Subd. 3. **Review of proposed rules.** (a) Prior to the implementation of rules proposed under section 62V.05, subdivision 8, paragraph (b), the board shall submit the proposed rules to the committee at the same time the proposed rules are published in the State Register.

(b) When the legislature is in session, the rule may be adopted, but, if within ten days of receipt of the proposed rule a majority of the committee members appointed by the senate and a majority of the committee members appointed by the house of representatives request further review of the proposed rule, the rule shall not be effective until the request has been satisfied and withdrawn, the rule is approved in law, or the regular session of the legislature is adjourned for the year.

(c) If the legislature is not in session, the rule may be adopted, but, if within ten days of receipt of the proposed rule a majority of the committee members appointed by the senate and a majority of the committee members appointed by the house of representatives request further review of the proposed rule, the rule shall not be effective until the request has been satisfied and withdrawn, or February 1, whichever occurs first.

148.57 LICENSE.

Subd. 3. **Revocation, suspension.** The board may revoke the license or suspend or restrict the right to practice of any person who has been convicted of any violation of sections 148.52 to 148.62 or of any other criminal offense, or who violates any provision of sections 148.571 to 148.576 or who is found by the board to be incompetent or guilty of unprofessional conduct. "Unprofessional conduct" means any conduct of a character likely to deceive or defraud the public, including, among other things, free examination advertising, the loaning of a license by any licensed optometrist to any person; the employment of "cappers" or "steerers" to obtain business; splitting or dividing a fee with any person; the obtaining of any fee or compensation by fraud or misrepresentation; employing directly or indirectly any suspended or unlicensed optometrist to perform any work covered by sections 148.52 to 148.62; the advertising by any means of optometric practice or treatment or advice in which untruthful, improbable, misleading, or impossible statements are made. After one year, upon application and proof that the disqualification has ceased, the board may reinstate such person.

Subd. 4. **Peddling or canvassing forbidden.** Every licensed optometrist who shall temporarily practice optometry outside or away from the regular registered place of business shall display the license and deliver to each customer or person there fitted or supplied with glasses a receipt or record which shall contain the signature, permanent registered place of business or post office address, and number of license of the optometrist, together with the amount charged therefor, but nothing contained in this section shall be construed as to permit peddling or canvassing by licensed optometrists.

148.571 USE OF TOPICAL OCULAR DRUGS.

Subdivision 1. **Authority.** Subject to the provisions of sections 148.571 to 148.574, optometrists who are currently licensed on August 1, 2007, and are not board certified under section 148.575 may possess a valid topical ocular drug certificate, referred to in sections 148.571 to 148.574, allowing them to administer topical ocular drugs to the anterior segment of the human eye during an eye examination in the course of practice in their normal practice setting, solely for the purposes of determining the refractive, muscular, or functional origin of sources of visual discomfort or difficulty, and detecting abnormalities which may be evidence of disease. Authority granted under sections 148.571 to 148.574 is granted to optometrists who are board certified under section 148.575.

Subd. 2. **Drugs specified.** For purposes of sections 148.571 to 148.574, "topical ocular drugs" means:

(1) commercially prepared topical anesthetics as follows: proparacaine HCl 0.5 percent, tetracaine HCl 0.5 percent, and benoxinate HCl 0.4 percent;

(2) commercially prepared mydriatics as follows: phenylephrine HCl in strength not greater than 2.5 percent and hydroxyamphetamine HBr in strength not greater than 1 percent; and

(3) commercially prepared cycloplegics/mydriatics as follows: tropicamide in strength not greater than 1 percent and cyclopentolate in strength not greater than 1 percent.

148.572 ADVICE TO SEEK DIAGNOSIS AND TREATMENT.

APPENDIX

Repealed Minnesota Statutes: S1458-3

Whether or not topical ocular drugs have been used, if any licensed optometrist is informed by a patient or determines from examining a patient, using judgment and that degree of skill, care, knowledge and attention ordinarily possessed and exercised by optometrists in good standing under like circumstances, that there are present in that patient signs or symptoms which may be evidence of disease that requires treatment that is beyond the practice of optometry permitted by law, then the licensed optometrist shall (1) promptly advise that patient to seek evaluation by an appropriate licensed physician for diagnosis and possible treatment and (2) not attempt to treat such condition by the use of drugs or any other means.

148.573 TOPICAL OCULAR DRUG USE.

Subdivision 1. **Certificate required.** A licensed optometrist shall not purchase, possess or administer any topical ocular drugs unless the optometrist has obtained a topical ocular drug certificate from the Board of Optometry certifying that the optometrist has complied with the requirements in paragraphs (a) and (b).

(a) Successful completion of 60 classroom hours of study in general and clinical pharmacology as it relates to the practice of optometry, with particular emphasis on the use of topical ocular drugs for examination purposes. At least 30 of the 60 classroom hours shall be in ocular pharmacology and shall emphasize the systemic effects of and reactions to topical ocular drugs, including the emergency management and referral of any adverse reactions that may occur. The course of study shall be approved by the Board of Optometry, and shall be offered by an institution which is accredited by a regional or professional accreditation organization recognized or approved by the Council on Postsecondary Education or the United States Department of Education or their successors. The course shall be completed prior to entering the examination required by this section.

(b) Successful completion of an examination approved by the Board of Optometry on the subject of general and ocular pharmacology as it relates to optometry with particular emphasis on the use of topical ocular drugs, including emergency management and referral of any adverse reactions that may occur.

148.575 CERTIFICATE REQUIRED FOR USE OF TOPICAL LEGEND DRUGS.

Subdivision 1. **Certificate required for use of legend drugs.** A licensed optometrist must be board certified to use legend drugs for therapy under section 148.576.

Subd. 3. **Display of certificate required.** A certificate issued under this section to a licensed optometrist by the Board of Optometry supersedes any previously issued certificate limited to topical ocular drugs described in sections 148.571 to 148.574 and must be displayed in a prominent place in the licensed optometrist's office.

Subd. 5. **Notice to Board of Pharmacy.** The Board of Optometry shall notify the Board of Pharmacy of each licensed optometrist who meets the certification requirements in this section.

Subd. 6. **Board certification required.** Optometrists who were licensed in this state prior to August 1, 2007, must have met the board certification requirements under this section by August 1, 2012, in order to renew their license.

148.576 USE OF LEGEND DRUGS; LIMITATIONS; REPORTS.

Subdivision 1. **Authority to prescribe or administer.** A licensed optometrist who is board certified under section 148.575 may prescribe or administer legend drugs to aid in the diagnosis, cure, mitigation, prevention, treatment, or management of disease, deficiency, deformity, or abnormality of the human eye and adnexa included in the curricula of accredited schools or colleges of optometry. Nothing in this section shall allow (1) legend drugs to be administered intravenously, intramuscularly, or by injection except for treatment of anaphylaxis, (2) invasive surgery including, but not limited to, surgery using lasers, (3) Schedule II and III oral legend drugs and oral steroids to be administered or prescribed, (4) oral antivirals to be prescribed or administered for more than ten days, or (5) oral carbonic anhydrase inhibitors to be prescribed or administered for more than seven days.

Subd. 2. **Adverse reaction reports.** An optometrist certified to prescribe legend drugs shall file with the Board of Optometry within ten working days of its occurrence a report on any adverse reaction resulting from the optometrist's administration of a drug. The report must include the optometrist's name, address, and license number; the patient's name, address, and

APPENDIX

Repealed Minnesota Statutes: S1458-3

age; the patient's presenting problem; the diagnosis; the agent administered and the method of administration; the reaction; and the subsequent action taken.

148E.060 TEMPORARY LICENSES.

Subd. 12. **Ineligibility.** An applicant who is currently practicing social work in Minnesota in a setting that is not exempt under section 148E.065 at the time of application is ineligible for a temporary license.

148E.075 INACTIVE LICENSES.

Subd. 4. **Time limits for temporary leaves.** A licensee may maintain an inactive license on temporary leave for no more than five consecutive years. If a licensee does not apply for reactivation within 60 days following the end of the consecutive five-year period, the license automatically expires.

Subd. 5. **Time limits for emeritus license.** A licensee with an emeritus license may not apply for reactivation according to section 148E.080 after five years following the granting of the emeritus license. However, after five years following the granting of the emeritus license, an individual may apply for new licensure according to section 148E.055.

Subd. 6. **Prohibition on practice.** (a) Except as provided in paragraph (b), a licensee whose license is inactive must not practice, attempt to practice, offer to practice, or advertise or hold out as authorized to practice social work.

(b) The board may grant a variance to the requirements of paragraph (a) if a licensee on inactive status provides emergency social work services. A variance is granted only if the board provides the variance in writing to the licensee. The board may impose conditions or restrictions on the variance.

Subd. 7. **Representations of professional status.** In making representations of professional status to the public, a licensee whose license is inactive must state that the license is inactive and that the licensee cannot practice social work.

256.01 COMMISSIONER OF HUMAN SERVICES; POWERS, DUTIES.

Subd. 35. **Federal approval.** (a) The commissioner shall seek federal authority from the U.S. Department of Health and Human Services necessary to operate a health coverage program for Minnesotans with incomes up to 275 percent of the federal poverty guidelines (FPG). The proposal shall seek to secure all federal funding available from at least the following sources:

(1) all premium tax credits and cost sharing subsidies available under United States Code, title 26, section 36B, and United States Code, title 42, section 18071, for individuals with incomes above 133 percent and at or below 275 percent of the federal poverty guidelines who would otherwise be enrolled in MNsure as defined in section 62V.02;

(2) Medicaid funding; and

(3) other funding sources identified by the commissioner that support coverage or care redesign in Minnesota.

(b) Funding received shall be used to design and implement a health coverage program that creates a single streamlined program and meets the needs of Minnesotans with incomes up to 275 percent of the federal poverty guidelines. The program must incorporate:

(1) payment reform characteristics included in the health care delivery system and accountable care organization payment models;

(2) flexibility in benefit set design such that benefits can be targeted to meet enrollee needs in different income and health status situations and can provide a more seamless transition from public to private health care coverage;

(3) flexibility in co-payment or premium structures to incent patients to seek high-quality, low-cost care settings; and

(4) flexibility in premium structures to ease the transition from public to private health care coverage.

(c) The commissioner shall develop and submit a proposal consistent with the above criteria and shall seek all federal authority necessary to implement the health coverage program. In developing the request, the commissioner shall consult with appropriate stakeholder groups and consumers.

(d) The commissioner is authorized to seek any available waivers or federal approvals to accomplish the goals under paragraph (b) prior to 2017.

(e) The commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and financing by

APPENDIX

Repealed Minnesota Statutes: S1458-3

January 15, 2015, on the progress of receiving a federal waiver and shall make recommendations on any legislative changes necessary to accomplish the project in this subdivision. Any implementation of the waiver that requires a state financial contribution to operate a health coverage program for Minnesotans with incomes between 200 and 275 percent of the federal poverty guidelines, shall be contingent on legislative action approving the contribution.

(f) The commissioner is authorized to accept and expend federal funds that support the purposes of this subdivision.

256.969 PAYMENT RATES.

Subd. 23. **Hospital payment adjustment after June 30, 1993.** (a) For admissions occurring after June 30, 1993, the commissioner shall adjust the medical assistance payment paid to a hospital, excluding regional treatment centers and facilities of the federal Indian Health Service, with a medical assistance inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined as follows:

(1) for a hospital with a medical assistance inpatient utilization rate above the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service, the adjustment must be determined by multiplying the total of the operating and property payment rates by the difference between the hospital's actual medical assistance inpatient utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service; and

(2) for a hospital with a medical assistance inpatient utilization rate above one standard deviation above the mean, the adjustment must be determined by multiplying the adjustment under clause (1) for that hospital by 1.1.

(b) Any payment under this subdivision must be reduced by the amount of any payment received under subdivision 9, paragraph (b), clause (1) or (2). For purposes of this subdivision, medical assistance does not include general assistance medical care.

(c) The commissioner shall adjust rates paid to a health maintenance organization under contract with the commissioner to reflect rate increases provided in this section. The adjustment must be made on a nondiscounted hospital-specific basis.

Subd. 30. **Payment rates for births.** (a) For admissions occurring on or after November 1, 2014, the total operating and property payment rate, excluding disproportionate population adjustment, for the following diagnosis-related groups, as they fall within the APR-DRG categories: (1) 5601, 5602, 5603, 5604 vaginal delivery; and (2) 5401, 5402, 5403, 5404 cesarean section, shall be no greater than \$3,528.

(b) The rates described in this subdivision do not include newborn care.

(c) Payments to managed care and county-based purchasing plans under section 256B.69, 256B.692, or 256L.12 shall be reduced for services provided on or after October 1, 2009, to reflect the adjustments in paragraph (a).

(d) Prior authorization shall not be required before reimbursement is paid for a cesarean section delivery.

256B.434 ALTERNATIVE PAYMENT DEMONSTRATION PROJECT.

Subd. 19b. **Nursing facility rate adjustments beginning October 1, 2015.** A total of a 3.2 percent average rate adjustment shall be provided as described under this subdivision and under section 256B.441, subdivision 46c.

(a) Beginning October 1, 2015, the commissioner shall make available to each nursing facility reimbursed under this section a 2.4 percent operating payment rate increase, in accordance with paragraphs (b) to (g).

(b) Seventy-five percent of the money resulting from the rate adjustment under paragraph (a) must be used for increases in compensation-related costs for employees directly employed by the nursing facility on or after the effective date of the rate adjustment, except:

(1) the administrator;

(2) persons employed in the central office of a corporation that has an ownership interest in the nursing facility or exercises control over the nursing facility; and

(3) persons paid by the nursing facility under a management contract.

(c) The commissioner shall allow as compensation-related costs all costs for:

(1) wage and salary increases effective after May 25, 2015;

(2) the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, and workers' compensation;

APPENDIX

Repealed Minnesota Statutes: S1458-3

(3) the employer's share of health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, and pensions; and

(4) other benefits provided and workforce needs, including the recruiting and training of employees, subject to the approval of the commissioner.

(d) The portion of the rate adjustment under paragraph (a) that is not subject to the requirements of paragraph (b) shall be provided to nursing facilities effective October 1, 2015. Nursing facilities may apply for the portion of the rate adjustment under paragraph (a) that is subject to the requirements in paragraph (b). The application must be submitted to the commissioner within six months of the effective date of the rate adjustment, and the nursing facility must provide additional information required by the commissioner within nine months of the effective date of the rate adjustment. The commissioner must respond to all applications within three weeks of receipt. The commissioner may waive the deadlines in this paragraph under extraordinary circumstances, to be determined at the sole discretion of the commissioner. The application must contain:

(1) an estimate of the amounts of money that must be used as specified in paragraph (b);

(2) a detailed distribution plan specifying the allowable compensation-related increases the nursing facility will implement to use the funds available in clause (1);

(3) a description of how the nursing facility will notify eligible employees of the contents of the approved application, which must provide for giving each eligible employee a copy of the approved application, excluding the information required in clause (1), or posting a copy of the approved application, excluding the information required in clause (1), for a period of at least six weeks in an area of the nursing facility to which all eligible employees have access; and

(4) instructions for employees who believe they have not received the compensation-related increases specified in clause (2), as approved by the commissioner, and which must include a mailing address, e-mail address, and the telephone number that may be used by the employee to contact the commissioner or the commissioner's representative.

(e) The commissioner shall ensure that cost increases in distribution plans under paragraph (d), clause (2), that may be included in approved applications, comply with the following requirements:

(1) a portion of the costs resulting from tenure-related wage or salary increases may be considered to be allowable wage increases, according to formulas that the commissioner shall provide, where employee retention is above the average statewide rate of retention of direct-care employees;

(2) the annualized amount of increases in costs for the employer's share of health and dental insurance, life insurance, disability insurance, and workers' compensation shall be allowable compensation-related increases if they are effective on or after April 1, 2015, and prior to April 1, 2016; and

(3) for nursing facilities in which employees are represented by an exclusive bargaining representative, the commissioner shall approve the application only upon receipt of a letter of acceptance of the distribution plan, in regard to members of the bargaining unit, signed by the exclusive bargaining agent and dated after May 25, 2015.

Upon receipt of the letter of acceptance, the commissioner shall deem all requirements of this provision as having been met in regard to the members of the bargaining unit.

(f) The commissioner shall review applications received under paragraph (d) and shall provide the portion of the rate adjustment under paragraph (b) if the requirements of this subdivision have been met. The rate adjustment shall be effective October 1, 2015. Notwithstanding paragraph (a), if the approved application distributes less money than is available, the amount of the rate adjustment shall be reduced so that the amount of money made available is equal to the amount to be distributed.

(g) The increase in this subdivision shall be applied as a percentage to operating payment rates in effect on September 30, 2015. For each facility, the commissioner shall determine the operating payment rate, not including any rate components resulting from equitable cost-sharing for publicly owned nursing facility program participation under section 256B.441, subdivision 55a, critical access nursing facility program participation under section 256B.441, subdivision 63, or performance-based incentive payment program participation under subdivision 4, paragraph (d), for a RUG class with a weight of 1.00 in effect on September 30, 2015.

256B.441 VALUE-BASED NURSING FACILITY REIMBURSEMENT SYSTEM.

Subd. 14a. **Facility type groups.** Facilities shall be classified into two groups, called "facility type groups," which shall consist of:

APPENDIX

Repealed Minnesota Statutes: S1458-3

(1) C&NC/R80: facilities that are hospital-attached, or are licensed under Minnesota Rules, parts 9570.2000 to 9570.3400; and

(2) freestanding: all other facilities.

Subd. 19. **Hospital-attached nursing facility status.** (a) For the purpose of setting rates under this section, for rate years beginning after September 30, 2006, "hospital-attached nursing facility" means a nursing facility which meets the requirements of clauses (1) and (2); or (3); or (4), or had hospital-attached status prior to January 1, 1995, and has been recognized as having hospital-attached status by CMS continuously since that date:

(1) the nursing facility is recognized by the federal Medicare program to be a hospital-based nursing facility;

(2) the hospital and nursing facility are physically attached or connected by a corridor;

(3) a nursing facility and hospital, which have applied for hospital-based nursing facility status under the federal Medicare program during the reporting year, shall be considered a hospital-attached nursing facility for purposes of setting payment rates under this section. The nursing facility must file its cost report for that reporting year using Medicare principles and Medicare's recommended cost allocation methods had the Medicare program's hospital-based nursing facility status been granted to the nursing facility. For each subsequent rate year, the nursing facility must meet the definition requirements in clauses (1) and (2). If the nursing facility is denied hospital-based nursing facility status under the Medicare program, the nursing facility's payment rates for the rate years the nursing facility was considered to be a hospital-attached nursing facility according to this paragraph shall be recalculated treating the nursing facility as a non-hospital-attached nursing facility;

(4) if a nonprofit or community-operated hospital and attached nursing facility suspend operation of the hospital, the remaining nursing facility must be allowed to continue its status as hospital-attached for rate calculations in the three rate years subsequent to the one in which the hospital ceased operations.

(b) The nursing facility's cost report filed as hospital-attached facility shall use the same cost allocation principles and methods used in the reports filed for the Medicare program. Direct identification of costs to the nursing facility cost center will be permitted only when the comparable hospital costs have also been directly identified to a cost center which is not allocated to the nursing facility.

Subd. 50a. **Determination of proximity adjustments.** (a) For a nursing facility located in close proximity to another nursing facility of the same facility group type but in a different peer group and that has higher limits for care-related or other operating costs, the commissioner shall adjust the limits in accordance with clauses (1) to (4):

(1) determine the difference between the limits;

(2) determine the distance between the two facilities, by the shortest driving route. If the distance exceeds 20 miles, no adjustment shall be made;

(3) subtract the value in clause (2) from 20 miles, divide by 20, and convert to a percentage; and

(4) increase the limits for the nursing facility with the lower limits by the value determined in clause (1) multiplied by the value determined in clause (3).

(b) Effective October 1, 2011, nursing facilities located no more than one-quarter mile from a peer group with higher limits under either subdivision 50 or 51, may receive an operating rate adjustment. The operating payment rates of a lower-limit peer group facility must be adjusted to be equal to those of the nearest facility in a higher-limit peer group if that facility's RUG rate with a weight of 1.00 is higher than the lower-limit peer group facility. Peer groups are those defined in subdivision 30. The nearest facility must be determined by the most direct driving route.

Subd. 52. **Determination of efficiency incentive.** Each facility shall be eligible for an efficiency incentive based on its other operating per diem. A facility with an other operating per diem that exceeds the limit in subdivision 51 shall receive no efficiency incentive. All other facilities shall receive an incentive calculated as 50 percent times the difference between the facility's other operating per diem and its other operating per diem limit, up to a maximum incentive of \$3.

Subd. 55. **Phase-in of rebased operating payment rates.** (a) For the rate years beginning October 1, 2008, to October 1, 2015, the operating payment rate calculated under this section shall be phased in by blending the operating rate with the operating payment rate determined under section 256B.434. For purposes of this subdivision, the rate to be used that is determined under section 256B.434 shall not include the portion of the operating payment rate related to performance-based incentive payments under section 256B.434, subdivision 4, paragraph (d). For the rate year beginning October 1, 2008, the operating payment rate for each facility shall be 13 percent of the operating payment rate from this section, and 87 percent of the operating

APPENDIX

Repealed Minnesota Statutes: S1458-3

payment rate from section 256B.434. For the rate period from October 1, 2009, to September 30, 2013, no rate adjustments shall be implemented under this section, but shall be determined under section 256B.434. For the rate year beginning October 1, 2013, the operating payment rate for each facility shall be 65 percent of the operating payment rate from this section, and 35 percent of the operating payment rate from section 256B.434. For the rate year beginning October 1, 2014, the operating payment rate for each facility shall be 82 percent of the operating payment rate from this section, and 18 percent of the operating payment rate from section 256B.434. For the rate year beginning October 1, 2015, the operating payment rate for each facility shall be the operating payment rate determined under this section. The blending of operating payment rates under this section shall be performed separately for each RUG's class.

(b) For the rate year beginning October 1, 2008, the commissioner shall apply limits to the operating payment rate increases under paragraph (a) by creating a minimum percentage increase and a maximum percentage increase.

(1) Each nursing facility that receives a blended October 1, 2008, operating payment rate increase under paragraph (a) of less than one percent, when compared to its operating payment rate on September 30, 2008, computed using rates with RUG's weight of 1.00, shall receive a rate adjustment of one percent.

(2) The commissioner shall determine a maximum percentage increase that will result in savings equal to the cost of allowing the minimum increase in clause (1). Nursing facilities with a blended October 1, 2008, operating payment rate increase under paragraph (a) greater than the maximum percentage increase determined by the commissioner, when compared to its operating payment rate on September 30, 2008, computed using rates with a RUG's weight of 1.00, shall receive the maximum percentage increase.

(3) Nursing facilities with a blended October 1, 2008, operating payment rate increase under paragraph (a) greater than one percent and less than the maximum percentage increase determined by the commissioner, when compared to its operating payment rate on September 30, 2008, computed using rates with a RUG's weight of 1.00, shall receive the blended October 1, 2008, operating payment rate increase determined under paragraph (a).

(4) The October 1, 2009, through October 1, 2015, operating payment rate for facilities receiving the maximum percentage increase determined in clause (2) shall be the amount determined under paragraph (a) less the difference between the amount determined under paragraph (a) for October 1, 2008, and the amount allowed under clause (2). This rate restriction does not apply to rate increases provided in any other section.

(c) A portion of the funds received under this subdivision that are in excess of operating payment rates that a facility would have received under section 256B.434, as determined in accordance with clauses (1) to (3), shall be subject to the requirements in section 256B.434, subdivision 19, paragraphs (b) to (h).

(1) Determine the amount of additional funding available to a facility, which shall be equal to total medical assistance resident days from the most recent reporting year times the difference between the blended rate determined in paragraph (a) for the rate year being computed and the blended rate for the prior year.

(2) Determine the portion of all operating costs, for the most recent reporting year, that are compensation related. If this value exceeds 75 percent, use 75 percent.

(3) Subtract the amount determined in clause (2) from 75 percent.

(4) The portion of the fund received under this subdivision that shall be subject to the requirements in section 256B.434, subdivision 19, paragraphs (b) to (h), shall equal the amount determined in clause (1) times the amount determined in clause (3).

Subd. 58. **Implementation delay.** Within six months prior to the effective date of (1) rebasing of property payment rates under subdivision 1; (2) quality-based rate limits under subdivision 50; and (3) the removal of planned closure rate adjustments and single bed room incentives from external fixed costs under subdivision 53, the commissioner shall compare the average operating cost for all facilities combined from the most recent cost reports to the average medical assistance operating payment rates for all facilities combined from the same time period. Each provision shall not go into effect until the average medical assistance operating payment rate is at least 92 percent of the average operating cost. The rebasing of property payment rates under subdivision 1, and the removal of planned closure rate adjustments and single-bed room incentives from external fixed costs under subdivision 53 shall not go into effect until 82 percent of the operating payment rate from this section is phased in as described in subdivision 55.

APPENDIX

Repealed Minnesota Statutes: S1458-3

Subd. 62. **Repeal of rebased operating payment rates.** Notwithstanding subdivision 54 or 55, no further steps toward phase-in of rebased operating payment rates shall be taken.

256B.69 PREPAID HEALTH PLANS.

Subd. 32. **Initiatives to reduce incidence of low birth weight.** The commissioner shall require managed care and county-based purchasing plans, as a condition of contract, to implement strategies to reduce the incidence of low birth weight in geographic areas identified by the commissioner as having a higher than average incidence of low birth weight. The strategies must coordinate health care with social services and the local public health system. Each plan shall develop and report to the commissioner outcome measures related to reducing the incidence of low birth weight. The commissioner shall consider the outcomes reported when considering plan participation in the competitive bidding program established under subdivision 33.

256D.0513 BUDGETING LUMP SUMS.

Effective January 1, 1998, nonrecurring lump-sum income received by a recipient of general assistance must be budgeted in the normal retrospective cycle.

256D.06 AMOUNT OF ASSISTANCE.

Subd. 8. **Recovery of ATM errors.** For recipients receiving benefits via electronic benefit transfer, if the recipient is overpaid as a result of an automated teller machine (ATM) dispensing funds in error to the recipient, the agency may recover the ATM error by immediately withdrawing funds from the recipient's electronic benefit transfer account, up to the amount of the error.

256D.09 PAYMENT; ASSESSMENT; OVERPAYMENT.

Subd. 6. **Recovery of overpayments.** (a) If an amount of general assistance or family general assistance is paid to a recipient in excess of the payment due, it shall be recoverable by the county agency. The agency shall give written notice to the recipient of its intention to recover the overpayment.

(b) Except as provided for interim assistance in section 256D.06, subdivision 5, when an overpayment occurs, the county agency shall recover the overpayment from a current recipient by reducing the amount of aid payable to the assistance unit of which the recipient is a member, for one or more monthly assistance payments, until the overpayment is repaid. All county agencies in the state shall reduce the assistance payment by three percent of the assistance unit's standard of need in nonfraud cases and ten percent where fraud has occurred, or the amount of the monthly payment, whichever is less, for all overpayments.

(c) In cases when there is both an overpayment and underpayment, the county agency shall offset one against the other in correcting the payment.

(d) Overpayments may also be voluntarily repaid, in part or in full, by the individual, in addition to the aid reductions provided in this subdivision, to include further voluntary reductions in the grant level agreed to in writing by the individual, until the total amount of the overpayment is repaid.

(e) The county agency shall make reasonable efforts to recover overpayments to persons no longer on assistance under standards adopted in rule by the commissioner of human services. The county agency need not attempt to recover overpayments of less than \$35 paid to an individual no longer on assistance if the individual does not receive assistance again within three years, unless the individual has been convicted of violating section 256.98.

(f) Establishment of an overpayment is limited to 12 months prior to the month of discovery due to agency error and six years prior to the month of discovery due to client error or an intentional program violation determined under section 256.046.

256D.49 PAYMENT CORRECTION.

Subdivision 1. **When.** When the county agency finds that the recipient has received less than or more than the correct payment of Minnesota supplemental aid benefits, the county agency shall issue a corrective payment or initiate recovery under subdivision 3, as appropriate.

Subd. 2. **Underpayment of monthly grants.** When the county agency determines that an underpayment of the recipient's monthly payment has occurred, it shall, during that same month, issue a corrective payment. Corrective payments must be excluded when determining the applicant's or recipient's income and resources for the month of payment.

APPENDIX

Repealed Minnesota Statutes: S1458-3

Subd. 3. **Overpayment of monthly grants and recovery of ATM errors.** (a) When the county agency determines that an overpayment of the recipient's monthly payment of Minnesota supplemental aid has occurred, it shall issue a notice of overpayment to the recipient. If the person is no longer receiving Minnesota supplemental aid, the county agency may request voluntary repayment or pursue civil recovery. If the person is receiving Minnesota supplemental aid, the county agency shall recover the overpayment by withholding an amount equal to three percent of the standard of assistance for the recipient or the total amount of the monthly grant, whichever is less.

(b) Establishment of an overpayment is limited to 12 months from the date of discovery due to agency error. Establishment of an overpayment is limited to six years prior to the month of discovery due to client error or an intentional program violation determined under section 256.046.

(c) For recipients receiving benefits via electronic benefit transfer, if the overpayment is a result of an automated teller machine (ATM) dispensing funds in error to the recipient, the agency may recover the ATM error by immediately withdrawing funds from the recipient's electronic benefit transfer account, up to the amount of the error.

(d) Residents of licensed residential facilities shall not have overpayments recovered from their personal needs allowance.

256J.38 CORRECTION OF OVERPAYMENTS AND UNDERPAYMENTS.

Subdivision 1. **Scope of overpayment.** (a) When a participant or former participant receives an overpayment due to agency, client, or ATM error, or due to assistance received while an appeal is pending and the participant or former participant is determined ineligible for assistance or for less assistance than was received, the county agency must recoup or recover the overpayment using the following methods:

- (1) reconstruct each affected budget month and corresponding payment month;
- (2) use the policies and procedures that were in effect for the payment month; and
- (3) do not allow employment disregards in section 256J.21, subdivision 3 or 4, in the calculation of the overpayment when the unit has not reported within two calendar months following the end of the month in which the income was received.

(b) Establishment of an overpayment is limited to 12 months prior to the month of discovery due to agency error. Establishment of an overpayment is limited to six years prior to the month of discovery due to client error or an intentional program violation determined under section 256.046.

Subd. 2. **Notice of overpayment.** When a county agency discovers that a participant or former participant has received an overpayment for one or more months, the county agency must notify the participant or former participant of the overpayment in writing. A notice of overpayment must specify the reason for the overpayment, the authority for citing the overpayment, the time period in which the overpayment occurred, the amount of the overpayment, and the participant's or former participant's right to appeal. No limit applies to the period in which the county agency is required to recoup or recover an overpayment according to subdivisions 3 and 4.

Subd. 3. **Recovering overpayments.** A county agency must initiate efforts to recover overpayments paid to a former participant or caregiver. Caregivers, both parental and nonparental, and minor caregivers of an assistance unit at the time an overpayment occurs, whether receiving assistance or not, are jointly and individually liable for repayment of the overpayment. The county agency must request repayment from the former participants and caregivers. When an agreement for repayment is not completed within six months of the date of discovery or when there is a default on an agreement for repayment after six months, the county agency must initiate recovery consistent with chapter 270A, or section 541.05. When a person has been convicted of fraud under section 256.98, recovery must be sought regardless of the amount of overpayment. When an overpayment is less than \$35, and is not the result of a fraud conviction under section 256.98, the county agency must not seek recovery under this subdivision. The county agency must retain information about all overpayments regardless of the amount. When an adult, adult caregiver, or minor caregiver reapplies for assistance, the overpayment must be recouped under subdivision 4.

Subd. 4. **Recouping overpayments from participants.** A participant may voluntarily repay, in part or in full, an overpayment even if assistance is reduced under this subdivision, until the total amount of the overpayment is repaid. When an overpayment occurs due to fraud, the county agency must recover from the overpaid assistance unit, including child only cases, ten percent of the applicable standard or the amount of the monthly assistance payment, whichever is less. When a nonfraud overpayment occurs, the county agency must recover from the overpaid assistance unit, including child only cases, three percent of the MFIP standard of need or the amount of the monthly assistance payment, whichever is less.

APPENDIX

Repealed Minnesota Statutes: S1458-3

Subd. 5. **Recovering automatic teller machine errors.** For recipients receiving benefits via electronic benefit transfer, if the overpayment is a result of an ATM dispensing funds in error to the recipient, the agency may recover the ATM error by immediately withdrawing funds from the recipient's electronic benefit transfer account, up to the amount of the error.

Subd. 6. **Scope of underpayments.** A county agency must issue a corrective payment for underpayments made to a participant or to a person who would be a participant if an agency or client error causing the underpayment had not occurred. Corrective payments are limited to 12 months prior to the month of discovery. The county agency must issue the corrective payment according to subdivision 8.

Subd. 7. **Identifying the underpayment.** An underpayment may be identified by a county agency, by a participant, by a former participant, or by a person who would be a participant except for agency or client error.

Subd. 8. **Issuing corrective payments.** A county agency must correct an underpayment within seven calendar days after the underpayment has been identified, by adding the corrective payment amount to the monthly assistance payment of the participant or by issuing a separate payment to a participant or former participant, or by reducing an existing overpayment balance. When an underpayment occurs in a payment month and is not identified until the next payment month or later, the county agency must first subtract the underpayment from any overpayment balance before issuing the corrective payment. The county agency must not apply an underpayment in a current payment month against an overpayment balance. When an underpayment in the current payment month is identified, the corrective payment must be issued within seven calendar days after the underpayment is identified.

Subd. 9. **Appeals.** A participant may appeal an underpayment, an overpayment, and a reduction in an assistance payment made to recoup the overpayment under subdivision 4. The participant's appeal of each issue must be timely under section 256.045. When an appeal based on the notice issued under subdivision 2 is not timely, the fact or the amount of that overpayment must not be considered as a part of a later appeal, including an appeal of a reduction in an assistance payment to recoup that overpayment.

256L.02 PROGRAM ADMINISTRATION.

Subd. 3. **Financial management.** (a) The commissioner shall manage spending for the MinnesotaCare program in a manner that maintains a minimum reserve. As part of each state revenue and expenditure forecast, the commissioner must make an assessment of the expected expenditures for the covered services for the remainder of the current biennium and for the following biennium. The estimated expenditure, including the reserve, shall be compared to an estimate of the revenues that will be available in the health care access fund. Based on this comparison, and after consulting with the chairs of the house of representatives Ways and Means Committee and the senate Finance Committee, the commissioner shall, as necessary, make the adjustments specified in paragraph (b) to ensure that expenditures remain within the limits of available revenues for the remainder of the current biennium and for the following biennium. The commissioner shall not hire additional staff using appropriations from the health care access fund until the commissioner of management and budget makes a determination that the adjustments implemented under paragraph (b) are sufficient to allow MinnesotaCare expenditures to remain within the limits of available revenues for the remainder of the current biennium and for the following biennium.

(b) The adjustments the commissioner shall use must be implemented in this order: first, stop enrollment of single adults and households without children; second, upon 45 days' notice, stop coverage of single adults and households without children already enrolled in the MinnesotaCare program; third, upon 90 days' notice, decrease the premium subsidy amounts by ten percent for families with gross annual income above 200 percent of the federal poverty guidelines; fourth, upon 90 days' notice, decrease the premium subsidy amounts by ten percent for families with gross annual income at or below 200 percent; and fifth, require applicants to be uninsured for at least six months prior to eligibility in the MinnesotaCare program. If these measures are insufficient to limit the expenditures to the estimated amount of revenue, the commissioner shall further limit enrollment or decrease premium subsidies.

256L.05 APPLICATION PROCEDURES.

Subd. 1b. **MinnesotaCare enrollment by county agencies.** Beginning September 1, 2006, county agencies shall enroll single adults and households with no children formerly enrolled in general assistance medical care in MinnesotaCare according to Minnesota Statutes

APPENDIX

Repealed Minnesota Statutes: S1458-3

2009 Supplement, section 256D.03, subdivision 3. County agencies shall perform all duties necessary to administer the MinnesotaCare program ongoing for these enrollees, including the redetermination of MinnesotaCare eligibility at renewal.

Subd. 1c. **Open enrollment and streamlined application and enrollment process.**

Subd. 3c. **Retroactive coverage.** Notwithstanding subdivision 3, the effective date of coverage shall be the first day of the month following termination from medical assistance for families and individuals who are eligible for MinnesotaCare and who submitted a written request for retroactive MinnesotaCare coverage with a completed application within 30 days of the mailing of notification of termination from medical assistance. The applicant must provide all required verifications within 30 days of the written request for verification. For retroactive coverage, premiums must be paid in full for any retroactive month, current month, and next month within 30 days of the premium billing. This subdivision does not apply, and shall not be implemented by the commissioner, once eligibility determination for MinnesotaCare is conducted by the MNsure eligibility determination system.

Subd. 5. **Availability of private insurance.** The commissioner, in consultation with the commissioners of health and commerce, shall provide information regarding the availability of private health insurance coverage and the possibility of disenrollment under section 256L.07, subdivision 1, to all: (1) families enrolled in the MinnesotaCare program whose gross family income is equal to or more than 225 percent of the federal poverty guidelines; and (2) single adults and households without children enrolled in the MinnesotaCare program whose gross family income is equal to or more than 165 percent of the federal poverty guidelines. This information must be provided upon initial enrollment and annually thereafter. The commissioner shall also include information regarding the availability of private health insurance coverage in the notice of ineligibility provided to persons subject to disenrollment under section 256L.07, subdivision 1.

Laws 2012, chapter 247, article 4, section 47, as amended by Laws 2014, chapter 312, article 27, section 72

Sec. 72. Laws 2012, chapter 247, article 4, section 47, is amended to read:

Sec. 47. COMMISSIONER TO SEEK AMENDMENT FOR EXCEPTION TO CONSUMER-DIRECTED COMMUNITY SUPPORTS BUDGET METHODOLOGY.

By July 1, 2014, if necessary, the commissioner shall request an amendment to the home and community-based services waivers authorized under Minnesota Statutes, sections 256B.092 and 256B.49, to establish an exception to the consumer-directed community supports budget methodology to provide up to 20 percent more funds for those participants who have their 21st birthday and graduate from high school between 2013 to 2015 and are authorized for more services under consumer-directed community supports prior to graduation than the amount they are eligible to receive under the current consumer-directed community supports budget methodology. The exception is limited to those who can demonstrate that they will have to leave consumer-directed community supports and use other waiver services because their need for day or employment supports cannot be met within the consumer-directed community supports budget limits. The commissioner shall consult with the stakeholder group authorized under Minnesota Statutes, section 256B.0657, subdivision 11, to implement this provision. The exception process shall be effective upon federal approval for persons eligible through June 30, 2017.

3400.0170 INCOME ELIGIBILITY FOR CHILD CARE ASSISTANCE.

Subp. 5. **Earned income of wage and salary employees.** Earned income means earned income from employment before mandatory and voluntary payroll deductions. Earned income includes, but is not limited to, salaries, wages, tips, gratuities, commissions, incentive payments from work or training programs, payments made by an employer for regularly accrued vacation or sick leave, payment for jury duty, and profits from other activity earned by an individual's effort or labor. Earned income includes uniform, mileage, and meal allowances if federal income tax is deducted from the allowance. Earned income includes flexible work benefits received from an employer if the employee has the option of receiving the benefit or benefits in cash. Earned income received by persons employed on a contractual basis must be prorated over the period covered by the contract even when payments are received over a lesser period of time. When housing is provided as part of the total work compensation, the fair market value of such housing shall be considered as if it were paid in cash.

3400.0170 INCOME ELIGIBILITY FOR CHILD CARE ASSISTANCE.

Subp. 6. **Excluded income.** The administering agency shall exclude items A to H from annual income:

- A. scholarships, work-study income, and grants that cover costs or reimburse for tuition, fees, books, and educational supplies;
- B. student loans for tuition, fees, books, supplies, and living expenses;
- C. state and federal earned income tax credits, in-kind noncash public assistance income such as food stamps or food support, energy assistance, foster care assistance, child care assistance, medical assistance, and housing subsidies;
- D. earned income of full-time or part-time students up to the age of 19 who have not earned a high school diploma or GED high school equivalency diploma, including earnings from summer employment;
- E. grant awards under the family subsidy program;
- F. nonrecurring lump sum income that is earmarked and used for the purpose for which it is paid;
- G. supplemental security income; and
- H. income assigned to the public authority under Minnesota Statutes, section 256.741.

3400.0170 INCOME ELIGIBILITY FOR CHILD CARE ASSISTANCE.

Subp. 12. **Determination of unearned income.** Unearned income includes, but is not limited to, the cash portion of MFIP or DWP; adoption assistance; relative custody assistance received under Minnesota Statutes, section 257.85; interest; dividends; unemployment compensation; disability insurance payments; veteran benefits; pension payments; child support and spousal support received or anticipated to be received by a family including child support and maintenance distributed to the family under Minnesota Statutes, section 256.741, subdivision 15; insurance payments or settlements; retirement; survivor's and disability insurance (RSDI) payment; and severance payments. Expenditures necessary to secure payment of unearned income are deducted from unearned income. Payments for illness or disability, except for those payments described as earned income in subpart 5, are considered unearned income whether the premium payments are made wholly or in part by an employer or by a recipient.

3400.0170 INCOME ELIGIBILITY FOR CHILD CARE ASSISTANCE.

Subp. 13. **Treatment of lump-sum payments.** Lump-sum payments received by a family must be considered earned income under subparts 7 to 11 or unearned income according to subpart 12. Nonrecurring lump sums that are earmarked and used for the purpose for which they are paid are not to be included in the determination of income. All other lump sums are to be annualized over 12 months. The sale of property including, but not limited to, a residence is not considered income up to the amount of the original purchase price plus improvements.

8840.5900 DRIVER QUALIFICATIONS.

Subp. 12. **Criminal record.** A driver must not have a criminal record for which the person was convicted of or pled guilty to, either crimes against persons or crimes reasonably related to providing special transportation services.

APPENDIX
Repealed Minnesota Rule: S1458-3

A. For purposes of this subpart, "criminal record" means the conviction records of the Minnesota Bureau of Criminal Apprehension or other states' criminal history repository in which the last date of discharge from the criminal justice system is less than 15 years.

B. Conviction has the meaning given it in Minnesota Statutes, section 171.01, subdivision 29.

C. Criminal record and driving record includes a conviction, suspension, cancellation, or revocation for a crime in another jurisdiction that would be a violation under this part.

D. The following offenses are considered crimes against persons or reasonably related to providing special transportation services, or both:

- (1) Minnesota Statutes, section 609.17, attempts;
- (2) Minnesota Statutes, section 609.175, conspiracy;
- (3) Minnesota Statutes, section 609.185, murder in the first degree;
- (4) Minnesota Statutes, section 609.19, murder in the second degree;
- (5) Minnesota Statutes, section 609.195, murder in the third degree;
- (6) Minnesota Statutes, section 609.20, manslaughter in the first degree;
- (7) Minnesota Statutes, section 609.205, manslaughter in the second degree;
- (8) Minnesota Statutes, section 609.2112, 609.2113, or 609.2114, or Minnesota Statutes 2012, section 609.21, criminal vehicular homicide and injury;
- (9) Minnesota Statutes, section 609.215, suicide;
- (10) Minnesota Statutes, section 609.221, assault in the first degree;
- (11) Minnesota Statutes, section 609.222, assault in the second degree;
- (12) Minnesota Statutes, section 609.223, assault in the third degree;
- (13) Minnesota Statutes, section 609.2231, assault in the fourth degree;
- (14) Minnesota Statutes, section 609.224, assault in the fifth degree;
- (15) Minnesota Statutes, section 609.228, great bodily harm caused by distribution of drugs;
- (16) Minnesota Statutes, section 609.23, mistreatment of persons confined;
- (17) Minnesota Statutes, section 609.231, mistreatment of residents or patients;
- (18) Minnesota Statutes, section 609.235, use of drugs to injure or facilitate crime;
- (19) Minnesota Statutes, section 609.24, simple robbery;
- (20) Minnesota Statutes, section 609.245, aggravated robbery;
- (21) Minnesota Statutes, section 609.25, kidnapping;
- (22) Minnesota Statutes, section 609.255, false imprisonment;
- (23) Minnesota Statutes, section 609.265, abduction;
- (24) Minnesota Statutes, section 609.2661, murder of an unborn child in the first degree;
- (25) Minnesota Statutes, section 609.2662, murder of an unborn child in the second degree;
- (26) Minnesota Statutes, section 609.2663, murder of an unborn child in the third degree;
- (27) Minnesota Statutes, section 609.2664, manslaughter of an unborn child in the first degree;
- (28) Minnesota Statutes, section 609.2665, manslaughter of an unborn child in the second degree;
- (29) Minnesota Statutes, section 609.267, assault of an unborn child in the first degree;
- (30) Minnesota Statutes, section 609.2671, assault of an unborn child in the second degree;
- (31) Minnesota Statutes, section 609.2672, assault of an unborn child in the third degree;
- (32) Minnesota Statutes, section 609.268, injury or death of an unborn child in the commission of a crime;
- (33) Minnesota Statutes, section 609.322, solicitation, inducement, and promotion of prostitution;
- (34) Minnesota Statutes, section 609.323, receiving profit from prostitution;

APPENDIX
Repealed Minnesota Rule: S1458-3

- (35) Minnesota Statutes, section 609.324, subdivisions 1 and 1a, other prohibited acts;
- (36) Minnesota Statutes, section 609.33, disorderly house;
- (37) Minnesota Statutes, section 609.342, criminal sexual conduct in the first degree;
- (38) Minnesota Statutes, section 609.343, criminal sexual conduct in the second degree;
- (39) Minnesota Statutes, section 609.344, criminal sexual conduct in the third degree;
- (40) Minnesota Statutes, section 609.345, criminal sexual conduct in the fourth degree;
- (41) Minnesota Statutes, section 609.3451, criminal sexual conduct in the fifth degree;
- (42) Minnesota Statutes, section 609.352, solicitation of children to engage in sexual conduct;
- (43) Minnesota Statutes, section 609.365, incest;
- (44) Minnesota Statutes, section 609.377, malicious punishment of a child;
- (45) Minnesota Statutes, section 609.378, neglect or endangerment of a child;
- (46) Minnesota Statutes, section 609.498, tampering with a witness;
- (47) Minnesota Statutes, section 609.52, felony theft;
- (48) Minnesota Statutes, section 609.561, arson in the first degree;
- (49) Minnesota Statutes, section 609.582, subdivisions 1 and 2, burglary;
- (50) Minnesota Statutes, section 609.713, terroristic threats;
- (51) Minnesota Statutes, section 609.749, nonfelony, harassment and stalking;
- (52) Minnesota Statutes, section 617.23, indecent exposure;
- (53) Minnesota Statutes, section 617.241, obscene materials and performances;
- (54) Minnesota Statutes, section 617.243, indecent literature, distribution;
- (55) Minnesota Statutes, section 617.246, use of minors in sexual performance;
- (56) Minnesota Statutes, section 617.247, possession of pictorial representations of minors;
- (57) Minnesota Statutes, section 617.293, harmful materials; dissemination and display to minors; and
- (58) felony convictions under Minnesota Statutes, chapter 152, prohibited drugs.

8840.5900 DRIVER QUALIFICATIONS.

Subp. 14. **Provider responsibility; driver's traffic and criminal record.** Before using or hiring a driver to provide special transportation service, a provider must obtain and review the driving and criminal records of a driver. In addition, a provider shall annually review the driving and criminal record of a driver it uses or employs.

A. The driving and criminal record review must include an examination of the records of the Department of Public Safety, Division of Driver and Vehicle Services, to determine if the driver meets the standards of subparts 9, 10, and 11. The review must also include an examination of the conviction records of the Minnesota Bureau of Criminal Apprehension to determine if the driver has a criminal record of convictions for crimes listed in subpart 12.

B. A provider satisfies the requirements of this subpart by obtaining a background check from the Minnesota Bureau of Criminal Apprehension. A private business or local law enforcement agency may be used for conducting the criminal background check if the review consists of an examination of the records of the Minnesota Bureau of Criminal Apprehension.

C. If a person has resided in Minnesota for less than ten years, the provider shall also conduct a search of the criminal history repository records in each state where the person has resided for the preceding ten years.

D. If a person has held a driver's license in a state other than Minnesota for the preceding three years, the provider shall review the driving record in each state where the person has held a driver's license for the preceding three-year period.